INCORPORATION OF THE TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM

MARTHA GELEMETE PINKOANE

M. CUR (PU VIR CHO); B. CUR. I et A (UNIN) ; DIPLOMA NURSING (GENERAL AND MIDWIFERY)

Thesis presented for the degree

DOCTOR PHILOSOPHIAE (COMMUNITY NURSING)

in the

SCHOOL OF NURSING SCIENCE

at the

POTCHEFSTROOM CAMPUS OF THE NORTH-WEST UNIVERSITY

Study Leader: Prof. Dr. Minrie Greeff
Co-Leader: Prof. Dr. M.P.Koen
School of Nursing Science
Potchefstroom

November 2005

RESEARCH OUTLINE

The research is presented in an article format including the following:

1. An overview of the research and annexures
2. Six article as follows:

Article Title	Journal Submitted to
Article 1: Models for the incorporation of traditional healers into the National Health Care Delivery System: A literature review	Ethnicity and Health
Article 2: The traditional healers' perceptions and attitudes regarding their incorporation into the National Health Care Delivery System of South Africa	Ethnicity and Health
Article 3: The biomedical personnel's perceptions and attitudes regarding the incorporation of traditional healers into the National Health Care Delivery System of South Africa	Social Science and Medicine
Article 4: The patients' perceptions and attitudes regarding the incorporation of traditional healers into the National Health Care Delivery System of South Africa	South African Family Practice
Article 5: The policy makers' perceptions and attitudes regarding the incorporation of traditional healers into the National health Care Delivery System of South Africa	Curationis
Article 6: A model for incorporation of the traditional healers into the National Health Care Delivery System of South Africa: Theory generation	Social Science and Medicine

3. Conclusions, shortcomings, and recommendations for the incorporation of traditional healers into the National Health Care Delivery System of South Africa.

AUTHORS' CONTRIBUTION

This study has been planned and carried out by three researchers from the School of Nursing Science at the Potchefstroom Campus of the North-West University. Each researcher's contribution is listed in the table below.

Ms M.G. Pinkoane	Ph. D student, responsible for literature study, conducting a pilot study implementing the research process and writing the text
Prof. Dr. M. Greeff Ph. D. Psychiatric Nursing Science	Promoter, supervisor, and critical reviewer of the study
Prof. Dr. M.P. Koen Ph. D. Professional Nursing	Co–Promoter, assistant supervisor, and critical reviewer of the study

The following statement is a declaration by the co authors to confirm their role in the study and agree to its nature of being in an article format for binding as a thesis.

A declaration:

I hereby declare that I have approved the inclusion of all six (6) articles mentioned above in this thesis and that my role in this study complies with what is described above. I hereby give consent that these articles may be published as part of the Ph . D thesis of Ms Martha G. Pinkoane.

_____

Prof. Dr. M. Greeff

_____

Prof. Dr. M. P. Koen

In honour of Mme her work and the contribution she made to the lives of those who knew her as a resourceful person.

ACKNOWLEDGEMENTS
WORD OF THANKS TO THE FOLLOWING

- My children Letticia, Lehlohonolo and Nthabiseng, the brains in my life, and for bearing the heavy "cross" with me, you are my most loving assets and it is for you that I had to toil for this.
- My navigator Tsietsi for driving me tirelessly across rivers, valleys and over mountains, your contribution is immeasurable.
- My husband for taking care of the children.
- Mr Selole Maelangoe for being a supporting pinnacle of strength.
- Lezyda Venter and Charmaine van der Westhuizen for unending practical and friendly help.
- Participants in the three Provinces and towns of Gauteng, North West and Free State without whom this research would not have been realised.
- The Vaal University of Technology, interlibrary loans for all data;
  research directorate for financial assistance throughout my studies;
  graphic department for illustrations.
- The Automobile Association of South Africa in Vanderbijlpark, for road maps and advise on how to access all areas in the three provinces.
- The Catography Department of North-West University for mapping out all areas in the three provinces.
- Ms Henriette Visser and Dr Amanda van der Merwe for editing.
- Ms. U. Terreblanche and C. Grobelaar for technical and Afrikaans translation.
- Ms Mookho Makhale for your hands that produced wonders, when mine failed.
- Ms. Emmarentia du Plessis for acting as a co-coder, you are always there.
- Prof. Dr. Daleen Koen for encouragement, and continuous support, you are a star.
- Prof. Dr. Minrie Greeff for believing in me, supporting and bringing out the best in me. God bless us all for having come this far.

WORK HARD AND REAP THE FRUITS OF YOUR LABOUR

ABSTRACT

The process for the incorporation, integration or collaboration of traditional healers into the National Health Care Delivery System of South Africa was marred by an array of mixed attitudes from all the parties concerned, namely traditional healers, patients, biomedical personnel, and the policy makers. The variety of approaches for inclusion of the traditional healers into the National Health Care System of South Africa was a further indication of the complexity of the situation. The possibility of functioning together between traditional healers and biomedical personnel existed before 1990 when the two groups met in Johannesburg in 1986 to discuss ways by which functioning together can be established. A series of meetings and discussions followed after which came the promulgation of the Chiropractors Homeopaths and Allied Health Services Professionals Act of 1996, which gives traditional healers their due recognition but does not include them as part of health care providers.

The process of functioning together is a recommendation made by the World Health Organization and the most used terms for this functioning together is, incorporation, integration and collaboration. The process of incorporation can be realised by ensuring that both biomedical personnel and traditional healers remain autonomous, not controlling each other, respecting the existence of one another, as well as each other's own methods of healing.

Integration was another method whereby the two health care systems can function together, even though integration differs in context from incorporation. Integration means that the traditional healers will have to function within the health care system under the directions of the biomedical personnel, whereby the patient receives a combination of both treatment methods depending on the problem or diagnosis. The third modality of getting the two health care systems to function together could be by collaboration. Collaboration was seen as a two sided effort whereby the healing methods of one are brought to fore and the most effective one is chosen to cure the patient's identified

problem at that time. For the process of functioning together to be meaningful, it was necessary to get the government to review licensing the traditional healer's practices, so as to identify the healing techniques that are of value and use these to treat the patients.

It was not really possible to clearly separate the three approaches because they all addressed the issue of having the two health care systems function together to increase health care services and fulfil the patients' health needs. For the purpose of this research the word incorporation was used.

In South Africa the traditional healer is identified as the health care choice of 80-90% of the black population. If this large number of black people uses traditional healing, then it becomes necessary to investigate the manner in which the traditional healer can be utilized effectively in the National Health Care Delivery System of South Africa to render the services that the patient needs for his/her health needs. It is for this reason that the researcher aimed at investigating the existing models of incorporation of traditional healers, the perceptions and attitudes of the traditional healers, biomedical personnel, patients and the policy makers regarding incorporation, their views on how this incorporation should be achieved, as well as how the incorporation of traditional healers into the National Health Care Delivery System of South Africa could be realised.

A qualitative research design and theory generating approach was followed, and the research was conducted in two stages. In stage one qualitative research, participants were traditional healers, biomedical personnel, patients and policy makers, selected by means of non-probable purposive voluntary sampling. Data was collected by means of conducting semi-structured interviews with all the participants in the three identified provinces of South Africa. Field notes were recorded after each interview session. Data analysis was achieved by open coding. A co-coder and the researcher analysed the data independently after which consensus discussions took place to finalise the analysed data. Ethical principles were applied according to the guidelines of the Democratic Nurses Organisation of South Africa and the Department of Health. The second stage which was

a theory generation approach, was used to formulate a model for the incorporation of the traditional healers into the National Health Care Delivery System of South African.

Key terminology: incorporation; integration; collaboration; biomedical personnel; traditional healer; patients; policy makers; National Health Care Delivery System; traditional medicine; biomedicine; model; theory.

OPSOMMING

Die proses vir die inlywing, inskakeling en samewerking van tradisionele genesers by die Nasionale Gesondheidsorg Sisteem van Suid Afrika is gekenmerk deur gemengde standpunte van al die betrokke partye, naamlik, tradisionele genesers, biomediese personeel, pasiënte, en beleidmakers. Die verskeie benaderings tot die insluiting van tradisionele genesers in die Nasionale Gesondheidsorg Sisteem, is 'n verdere aanduiding van die kompleksiteit van die situasie. Die moontlikheid van samewerking tussen die tradisionele genesers en biomediese personeel het reeds voor 1990 ontstaan toe die twee groepe in 1986 in Johannesburg ontmoet het, met die doel om vas te stel op watter wyse hulle saam kan funksioneer. Hierna het verskeie vergaderings en samesprekings gevolg waarna die wet op *Chiropractors Homeopaths and Allied Health Services Professionals Act of 1996,* gepromulgeer is. Hierdie stap gun die tradisionele genesers hul regmatige erkenning, alhoewel hulle nie ingesluit word as gesondheidsorg voorsieners nie.

'n Proses van samewerking is aanbeveel deur die Wêreld Gesondheid Organisasie en die mees algemene terme wat gebruik word om dit in werking te stel is, inlywing, inskakeling en samewerking. Die proses van inlywing kan bereik word deur te verseker dat beide biomediese personeel en tradisionele genesers outonoom bly, nie beheer oor mekaar uitoefen nie en wedersydse respek betoon teenoor die onderskeie metodes van genesing.

Inskakeling is 'n ander metode waardeur die twee gesondheidsorg sisteme saam kan funksioneer, alhoewel inskakeling in konteks verskil van inlywing. Inskakeling beteken dat tradisionele genesers moet funksioneer binne die gesondheidsorg sisteem, onder die toesig van biomediese personeel en die pasiënt 'n kombinasie van behandeling sal ontvang na gelang van die probleem of diagnose.

Die derde metode waarvolgens die twee gesondheidsorg sisteme saam kan funksioneer is deur samewerking. Samewerking word gesien as 'n tweesydige metode waardeur die genesingsmetodes van een na vore gebring word en die mees effektiewe metode

geïdentifiseer word om die pasiënt te behandel. Vir die proses van samewerking om betekenisvol te wees, is dit belangrik dat die regering die lisensiëring van tradisionele genesers hersien, om sodoende die waardevolle genesende tegnieke te identifiseer en om pasiënte te behandel.

Dit is nie moontlik om 'n duidelike onderskeid te tref tussen die drie benaderings nie, aangesien die uitgangspunt dat twee gesondheidsorg sisteme saam moet funksioneer om die beste gesondheid sorg vir pasiënte daar te stel, deur al drie onderskryf word. Vir die doel van hierdie navorsing word die woord inlywing gebruik.

In SA word die tradisionele genesing geïdentifiseer as die gesondheidsorg keuse van 80-90 % van die swart bevolking. Wanneer so 'n groot persentasie van die bogenoemde bevolkingsgroep van tradisionele genesing gebruik maak, het dit noodsaaklik geword om navorsing te doen op welke wyse die tradisionele geneser effektief gebruik kan word in die Nasionale Gesondheidsorg Sisteem van Suid Afrika. Dit is om hierdie rede dat die navorser ondersoek ingestel het na die modelle van inlywing wat bestaan, die persepsies en houdings van die tradisionele genesers, biomediese personeel, pasiënte en beleidmakers rakende inlywing, hul mening oor hoe die inlywing sal geskied, sowel as hoe die inlywing van tradisionele genesers in die Nasionale Gesondheidsorg Sisteem van Suid Afrika bereik kan word.

'n Kwalitatiewe navorsingsmetode en teorie generering benadering was gevolg. Die navorsing was uitgevoer in twee fases. In fase een, kwalitatiewe navorsing, is deelnemers gekies by wyse van nie-waarskynlike, doelbewuste, vrywillige steekproewe. Data was versamel deur semi-gestruktureede onderhoude met alle deelnemers in die drie geïdentifiseerde provinsies in Suid Afrika te voer. Na elke onderhoudsessie was veldnotas aangeteken.

Data-analise was verkry deur oop-kodering. 'n Mede-kodeerder en die navorser het die data afsonderlik geanaliseer, waarna konsensus gesprekke gevoer is om die geanaliseerde data te finaliseer.

Etiese beginsels was toegepas volgens die handleiding van die Demokratiese Verplegings Organisasie van Suid Afrika en die Departement Gesondheid. Fase twee, die generering van teorie was gebruik om 'n model te formuleer vir die inlywing van tradisionele genesers in die Nasionale Gesondheidsorg Sisteem van Suid Afrika.

SLEUTEL WOORDE: Inlywing, inskakeling, samewerking, biomediese personeel, tradisionele geneser; pasiënt; beleidmakers; Nasionale Gesondheidsorg Sisteem; tradisionele medisyne; biomedisyne; model; teorie.

TABLE OF CONTENTS

OVERVIEW OF THE RESEARCH

1 INTRODUCTION AND PROBLEM STATEMENT

Traditional healing need to be part of the National health care delivery system in South Africa, whether it be by incorporation, integration, or collaboration. Underlying this debate is an array of mixed attitudes from all the parties concerned namely the traditional healers, biomedical personnel, patients, and the policy makers. This array of mixed attitudes and perceptions is a barrier to the process of incorporating the traditional healer into the National Health Care System. The identified variety of approaches for inclusion of the traditional healers into the National Health Care System is an indication of the complexity of the situation.

The possibility of traditional healers and biomedical personnel functioning together existed since the eighties. The two groups met in Johannesburg in 1986 to discuss ways by which functioning together can be established (Zungu, 1992:24). A series of meetings and discussions followed after which, came the promulgation of the Chiropractors Homeopaths and Allied Health Services Professionals Act of 1996. This Act gives the traditional healers their due recognition but does not include them as part of health care providers, based on the premise that traditional medicines need to be scientifically tested first, before the traditional healer can be allowed to work with the biomedical personnel (Department of Health, 1996:24).

According to Pearce (1982:1612), incorporation is the option, and forging ahead with this process requires that the aforementioned distinct groups, should meet and identify the manner in which their functioning together can be established. This statement of Pearce (1982:1612) is supported by the researcher in her previous study titled "the relationship and therapeutic techniques of the traditional healer". In this study the researcher states that an investigation need to be undertaken on how the biomedical personnel and traditional healers can be linked in a supportive capacity, to serve the needs of the population in an effective way (Pinkoane, Greeff & Williams, 2001:6). Therefore functioning together to resolve the patient's health problems is only feasible if the identified need of working together can be made a reality through the process of

incorporation. It is to be noted that various authors utilize different words to indicate a process of functioning together as identified by the World Health Organization (W.H.O, 1978:22). The most used terms are incorporation, integration and collaboration and these variations needs further attention.

Incorporation is defined by the Oxford dictionary as "unity where two bodies combine to form one body authorised to act as one legal individual" (Dictionary of South African English (DSAE), 1996:670). The World Health Organisation (WHO) supports the Dictionary of South African English in defining incorporation. This organisation define incorporation of traditional healers as " forming a body authorised to act as an effective organ made up of different practitioners functioning within an overall National Health Care System" (W.H.O, 1987: 7). Freeman and Motsei (1992:1189), as one of the authors supporting the process of incorporation, states that incorporation can be realised by ensuring that both biomedical personnel and traditional healers remain autonomous, not controlling each other, respecting the existence of one another, and own methods of healing. Steenkamp (1993:16) supports Freeman and Motsei by stating that, should the traditional healer remain autonomous, it will be imperative to spell out clearly what his role would be in health care provision prior to the process of incorporation. According to Oskowitz (1991:24), once his role is spelled out, then both the traditional healer and the biomedical personnel can operate through recognition of what is valuable from each side with mutual referral and an agreement of what illnesses should be treated or referred from one to the other.

Staugard (1985:200-202) and Levitz, (1992:25) supports incorporation by stating that incorporation will mean that the traditional healers should not only be given recognition, but will have to function alongside the biomedical personnel. Gumede (1992:235) refers to incorporation as a way of using a multi disciplinary approach to health care delivery. It is for this reason that if a multidisciplinary approach is envisaged then it becomes necessary to legalise traditional healing so as to better be able to exercise control over their activities (Chavunduka, 1986:99). Pantanowitz (1994:13) views this working relationship as beneficial because both the traditional healer and the biomedical personnel can function in harmony, thereby decreasing the negative attitudes from both sides. Knottenbelt (1993; 241) further refers to

incorporation as bringing the best out of the two health care systems because the mode of action would be to teach each other therapeutic techniques which can be efficient regarding a particular disease. The implications are that, where one fails the other should take over. Straker (1994:24) supports the previous authors by stating that the process of incorporating the traditional healers into the health care system will be a measure of relieving the problem of shortage of personnel in health care institutions as well as resolve the patient's health problems. If legalisation is identified as the best option prior to incorporation, then it becomes necessary first, to review other methods of getting the two health care systems to function alongside each other, to increase health care resources and resolve the patient's health problems.

Integration is another method whereby the two health care systems can function together, even though integration differs in context from incorporation. The Dictionary of South African English defines integration as "a combination of diverse elements of perceptions whereby different view points are identified for their differences and similarities and yet be seen to attain the desired goal" (DSAE, 1996:521). In this instance integration means that the traditional healer and biomedical personnel possess different elements of perception, and yet are healing systems that are used by the patients to resolve their health problems. Fassin and Fassin (1988:354) identifies this integration as a way in which the traditional healer functions with biomedical personnel within primary health care settings. Further, one of the conditions prior to integration need to be that the traditional healers who are to work with the biomedical personnel are to state two conditions which they are able to treat, so as to reduce quacks and charlatans from being part of the integration process.

According to Freeman and Motsei (1992:1190), integration of the two health care systems means blending them, where the patient receives a combination of both treatment methods depending on the diagnosis. An example of this combination of health care systems is the Chinese model as described by the World Health Organization (WHO), which remains to be identified to be the most effective modality of health care provision. The World Health Organisation refers to the Chinese model of integration as using the two health care systems where essential techniques used by the traditional healers are selected and used in biomedical health care settings. The

use of these plants and herbs does not go without any further evaluation and review to determine their efficacy as the need arise (WHO, 1978:12).

The general view however is to oppose integration and as Oskowitz (1991:12) supported by Melato (2000:22), clarifies the reason for the opposition as being that, the traditional healers view integration as giving the biomedical personnel power over them. To this integration the traditional healers object strongly, basing their objection on the fact that their powers to heal is a gift bestowed upon them by their ancestors and that the ancestors may take away these healing powers if they are to function without their guidance (ancestors), and listen to what other people (biomedical) direct them to do (Peu, Troskie and Hatting, 2001:36; Pinkoane *et al.*, 2001:89). It is imperative that these two healing systems are availed to the patient according to the prevailing health problem, that the most dominant aspect of what is valuable and useful for the patient be used to eliminate the problem. The third approach of using the two health care systems together can be by collaboration.

Collaboration as the third possibility of getting the two health care systems to function together is a modality mentioned in the literature and supported by the dictionary as a joint effort of working together (DSAE, 1996:664), which Abdool-Karim *et al.*, (1994:4) emphasises as a joint effort that has been advocated by the WHO at Alma Ata in 1978. At Alma-Ata the WHO was advocating for a working relationship and urged the member countries to opt for either, incorporation, integration or collaboration, because the most important denominator here is the patient. The way in which these two health care systems can be used to avail the needed services for the patient, should be the choice of that country. According to Green and Makhubu (1984:1078) collaboration is seen as a two sided effort whereby the healing methods of one are brought to fore and the most effective one is chosen to cure the patient's identified problem at that time. Collaboration is the method of health care that the Swaziland government is opting for when using the traditional healer as a partner in health care provision. In Swaziland the most effective healing techniques is identified and used. The government is involved in getting the traditional healer educated on the basic oral hydration therapy whilst at the same time using his techniques that are of value to treat the patient. Neuman and Lauro (1982:1819) is of meaning that if this collaboration is

to be meaningful then it is necessary to get the government to review licensing the traditional healer's practices, so as to identify the healing techniques that are of value and use these to treat the patients. In collaboration the license should be given only to those who have completed some recognised education and had shown some level of competencies. These are the traditional healers who can be used in rural areas. Abdool Karim *et al.,* (1994:11) and Peu *et al.*, (2001:54) are of a meaning that it is essential that traditional healers should receive some form of education to can effectively realise any form of a working relationship.

In this way when the traditional healer is educated in any method of patient care, both biomedical personnel and the traditional healer can attend to the patients' health problems. According to Jilek (1994:249), in collaboration it is essential that any efforts of working together, should not involve traditional healers and biomedical personnel only, but political office bearers as well, so as to promote legislative changes. Legislative change is a call made way back during the eighties by among others, Neuman and Lauro (1982: 1078); Green and Makhubu (1984: 1078); Green (1988:1129), supported during the nineties by Abdool Karim *et al.*, (1994:5); Hopa, Simbayi and Du Toit (1998:10), and of late by Peu *et al.,*(2001:54) and Pinkoane *et al.*, (2001:98). The strong conviction that the patient has in the healing powers of the traditional healer clarifies the need to include him as a healer and a partner in health care provision (Gumede, 1990:185; Green, 1995:505; Anderson, Beaumont, Pryer & Robb, 1996:8).

From the previous discussion it seems that it is not really possible to clearly separate the definitions and processes of the three approaches, namely, *incorporation, integration and collaboration* because they all address the issue of having the two health care systems functioning together to increase health care resources and resolve the patients' health problems. The difference that has been identified lies in the interpretation and perceptions and has no bearing on which approach should be regarded as the most important to use when selecting a model for the traditional healers to work together with the biomedical personnel. For the purpose of this research the word *incorporation* will be used, as it has a bearing on all three concepts, and seems that most authors favour its use to get the two health care systems to function together.

Reviewing the past, incorporation was initiated in South Africa in 1947 when the traditional healers association then known as the Dingaka Association, took an initiative and had petitioned the South African Medical and Dental Council for registration as practitioners (Holdstock, 1979:122). The South African Medical Council had questions for the traditional healers, which by then could not be answered. According to Gumede (1992:25) both the biomedical personnel and the traditional healers, retreated behind their sterile masks, gall bladder curtains, plastic and skin aprons respectively, and reached a stalemate. However, to address the health needs of the population, there is a need to take a giant leap into the future of health care provision and the way forward is to get the biomedical personnel, traditional healers and the policy makers to identify their priorities with regard to the process of incorporation.

The challenge of having the traditional healer working together with the biomedical personnel is however an international challenge which is also faced by other countries, for example, the United States of America, Britain and the Netherlands (Anon, 1994: 94). In these western countries the traditional healer is described as a complementary or alternative practitioner, who has been identified to avail health care services outside the parameters of the biomedical personnel. According to Fulder (1985:89), supported by Reilly (1986:45) when the patients get no relieve from using the biomedical personnel's treatment, they consults the complementary or alternative health practitioner. It is for this reason that where the patients consults the two health care practitioners simultaneously, the process of getting the alternative practitioner and the biomedical personnel to work together, becomes a reality. In countries such as India (Jeffrey, 1982: 1838), China (Neuman & Lauro, 1982:1819) and other African countries like, to name one, Nigeria (Pearce, 1982:1612) the process of getting the two-health systems to function together is identified by these countries as complying with the recommendations of the World Health Organisation. If other developed and developing countries show interest in the need for biomedical personnel and the traditional healers to work together, why not South Africa?

In South Africa the traditional healer is identified as the health care choice of 80-90% for the black population (Abdool Karim *et al.*, 1994:2). If this large number of black people uses traditional healing, then it becomes necessary to investigate the manner in which the traditional healer can be utilized effectively in the National Health Care Delivery System to render the services that the patient needs for her culturally defined illnesses. Nzima, Edwards and Makunga (1992:89) supports Abdool Karim *et al.*, (1994:5) by stating that it remains necessary to draw attention to the role the traditional healer plays in the life of black people, because the traditional healer is accessible and sometimes the only available health care service nearer to the people in event of illness. He is seen as a resource person, a teacher, a conserver of cultural practices, and a religious consultant who has the ability to mediate between the people and the ancestors. The people respect the traditional healer, and his traditional therapeutic techniques are used without any questions or comments (Pinkoane *et al.*, 2001:55). Reilly (1983:339) is of meaning that a whole person needs a whole doctor to resolve her problems holistically and if the biomedical personnel and traditional healers are to work together, then both health care systems can be utilised to effect the holistic approach to patient care. According to Oskowitz (1991: 24) the patients feel that the two existing health care systems can avail the best services to meet their health problems if they can be made to function under one body. There are biomedical personnel that indicate the need to function together (Peu *et al.*, 2001:34). According to Nzima *et al.*, (1992: 89) the only identified problem for failure to work together, is the need for biomedical personnel and traditional healers to be involved in mutual exchange of ideas that pertain to illness and health according to their cultural systems. This exchange of ideas will bring to fore both health systems' unknown facets which can be used in treating the patient.

Rappaport and Rappaport (1981:774) states that it is important to recognize that the success of biomedicine should be viewed in the same way as the success that has been identified for traditional healing, because these two diverse modalities of treatment have common elements that exists between them. Successes and failures do occur in both biomedicine and traditional healing practices and therefore why should the failures of traditional healing be based on the fact that it is unscientific, crude and harmful (Gumede, 1990:125), then, on what grounds does the inefficacy of

biomedicine rests? Research has proven beyond reasonable doubt that biomedicine does fail to produce the desired effects even with scientific non-crude evidence of its efficacy (Gort, 1981:1100). Furthermore, it is the duty of the policy makers and biomedical personnel to undertake research into the pharmacopoeia of traditional medicines so as to bring to fore its efficacy or toxicity, after which, those identified to be effective can be used to treat the patients (Yoder, 1982:1186). It is for this reason that Yagni-Angate (1981:243) indicates that to effect the process of functioning together, demystification of traditional healing should not be a one sided effort but a concerted action by all parties concerned to aid the process of rational convergence between the two health care systems.

Pantanowitz (1994:13) is of meaning that the Medical Association of South Africa need to harness the traditional healer's alien methodology to work in harmony with biomedical personnel. The alien methodology that has been identified by the biomedical personnel as existing in traditional medicines should not be viewed as a problem for not working together. Glasser (1988:1463) is of meaning that both traditional healing and biomedicine are geared in the same direction, which is, effective medicine for the people who are in need and entitled to reasonable health care. Karlsson and Molantoa (1984:47) has identified a relationship which exists between these two health care systems as representing a form of referral system where the patients seen by the traditional healers are sent, or if not sent, wilfully present themselves to the biomedical personnel for further treatment as the need arises.

Fassin and Fassin (1988:354) supported by Dauskardt (1990:357) states that it is thus imperative to review the need to legalise the traditional healer's involvement in health care provision, therefore policy will have to be formulated to legalise and control organisational practices of the traditional healer. This legalisation will ensure safety of the consumers of health care services against the traditional healer's practices. The DSAE defines legalisation as a process of making lawful by decree, whereby an act is passed which gives legal recognition to a body or an organisation (DSAE, 1996:639). Steenkamp (1987:16); Staugard (1989:201) supported by Jilek (1994:249) states that it is imperative to give legal authority to the existence and practices of the traditional healer so as to promote the manner in which incorporation into the health care system

can be realized. To have policy and legislation in place is a great leap into the future of health care provision and this means that the traditional healers is afforded an opportunity to: one, clarify explicitly their roles and functions within the health care system; two, legally control and regulate their actions thereby safeguarding the patients; three, legitimise their status amongst health care providers, and at the same time, weed out quacks and charlatans (Molaudzi, 2001:12).

If South Africa should opt for incorporation, then the process of legalising the traditional healer and his practice need to be in place. South of the Equator in Africa, the Zimbabwean method of legalisation as described by Chavunduka (1986:99) can be used as an example. In this legalization the traditional healers' practice is allowed by legislation, and they are required by law to form organizations. These organizations are responsible for the ethical control of the traditional healers' practices. Jurg and Marrato (1994:97) states that it is not only Zimbabwe that initiated incorporation by firstly legalizing traditional healing, Mozambique is another country to be reckoned with, regarding legalisation of the traditional healer and his practices.

According to Karlsson and Molantoa (1984:147) supported by Freeman and Motsei (1992:1168), it is the government through its National Health Care System that needs to pave the way forward by formulating a policy that is to legalize the traditional healers' practices so as to work together with biomedical personnel in availing the needed health care services. Dunlop (1989:124) supported by Jilek (1994:249) mentions policy formulation, and clarifies that once this policy is in place it will facilitate to a greater degree the way forward for resolving the existing need to increase health care personnel and resolve the patient's problems. Bhengu (2002:10) is of the notion that South Africa and China are now in the process of working together to develop and regulate traditional medicines using the Chinese model of regulation to protect the people against unscrupulous and bogus traditional healers. This move by the government to cooperate with China regarding the regulation of traditional medicines is a step forward to initiate the process of legalisation solely because to obtain these medicines, implies requesting the traditional healer to avail these medicines, so as to analyse those that can be identified to be beneficial and exclude those that are harmful for the patients (Geest & van der Geest, 1997:905). According

to Oyeneye (1985:68) the incorporation of the traditional healers need not to be viewed only as a means of increasing manpower, but also to give answers to the patients' social and mystical health problems, therefore the process of incorporating them legally need to be weighed seriously.

Akerele (1978:177); Holdstock (1979:122); Yoder (1982:1186); Oppong (1989:611); Gumede (1990:215); Freeman (1992:67); Abdool-Karim *et al.*, (1994:5) and Peu *et al.*, (2001:54) support each other and feel that there is a need to work together towards the process of incorporation if the joint goal is "health for all by the twenty first century." There is a growing need and demand not only from the recipients of health care, but also from the health care providers and policy makers that working together is a necessity more than a liability. Therefore it remains imperative to further investigate perceptions and attitudes of those affected by lack of health care resources and those concerned with the patients health needs and problems, to get a better understanding of how they feel about this incorporation process. Once these perceptions and attitudes have been explored, it is then feasible to further review the best modality that can be used to pave the way forward to get the two health care systems to work together. Those who have the interest of the health care consumers at heart are encouraged to be prepared to set up a model that will be seen to navigate the process of incorporation in the right positive direction.

An effective health care system can only be availed by realising that there is a need to agree on the manner in which these two health care systems should work together. By airing views and verbalising perceptions, a way forward will be derived from what these perceptions and attitudes will be, regarding this working together. It is these opinions of all stakeholders that is a cornerstone to get the way forward regarding the process of incorporation. The biomedical personnel as the people who treat the patients; the traditional healers, as most often, the first contact person for the patients; the patients who utilises the two existing health services simultaneously and the policy makers who formulate policies and legislation affecting health care provision.

Therefore in the interest of all the parties concerned, it is of utmost importance to know these perceptions and attitudes, since it is these perceptions and attitudes that have

been identified to create a barrier for effective interaction and communication to take place. The guidelines that the researcher formulated in her previous study, indicate that for the incorporation of the traditional healers into the National Health Care Delivery System to be a reality, those involved in health care provision need to remove the barriers and interact so as to give attention to the needs of the community that far outweighs their personal opinions (Pinkoane *et al.*, 2001:121).

As of now there is no formal way of explicitly describing the role the traditional healers should play in health care provision, except recognition of his existence as described in, the National Health Plan of 1994 (S.A, 1994:23); the Chiropractors, Homeopaths and Allied Health Services Professions Act of 1996 (S.A, 1996:36) and the White Paper for the Transformation of Health Care System of 1997 (S.A, 1997:25). According to these policy documents, there is some form of recognition for their existence but there is no legal support for their practice. At this point there is no control over what they may or may not do in their practices, although in 2003, a bill which clarifies the need to have the traditional healers' council in place, was availed. The purpose of the bill is to clarify the need for traditional healers to have their own council or organisation which is to ensure the efficacy, safety, and quality of traditional health care practices (S.A, 2003:3- 36). This bill does not deal with any form of how they should work together with the biomedical personnel and yet the problem of dual consultation remains a reality. It is for this reason that it remains necessary to identify how the health problems of communities can be resolved as well as how health care personnel can be increased, that it is imperative to investigate the perceptions and attitudes of the traditional healers, biomedical personnel, patients and the policy makers regarding the process of incorporation of the traditional healers into the National Health Care Delivery System of South Africa as well as their views on how this incorporation should be achieved. Further questions that arise from the aforementioned introduction and problem statement are:

What models exists for the incorporation of traditional healers into the National Health Care Delivery System of South Africa?

How can the incorporation of traditional healers into the National Health Care Delivery System of South Africa be realised?

2 RESEARCH OBJECTIVES

To be able to answer the above mentioned questions the following research objectives need to be attained:

2.1 Investigate the existing models for the incorporation of traditional healers into the National Health Care Delivery System of South Africa.

2.2 Explore the perceptions and attitudes of the traditional healers, biomedical personnel, patients and policy makers regarding the process for the incorporation of traditional healers into the National Health Care Delivery System of South Africa, as well as their views on how this incorporation should be achieved.

2.3 Formulate a model for the realization of the incorporation of traditional healers into the National Health Care Delivery System of South Africa.

3 PARADIGMATIC PERSPECTIVE

The paradigmatic perspective of this research encompass the metatheoretical assumptions, theoretical statements and methodological statements, and are subsequently discussed.

3.1 Metatheoretical assumptions

The Metatheoretical assumptions for this research are based on the researcher's own philosophy, Madeleine Leininger's Culture Care Diversity and Universality (George, 1995:79; Fiztpatrick & Whall, 1996:186) as well as Giger and Davidhizar's (1997:67) theory of trans-cultural nursing care. The researcher supports the

emphasises that these theories places on the historical, social and cultural contexts of human beings so as to explain and predict broad dimensions of human care. Caring for humans involves culture congruency based on values, beliefs and lifestyles of people of diverse cultures. In caring it is imperative to respect other people's cultures so as to render care that is most suitable and appropriate for them. From within these theories, emphasis is placed upon culturally defined health care, its maintenance, the well being of people or helping them face death in a culturally appropriate way. The Metatheoretical assumptions of the researcher are described as: persons, health, illness, nursing and environment.

3.1.1 Persons

The researcher accepts persons as representing man who is a cultural being who has survived through time and place because of his ability to care for the physical, spiritual, psycho- social and cultural well being of other men, across the life span in a variety of environments and in different ways (Fitzpatrick & Whall, 1997:187). This person as described by the researcher is a dynamic unique being who lives and acts within a psycho-social and cultural environment and constantly interacts with other men within the same milieu (Giger & Davidhizar, 1997:90). The interaction is greatly enhanced by individuals, family and the community within which he/she is born and brought up. These groups influences his philosophical convictions which are deeply embedded in his cultural/religious foundations.

3.1.2 Health

Health refers to a state of well-being that is culturally defined, valued and practised, and reflects the ability of individuals, family and communities to perform their activities in a culturally expressed, beneficial and patterned ways (Fitzpatrick & Whall, 1996: 187). Health is therefore closely associated with these social and cultural activities, which if not respected leads to health problems that are identified as existing among the people.

3.1.3 Illness

For the purpose of this research, the description of illness, according to Hammond-Tooke (1989:57); Gumede (1990:19) and Abdool Karim *et al.*, (1994:4) and supported by the researcher "... is believed to be intentionally caused by four possible agents: God, the ancestors, witches and pollution." Illness is a state of not being well resulting from man's interaction with an external environment, which comprises of the above four named agents. This state of not being well is a mechanism of fending off these agents by consulting the traditional healer and biomedical personnel simultaneously (Pinkoane *et al.*, 2001:64). Fending off the four agents enables man to regain a state of well being temporary or permanently.

3.1.4 Nursing

Nursing is the facilitation of health care focusing on helping the patient to regain his physical, psychological and spiritual well being. In this research the focus is on the combined activities of both the traditional healers and biomedical personnel whereby when both are incorporated, prevents, promotes and cures illnesses, or help the patient accept death in a dignified way. The family and or community also participate in caring for the individual if unable to independently care for himself within a culture congruent environment.

3.1.5 Environment

An environment is a dynamic ecological system within which human, plant and animal life nurtures and unfolds. It comprises of both internal and external environment. Man is constantly interacting with both the internal and external environment in a variety of ways. The internal environment of the individual consists of his/her own physical, psychological and spiritual and cultural being. The external environment is all areas where health care is provided, be it at health care centres where biomedical personnel avail health services or at the traditional healer's place. To satisfy his health needs it is

imperative to access the health services of the traditional healers and if these health needs are not met, then the services of the biomedical personnel are utilised, or vice versa. An individual's internal and external environment is to a great extent shaped and moulded by the family or community within which one is born, which, if not respected or preserved in a meaningful way, may lead to a state of not being well, therefore to illness (Giger & Davidhizar, 1997:68; Pinkoane *et al.*, 2001:87).

3.2 Theoretical statements

The theoretical statements for this research includes the central theoretical argument as well as the conceptual definitions which are to be used to construct the conceptual framework which is to be used for formulating the preliminary model (Walker & Avant, 1995:30).

3.2.1 Central theoretical argument

The research focuses on the need to formulate a model for the incorporation of the traditional healers into the National Health Care Delivery System. This need to have the two health care systems functioning together arises from an identified pattern used by the patients when afflicted with illness. They shunt from the traditional healer to the biomedical personnel in search of treatment to resolve their health problem and in so doing use both health services simultaneously. It is for this reason of dual consultation that this research aim to acquire knowledge and insight into the perceptions and attitudes of biomedical personnel, traditional healers, patients and policy makers regarding the process of incorporation of the traditional healers into the National Health Care Delivery System, as well as how this incorporation should be achieved. The perceptions and attitudes that are to be established, will facilitate the process of concept identification, whereby these concepts are to be used for framework construction. The framework is to be used in formulation of the model for the incorporation of the traditional healers into the National Health Care Delivery System of South Africa.

3.2.2 Conceptual definitions

The following concepts are derived from the literature and the researcher's previous study, are applicable to this research and subsequently synthesised and described.

- **National Health Care System**

The total network or system of services and provision of health care in a specific country, including all particular health care systems of whatever nature which occur in a country (WHO, 1990:16; van Rensburg, Fourie & Pretorius, 1994:2).

- **Traditional Healer**

A person who is recognised to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background, as well as 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).

In this research, reference to the traditional healer implies both male and female traditional healers. Where HE or HIS is used in this research, it also refers to female traditional healers.

- **Traditional Healing**

A sum total of all knowledge and practices, explicable or not, used in the diagnosis, prevention, promotion, curing and elimination of physical, psychosocial or spiritual illness caused by four agents, namely, God, ancestors, witches, pollution, and relying exclusively on practical experience and observation handed down from generation to generation whether verbally or in writing (WHO, 1978:8).

In this research traditional healing focuses on the actions of the traditional healer to fend off illnesses caused by these four agents.

- **Healing Process**

In this research the healing process refers to a process through which an ill person is restored back to health. This occurs by a series of steps or actions undertaken by the traditional healers and biomedical personnel simultaneously, which in the case of the traditional healer will entail supernatural divination to make a diagnosis, performance of rituals and/or ceremonies and prescription of medications (adjusted from Hammond-Tooke, 1989:115; Abdool Karim *et al.*, 1994:5; and Pinkoane *et al.*, 2001:62). In the case of biomedical personnel the actions include making a diagnosis using diagnostic equipment, prescribing scientifically proven therapeutic techniques. In both cases the patient accepts the prescriptions from one and if they avail no efficacy alternates and seeks help of the other, in a way of shunting to and from, until the right cure is found (Pinkoane *et al.*, 2001:127).

- **Biomedicine**

An inclusive system of health care, based on scientific and empirical knowledge and methods of treatment that are scientifically tested (Anon, 1996:51; Peu *et al.*, 2000:78) and substantiated by research results preserved in writing (Hammond-Tooke, 1989:1).

- **Biomedical Personnel**

Doctors, nurses, pharmacists, psychologists/psychiatrists who have been scientifically trained for years as professionals at an institution of learning, university or college (Holdstock, 1979:121; Abdool Karim *et al.*, 1994:2; Arthur, 1997:65).

In this research HE is used to refer to both male and female biomedical personnel

- **Incorporation**

For the purpose of this research incorporation refers to a process of combining or bringing two bodies to function as one (DSAE, 1996:507), it also entails aspects of integration and collaboration where these bodies are be made up of different professionals with the same objectives, authorised to function officially by passing a law to enhance and legalise their working together (WHO, 1987:7). This research focuses on having the traditional healers work with the biomedical personnel under the South African National Health Department, whereby policy will be passed to effect their working together.

- **Patient**

In this research, a patient is defined as a "... person, male, female or child experiencing illness or sickness, who feels the pain and seeks to find the reasons for what is happening" (Ngubane, 1977:100; Mburu, 1977:164; Ingstad, 1989:274; Pinkoane *et al.*, 2001:105).

In this research HER is used to refer to patients both male, female and children.

- **Policy makers**

The persons or appointed officials within the regions or districts assigned with decision making for administration, management and research of health care provision within health services (Andrews, 1990:34; du Toit, van der Walt & Cheminais, 1998:80).

3.3 Methodological Statements

The methodological statements of this research are based on the model of Botes (1995:1-9) and supports the functional thought approach, which is a basis for practicability and applicability, and highlight the three orders from which research emanates. The three orders are interrelated and influence each other and are as follows:

The first order constitutes the practise area and endeavour to find possible solutions through research in order to resolve the identified problems. Identified problems in this research are the patients who are in need of health services and utilises the services of both traditional healers and biomedical personnel simultaneously by shunting to and from, where if one does not yield the expected results the other one is used. This use of both services creates conflict because the biomedical personnel do not accept the practices of traditional healers, when complications arise one blames the other. In this research the incorporation of the traditional healers into the National Health Care Delivery System is identified as a measure to increase health care resources and resolve the patients' health problems. This identified need constitute the practice area.

The second order constitute the research methodology for theory generation as the activity. In this research an investigation is to be conducted from the first order about the perceptions and attitudes of biomedical personnel, traditional healers, patients and policy makers regarding the incorporation process and how this incorporation should be achieved. In this order emphasis is placed on the identification of concepts which will be used to construct a conceptual framework which is to be used to construct a model for the incorporation of the traditional healers into the National Health Care Delivery System of South Africa.

The third order comprises the philosophical framework. In this research the Metatheoretical assumptions are based on the theory of Madeleine Leininger's Culture Care Diversity and Universality (George, 1995:375; Fitzpatrick & Whall,1996:183-195); and the theory of Giger and Davidhizer's (1997:67) trans-cultural nursing care model. Inclusive in the formulation of these Metatheoretical assumptions are concepts from other authors like Hammond Tooke (1989:57), Gumede (1990:9) and the DSAE (1996:521;664;670). The theoretical statement includes central theoretical argument as well as conceptual definitions from the researcher's previous research, as well as definitions from nursing and associated fields.

4 RESEARCH DESIGN

This outlay gives a short description of the research design and method to be followed. The research will use a qualitative design (Mouton & Marais, 1992:45), with the goal of exploring and describing the perceptions and attitudes of the traditional healers, biomedical personnel, patients and policy makers regarding the process for incorporation of the traditional healers into the National Health Care Delivery System of South Africa, as well as their views on how this should achieved. Subsequently a model is formulated for the incorporation of traditional healers into the National Health Care Delivery System of South Africa (Chinn & Jacobs, 1995:45; Walker & Avant, 1995:12). The research will be conducted in several provinces in South Africa.

5 LITERATURE REVIEW

A critical literature review is undertaken to gain more knowledge and information about the incorporation, integration and collaboration processes, to ground the interview schedules used to conduct interviews to explore the perceptions and attitudes of the biomedical personnel, traditional healers, patients and policy makers regarding the process of incorporation. Furthermore to review existing models for incorporation, integration and collaboration of traditional healers into the National Health Care Delivery Systems, so as to give scientific grounding for the model which is to be formulated to make the process of incorporation of traditional healers a reality.

6 RESEARCH METHOD

A brief outlay of the exposition of the research method is given, namely, the two stages in which the research is conducted namely, stage one that deals with the initial part of theory generation namely, qualitative research and stage two dealing with model formulation as part of theory generation. These two stages are discussed separately in the following headings.

6.1 STAGE ONE: QUALITATIVE RESEARCH

The qualitative research method followed during the initial stage of the research is described hereunder as sampling, data collection, data analysis, trustworthiness and ethical aspects.

6.1.1 Sampling

For the purpose of this research samples are selected from four populations namely: traditional healers, biomedical personnel, patients and policy makers. The population, sampling and choice of inter-mediators differ and is described separately for each sample.

6.1.1.1 Sample One : Traditional Healers

Described here is the population, sampling, and choice of intermediators for the traditional healers.

a) Population

The population consists of traditional healers practising in three identified provinces of Gauteng, North West and Free State. These traditional healers practice independently of each other within these three mentioned provinces.

b) Sample

A non-probable purposive voluntary sample (Rubin & Babbie, 1997:226) is used for the senior and other traditional healers using the same selection criteria.

Selection criteria for traditional healers

For the purpose of this research the selection criteria for the senior traditional healers is the same as for the other traditional healers and is as follows:

- are practising in any one of the three provinces namely Free State, North West and Gauteng;
- meet the definition of traditional healer according to World Health Organisation's definition (WHO, 1978:7);
- are able to understand and communicate with the researcher through the medium of North or South Sotho, Tswana, Zulu, Xhosa, English;
- are willing to give written or tape recorded informed consent after being told about the reasons and procedures of the research;
- are prepared to participate in a semi-structured interview, which will be recorded on tape.

c) Choice of Inter-mediators

A letter (see Annexure A) requesting the senior traditional healers to act as participants and inter-mediators is taken to them to inform them about their roles, as well what to expect when identifying other traditional healers for this research. They should:

- identify participants (traditional healers) according to set criteria as provided by the researcher;
- inform the participants about the following aspects as planned for the research;
    - the reasons for the research and methods of data collection;
    - that participation is voluntary and participants have a right to withdraw from the research at any stage and time;
    - interviews are conducted at their homes and the duration is about one and half hour per contact session or until all necessary information is obtained;
    - that the tape recorded interviews are translated and transcribed into English;

- that all participants nominated by the intermediator are necessarily not to be included;
- that anonymity is ensured whereby only the researcher, co-coder, promoter and co-promoter have access to the tapes and the transcriptions;
- that they are to be informed about the results of the research after which the tapes are to be erased.

- inform them that the researcher is to personally contact them telephonically to confirm their participation. In areas where there are no telephones, a letter is written and delivered by secured mail to confirm their participation and arrange for appointment to conduct interviews;
- encourage respective traditional healers to partake in the planned research;
- avail to the researcher the names, addresses and telephone numbers of traditional healers prepared to participate; and
- inform the researcher about the language preferred by the participants.

Once the senior traditional healer has identified the traditional healers, they are contacted by the researcher to request their permission to participate in the research (Annexure B). The researcher further request traditional healers to act as inter-mediators to select their patients who are to participate in the research.

6.1.1.2 Sample Two : Biomedical personnel

Described here is the population, sampling, and choice of inter-mediators for the biomedical personnel.

a) Population

The population consist of biomedical personnel practicing in the three of the nine provinces of South Africa, namely, Gauteng, North West and Free State.The population of biomedical personnel consists of professional nurses, medical doctors,

psychologists/clinical psychologists, psychiatrists, and pharmacists who practice independently and or in health centres.

b) Sample

A non probable purposive voluntary sample (Rubin & Babbie, 1997:266) is used. The selection for the various groups of biomedical personnel follows.

Selection criteria for nurses

Nurses should:

- represent each of the different health care centres in the three identified provinces;
- be professional nurses registered with the South Nursing Council under Act 50 of 1978;
- have been practicing for more than five years in health care centres;
- be prepared to participate in research and give written informed consent (see Annexure D) to participate in the research after receiving the reasons and the procedures of the research;
- be able to communicate effectively and interact with the researcher through the medium of English, Afrikaans, North and South Sotho, Tswana, Zulu and Xhosa; and
- be prepared to participate in the semi structured interview whilst recording it on tape.

Selection criteria for medical doctors, psychiatrists and psychologists

They should:

- be registered with the Health Professionals Council;
- be practicing for more than five years;
- be attending to patients in health care centres availing primary health care and receive referrals from these centres;
- be prepared to participate in research and give written informed consent after receiving the reasons and procedures of the research (see Annexure D);

- be able to communicate effectively and interact with the researcher through the medium of English, Afrikaans, North and South Sotho, Tswana, Zulu and Xhosa; and
- be prepared to participate in semi structured interview whilst recording it on tape.

Selection criteria for pharmacists

Pharmacists should:

- be registered with the Pharmacy Board;
- be practising in the community health centres in the identified three provinces;
- be dispensing medicines and related substances under the Act 101 of 1965 as emended by Act 90 of 1997, for more than five years;
- be prepared to participate in the research and give written informed consent after receiving the reasons and procedures for the research (see Annexure D);
- be prepared to participate in a semi structured interview while it is recorded on tape; and
- be able to communicate effectively and interact with the researcher through English, Afrikaans, North and South Sotho, Zulu and Xhosa.

c) Choice of an inter-mediator

A letter (see Annexure C) requesting the senior regional/district health services managers permission to conduct research, act as inter-mediator and participant is sent to them to inform them about their roles as inter-mediators and participants, as well as what to do when identifying biomedical personnel for the research.

They should:

- identify participants (biomedical personnel) according to the set criteria as provided by the researcher;
- inform the participants about the following aspects as planned for the research;
    - the reasons for the research and methods of data collection;

- that participation is voluntary and that they have a right to withdraw from the research at any stage;
- that the interviews are conducted at community health centres or any place suitable for them, for the duration of about one and half hours, per contact session, or until all the necessary information is obtained;
- that the interviews are tape recorded and transcribed into English,
- that anonymity is ensured by not mentioning anywhere in the research report their names; and only the researcher, co-coder, study promoter and co-promoter know this information;
- that all potential participants as nominated by the inter-mediator are not necessarily included, or may be included until data is saturated;
- that they are informed about the outcomes if they so wish to know, after which the tapes will be erased;
- that the researcher will avail her telephone numbers to enable them to communicate any uncertainty regarding the research.

- inform them that the researcher personally contacts them telephonically to confirm their participation, and arrange appointments to conduct the interviews;
- encourage various participants (biomedical personnel) to participate in the planned research;
- avail to the researcher the names, addresses and telephone numbers of biomedical personnel prepared to participate; and
- inform the researcher about the participants' language preference.

Once the senior regional/district health services managers identifies the biomedical personnel, they are contacted by the researcher to confirm their willingness to participate in the research.

6.1.1.3 Sample three : Patients of the traditional healers

The following is the description of the sample of the patients of the traditional healers.

a) Population

The population consists of the patients of the traditional healers residing in the three provinces namely Free State, North West and Gauteng.

b) Sample

The patients are selected using a non probable purposive voluntary sample (Rubin & Babbie, 1996:266). The selection criteria for the patients are as follows:

- live in the towns of the three identified provinces where the traditional healers reside;
- have consulted the traditional healers and biomedical personnel simultaneously;
- have no fear of participating in the research;
- can communicate effectively and interact with the researcher in English, Afrikaans, North or South Sotho, Tswana, Zulu or Xhosa;
- are prepared to participate in research and give written informed consent (see Annexure E) after being informed about the reasons and procedures of the research; and
- be prepared to have interviews recorded on tape.

c) Choice of intermediators

A letter requesting the senior traditional healers and traditional healers to act as intermediators is taken to them to inform them about their roles when selecting patients for this research. They should:

- Inform the participants about the following aspects as planned for the research:
    - the reasons for the research and methods of data collection;
    - that participation is voluntary and they have a right to withdraw from the research at any time and stage;
    - interviews are to be conducted at their homes for about one and half hour or until all data is saturated;
    - the tape recorded interviews are translated, transcribed into English;

- that anonymity is ensured, that the tapes are accessed by researcher, promoter, co promoter and co coder;
- that they are to be informed about the results after which the tapes are erased.

Avail the names, addresses and telephone numbers and language preference of the patients to the researcher and inform them that the researcher personally contact them to confirm their participation. In areas where there are no telephones a letter is delivered by secure mail, this is also to arrange for an appointment to conduct the interviews.

6.1.1.4 Sample Four: Policy Makers

The following is the description of sample four made up of policy makers from the three provinces of and Gauteng, North West and Free State. Permission for their participation was obtained from the offices of each of the Provincial Director General for health in Pretoria, Mabatho and Bloemfontein.

a) Population

The population consists of policy makers responsible for policy making regarding the administration and management of health service provision in the regions or districts of the three identified provinces.

b) Sample

A non -probable voluntary sample (Rubin & Babbie, 1996:266) is used. The following criteria is set :

- are officials in the Provincial Health Departments designated with the job of managing health care services in the districts/ regions within the identified provinces;
- are prepared and available to participate in the research and give informed consent after receiving the reasons and procedures of the research (see annexure F);

- are prepared to participate in the semi structured interview whilst it is recorded on tape;
- are able to communicate or interact with the researcher through the medium of English, Afrikaans, North or South Sotho, Tswana, Zulu and Xhosa.

The researcher inform the policy makers about the following aspects as planned for the research:

- the reasons for the research and methods of data collection;
- that participation is voluntary and that they have a right to withdraw from the research at any stage;
- that the interviews are conducted at places suitable for them for the duration of about one and half hours, per contact session, or until all the necessary information is obtained;
- that the interviews are tape recorded and transcribed into English;
- that anonymity is ensured by not mentioning anywhere in the research report about their names; and only the researcher, co–coder, study promoter and co promoter know this information;
- that they are informed about the out comes results if they so wish to know, after which the tapes will be erased;
- that the researcher will avail her telephone numbers to enable them to communicate any uncertainty regarding the research;
- that the researcher personally contacts them telephonically to confirm their participation and to arrange for an appointment to conduct an interview.

6.1.1.5 Sample Size

The number of the participants who are accessible and available to take part in the research will determine the size of the samples for all the participants and data is collected until saturated (Burns & Grove, 1997:302 - 306).

6.1.2 Data collection

The data collection method, field notes, physical setting, as well as the role of the researcher in this research are discussed hereunder.

6.1.2.1 Data Collection Method

Permission to conduct research in the regions or districts of the three provinces of Free State, North West and Gauteng, is obtained through a letter written to each of the senior district health services managers. Data collection is achieved by conducting semi-structured interviews (Burns & Grove, 1997:354) with all four samples, using an audio tape. Experts evaluate the interview schedules for the appropriateness and adjust them accordingly. A pilot study is conducted, involving a participant from each of the four samples who met the criteria for the inclusion in the research. The pilot study helps to determine whether the questions are clear and understandable to ensure that data collected is according to the research objectives. This also ensured that open-ended questions without clarity are refined accordingly and identified problems in the manner of questioning are corrected (Burns & Grove, 1997:52-57; 302).

Prior to conducting the interviews the interviewer (researcher) explains to all the participants what is expected of them during the interviewing sessions. Two types of tape recorders are used to record the interviews one with batteries and the other of electricity, to ensure that no data is lost during electricity or battery failure. The tape recorders are placed in such a manner that they do not cause a distraction during the interview (Annexure G). The researcher first explains to the participants what is to be expected of them during the interview. The participants are also reminded about all ethical aspects regarding the research (see ethical considerations) and the researcher endeavour to build rapport with all the participants to keep the atmosphere relaxed. The interview schedules are read out prior to commencing the interview, the purpose being to clarify any misunderstandings that could arise regarding the questions and what the interview is all about.

The semi structured interviews are then commenced by asking the questions in the interview schedules. The participants are informed that the interview continues until all the data is saturated and that they could converse freely as long as the conversation evolves around the objectives of the research. Enough time is given to each participant to answer questions as asked. On conducting the semi structured interviews with the traditional healers and their patients, the researcher takes their level of education into consideration, but encourage them to converse freely within the topic under discussion. The researcher exercises caution regarding giving personal perceptions, expectations, attitudes and meanings during the interviews since these could influence the outcome of the interview (Mouton & Marais, 1992:86).

During the interviews the following communication techniques as described by Okun (1992:70-71) are applied:

- **Paraphrasing**: A verbal message or word of the participant are repeated in other words without adding new ideas;
- **Reflecting**: Is used when the words of the participants are shown in an empathetic way and that their responses are heard and understood with no interpretation;
- **Summarising**: The researcher synthesises what is said during the interview and highlights the important affective and cognitive themes.
- **Clarifying**: The researcher attempts to focus on or obtain detailed information of what the participants say.
- **Minimal verbal responses**: Verbal and non verbal responses of the researcher are relayed to the participants to encourage them to continue talking, in the form of a nod, leaning forward, and the use of "uh huh", "yes" or "mmm".

The participants are to answer questions in their own words and the interview continue for all four population until all data is saturated.

6.1.2.2 Field Notes

Field notes are documented at the end of each interview session. Talbot (1995:478) and Polit and Hungler (1997:307) describe field notes as notes that describe the "what", "where", "who?" or "how?" of the situation (Annexure H). They comprise of the following:

- **Personal Notes :** These are notes of personal reactions, reflections and experiences as observed by the researcher. These notes expects the researcher to place herself/ himself in the potential position of the participants.

- **Observation Notes :** This is the description of events as seen and heard by the researcher and it entails the who, what, where, and how of the situation with as little interpretation as possible.

- **Methodological Notes :** These are the critiques of the researcher regarding the methodology for conducting of the interviews. It is the description of interpretations, directions and motivation that are formulated and serve as a guide or scheme for data analysis.

The researcher documents the dates, names of participants and places where field notes are taken to facilitate an orderly and full description of data for data analysis.

6.1.2.3 Physical Setting

Interviews are conducted at different settings. With the traditional healers and their patients, the interviews are conducted at each one's home. Interviews with biomedical personnel and policy makers are conducted at places suitable for them. The setting should be private, comfortable and pleasant, with no distractions. If there is a telephone or a cell phone anywhere near, it is disconnected or turned off, or calls are diverted to another line for the duration of the interview. The researcher has to make it clear to all participants that during the interview there are no disturbances or any consultation with any other person.

Polit and Hungler (1997:306) states that a physical setting is not to be constrained because it is a setting within which human behaviour unfolds. It should foster physical and psychological freedom to enhance participation. The researcher and the respective participants are to ensure that ventilation is normal and the sitting place is arranged to facilitate eye contact and continuous rapport. Even though the biomedical personnel

and policy makers may enjoy some degree of environmental privacy, the homes or areas of all the participants need not conform to strict controlled or manipulated settings because they are natural settings (Burns & Grove, 1997:42).

6.1.2.4 The Role of the Researcher

The researcher obtains the necessary written informed consent (Annexure A, B, and D) from the inter-mediators (senior traditional healers, traditional healers and senior district health services managers) who avails the names, addresses and telephone numbers of the participants (traditional healers, patients, and biomedical personnel) who are prepared to participate in the research. The policy makers gave personal consent without mediators. The written informed consent of the biomedical personnel and policy makers is obtained from them per fax, from patients by post or personally to determine whether the reasons for conducting the research are clear to him or her and to arrange for the date, time and place where the interviews are conducted. These appointments are to be confirmed the day before commencing with the interviews. The consent forms are detached from the letters and are kept as proof of voluntary participation in the research. To access all areas where the research is conducted the researcher makes an appointment with the Cartography Department of the Potchefstroom Campus, North-West University, and the Automobile Association of South Africa in Vanderbijlpark, for them to determine the routes and distances between the different areas where the participants reside.

6.1.3 Data analysis

The audio taped interviews are first translated from the original languages that the interviews were conducted in, into English, and transcribed verbatim by the researcher. Content analysis is used employing the method of open coding as adjusted by Greeff (1991) described by Tesch *in* Cresswell, (1990:153-155) as follows:

- Transcriptions are presented in such a manner that there is an area for notes; concepts noted on the left and researchers perceptions on the right side.

- All the transcriptions are read through to get a sense of the whole.
- Choose the most interesting or shortest transcription and read through it.
- Decide on words and themes as units of analysis.
- Read through the transcriptions underlining themes and words.
- From the transcriptions carry the spoken words to the left column and any perceptions are written on the right column.
- Read through the left column and look at any spontaneous main categories and subcategories that come to mind and systemise them in a table format.
- Spoken words are transferred to the subcategories and main categories in the table. Perceptions are used to help clarify these tables.
- Refine the table by translating it into scientific language.

The use of double coding is employed whereby a nurse specialist or an expert co-coder codes independently of the researcher. The co-coder will receives copies of the transcriptions, checklist and field notes, and a work protocol (see Annexure I), that indicates the objectives of the research the questions as asked to all the participants as well as the guide of steps to follow during the process of analysing. The researcher meets the co-coder to discuss the findings so as to reach consensus and to finalise the tables.

6.1.4 Trustworthiness

Trustworthiness is described as a measure to ensure reliability and validity in qualitative research. For trustworthiness in this research a combination of the approach of Guba *(in* Krefting, 1991:214) and the model of Woods and Catanzaro (1988:136-137) for reliability and validity is used. Guba (*in* Krefting, 1991:214) uses specific criteria to measure trustworthiness namely credibility, applicability, consistency and neutrality. Woods and Catanzaro (1988:137) refer to further threats to validity as observer effects, selection and regression as well as mortality. These criterion is therefore applied to this research in the following table 1.

Table 1 Measures to ensure trustworthiness

Credibility Guba (*in* Krefting, 1991:214-217)	Truth value accurate reflection of the truth in this research	Literature review/control is undertaken. Field notes taken after each interview. Independent data analysis controlled by co coder (Cross validation).
	Research was conducted in the identified context of three provinces	Specific area for conducting research is appropriately identified.
Applicability	Application to other situations	Dense description of data collection and analysis can be applied to other research.
Consistency	Recording and reporting	Consistent reporting and recording to make it easy for critique or further studies. Dense description of methodology and results given. Deductive, inductive and logical reasoning in the discussion used.
	Regression and mortality	Data collected once only for eight weeks. Similar interviews are conducted after obtaining consent forms.

Neutrality	Auditability to increase reliability and neutrality	Auditing interviews, field notes, raw data, keep records for peer review.
	Researcher's status	Build a trust relationship with participants. Emphasized the value of participation to all. Decrease distractions, tape recorder to be placed to blend with furniture. Use of co–coder to decode data. Used external experts.
	Choice and selection of participants	Use of purposive voluntary sample, set selection criteria, described essential elements for participation for the all samples. Build rapport with participants, explain value of their participation. Create conducive relaxed atmosphere.

6.1.5 Ethical aspects

Ethical aspects specific to this research are taken into consideration as detailed in the Guidelines for the Democratic Nurses' Organisation of South Africa (DENOSA, 1998:1-7) and the Department of Health (S.A, 2001:1-77). These ethical aspects shall be dealt with as follows:

6.1.5.1 Quality of the research

The researcher endeavours to attain and maintain the highest standards of the research through the use of thorough planning, implementation and documentation of the research findings. The research project is approached with integrity; inclusive support, opposing views and criticism during the literature study. The researcher ensures the high standards of the research by:

- following the Harvard style of bibliographic reference (North-West University, 2002);
- the use of a experts to audit the questionnaires in the interview schedule;
- the use of coding, translation and verbatim transcriptions of the semi-structured interviews; and
- the use of an expert co-coder during data analysis.

Quotations from the verbatim transcriptions will be included in the discussions and interpretations of the results. Acknowledgement will be given to participants, co-coder, promoter, co-promoter and financial supporters in written records and verbally (see page of acknowledgements).

6.1.5.2 Confidentiality and anonymity

Confidentiality and anonymity in this research will be ensured by not revealing anywhere in the report the identity of participants or instances where data was collected. Only the researcher, promoter, co-promoter will know the names of the participants, and as for the patients' names, the traditional healers and the aforementioned are the only ones who know their names. The promoter, co-promoter and co-coder involved in the research are also made aware of the importance of confidentiality and anonymity, and this is explained to the participants by the researcher (see Annexures A, B, C, D and E).

6.1.5.3 Privacy

Privacy is ensured by recording the conversation of the semi-structured interviews in total privacy at the homes or areas identified by the participants. Information from each one is not divulged to the other. The environment where the recordings are to be conducted are to be free of any disturbances, telephones or other people. A "Do not disturb" sign is placed on the door where the interviews are conducted. This ensures that the participants should function to their optimum level without the fear that their behaviour or thoughts may be used against them. Only information necessary for the research is obtained as set out in the interview schedule. The researcher endeavours to collect only data that is absolutely necessary to achieve the research objectives. According to Heacock, Souder and Chastian (1996:336-338), to decrease probing and enhance privacy the researcher need to ask the questions that are only outlined in the research objectives.

6.1.5.4 Consent

The research takes place within an identified area and therefore informed consent is obtained from all of them to conduct research in their homes or places suitable for them. The participant's humanity is considered even though voluntary participation implies consent. The desire or wish to withdraw from the research is respected even if the research is not yet completed. Informed consent from all the participants involved in the research is obtained in a written form. The Annexures A, B, C, D and E includes amongst other aspects: the reasons for undertaking the research; the research method; the duration of the interviews; the manner in which their participation is expected; how the results will be reported and published; the identity of the researcher and co-coder; possible discomforts during interviews; and how confidentiality and anonymity is ensured.

6.1.5.5 Risks

The research is planned and implemented with involvement of minimum or as little exposure to possible physical, psychological and social risks. The evidence of any discomfort and anxiety, which may be more than usually expected or experienced, shall be dealt with after conducting the interviews. Any physical and/or psychological discomfort experienced by the participants is described in the research results.

6.1.5.6 Termination

The interviews are terminated if the participants so desire. Termination of the research shall also occur if the relevant data cannot be obtained.

The above discussion completes the first stage of this research. In the following stage two a brief description of theory generation follows.

6.2 STAGE TWO: THEORY GENERATION

In this stage an exposition of theory generation is given and described in three levels according to the approach of Dickoff, James and Weidenbach (1968:435). Both Dickoff *et al.*, (1968:415) and Greeff (1991:80) proposes that the practice theory should progress through four levels that leads to theory formulation. For the purpose of this research only three levels are applied because the fourth level focuses on the operationalization of the model once it is finalized. These levels are factor isolating theory, factor relating theory and situation relating theory.

6.2.1 Level One : Factor Isolating theory

In factor isolating theory the concepts relating to incorporation of traditional healers into the National Health Care Delivery System are first identified, classified, analysed and defined within the context of the research. These concepts come from the

researchers' previous study, literature review and findings from the semi structured interviews

6.2.2 Level two: Factor Relating theory

In factor relating theory the researcher delineates the relationship between the identified concepts to make explicit the theoretical statements and to decide which variables are important and which relationships are most suitable. The relationship enables the researcher to construct a conceptual framework, which is used in the construction of the model. A survey list of Dickoff *et al.,* (1968:200) and the approach of Greeff (1991:60), is used to structure the model.

6.2.3 Level 3 : Situation Relating theory

In situation relating theory concepts are consolidated to form an overall picture of what the model should consist of. The new visual image of the model constructed need to depict the structure and process for the incorporation of traditional healers into the National Health Care Delivery System of South Africa. This model is evaluated using a combination of the criteria of Hardy (1973:18-20) and Chinn and Kramer (1995:118).

7 SUMMARY

In this overview of the research an introduction and problem statement is provided, as well as the objectives stated regarding the incorporation of the traditional healers into the National Health Care Delivery System of South Africa. The discussion also focuses on the paradigmatic perspectives of the research, the research design, the method followed in two stages of theory generation. The first stage is described in depth for the purpose of introducing the research whereas the second stage is theory generation and to be detailed in the sixth article of this research. In exclusion of this overview, the thesis consists of the following articles addressing the themes listed hereunder:

Article one: Models for the incorporation of traditional healers into the National Health Care Delivery System: A literature review;

Article two: The traditional healers' perceptions and attitudes of regarding their incorporation into the National Health Care Delivery System of South Africa;

Article three: The biomedical personnel's perceptions and attitudes regarding the incorporation of traditional healers into the National Health Care Delivery System of South Africa;

Article four: The patients' perceptions and attitudes regarding the incorporation of traditional healers into the National Health Care Delivery System of South Africa;

Article five: The policy makers' perceptions and attitudes regarding the incorporation of traditional healers into the National Health Care Delivery System of South Africa;

Article six: A model for the incorporation of traditional healers into the National Health Care Delivery System of South Africa.

The thesis will be concluded, shortcomings identified and recommendations for education, research, and practice are identified and the recommendations for practice are formulated as guidelines for incorporation of the traditional healers into the National Health Care Delivery System of South Africa.

8. BIBLIOGRAPHY

ABDOOL KARIM, S.S., ZIQUGU PAGE, T.T. & ARENDSE, R. 1994. Bridging the gap – potential for a health care partnership between African traditional healers and biomedicine in South Africa. *South African Medical Association Journal*, 84(2): 1-16. December.

AKERELE, O. 1987. The best of both worlds: bringing traditional medicine up to date. *Social Science & Medicine*, 24 (2): 177-187.

ANDERSON, E., BEAUMONT, P., PRYER, H. & ROBB, S. 1996. Attitudes towards reflexology held by the general practitioner's in Port Elizabeth. University of Port Elizabeth. May. 1-14. (Unpublished report).

ANDREWS, Y. 1990. Medical practitioners and nursing professionals as public managers. Pretoria: HAUM Publishers. 178 p.

ANON. 1994. Drugs and Backrubs. Science and Technology. *The Economist:* 10, December. 93-94.

ANON. 1996. Science versus tradition. *True Love*: 25, October. 51.

ARTHUR, M. 1997. The traditional biomedical dichotomy, in search of a common ground. *Curationis,* 20 (2): 63-65. July.

BHENGU, C. 2002. China and South Africa agree on traditional medicine. *Sowetan*: 10, May. 24.

BOTES, A. 1995. The operationalization of research model in qualitative research methodology. *RAUCUR,* 1(1):1-9.

BURNS, N. & GROVE, S.K. 1997. The practice of nursing research: Conduct, Critique and Utilization. Philadelphia: .B. Saunders. 798 p.

CHAVUNDUKA, G.L. (1986) ZINATHA. The organization of traditional medicines in Zimbabwe (in LAST, M. & CHAVUNDUKA, G.L. *eds*. The professionalization of African medicine. Manchester: Manchester University Press for International African Institute. p. 45.)

CHINN, P.L. & KRAMER, M.K. 1991. Theory and Nursing: A systematic approach. St. Louis: Mosby year book. 150p.

DAUSKARDT, R.P.A. 1990. Traditional medicine: *Perspectives and policies in health care development Southern Africa.* 7 (3): 351-357.

DENOSA **see** DEMOCRATIC NURSES ORGANIZATION

DEMOCRATIC NURSES ORGANIZATION. 1997. Ethical standards for nurse researchers. Pretoria: Denosa. 8 p.

DEPARTMENT OF HEALTH. **see** SOUTH AFRICA. DEPARTMENT OF HEALTH.

DICKOFF, S., JAMES, P. & WIEDEBACH, E. 1968. Theory in a practice discipline. Part 1. Practice orientated theory. *Nursing Research*, 17 (5): 415 –435. Sept – Oct.

DICTIONARY OF SOUTH AFRICAN ENGLISH on historical principles. 1996. Oxford. New York: Oxford University Press. Oxford. 825p

DUNLOP, D.W. 1979. Alternatives to modern health care delivery systems in South Africa: Public policy issues of traditional health systems.(*in* Ademuwagun, Z., Ayoade, A.A., Harrison, I.E. & Warren, D.M., *eds*. African Therapeutic systems. Massachusets: Cross roads Press. 201 p.)

DU TOIT, D.F.P., VAN DER WALT, G. & CHEMINAIS, J. 1998. Public Administration and management for effective governance. Kenwyn: Juta & Co. 273 p.

FASSIN, D. & FASSIN, E. 1988. Traditional medicine and the stakes of legitimisation in Senegal. *Social Science & Medicine,* 27 (4) : 353-357.

FITZPATRICK, J.J. & WHALL, A.L. 1996. Conceptual models of nursing: analyses and application. Connecticut: Appleton Lange. 456 p.

FREEMAN, M. 1992. Negotiating the future of traditional healers in South Africa. *Critical health,* 40. 64-69.

FREEMAN, M. & MOTSEI, M. 1991. Is there a role for traditional healers in health care in South Africa: A proposal. Centre for Health Policy. Johannesburg: University of Witwatersrand. December. 1-5.

FULDER, S. 1985. A new interest in complementary (alternative medicine): towards pluralism in medicine. *Impact of Science on Society,* 143:235-243.

GEEST.S. & VAN DER GEEST. S. 1997. Is there a role for traditional medicine in basic health services in Africa? A plea for a community perspective. *Tropical Medicine and International health,* 2 (9): 1099-1104.

GEORGE, B.J. 1995.Nursing Theories: The base for professional nursing. 4th Ed. New Jersey: Prentice Hall. 469p.

GIGER, J. N. & DAVIDHIZAR, R.E. 1995. Trans-cultural Nursing. Assessment and Intervention. St Louis: Mosby Year Book. 575p.

GLASSER, M. 1988. Accountability of Anthropologist, indigenous healers and their governments: A plea for reasonable medicine. *Social Science & Medicine,* 27 (12):1461-1464.

GORTE, E. 1989. Changing traditional medicine in rural Swaziland. Effects on global system. *Social science & medicine*, 29 (9) :1099-1104

GREEN, E. & MAKHUBU, L. 1984. Traditional healers in Swaziland: Towards improved cooperation between traditional healers and modern health sectors. *Social Science & Medicine*, 18(12): 1071-1074.

GREEN, E. C. 1988. Can collaborative programs between biomedical and African indigenous health practitioners succeed? *Social Science & Medicine*, 27(1): 1125-1130.

GUBA, E.G. *(in* KREFTING, L. 1991. *Ed.* Rigor in qualitative research: the assessment of trustworthiness. *American Journal of Occupational Therapy,* 45(3): 214-221. March.)

GUMEDE, M. V. 1990. Traditional healers: a medical doctor's perspective. Johannesburg: Vista University Press. 238 p.

GUMEDE, M. 1992. Side by side. *Publico,* 24-25, October.

HAMMOND-TOOKE, D. 1989. Rituals and Medicine. Johannesburg: A. D. Donker Publisher.155p.

HEACOCK, P., SOUDER, E. & CHASTIAN, J. 1996. Subjects, data and videotapes. *Nursing research,* 45(6):336-339. Nov/Dec.

HOLDSTOCK, T.L. 1979. Indigenous healing in South Africa: a neglected potential. *South African Journal of Psychology*, 9:118-123. May.

HOPA, M., SIMBAYI, C.C. & DU TOIT, C.D. 1998. Perceptions on integration of traditional and Western healing in the new South Africa. *South African Journal of Psychology*, 28 (1): 8-14.

INGSTAD, B. 1989. Healer, witch, prophet or modern health worker? The changing role of ngaka ya Setswana (*In* WIDING, A. J. & VESTERLUND, A. *eds.* Experience and pluralism: Essays on African ideas of illness and healing. Stockholm: Almqvist & Wikrell. 308p.)

JEFFREY, R. 1982. Policies towards indigenous healers in independent India. *Social Science & Medicine,* 16 (1): 1835-1841.

JILEK, W.G. 1994. Traditional Healing in the Prevention and Treatment of alcohol and drug abuse. *Trans-cultural Psychiatric Research Review,* 31 : 219 –258.

JURG, A. M. & MARRATO. J. 1992. Mozambican experience – policy and developments since independence. Centre for Health policy. Johannesburg: University. of Witwatersrand. 14-18.

KNOTTENBELT, J.D. 1993. Systems of alternative medicine. *South African Medical Journal,* 83 (2): 241, April.

KARLSSON, E.L. & MOLANTOA, K.E.M. 1984. The traditional healer in Primary Health Care. *Continuing Medical Education,* 2 :43-47, April.

LAST, M. & CHAVUNDUKA, G. L. 1985. *eds.* The proffessionalistion of African Medicine. Manchester: Manchester University Press. p. 237-258.

LEVITZ. E. 1992. Traditional Medicine: friend or foe? *Publico,* 233-236. October.

MBURU, F.M. 1977. The duality of traditional and western medicine in Africa: Mystics, myths and reality. Essays in critique of medical anthropology. Rochester: Oakland University. 210 p.

MELATO S. R. 2000. Traditional healer's perception of the integration of their practices into the South African national health systems. University of Natal. (Dissertation- M. Soc.) 200 p.

MOUTON, J. & MARAIS, D.C. 1996. Basic concepts in the methodology of social sciences. Pretoria: R.G.N. Publishers. 310 p.

NEUMAN, A.K. & LAURO, P. 1982. Ethno medicine and biomedicine linking. *Social Science & Medicine*, 16 (210) :1817-1824.

NGUBANE, H. 1977. Body and mind in Zulu medicine. London: Academic Press.158 p.

NZIMA, D.R., EDWARDS, S.D & MAKUNGA, N.V. 1992. Professionalization of traditional healers in South Africa: a case study. *University of Zululand Journal of Psychology*, 8:82-91.

OKUN, B.F. 1992. Effective helping: Interview and counselling techniques. California: Brookes/Cole. 283 p.

OPPONG, A.C.K. 1989. Healers in transition. S*ocial Science & Medicine*. 28 (6): 605 – 612.

OYENEYE, O.Y. 1985. Mobilising indigenous resources for Primary Health Care in Nigeria. A note on the place of traditional medicine. *Social Science & Medicine,* 20 (1): 67-69.

OSKOWITZ, B. 1991. Bridging the communication gap between traditional healers and nurses. *Nursing RSA*, 6 (7): 20-22. July.

PANTANOWITZ. D. 1993. Alternative medicine – A rational viewpoint is necessary. *South African Medical Journal,* 83(1): 638.

PEARCE, T. 1986. Professional interests and the creation of medical knowledge in Nigeria. (*In* LAST, M. & CHAVUNDUKA, G. L., *eds.* The proffessionalization of African Medicine. Manchester : Manchester University Press. p. 237-258.)

PEU, M.D., TROSKIE, R. & HATTING, S.P. 2001. Attitude of community health nurses towards integration of traditional healers in Primary Health Care in North West Province. *Curations,* 25 (1) 49-55.

PINKOANE, M.G., GREEFF, M. & WILLIAMS, M.S.J. 2001. Patient relationship and therapeutic techniques of the South Sotho traditional healer. Potchfestroom: North West-University (Dissertation -M.Cur.) 207 p.

POLIT, D. F. & HUNGLER, B.P. 1997. Nursing Research: Principles and Methods. Philadelphia: J.B. Lippincot Company. 694 p.

RAPPAPORT, H & RAPPAPORT, M. 1981. The integration of scientific and traditional medicine: a proposed model. *American Psychologist,* 367: 774-781, July.

REILLEY, D.T. 1983. Young doctor's views on alternative medicine. *British Medical Journal,* 287: 337 – 339, July. 30.

RUBIN, A. & BABBIE, E. 1997. Research methods for social work. 3rd Ed. Pacific Grove: Brooks/Cole. 758 p.

S.A. **see** SOUTH AFRICA.

SOUTH AFRICA. Department of health. 1996. Annual Report. Pretoria: Government Printers. 60 p.

SOUTH AFRICA. Department of health. 1997. White Paper for the transformation of the health system in South Africa. (Notice 667). *Government Gazette*, 17:910-1. April 16. 232 p.

SOUTH AFRICAN NURSING COUNCIL. 1978. *The Nursing Act 50 of 1978 as amended.* Pretoria: Government Printers. Membership for the profession. 1998. 13. 31.

STAUGARD, F. 1985. Traditional medicine in Botswana: traditional healers. Gaborone: Ipelegeng Publishers. 215 p.

STEENKAMP, C.S. 1987. Chiropraktyk en Homeopatie: 'n voorbeeld van die legitimering van 'n newe struktuur. *South African Journal of Sociology,* 18 (2): 66-74.

STEVENS–BARNUM, B.J. 1994. Nursing Theory: Analysis, application and evaluation. Philadelphia: J.B. Lippincot Company. 150 p.

STRAKER, G. 1994. Integrating African and western healing practices in South Africa. *American Journal of Psychotherapy,* 48: 455 – 467.

SYKES.J.B. 1987. The Oxford Dictionary. New York: Oxford University Press. 825 p.

TALBOT, L. 1995. Principles and practice of nursing research. St Louis: C.V. Mosby. 700 p.

TESCH, J. 1990. Research design: qualitative and quantitative approaches. (*In* CRESSWELL, J. *Ed.* A qualitative approach. *Library of congress catalogues in publication data.* 133-157.)

WALKER L.O. & AVANT, K.C. 1983. Strategies for theory construction in nursing. Norwalk Connecticut: Appleton Century Croft. 190 p.

VAN RENSBURG, H.J.C., FOURIE, A. & PRETORIUS, E. 1994. Health care in South Africa: Structure and dynamics. Pretoria: Academica. 435 p.

WHO **see** WORLD HEALTH ORGANIZATION.

WORLD HEALTH ORGANIZATION. 1978. The promotion and development of traditional medicine. Technical report series 622. Geneva: WHO Publications. 21 p.

WORLD HEALTH ORGANIZATION. 1987. Traditional healers as community health care workers. A review of projects using traditional healer as Community Health Care worker. Geneva: WHO publications. 15 p.

WORLD HEALTH ORGANIZATION. 1996. Traditional medicine. Fact sheet 134. Geneva: WHO (http://www.who.ch/) September.

YANGNI-ANGATE, A. 1981. Understanding traditional medicine. *World Health Forum,* 2 (3): 465-466.

YODER P.S. 1982. Biomedical and Ethno-medical Practice in rural Zaire. *Social Science & Medicine,* 16 (2): 1851-1857.

ZUNGU CHIEF. 1992. Should traditional healers be recognised and registered/ If so, how should this occur? Centre for Health Policy. Johannesburg: University of Witwatersrand.17 p.

ANNEXURES

ANNEXURE A: A LETTER TO THE SENIOR TRADITIONAL HEALERS

Dear Sir/ Madam

LETTER OF CONSENT TO SENIOR TRADITIONAL HEALER TO ACT AS A PARTICIPANT AND A MEDIATOR IN THE RESEARCH

I am a black nurse and a student at the North-West University and currently doing a Ph.D. (doctorate) in nursing. I am working on a research project dealing with **the incorporation of the traditional healer into the National Health Care Delivery System.**

The goal of this research is to formulate a model which is to be used to make the biomedical personnel to work together with the traditional healers.

I kindly request you to partake in this research to act as a participant and a "go between". Your involvement in acting as "a go between", will require you to identify at least eight other traditional healers who would be willing to participate in this research. The criteria for selection of traditional healers are:

- living in the areas where you work and stay;
- willing to participate in the research (and will give written informed consent) after having been informed about the purpose and procedures of the research;
- practising as traditional healers for two or more years;
- able to communicate openly and are prepared to have a tape recorded interview with the researcher.

Your involvement in acting as a participant, is to allow the researcher to conduct an interview with you, which will be recorded on a tape recorder and these tapes will be erased after the research. The interview is to explore your views and feelings regarding the incorporation process, as well as how this incorporation should be achieved.

I undertake to keep all information of the participants in confidence. Names and addresses of all participants will never be known except to the researcher, promoter

and co promoter. Included herewith is a letter to the participants explaining the purpose and method to be followed in the research. This letter will be sent to them individually.

Your involvement in this research will be very valuable. Should you be prepared to partake and act as a "go between", I would appreciate it if you could forward the following information regarding the traditional healers to me .

1. Name
2. Residential address
3. Telephone number where the person can be contacted
4. Language preferred for conducting the interview

Please find attached to this letter, two written consent forms for you to fill in should you agree to act as a participant and as a "go between" , as well as a copy of a letter to the other traditional healers. If you cannot read and write, this information will be read to you by the researcher the day she comes to arrange for an appointment. Once you have made the decision to participate in the research you may contact me, and I will collect the consent form during the interview.

Yours faithfully

.....

MS M.G. PINKOANE
RESEARCHER

.....

PROF. M. GREEFF
POMOTOR

.....

PROF. M P. KOEN
CO-PROMOTOR

CONSENT FORM TO ACT AS A "GO BETWEEN" FOR THE RESEARCH

I, ... hereby consent to be a participant in the research project "Incorporation of the traditional healers into the National Health Care Delivery System" and act as a "go between" to identify patients, as well as traditional healers who are willing to partake in this research.

Signed at .....

on the ..... day of .....2003.

.....

SENIOR TRADITIONAL HEALER

Signed at .....

on the ..... day of .....2003.

_____

RESEARCHER

CONSENT FORM TO ACT AS A PARTICIPANT FOR THE RESEARCH

I, ... hereby consent to be a participant in the research project "Incorporation of the traditional healers into the National Health Care System"

Signed at

on the ..... day of .....2003.

.....

SENIOR TRADITIONAL HEALER

Signed at .....

on the ..... day of .....2003.

_____

RESEARCHER

ANNEXURE B : A LETTER OF CONSENT FOR TRADITIONAL HEALERS TO PARTAKE AND ACT AS MEDIATORS FOR IDENTIFYING PATIENTS IN THE RESEARCH

Dear Sir/Madam

I am a nurse and a student at the North-West University and doing a Ph. D (doctorate) in nursing. I am working on a research project dealing with **the incorporation of the traditional healers into the National Health Care Delivery System.** The goal of this research is formulate a model which is to be used to make the biomedical personnel to work together with the traditional healers.

I am requesting you to be involved in this research to act as a participant and as a "go between." Your involvement as a "go between" will require you to identify at least eight patients who would be willing to participate in the research. The criteria for selection of patients are:

- staying in your own residential area;
- not using traditional medicines for the first time;
- having no fear of open communication and involvement in research;
- prepared to be interviewed which will be recorded on tape and;
- willing to give written informed consent after having been informed about the purpose and the methods of the research.

Your involvement in acting as a participant, is to allow the researcher to conduct an interview with you which will be recorded on a tape recorder and these tapes will be erased after the research. The interview is to explore your views and attitude regarding the incorporation of the traditional healers into the National Health Care Delivery System, as well as how this should be achieved.

I undertake to keep all information in confidence. Names and addresses of all participants will never be known except to the researcher, promoter and co promoter. Each person has a right to withdraw at any time during the research. Included herewith

is a letter to the patients explaining the purpose and method to be followed in the research. This letter will be sent to them individually.

Your involvement will be very valuable. Should you be prepared to partake and act as a "go between," I would appreciate it if you could avail the following information regarding the patient to me.

1. Name
2. Residential address
3. Telephone number where the person can be contacted
4. Language preferred

Please find attached to this letter, two written consent forms for you to fill in should you agree to act as a participant and a "go between", as well as a copy of a letter to the patients. If you cannot read and write, this information will be read to you by the researcher the day she comes to arrange for an appointment. Once you have made the decision to participate in this research, you may contact me and I will collect the consent forms during the interview.

Yours faithfully

.....

MS M.G. PINKOANE
RESEARCHER

.....

PROF. DR M. GREEFF
PROMOTER

.....

PROF. DR M.P. KOEN
CO- PROMOTER

CONSENT FORM TO ACT AS A "GO BETWEEN" FOR THE RESEARCH

I, ... hereby consent to be a "go between" in the research project "Incorporation of the traditional healers into the National Health Care Delivery System" and to identify patients, who are willing to partake in this research.

Signed at .....

on the ..... day of .....2003.

.....

TRADITIONAL HEALER

Signed at .....

on the ..... day of .....2003.

_____

RESEARCHER

CONSENT FORM TO ACT AS A PARTICIPANT FOR THE RESEARCH

I, ... hereby consent to be a participant in the research project "Incorporation of the traditional healers into the National Health Care Delivery System"

Signed at .....

on the ..... day of .....2003.

.....

TRADITIONAL HEALER

Signed at .....

on the ..... day of .....2003.

_____

RESEARCHER

ANNEXURE C: A REQUEST FOR CONSENT BY THE SENIOR DISTRICT HEALTH SERVICES MANAGER TO CONDUCT RESEARCH, ACT AS A PARTICIPANT AS WELL AS A MEDIATOR IN THE RESEARCH

Dear Sir/Madam

I am a black nurse and a Ph. D student at the North-West University and currently doing research, working on a project dealing with **the Incorporation of traditional healers into the National Health Care Delivery System.** The objectives of this research are to:

- Explore the perceptions and attitudes of biomedical personnel, traditional healers, patients and policy makers regarding this incorporation process, as well as their views regarding how this incorporation should be achieved;
- Investigate the existing models for incorporation of the traditional healers into the various National Health Care Systems;
- Formulate a model for the incorporation of traditional healers into the South African National Health Care System.

I kindly request you to grant me permission to conduct research in your district/region to attain the above objectives. I pledge myself to adhere to all the Ethical principles for researchers as laid down by the Department of Health and the Democratic Nursing Organisation.

Secondly, I request your participation in this research by acting as a participant as well as a "go between." Your involvement in acting as a "go between" will require you to identify at least eight biomedical personnel from each of the following groups; nurses, doctors, pharmacists, clinical psychologists and psychiatrists, who would be willing to participate in this research. The criteria for selection of biomedical personnel are:

- practicing in the district/ region in the identified province, within your jurisdiction;
- willing to participate in the research;
- willing to give written informed consent, after having been informed about the objectives and methods followed in the research;

- practising as biomedical personnel for two or more years;
- able to communicate openly; and
- prepared and willing to have a taped recorded interview with the researcher.

Your involvement in acting as a participant is to allow the researcher to conduct an interview with you, which will be recorded on tape and these tapes will be erased after the research. The interview is to explore your views and attitude regarding the incorporation process, as well as how this should be achieved. I undertake to keep all information of the participants in confidence. Names and addresses will never be known except to the researcher, promoter and co promoter. Included herewith is a letter to the participants explaining the objectives and method to be followed in the research. This letter will be sent to each of them individually. Your involvement in this research will be very valuable. Should you be prepared to partake and act as a "go between", I would appreciate it if you could forward the following information regarding the biomedical personnel.

1. Name
2. Professional category (nurse, doctor, pharmacist, clinical psychologist, psychiatrist)
3. Telephone number where the person can be contacted
4. Language preferred for conducting the interview

Please find attached to this letter, two written consent forms for you to fill in should you agree to act as a participant and as a "go between", as well as a copy of a letter to the biomedical personnel. Once you have made the decision to participate you may contact me and I will collect the consent forms during the interview.

Yours faithfully

.....

MS M.G. PINKOANE
RESEARCHER

.....

PROF. M. GREEFF
PROMOTER

.....

PROF. M. P. KOEN
CO- PROMOTER

CONSENT FORM TO ACT AS A "GO BETWEEN" FOR THE RESEARCH

I, ... hereby consent to be a participant in the research project "Incorporation of the traditional healer into the National Health Care Delivery System" and act as a "go between" to identify biomedical personnel, who are willing to partake in this research.

Signed at .....

on the ..... day of .....2003.

.....

SENIOR DISTRICT / REGIONAL HEALTH SERVICES MANAGER

Signed at .....

on the ..... day of .....2003.

_____

RESEARCHER

CONSENT FORM TO ACT AS A PARTICIPANT FOR THE RESEARCH

I, ... hereby consent to be a participant in the research project "Incorporation of the traditional healer into the National Health Care Delivery System"

Signed at .....

on the ..... day of .....2003.

.....

SENIOR DISTRICT / REGIONAL HEALTH SERVICES MANAGER

Signed at .....

on the ..... day of .....2003.

_____

RESEARCHER

ANNEXURE D: LETTER OF CONSENT FOR BIOMEDICAL PESONNEL TO PARTAKE IN THE RESEARCH

Dear Prof, Dr, Sir, Madam

I am a black nurse and a Ph.D. student at the North-West University and currently doing research, working on a project dealing with the **Incorporation of the traditional healers into the National Health Care Delivery System.** I have obtained permission to conduct this research from the Senior District/ Regional Health Services Manager. I am kindly requesting your participation which involves conducting an interview with you about your perceptions and attitude regarding the incorporation of the traditional healers into the National Health Care Delivery System, as well as how this incorporation should be achieved. This interview will be recorded on audio-tape. I will be honoured by your participation because it will be valuable to this research.

I undertake to keep all information in confidence, your name and address will never be known, except to the researcher, promoter and co promoter. You have a right to withdraw from this research at any time if you so wish. Please find attached to this letter a consent form which you are to complete if you should be prepared to partake in this study.

Once you have made the decision to participate in the research, I shall appreciate your contacting me at any of the telephone numbers indicated below, to make an appointment,016 981 9499/ 073 230 2011.I will collect the consent form during our interview.

Yours faithfully

.....

MS M.G. PINKOANE

RESEARCHER

.....

PROF. M. GREEFF

PROMOTER

.....

PROF. M. P. KOEN

CO-PROMOTER

CONSENT FORM TO PARTAKE AS A BIOMEDICAL PERSONNEL IN THE RESEARCH

I, ... hereby consent to be a participant in the research project "Incorporation of the traditional healers into the National Health Care Delivery System"

Signed at .....

on the ..... day of 2003

.....

BIOMEDICAL PERSONNEL

Signed at .....

on the ..... day of 2003

_____

RESEARCHER

ANNEXURE E: LETTER OF CONSENT FOR PATIENTS TO PARTAKE IN THE RESEARCH

Dear Mr/Ms

I am a nurse and a Ph. D student at the North-West University, currently doing research, and working on a project dealing with **the incorporation of the traditional healer into the National Health Care Delivery System.** Your name was given to me by the traditional healer that you have consulted. I want to thank you for agreeing to participate in this research.

I am kindly requesting your participation in this research which involves conducting an interview with you about your views and attitudes regarding the incorporation of the traditional healer into the National Health Care System, as well as how this should be achieved. This interview will be recorded on a tape recorder in your home, and the tapes will be erased after the research. I will be honoured by your participation because it will be valuable to this research. I undertake to keep all information in confidence, your name and address will never be known, except to the promoter, co-promoter and researcher. You have a right to withdraw from this research at any time if you so wish. Please find attached to this letter a consent form which you are to complete if you should be prepared to partake in the study.

Once you have made the decision to participate in the research, please contact me at any of the telephone numbers indicated here to make an appointment and I will collect the consent form during the interview.

Yours faithfully

.....

MS M.G. PINKOANE
RESEARCHER

PROF. M. GREEFF	**PROF. M.P.KOEN**
PROMOTER	**CO-PROMOTER**

CONSENT FORM TO PARTAKE AS A PATIENT IN THE RESEARCH

I, ... hereby consent to be a participant in the research project "Incorporation of the traditional healers into the National Health Care System".

Signed at .....

on the ..... day of .....2003.

.....

PATIENT

Signed at .....

on the ..... day of .....**2003.**

_____

RESEARCHER

ANNEXURE F: LETTER OF CONSENT FOR POLICY MAKERS TO PARTAKE IN THE RESEARCH

Dear Prof, Dr, Sir/Madam

I am a black nurse and a Ph.D. student at the North-West University and currently doing research on a project dealing with the **incorporation of the traditional healers into the National Health Care Delivery System.** I have obtained permission to conduct this research from the Senior Regional Health Services Manager.

I am kindly requesting your participation which involves conducting an interview with you about your perceptions and attitude regarding the incorporation of the traditional healers into the National Health Care Delivery System, as well as how this incorporation should be achieved. This interview will be recorded on audiotape and these tapes will be erased after the research. I will be honoured by your participation because it will be valuable to this research. I undertake to keep all information in confidence, your name and address will never be known, except to the researcher, promoter and co promoter. You have a right to withdraw from this research at any time if you so wish. Please find attached to this letter a consent form which you are to complete if you should be prepared to partake in this study.

Once you have made the decision to participate in the research, please contact me at any of the telephone numbers indicated here to make an appointment, and I will collect the consent during the interview.

Yours faithfully

.....

MS M.G. PINKOANE
RESEARCHER

.....

PROF. M. GREEFF
PROMOTER

.....

PROF. M. P. KOEN
CO-PROMOTER

CONSENT FORM TO PARTAKE AS A POLICY MAKER IN THE RESEARCH

I, ... hereby consent to be a participant in the research project "Incorporation of the traditional healers into the National Health Care Delivery System"

Signed at .....

on the ..... day of 2003

.....

POLICY MAKER IN THE DISTRICT/ REGIONAL HEALTH SERVICES

Signed at .....

on the ..... day of 2003

_____

RESEARCHER

ANNEXURE G: INTERVIEW SCHEDULE FOR BIOMEDICAL PERSONNEL AND POLICY MAKERS

SEMI-STRUCTURED INTERVIEW TO EXPLORE THE PERCEPTIONS AND ATTITUDES REGARDING THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM AS WELL AS VIEWS ON HOW THIS SHOULD BE ACHIEVED.

1.What are your views regarding the incorporation of traditional healers into the national health care system?

2. How do you feel about this incorporation process?

3. How do you think this incorporation should be achieved?

ANNEXURE H: INTERVIEW SCHEDULE FOR TRADITIONAL HEALERS AND PATIENTS

1. "What are your views regarding the incorporation of traditional healers into the National Health Care Delivery System?"

"O bona jwang taba e ya hore dingaka tsa Setho di sebedisane mmoho le dingaka tsa sekgowa?"

2. "How do you feel about this incorporation process?"

"Maikutlo a hao ke afeng tabeng e ya hore dingaka tsee tse pedi di sebedisane mmoho?"

3. "How do you think this incorporation should be achieved?"

"O nahana hore tshebedisano mmoho e e ka fihlellwa jwang?"

ANNEXURE I: WORK PROTOCOL FOR THE DATA ANALYSIS OF THE RESEARCH PROJECT TITLED "INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM"

Dear Ms/Mr .....

I am a student at the University of North-West and currently studying for Ph.D. (Nursing) and working on the above named project.

Thank you for your willingness to be part of this research and act as a co-coder.

The objectives of this research are to:

* Explore the perceptions and attitudes of the traditional healers, biomedical personnel, patients and the policy makers regarding the process of incorporation of the traditional healers into the National Health Care System.
* Explore the views of the traditional healers, biomedical personnel, patients and policy makers on how this incorporation should be achieved.
* Investigate the existing models of incorporation of the traditional healers into the National Health Care System.
* Formulate a model for the realisation of the incorporation of the South Sotho traditional healers in the National Health Care System.

Your participation in this research is as follows:

You are expected to decode four transcriptions of eight (8) sets of interviews done with the biomedical personnel comprising of nurses, doctors, pharmacists, psychiatrists and clinical psychologists; traditional healers; patients and policy makers. These interviews explores the perceptions and attitudes of the above named participants regarding the process of incorporation of the traditional healers into the National Health Care System. These interviews are to be decoded using guidelines as described below using a method of Tesch (*in* Creswell, 1994:153-157) eight steps of open coding. This process is as follows:

- Transcriptions will be presented in such a manner that there is an area for concepts noted on the left, and the researcher's perceptions on the right side.
- Read through all the transcriptions to get a sense of the whole.
- Choose the most interesting or the shortest transcription and read through it.
- Decide on words and themes as units of analysis.
- Read through the transcriptions underlining these themes and words.
- Go into the transcriptions and carry the spoken words to the left column and any perceptions are written in the right column.
- Read through the left column and look at any spontaneous main categories and subcategories that come to mind and write them in a table format.
- Spoken words are transferred to the subcategories and main categories in the table, perceptions are used to clarify these tables.
- Look at the remaining themes also in this column.
- Refine the table by translating the table into scientific language. Giorgi (*in* Omery, 1983:570) recommends that redundancies in the themes should be eliminated.

After the process of analysing and decoding, I will appreciate it if we can agree on a date on which we can meet to discuss our findings and reach a consensus regarding the analysis of this data. Your activities as a co-coder are highly appreciated and I hope that this is going to be interesting and meaningful to you as well. You are welcome to contact me should you require any clarity or further information.

Thank you for your due concern

Yours faithfully

.....

MS M.G. PINKOANE

RESEARCHER

.....

PROF. M. GREEFF

PROMOTER

.....

PROF. M. P.KOEN

CO- PROMOTER

ANNEXURE J: FIELDS NOTES OF AN INTERVIEW WITH A TRADITIONAL HEALER, BIOMEDICAL PERSON, PATIENT AND A POLICY MAKER

FIELD NOTES NO 1: INTERVIEW WITH A TRADITIONAL HEALER

PERSONAL NOTES

The room where the interview was conducted is also a consulting room full of medicines of all sorts, some are in bags.

The place is crammed up and with little space for any form of therapeutic intervention to be undertaken there.

The other room was used for application of therapy like bathing, same used as initiates sleeping rooms.

The interview session is viewed with an expectation and eagerness as if incorporation is something to happen in due time.

The traditional healer seem enthusiastic and ready answers pour out easily.

Issues of malpractice are handled with caution even though these are identified as existing.

OBSERVATION NOTES

The problem of self organization is handled cautiously as if they have been warned not to divulge any information in this regard.

The initiates answer in a monotonous voice, maybe the low amount of "vula molomo" paid out.

The interview is not too long, the senior wanted everyone else to participate and give own opinion.

METHODOLOGICAL NOTES

The questionnaires in vernacular sounded almost similar.

Some answered in a round about way as if avoiding straight answers.

Traditional healers use communication techniques like nodding where words should be given.

The tape recorder suddenly made a whirring sound as if its dry, muffling voices, a spontaneous technical error resolved on its own.

The themes that were covered all evolved about the need to be respected in the process; that biomedical personnel should evaluate their herbs on merit and not generalize that all herbs are toxic; that given an opportunity to work together can heal the nation.

FIELD NOTES NO 2: INTERVIEW WITH A BIOMEDICAL PERSON

PERSONAL NOTES

The biomedical personnel feel at ease with incorporation.

Already some activities are undertaken between traditional healers and biomedical personnel.

The mood of interaction seem to be more of biomedical personnel play a paternalistic role in the whole process.

The incorporation is seen to be a mode of taming the traditional healers more than of partnership.

The biomedical personnel seem to be open up about working towards reaching a compromise but seem dubious about allowing hospital care of patients by traditional healers.

The issue of medical scheme payment was handled cautiously, same as for property rights to herbs.

OBSERVATION NOTES

Traditional healers are still viewed as old and yet some who interacted with them are said to be younger.

The biomedical personnel lead the conversation because they feel they already know what would be best for the patients.

They still feel health provision lies in their hands, they feel they have expert power.

They are manipulative when it comes to what the modus operandi should be, partnership or traditional healers being subservient.

METHODOLOGICAL NOTES

The questions seem to yield similar answers but themes emerged and that changed the mode of answering.

The themes were: feasibility of incorporation based on different world views; terms and conditions to be set for traditional healers to conform to expected practices; open communication channels to effect proper patient care.

FIELD NOTES NO 3: INTERVIEW WITH A POLICY MAKER

PERSONAL NOTES

Policy makers are non committal, based on the ongoing debate about HIV/AIDS cure.

They give an impression that traditional healers to be incorporated they should be controlled.

There is a feeling of mistrust about what traditional healers can do and what they may not do.

Some policy makers are themselves biomedical personnel and their duty is still geared towards patient satisfaction.

Policy makers who are political nominees find it difficult to come to terms with the issue of the traditional healers working with biomedical personnel.

The time for incorporation could be delayed while seeking a cure for HIV/AIDS is on going, even though they say it can still be done.

OBSERVATION NOTES

The views of partnership exists but with a low key of involvement.

They claim the way to go is for government to pave the way.

Public officials are policy oriented, need written guidelines to function, everything is protocol with policy makers.

Policy makers are autocratic in their approach to the practical aspects of health care.

METHODOLOGICAL NOTES

The questions were answered in a meaningful way, the themes came out clear that government is the sole provider of policy in any given government institution; that government should agree in principle about incorporation; health care is the function of government for the people of that country.

ANNEXURE K: SECTION OF A TRANSCRIPT OF AN INTERVIEW

Key: R – RESEARCHER

P – PARTICIPANT

R – I want to thank you for agreeing to participate in this study about incorporation of traditional healers into existing health system. I want you to tell me your feelings and how do you see this incorporation.

P – Let there be light ma. When I started as a traditional healer I was chosen like my master traditional healer.

R – Continue please, I am listening

P – To be a traditional healer I want to first to explain that I am born from a family of healers even through I am educated person. What was peculiar is that they used to heal each other only and not outsiders.

R – You mean you are educated as you are?

P – Yes I am educated. I am qualified teacher by profession and I used to have pains and dreams and some of there to ensure into reality and frightened me. I went to the new church of Christianity (Bazalwane) to get help to rid me of these demons. (interpretation)

R – Yes continue ma'am

P – My ancestors protected me, guided me even in education up until I did my BA in Education, then my honours.

R – You really are educated?

P – I was worse because when I registered for my masters I lost it. When I had to do course work.

R – Is it they say traditional healers are mad.

P – Mmmhhh!!! When I had to finish my course work the ancestors said you leave books and start other career. I did three chapters of environmental education with RAU.

R – Good Lord you were so far with your studies.

P – In 2001 I had to tell my supervisor that I have problems related to this issue. My supervisor (promoter) agreed and said write me a letter and send it to me I will authorize it and when you are though your initiation we will continue from there. That's when I came this way and meet Mme here as my trainer.

R - If you need help to study I will really help you with your studies in future invite me to help you .Go on

P – Another aspect of my life that has changed is the fact that educated as I am, in traditional you start schooling afresh. It is a different dimension altogether .

R – I really do understand where you came from, can you please explain to me then, how do you see yourself as making together with biomedical people?

P – I do not foresee any problem except for when we get to the ancestors. Ancestors are not the same, secondly we have differed in our view of what healer is, religious people fight and say they are the better ones God belongs to them, and this disagreement make it difficult for us to reach agreement about what makes a true healer to work with biomedical people. We need to reach a consensus about which one of us are to work with biomedical people so as to form partnership prior to working with biomedical people.

R – Eish! we all want ourselves in front, but as of now how do you see this working together?

P - I think as for me having been to different denominations seeking a cure, it becomes meaning full for us to be examples to the educated and unbelievers that there is truth to traditional healer, we becoming examples of this that traditional healers are educated when a person is enlightened comes to these biomedicals as enlightened and issues that are important are discussed, it is for them truly see that traditional healers are also knowledgeable and need to be heard.

R – I hear you and understand what you mean but, how do you feel about being working together/

P – We have talked amongst ourselves that we need to be licensed to practice. Like Mme here, she went to get a license we do need to be licensed, these licenses we should obtain from our masters they are the ones who thought us and should know what and how we treat people.

R – How do you think these licensed are going to affect the working together for other traditional healers.

P – Traditional healing is now in tatters, people go around pretending to be doing what is right in the name of the traditional healers when in actual fact they are putting traditional healers into disrepute if there is some form of control be it in a form of a letter, it will help ameliorate to a great extend the bogus healers. Again when I have

given out medicines and these are lethal I should be held accountable for that and again we do not get these licenses we end up doing what we want as it is right now.

Foot note: The rest of the transcripts are available on request

ARTICLE 1: MODELS FOR THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM : A LITERATURE REVIEW

GUIDELINES FOR THE JOURNAL: ETHNICITY AND HEALTH

Instructions for Authors:

Notes for Contributors

Submissions. *Ethnicity & Health* welcomes original contributions from all parts of the world on the understanding that their contents have not previously been published or submitted for publication elsewhere. Manuscripts should be sent as an e-mail attachment to: ethnicity.health@gerrish.org.uk. The manuscript should be in the form of a single word-processed file in MS Word or rich text format. Any tables and figures should be positioned at the end of this document. In exceptional circumstances if e-mail is not available, hard copy will be acceptable. Four complete copies, together with a copy on disc conforming to the above specification should be sent to: Professor Kate Gerrish, School of Nursing and Midwifery, University of Sheffield, Samuel Fox House, Northern General Hospital, Herries Road, Sheffield, S5 7AU, UK. Full notes for contributors can also be found on the Taylor & Francis website at www.tandf.co.uk/journals.

Manuscripts. All submissions must be in the style of the *Uniform Requirements for Manuscripts Submitted to Biomedical Journals* (International Committee of Medical Journal Editors, 5th ed., *N Eng J Med* 1997; 356: 309-15). Papers should be typed on one side of the paper, double spaced, with margins of at least 2.5 cm (1 inch). All pages must be numbered. The first page should include the title of the paper, first name, middle initial(s) and last name of the author(s), for each author a short institutional address, and an abbreviated title (for running headlines within the article). At the bottom of the page give the full name and address (including fax number and e-mail address if possible) of the author to whom all correspondence (including proofs) should be sent. The second page should repeat the title and contain an abstract of not more than 300 words. The third page should repeat the title as a heading to the main body of the text. The text should normally be divided into sections with the headings: Introduction, Methods, Results and Discussion. Long articles may need subheadings within some sections to clarify their contents.

Authors are requested to nominate up to three independent reviewers. Please submit suggested reviewers with your manuscript, together with their postal and e-mail addresses.

Abstracts. All papers must be summarized in an abstract, structured under the headings Objective(s), Design, Result(s) and Conclusion if appropriate. If they so wish, authors are welcome to prepare an abstract in a second language, where appropriate, alongside the abstrac in English.

References. The reference system preferred in this journal (Harvard style) uses within the text, the name of the author and the date of publication in chronological order, e.g. (Harvey 1997; Jackson 1998). Where there are three or more authors, the first author's name follow by *et al.* should be used, e.g. (Dear *et al* 1997), but all authors should be cited in the reference list. Two or more works by one author in the same year should be distinguished by using 1980a, 1980b, etc. Page numbers should be given in the text for all quotations e.g. (Jackson 1998: 56).

References should be listed in alphabetical order according to first author. The content and form of the reference list should conform to the following examples.

Journal article: the reference should include authors' surnames and initials, date of publication, title of paper, name of journal, volume number (and issue number where volume pages do not run on) and first and last page numbers, e.g. James S.A., Strogatz D.S., Wing S.B & Ramsey D.L. (1987) 'Socio-economic status, John Henryism and hypertension in blacks and whites', *American Journal of Epidemiology* vol. 126, pp. 664-673.

Book: the reference should include authors' surnames and initials, date of publication, title of book, place of publication and publisher, e.g. Fenton S. (1999) *Ethnicity: Racism, Class and Culture*, Basingstoke, MacMillan.

Chapter in an edited book: the reference should include details of the authors and editors together with the first and last pages, e.g. Kriege N. (2000) 'Discrimination and Health', in *Social Epidemiology*, eds L. Berkman & I. Kawachi, Oxford, Oxford University Press, pp. 36-75.

Theses: the reference should include the type of degree and awarding institution, e.g. Currer C.M. (1986) *Health concepts and illness behaviour: the case of Pathan women in Britain.* PhD thesis, University of Warwick.

Newspaper: the reference should include the title of the publication, the date of publication and the page number, e.g. Marr A. (1999) So what kind of England do we really stand for?, *Observer*, 31 Oct. 22-23.

Units of measurement must be cited in SI units.

Illustrations (including photographs, graphs and diagrams) should be referred to as Figures and their position indicated in the text (e.g. Figure 3). Each should be submitted on a separate page, numbered in Arabic numerals. The captions should also be submitted on a separate page, should include keys to symbols and should make interpretation possible without reference to the text. Figures should ideally be professionally drawn and designed with the format of the journal (248×175 mm) in mind and should be capable of reduction.

Tables should be submitted on separate pages, numbered in Arabic numerals, and their position indicated in the text (e.g. Table 1). Each table should have a short, self-explanatory title. Vertical rules should not be used to separate columns. Units should not appear in the body of the table. Any explanatory notes should be given as a footnote at the bottom of the table.

Proofs are supplied for checking and making essential typographical corrections, not for general revision or alteration. Proof corrections must be returned (by e-mail or fax) within 72 hours of receipt.

Early Electronic Offprints. Corresponding authors can now receive their article by e-mail as a complete PDF. This allows the author to print up to 50 copies, free of charge, and disseminate them to colleagues. In many cases this facility will be available up to two weeks prior to publication. Or, alternatively, corresponding authors will receive the traditional 50 offprints. A copy of the journal will be sent by post to all corresponding authors after publication. Additional copies of the journal can be purchased at the author's preferential rate of £15.00 per copy.

Copyright. It is a condition of publication that authors assign copyright or license the publication rights in their articles, including abstracts, to Taylor & Francis. This enables us to ensure full copyright protection and to disseminate the article, and of course the Journal, to the widest possible readership in print and electronic formats as appropriate. Authors may, of course, use the article elsewhere after publication without prior permission from Taylor & Francis, provided that acknowledgement is given to the Journal as original source of publication, and that Taylor & Francis is notified so that our records show that its use is properly authorised. Authors retain a number of other rights under the Taylor & Francis rights policies documents. These policies are referred to at http://www.tandf.co.uk/journals/authorrights.pdf for full details. Authors are themselves responsible for obtaining permission to reproduce copyright material from other sources.

MODELS FOR THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM : A LITERATURE REVIEW

Martha G. Pinkoane Ms

***Ph.D candidate** (Potchefstroom campus of the North-West University)

Private Bag x021, Vaal University of Technology

Vanderbijlpark

South Africa

e-mail:martha@vut.ac.za

***Promoter**

Minrie Greeff Prof. Dr.

School of Nursing Science

Potchefstroom campus of the North-West University

Potchefstroom

e mail: vpkmg@puk.ac

South Africa

***Co –promoter**

Magdalena P. Koen Prof. Dr.

School of Nursing Science

Potchefstroom campus of the North-West University

Potchefstroom

South Africa

e-mail:vpkmpk@puk.ac.za

***Forwarding address**

Prof. Dr. Minrie Greeff

School of Nursing Science

Potchefstroom Campus of the North-West University

Private Bag x 6001, Potchefstroom

North- West Province,

South Africa

Fax number: +27 18 299- 1827

e-mail: vpkmg@puk.ac.za

MODELS FOR THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM : A LITERATURE REVIEW

ABSTRACT

Different words are used by all stake holders in health care provision to indicate a process of working together between the biomedical personnel and traditional healers. The difference that has been identified lies in the interpretation and perceptions and bears little impact on which approach is regarded as important when selecting a model for getting the two health care providers to work together.

The main approaches, namely, *incorporation, integration and collaboration* are the three most commonly debated concepts, because they all address the issue of having the two health care systems work together to increase health care resources and resolve the patients' health problems. A literature review is undertaken regarding models for incorporation of the traditional healers into various international and the South African National Health Care Delivery System, to highlight the way in which these two health care systems are used to avail health services.

Internationally the focus is on communities residing in the West like the United States of America, England, New Zealand, Scandinavia, and Netherland, where traditional healers are referred to as complementary or alternative practitioners practicing from health care settings outside the borders of legitimate health care services.

Eastern countries such as China, India, Indonesia, Malaysia, Phillipines and Antananarive, portray how their best traditional healing practices are used in both urban and rural settings. In Africa the focus is on Senegal, Nigeria, Zaire, Congo, Liberia, Zimbabwe, Mozambique, Swaziland and Botswana where the traditional healer is used and sometimes is the only available health care choice for the people in rural and or urban settings.

In South Africa there are identified provinces where activities are undertaken to enhance working together between traditional healers and biomedical personnel. The projects that are discussed demonstrate this working together to increase health care resources and fulfil the patients' health needs.

MODELS FOR THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM : A LITERATURE REVIEW

1 INTRODUCTION

A literature review of the models for the incorporation of traditional healers into Health Care Delivery Systems is discussed in this article of the research. In the previous study on "The relationship and therapeutic techniques of the South Sotho traditional healer" the researcher made recommendations for further research to be undertaken, one of which was to formulate a model for the incorporation of the traditional healers into the National Health Care Delivery System of South Africa (Pinkoane , Greeff & Williams, 2001:184).

The possibility of traditional healers and biomedical personnel functioning together existed since the eighties when the two groups met in Johannesburg, South Africa in 1986 to discuss ways by which functioning together could be established (Zungu, 1992:24). A series of meetings and discussions followed but no conclusive statement was reached to include them as part of health care providers.

The main approaches, namely, *incorporation, integration and collaboration* are the three most commonly debated concepts, because they all address the issue of having the biomedical personnel functioning together with traditional healers. The difference that has been identified lies in the interpretation and perceptions and has no

bearing on which approach is regarded as the most important when selecting a model for the process of working together. Various authors utilise different words to indicate a process whereby the two can function together as identified by the World Health Organisation (W.H.O, 1978:22). A brief exposition is given to these approaches so as to form a better understanding of the context from the literature.

Incorporation as the first concept is defined by the Dictionary of South African English as "unity where two bodies combine to form one body authorised to act as one legal individual" (Dictionary of South African English, 1996:670). The World Health Organisation supports the Dictionary of South African English (DSAE) regarding the definition of incorporation and defines it to be "a body authorised to act as an effective organ made up of different practitioners functioning within an overall National Health Care System" (WHO,1987:7). Pearce (1986:1612) and Freeman and Motsei (1992:1189), states that the process of incorporation can be made a reality by ensuring that both biomedical personnel and traditional healers remain autonomous, not to control each other, respect the existence of one another, and each other's methods of healing.

As indicated earlier on, different terms are used, and the next most used term is *integration* which is defined by the Dictionary of South African English as "a combination of diverse elements of perceptions whereby different view points are identified for their differences and similarities and yet be seen to attain the desired goal" (DSAE, 1996:521). In integration the traditional healer and biomedical personnel are healing systems that Fassin and Fassin (1988:354) identifies as a way in which the traditional healer is to function with biomedical personnel in primary

health care settings, for the patients to receive a combination of both treatment methods depending on the diagnosis (Abdool Karim, Ziqubu-Page & Arendse, 1994:5). The third approach of using the two health care systems together can be by *collaboration.*

The DSAE (1996:664) defines *collaboration* as a joint effort of working together which according to Green and Makhubu (1984:1078) is seen as a two sided effort whereby the healing methods of one are brought to fore and the most effective one is chosen to avail the needed services for the patient to cure the identified problem at that time (WHO, 1987: 7).

Researchers have identified that traditional healers have been working together with the biomedical personnel to attend to the patient's problems even though neither party openly acknowledged the presence of the other (Muller & Steyn, 1999:8). The patient often start by consulting either the traditional healer first and on getting no relieve from the experienced problem, will then go to the biomedical personnel in a way of shunting to and from. This dual consultation carries with it unresolved health problems because up until now when complications arises, one blames the other but when efficacy is identified both health care systems want the credit for the positive results (Melato, 2000:100). It is because of this dual consultation that the patient need to be helped by bringing the two health care systems together so that the patient does not shunt to and from in need of the most appropriate health service to resolve his/her problems.

For the purpose of this article the word incorporation will be used and has no bearing on the other two concepts, and the focus is on a review of the literature regarding models utilized for the incorporation of international and South African traditional healers into National Health Care Delivery Systems.

2 MODELS FOR THE INCORPORATION OF THE TRADITIONAL HEALERS INTO NATIONAL HEALTH CARE DELIVERY SYSTEMS

According to the literature there are different models that researchers have described for incorporation of the traditional healers into National Health Care Delivery Systems, both internationally and nationally.

The discussion focuses on international and national models respectively.

2.1 Incorporation of traditional healers: International models

International communities are described as communities residing beyond the borders of the Republic of South Africa. Data discussed in this research reviews models for incorporation in the western parts of the world such as United States of America, England, New Zealand, Scandinavia, and Netherlands. In the east, countries such as China, India, Indonesia, Malaysia, Phillipines and Antananarive received attention. In Africa the focus is on Senegal, Nigeria, Zaire, Congo, Liberia, Zimbabwe, Mozambique, Swaziland and Botswana.

For the purpose of this research an exposition is given on each of the countries that have initiated this process. The first discussion focuses on Western models for the incorporation of traditional healers into National Health Care Delivery Systems.

2.1.1 Western approaches for the incorporation of traditional healers into the National Health Care Delivery Systems

In the west traditional healers are referred to as complementary or alternative Practitioners practicing from health care settings outside the borders of legitimate health care services of that country (Wiltcher,1989:22). First a brief description is given to the models that are used in the United States of America.

2.1.1.1 The American model for incorporation of complementary or alternative practitioners

According to Hess (2002:1579) in America, the terms complementary or alternative therapy are used to refer to treatment that is used either as a replacement or adjuvant to the biomedical conventional therapy. Selenzio (2002:1563) states that the American society's health care resources are best understood as a pluralistic continuum of alternative, complementary and biomedical systems. It is noted that alternative therapies are receiving support and are giving patients greater choices to replace or use simultaneously with biomedicine.

The role of alternative therapy is receiving support from the government to pursue its objective of palliative treatment for cancer.

Northridge (2002:1561) explains that spending on alternative therapy stands at 2.7 million dollars a year, and there is a growing number of patients who are beginning to rely on alternative therapy for preventive and palliative treatment. Trachtenberg (2002:1567) mention that the government formed the National Centre for Complementary and Alternative Medicine to serve the American public, irrespective of the commotion caused by the biomedical practitioners, who want these health practices to be ignored or marginalized. This issue of including alternative therapy remains in the minds of policy makers as a point of debate because the WHO has advocated for its use, and the patients are in need of its medicines. According to Hess (2002:1580) scientific research can guide policies and practice regarding the integration of alternative therapies. This maybe the reason why the government is reviewing its policy guidelines because of the patients' need for a cure. Park (2002:1568) states that it is imperative as a biomedical person when treating a patient who consults an alternative practitioner to enhance doctor patient relationship by allowing this patient to discuss her therapies with you. The discussions opens up avenues which enable linking both therapies to improve her health. King (1985:550) further describes that it creates a better understanding of the patients' use of these therapies and at the same time gives biomedical personnel a better working relationship with the alternative practitioner.

Maddock (1985:551) explains that the best modality of working together with these complementary or alternative therapists is to educate each other about the healing methods that may be alien to another.

Hess (2002:1581) supports the reciprocal education method and mentions that two universities came in support for the use of alternative practitioners to treat cancer by establishing a cancer research centre named National Centre for Complementary and Alternative Medicines of the National Institute of Health. In this laboratory the focus is to identify alternative treatment that is best to treat the patients with cancer. Dr Eisenberg used a model that placed the biomedical personnel as gate keepers to monitor the patients' progress when these two therapies are used. It becomes the biomedical personnel's responsibility to ensure that outcomes such as drug- herb interaction is kept at bay. The complementary/alternative health practitioners, are involved in this approach to identify how each healing methods can best be used where the other does not yield the expected results. To further confirm that it is not only cases of curative therapy, Northridge (2002:1565) mentions yet another collaborative effort of a research project funded through the Harlem Health Promotion Centre, by the Centres for Disease Control and Prevention, where both therapies were used with identified positive results.

Anon (1994:94) supports the above mentioned models, and describes them as applied with success in Boston's Beth Israel Hospital where the best of the two healing methods were used to treat the patients. The alternative practitioners reached a consensus with the biomedical personnel about the best treatment method to use in resolving the patients' health problems.

2.1.1.2 Britain

In Britain the use of alternative practitioner is viewed both negatively and positively as in any other country. The negative connotations are described as having quacks allowed to treat patients. Campbell (1994:14) argues and states that there are quacks who are allowed to practice, for an example, Sir Harry Powell of the Powell College of Health Sciences in Britain. Sir Harry profess to biomedical practitioners that shark cartilage can cure Kaporski's sarcoma. This approach gives patients hope, and an experiment was conducted in the Bristol Cancer Centre in the same fashion as in the United States (Weltzer, 2001:112) and the results proved that it is important to look at other therapies if patients are to be treated comprehensively and have their problems resolved. Ernest (1995:244-247) explains that the debate about the usefulness of alternative therapy is often regrettably an emotional issue, which conjures up feelings of allowing quacks to treat the patients and yet the very patient is seen to benefit from this practice.

Another positive connotation according to Bodecker and Kronenberg (2002:1585) is that there is a growing trend in Great Britain for the National Health Service to pay for the services of alternative therapy. This move is identified as helping patients with chronic conditions that are said to be costly like chronic pain, arthritis, cardiac conditions, cancer and HIV related illnesses.

Another identified model of incorporation that has been put to trial was a working relationship initiated in England's St Mary's hospital where biomedical practitioners

work with alternative health care practitioners to treat psychiatric patients. These patients were treated with both healing therapies and as Reilly (1983:1140) clarifies, with positive results.

The British government identified the need to have policy in place so as to regulate and control alternative practitioners. Bodecker and Kronenberg (2002:1587) mentions that the House of Lords Committee on Complementary Medicine has recommended that it is necessary to formalize the complementary practitioner because, self regulation is a cornerstone of practice control and serves to protect the patients. In self regulation the government gives the practitioners an authorized decision to form associations which are responsible and answerable to the government should any of their members becomes involved in malpractices. Marcus (2001:248 – 250) and Berman (2001:121- 122) highlights the fact that in Britain, teaching medical students and physicians about alternative therapy is now important. As of now there are already some biomedical personnel who have received some training in alternative therapy.

2.1.1.3 New Zealand

In New Zealand more than 600 Maori traditional healers have been legalized to work with the biomedical personnel and it is the government which has granted them this permission to work together. The Maori traditional healers provide the services within the wider spectrum of health services, while the government reimburses their services under health insurance (Bodecker & Kronenberg, 2002:1586). The New Zealand government pays their services under health insurance because according to legislation these healers must have their association which is responsible for setting up the criteria

for registration and control of their professional practices. Ultimately it is the people of New Zealand who stands to benefit from this initiative by the government to grant the alternative practitioners the chance to work with the biomedical personnel.

2.1.1.4 Scandinavia

In Scandinavia Christie (1991:550) mentions that in Oslo, Norway, the Norwegian government allowed the formation of dialogue group in 1989. This dialogue group discussed the manner in which incorporation can be a reality for them in their country. Both alternative practitioners and biomedical personnel agreed in principle to treat the same patient in a municipal health centre. At each session they would meet and discuss the patient's progress on a frank basis so as to teach each other the modalities of treatment that each has given to the patient. This cooperation provided the patient with a much better health service than when each treated the patient in isolation away from the other. In instances where the patient was seen either before or after the dialogue meeting, referral system was opted for, and in this way the patient benefited from both practitioners.

In this country, practitioners of alternative therapies pay for their tuition out of their pockets without any form of subsidy from the government, and this contribute to increase in tariffs for therapy. According to Bodeker and Kronenberg (2002:1584) it is the consumer who has to pay for his treatment because medical insurance does not cover these therapies.

What is surprising is the fact that the higher income group people are the ones using alternative therapies and paying a lot of money, which according to Fulder (1985:45) is no problem when comparing it with the value of human life.

Lastly the discussion is now on the Netherlands.

2.1.1.5 The Netherlands

In the Netherlands the use of alternative therapy is used for people as well as by farmers who have been using its dynamic properties for fifteen years. This mixture was applied to the crops simultaneously with the use of meditation, colours and cosmic energy to enhance crop growth, and positive results were identified.

The report of the Commission for Alternative Systems of Medicine provides a most comprehensive analyses of alternative therapies in the Netherlands. This lead to a complete change in the national medicine to incorporate all the therapies within the National Health System. This stance of the Dutch government towards alternative therapy enabled Lennon Pharmaceuticals to produce complementary remedies for a number of common ailments that are still in use right now (Louw, 2002:43). Aakster (1989:1140) further mention that, when these two groups work together the most dominant aspects of one is taught to the other, and this dominant aspect is to be used to treat the patient at that time according to the patient's prevailing ailment.

Conclusion

Alternative or complementary healing practices cannot be ignored by the western countries because these are practices that are already used by the people to resolve their health problems. There is a growing concern about what modalities need to be in place to incorporate the alternative practitioner into the biomedical practice.

Researchers have received funding from governments to undertake extensive work to include those practices identified to be of value for the treatment of cancer patients, as well as preventive treatment. Some countries have already embarked on allowing health insurance to pay for the use of alternative therapies.

The eastern approaches to incorporate the traditional healer into National Health Care Delivery Systems is now briefly discussed.

2.1.2 Eastern approaches to incorporate the traditional healer into the National Health Care Delivery System

In the eastern countries such as Malaysia, India, Phillipines, Indonesia, Antananarive and China, the definition of traditional healer is in accordance with the definition as described by the World Health Organization.

2.1.2.1 Malaysia, Indonesia, Phillipines, India and Antananarive

In Malaysia Harrison (1974:13) mentions that the Malaysian government sponsored elementary medicine and hygiene for the traditional healers. The duration of the course was three years after which the traditional healer was involved in rural health care provision.

Neuman and Lauro (1982:1819) confirm what Harrison (1974:13) mentions in the teaching of the traditional healers, and states that a licensing programme was initiated by the governments of Malaysia, Indonesia, and the Phillipines to issue licenses to those known to have completed some recognized work and their level of competence had improved. These are traditional healers whom the government used in biomedical settings in the rural areas.

Jeffrey (1982:1838) states that in India the government was initially hostile towards the involvement of the traditional healer in health care practice, but the states were free to use their initiatives without the government's consent and therefore, the use of traditional healers was initiated by first teaching them the basics of biomedical interventions. The traditional healer was then used as community health worker, whether trained or not. Glasser (1988:1464) mention that in some rural areas of India it became important to teach traditional healers the need to change their treatment which was proved to be dangerous to the patients like the use of cow dung for injuries.

To reciprocate the education of both groups the health minister announced that it was imperative to enlist the registered biomedical personnel in *Ayuverda, Unani, Siddah* and homeopathy. The duration of the training was for a short period of four month to provide them with a kit containing medicines for common ailments. According to Jilek (1994:249) the policy for mutual referral and exchange of ideas is encouraged because it is identified as a way to work together for the *Taoist, Bhuddists and Shamanic* people.

In Antananarive medicinal herbs and plants are used to treat cancer as part of the regime given to the patients who were also receiving biomedicine. The results were found to benefit the patients in biomedical setting as well as in the rural areas (Jilek, 1994:249).

2.1.2.2 China

In China like in India the traditional healer is used in primary health care settings. The most important elements of Chinese therapies are the use of herbs and acupuncture. These traditional health practices have been incorporated into the formal health education system and Neuman and Lauro (1982:1820) states that the techniques and essential herbs and plants are perfected and implemented according to their need in the biomedical settings. This involves the traditional healer to the best of his ability, and working together is monitored for efficiency. There is a system of self evaluation and feedback to review the need for changes or modifications according to the need as identified (Bodecker & Kronenberg, 2002:1568).

To effect working together, the Chinese government formulated a national policy that navigated this process of having the traditional healer work with biomedical personnel. Furthermore this institutionalized healing system avails its curricula covering both biomedicine as well as traditional healing over four to five years (Haverkort, Hiemstra & Hooft, 2000:22). The Chinese people are deeply rooted in their cultural healing practices and according to WHO (1978:24) and Maddock (1985:539), it is imperative for both developed and developing countries to take cognizance of the Chinese method of using the traditional healer in health care provision.

Conclusion

The Eastern method of the traditional healer working closely with the biomedical personnel is what the WHO is advocating for to ensure that all the countries are enabled to better serve their patients. In the east emphasis is placed more on using the best of what is already available and is deeply rooted in the people's culture. It is for this reason that it is identified that the biomedical personnel need to be encouraged to better equip themselves with the knowledge of this ancient art of healing. All these models to use the traditional healer in health care provision apply a multidisciplinary approach of availing treatment as advocated by the World Health Organization. The discussion of African models follow hereafter.

2.1.3 African models to incorporate the traditional healer into the National Health Care System

Africans like the people of the Eastern countries use the traditional healer for resolving the patients health problems as it is sometimes the only available health care of choice for the people who are in need of it in rural and or urban settings (Pinkoane *et al.*,2001:23).

2.1.3.1 Nigeria

According to Rappaport and Rappaport (1981:775) the government of Nigeria uses the traditional healers in the treatment of various illnesses.

The patients are attended by the traditional healers at their homes after which the biomedical personnel prescribe somatic treatment according to the symptoms the patient present with. This approach gives the traditional healers autonomous involvement and is endorsed by the biomedical personnel.

Pearce (1982:1612) supports the statement by describing Professor Lambo's study which initiated involving traditional healers with the biomedical personnel to treat patients in the same ward. This case study was allowed by the Federal Ministry of Health who also encouraged creation of a National Research Institute. This legal recognition allowed for official registration of traditional healers who worked with the biomedical personnel. Later a Traditional Medical Centre was established for training and licensure of traditional healers. The traditional healers are organized and each organization has laid down some form of organizational control for its members. They are constantly trying to keep abreast with changes so as to meet with the demands of biomedicine. According to Oyeneye (1985:67), it remains necessary to keep abreast for the reason of counteracting the criticism of biomedical personnel. Their organizational control is under the Traditional Medicine Council of Nigeria.

2.1.3.2 Senegal

According to Yangni Angate (1981:243), in Senegal they use a multi disciplinary approach to health care provision. The Senegalese traditional medicines identified to be important are given to the patients who simultaneously receive biomedical treatment. Fassin and Fassin (1988:354) clarifies how this multidisciplinary approach is regulated by the law in Senegal.

Traditional healers are incorporated in the primary health care setting based on the following criteria, that they:

- should be accepted by the community;
- indicate the two conditions they are skilled and able to treat;
- bring ten patients before and after treatment to see the results,

The traditional healers who meets this criteria receive certificates indicating their specialization. This is a method of identifying those that are better equipped to work with biomedical personnel and exclude quacks and charlatans that van Eeden (1993:443) refers to, for the incorporation process to be a success.

2.1.3.3 Zaire

In Zaire there is cooperation between traditional healers and biomedical personnel. Yoder (1982:1186) explains that the most important aspect being to teach each other fundamentals of treatment methods in each healing practice. When one identifies problems that are beyond his treatment regime, then these are referred one to the other with mutual understanding of what benefits the patient best at that time. Furthermore the government expects the traditional healers to be scientifically evaluated. To this scientific evaluation the traditional healers cry foul because they feel their autonomy is being underrated and yet there is an agreement to refer whenever necessary. According to Fassin and Fassin (1988:365) there is a training encyclopaedia of traditional medicine in Congo Brazzaville made available for reciprocal teaching and education.

2.1.3.4 Liberia

In Liberia, Holsoe (1982:17-26) describes training of traditional healers in simple biomedical treatment, by the government. After training they return to the village and are reimbursed for the time lost for family support, they are then used in primary health care settings. In event new biomedical treatment is availed, or there is loss of biomedical personnel to other areas, then retraining continues. According to Hooft, Haverkort and Hiemstra (2000:40) the adoption of new knowledge by the traditional healers is essential to ensure that experiences gained are used in health care settings. However continuous assessment remains necessary so that the knowledge acquired is used properly in patient care.

2.1.3.5 Zimbabwe

The Zimbabwean model to incorporate the traditional healer is similar to the Nigerian one, because Professor Doctor Chavunduka who is both a traditional healer and a biomedical person navigated registration and licensure of the traditional healer in the country so as to work together with the biomedical personnel. According to Chavunduka (1986:30), in Zimbabwe the traditional healers' practice is legal because there is a policy in place to control their practice as well as allow them to have a legal organization called ZINATHA. The Traditional Medical Practitioners' Act No 38 of 1981 clarifies the functions of the traditional healers' council. In this act the role of the traditional healer is clearly spelled out as to treat, identify, analyze, or diagnose without the application of any operative surgery, any illness of body or mind by traditional methods.

Involvement with the biomedical personnel to benefit the patient is legal and the biomedical organization and ZINATHA agree on the modalities to employ when treating patients as well as during referrals. Havekort *et al.*, (2000:26) states that traditional healers being the health care choice of black people, are more than willing to learn about biomedicine.

It is for this reason that the traditional healers in Zimbabwe have received this active governmental support to avail health services for the patients in urban and rural settings, because learning is reciprocal.

2.1.3.6 Mozambique

In Mozambique, Last (1986:13) explains that initially the Mozambican government had a political ideology of ostracizing the traditional healers, as is the case in all other countries where official recognition is still a problem. When the government structures changed the Mozambican government identified the need to incorporate the traditional healer in the same fashion as in Zimbabwe, their activities are legalized and working with the biomedical personnel is an agreement that is official (Jurg & Marrato, 1985:89).

2.1.3.7 Botswana

The Botswana government had passively overlooked the practice of the traditional healer, but their activities were monitored using laws and regulations. Staugard (1985: 202) explains that the ministry of health in Botswana has formulated a strategy for the future to exist between traditional healers and biomedical personnel.

This cooperation is to be implemented at central, regional and local level. Furthermore, research is currently undertaken to guide the planning for this process, but as of now there are four associations registered in this country with each having it objectives, membership fees, registration and or licensure clearly spelled.

Ingstad (1989:273) is of meaning that the traditional healers in their daily practice, presently refer patients to the biomedical personnel in the villages, when confronted by illnesses such as tuberculosis even though it is regarded as something they are able to cure. Sometimes it is even a prophet who refer patients. However, a system of mutual agreement need to be reached about how the two sectors can function together to avail the needed health services. It is for this reason that Staugardt (1985:75) mentions that the government is reviewing a policy aimed at recognizing the potential values of traditional healing and using this to benefit the patients.

2.1.3.8 Swaziland

In Swaziland there is an agreement on the part of the government to allow the traditional healers to work together with the biomedical personnel. Green and Makhubu (1984:1078) mention that there is ongoing teaching of the traditional healers for example on oral hydration for diarhoea. The biomedical personnel are further involved with the evaluation of traditional medicines to identify the healing techniques that are of value and can be used in the process of incorporation. According to Gort (1989:1103) in rural Swaziland there is a biomedical person working in a mission hospital, and is known to use both biomedicine and traditional healing therapies to treat the patients.

The authorities that are in power ignore these actions, because they benefit the patients. Since the government has identified the need to incorporate these services to increase health care resources, the actions are seen to benefit the patients and the use of these therapies is being given its due recognition (Dlamini,2000:56).

Conclusion

The African models of incorporating the traditional healer is almost similar to the eastern ones. Legalizing, teaching the traditional healer basic biomedical practices and some form of reciprocal referral system is identified as major elements to incorporate the traditional healer into these National Health Care Delivery Systems. Hereafter follows the discussion on models to incorporate the traditional healers into the South African National Health Care Delivery System.

2. 2 Incorporation of traditional healers: South African models

2.2.1 Introduction

In South Africa the incorporation of traditional healers is but an informal working relationship with a marked difference of giving recognition and not official legal power to work with the biomedical personnel. The National Health Plan (ANC, 1994:55) initiated recognition of traditional healing in so far as stating that it should be accepted so that its harmful properties can be identified and eliminated in order that the profession can be promoted. According to Pretorius (1998:6) in 1995 the government requested provinces to conduct public hearings on the viability of traditional health care.

These hearings were conducted in seven of the nine provinces during May and June of 1995, and by the end of 1997 the National Council of Provinces compiled a report and presented it to the National Assembly's Portfolio on health. The report indicated that the provinces were in favour of a statutory council for traditional healers, consisting of their own local representatives. In the mean time another recognition came from the government in the form of the Act of Homeopaths, Chiropractors and Allied Health Service Professions Act of 1996 (S.A,1996:57) and the White Paper for the transformation of Health Care Systems in South Africa (S.A,1997:47). All these identified acts, do not give authority for the traditional healer to practice and be used effectively in health care provision. However, during February of 1998 the Portfolio Committee conducted hearings to discuss traditional healers' professional status, training, ethics and a code of conduct. Pretorius (1998:5) further mentions that the recommendations of the report came in favour of these identified areas of concern as a way of giving the traditional healer not only recognition but official status as well.

So far South African researchers have written about modalities which can be employed to establish incorporation of traditional healers into the National Health Care Delivery System. Pilot studies where projects for working together were put on trial have been initiated, but so far no model has been formulated for this incorporation to be a reality. It is for this reason of having no model or a legal, official working relationship that the researcher is investigating existing modalities for incorporation so as to formulate a model to incorporate the traditional healers into the South African National Health Care Delivery System.

The following discussion will focus on the pilot projects for incorporation of traditional healers into the South African National Health Care Delivery System, after which attention will be given to the debate regarding proposed models for the incorporation process.

2.2.2 Projects initiated to incorporate the traditional healer into the South African National Health Care Delivery System.

In South Africa projects to incorporate the traditional healer into the National Health Care Delivery System have been initiated even with or without the government's approval or recognition. The discussion focuses on these projects that were initiated in the country.

2.2.2.1 Kwa Zulu Natal

In Kwa Zulu Natal various initiatives took place between biomedical personnel and traditional healers to work together to resolve the patients' health problems. According to Gumede (1990:218), in Nqutu at the Charles Johnson Memorial Hospital, biomedical personnel identified poor to zero results when they were treating psychiatric patients. It is at this point that it was noted that those patients who received treatment form the traditional healers recovered much faster than those in hospital. The biomedical personnel decided to refer patients to these traditional healers even though the process of referral was not legal. Patients received biomedical treatment alternated with traditional medicine. The patients who were treated with these combined therapies were identified to respond positively.

At Valley Trust, Drs Haley Stott, Irwin Friedman and Sister Thulile Ngidi included other biomedical personnel in meeting the traditional healers to discuss modalities for recognition of early complications, treatment and referral. All parties met as equals and professionals in their own right. Ultimately they resolved to cooperate for greater active involvement in patient treatment (Gumede, 1990:219).

The Madadeni project in Kwa-Zulu Natal is described by Freeman and Motsei (1992:1189) as a project that was aimed at involving the traditional healers in availing chronic medicines to patients who come for monthly treatment of chronic ailments. Instead of the patients travelling to the hospital or clinic, their medicines were to be availed by the traditional healer who would have received basic information about what to tell the patient when she comes to fetch her treatment. In this area the traditional healers worked with biomedical personnel to treat the patients with both treatment methods. Regular meetings were also held to discuss the problems encountered as well as teaching the traditional healer identification of early complications. Gumede (1992:24) makes mention of village health workers who were identified by the name of *Nompilo* meaning, "the one who nurtures life." These district health workers worked under the supervision of biomedical personnel to serve the rural areas where biomedical personnel are not available.

Mototo (1999:4) clarifies the position of Kwa Zulu Natal in relation to other provinces as the only province in South Africa where the traditional healer gets his due acceptance by the government. This acceptance is marked by the old Natal Code of Bantu Law 19 of 1891 and the Kwa Zulu Act 6 of 1981, which made it clear that the practice of traditional healing is official only if applied to its own people.

2.2.2.2 Northern Province (Limpopo)

According to Oskowitz (1991: 22) working together has been demonstrated in Mogopane, Northern Province. In this case the traditional healers were requested by the biomedical personnel to form part of a discussion group prior to initiation of working together as a pilot project. It was at this discussion meeting that both groups agreed that the traditional healer who consulted the patient first, if he wished to transfer the patient to hospital was allowed to accompany the patient so as to speed up the process of history taking. The biomedical personnel agreed to allow the traditional healer visitation rights for those patients whom they treated. The cases that are above the traditional healers' scope of healing were to be transferred to biomedical personnel. At discussion meetings it was agreed that the biomedical personnel are to be tolerant, learn from traditional healers and show them respect in the same fashion that the traditional healers are to learn from them, and show them respect.

Abdool Karim *et al.*, (1994:24) mentions a project which was spearheaded by the University of Witwatersrand at the George Masebe Hospital for their students of primary health care. The university arranged for meetings and workshops between themselves and the traditional healers of this part of the Northern Province. The idea was to exchange ideas and learn from each other. The university took some traditional medicines to test in their laboratory so as to identify useful ones and use them in treating patients. There was a mutual agreement on a referral system and during meetings the patients' progress was discussed. It was agreed by both traditional healers and the biomedical personnel that there is a need to learn from each other.

At this point in time the Health department of Limpopo is in the process of getting the traditional healers to form their own organization. According to Molaudzi (2001:67) this process is already progressing favourably and it is an initiative identified as important for this research even though the proceedings are not yet officially documented to be used as reference.

2.2.2.3 North West Province

In the district of Odi in the North West Province, Levitz (1992:25) describes a project by Dr Oberholzer who worked with Ms Jo Bierman on psychiatric patients who were seen by the traditional healers after referral from biomedical personnel. These patients were identified to be responding to both healing methods positively. Peu *et al.*, (2001:40) mentions an initiative which was undertaken by Professor Schalk Loots of the University of Pretoria in the North West Province, where he wanted to incorporate the traditional healers into primary health care. His colleagues lodged an objection to this initiative and this was aborted.

2.2.2.4 Gauteng Province

According to Straker (1994:459) a project was implemented in Johannesburg during a period of crisis caused by the uprisings. The biomedical personnel attended to anxiety states of patients who had been physically and psychologically traumatized. They allowed the patients to use their belief systems inclusive of traditional healing so as to resolve their anxiety states. It was identified that using these two therapies where the patients used biomedicine and traditional therapies, the results were satisfactory. Furthermore the need to work together with the traditional healers was identified by Holdstock (1979:122), when the traditional healers were requested by a business firm

to consult their employees having problems that were not resolved by biomedical personnel. This use of the traditional healer by this firm was said to yield the results which proved beneficial to both employer and employee alike, and the employees were retained.

There have been initiatives undertaken by researchers in Gauteng province, the only unfortunate part is the lack of documentation for such important initiatives, for the researcher to use as examples.

2.2.2.5 Eastern Cape

In the Eastern Cape, Anderson, Beaumont, Pryer and Robb (1996:65) describes a project involving alternative health practitioners and biomedical personnel. This project was undertaken in Port Elizabeth whereby the reflexologist manipulated and massaged the affected part whilst the biomedical personnel prescribed biomedicine. This combination yielded positive results which did benefit the patients.

The recent sepsis and death of young boys from initiation school has prompted the Gauteng, Free State, North West, Limpopo and Eastern Cape Health Departments to take cognizance of these initiation schools. The MEC for Health in the Eastern Cape in conjunction with Dr Sibongile Zungu, a biomedical person in the office of the MEC, requested that the traditional healers who work with these initiation schools be taught simple anti septic procedures like the use of clean blades and material for encouraging wound healing (Zungu, 2003:7).

This is a learning curve that is viewed with sceptism by some biomedical personnel and traditional healers, the results are said to be successful in decreasing sepsis and death of young men in their prime time.

The National House of Traditional Leaders for Circumcision, has been mandated with the task of providing some form of guidelines for these initiation schools even though there is the existence of the Traditional Circumcision Act which is presently to be complied with by all those participating in these activities (Ncaca, 2004:27).

2.2.2.6 Free State

The project which has been undertaken in the Free State was spearheaded by Dr Nono Khokho who is the head of Traditional Healers' Association in the Free State. She is the founder of the Bongani Traditional Clinic in the township of Rocklands in Mangaung, Bloemfontein.

The clinic is run in accordance with the agreement between them and a few biomedical personnel. This working relationship has some problems because the biomedical personnel do not refer the patients back to the traditional healers, and it is a one way process. At this time in the same province, because of its rural nature, the government identified the need to avail the copies of a bill which was passed to spearhead the process of enabling the traditional healers to work with biomedical personnel.

The bill is Notice 979 of 2003 passed as, the Traditional Health Practitioners Bill, 2003, which specifies the establishment of the traditional healers' council.

The functions of the council is to provide for a regulatory framework to ensure safety and quality of traditional health care services; to provide for control over registration, training, and practice of traditional health practitioners and what actions could be undertaken when providing health services (SA, 2003:1-36). The government of South Africa is in the process of reviewing this bill in preparation for it to be tabled. Davids and Keeton (2004:4) sees this move as paving a way forward to have the traditional healers join the biomedical personnel, a move long awaited by the traditional healers.

Conclusion

These projects as initiated by the provinces are examples of how the process of incorporation is really needed. The remarkable facts that are identified in these projects are the positive responses from patients when the two health care systems are used. These projects demonstrated that working together can be enhanced by agreement of what one group can do, which may not be repeated by the other, and can further be enhanced by reaching an agreement on how to resolve the patients' health problems. In all the nine (9) provinces of South Africa, there are identified continuous activities that are undertaken to enhance the incorporation of the traditional healers into the provincial health care systems. As of now the government has taken an initiative to request that the Medical Research Council develop protocols to assess claims regarding a cure from traditional medicines for HIV/AIDS, Type II Diabetes and Cancer (Smetherham. 2004:3).

This is a clear indication of how developments are progressing to speed up the process of incorporation in the country.

From the projects described above, follows the discussion on proposed approaches for incorporation of traditional healers into the National Health Care Delivery System.

3 Common themes in approaches for incorporation of the traditional healers into the National Health Care Delivery System.

Researchers who have written about the process of incorporation of the traditional healer almost all refer to the professionalization of the traditional healers. Under professionalization are different themes which are discussed hereunder. Attention will be given to the themes, such as policy formulation by the government, organizations and control of traditional healers' activities and practices, as well as reciprocal education and referral, to identify the most appropriate healing methods of some so as to teach the other. The ultimate goal is to form a partnership and be mutually involved in health care provision. These themes are described separately.

3.1 Policy formulation by the National Health Department

In South Africa there is presently no policy formulated to initiate any form of working together between the traditional healers and biomedical personnel be it by incorporation, collaboration or integration. According to the World Health Organization (WHO, 1996:5) each country is to have a national policy in place so as to be able to legalize traditional healing and to exercise control over the traditional healers' practices.

Harrison (1974:13) and Holdstock (1979:122) supported by Dunlop (1975:194), argue that there is a need for policy to be in place which will give clarity regarding the role that the traditional healer should play in health care provision. Daukstardt (1990:352-357) supports the statement and explains that once policy is formulated, it will pave the way for legalization of the traditional healers by the National Health Department.

The National Health Department of South Africa has passed The National Health Plan of 1994, The Homeopaths, Chiropractors and Allied Health Services Act of 1996, and the White Paper for the Transformation of Health Services of 1997, which all recognizes the existence of the traditional healer but does not explicitly define his role in health care provision. Setswe (1999:59) emphasizes that the ball is in the court of the National Health Department to formulate an act which will steer the process of incorporation in the right direction. This is regarded as a first step and a measure to bring about their official authorization to work with biomedical personnel.

According to Mototo (1999:96), Peu *et al.*, (2001: 124) and Melato (2001:78) traditional healers need to get a policy in place that authorizes them to function in health care settings, and this policy formulation is a process that needs to involve all stake holders from the multi – disciplinary health team, with the involvement of the government throughout.

3.2 Organizations for traditional healers

Organizations for traditional healers can exist only if the government legitimizes traditional healing. Dauskardt (1990: 354) is of meaning that it is imperative to have policy for this organization because one of its main functions will be to control members by registering them, licensing, evaluating their practices to see if they conform to the set norms and guidelines.

Abdool-Karim *et al., (*1994:7) add that the traditional healers need to have their own organization which is to be formulated within the act or policy to give them the authority to practice in South Africa. Further it delineates a safe position for the traditional healer to work closely with the biomedical personnel whereby the traditional healer may also communicate with the government through their own organization in the event of identified problems. A format of self organization can be in the same fashion as all the health professionals in South Africa as described by Freeman and Motsei (1991:1-5) whereby this organization establishes a body similar to the then South African Medical and Dental Council which is now replaced by the Health Professions Council.

The acts that are in place in South Africa to control the existence and practice of health professionals differ according to the education and training that has been received by that group of health professionals (Molaudzi,2001:89). The criteria for being a health professional belonging to that group is clearly spelled out and is constitution, for example no person can practice nursing in the republic of South Africa if that person does not meet the criteria to be a nurse according to the nursing Act 50 of 1978 as emended (S.A. Nursing Council,1995:6).

Hopa, *et al.*, (1998:10) is of meaning that if traditional healers are organized in that fashion, with own central controlling body then the process of working together can be feasible based on the premise that an agreement on how to cooperate can be reached by inviting only the executive of the organization to discuss the process of incorporation.

In May 2002 the World Health Organization launched the first global strategy in Traditional and Alternative Medicine. Peu (2001:54) supports the request of the WHO by saying that legislation passed at National level will to a greater extend grant professional status to the traditional healer and his practice. According to Muller and Steyn (1999:30) this strategy of the WHO provides a framework that policy makers can use to regulate both traditional healing and alternative medicine.

Chavunduka and Last (1986:35) explain that the Traditional Medical Practitioners Act No 38 of 1981 of Zimbabwe, enabled the traditional healers in that country to form their own council called Zimbabwe National Traditional Healers Association. This is a single national association which represents all traditional healers and has an official relationship with the government by virtue of its constitution through an act of parliament. All existing small associations were dissolved on the day of its establishment with the following purpose and functions:

- supervise and control the practice of traditional medical practitioners;
- promote the practice of traditional medical practitioner (identify, analyze or diagnose, treat without any application of operative surgery);
- foster research into and develop the knowledge of such practice;

- hold inquiries for the purpose of this act;
- make grants or loans to associations or persons where the council considers this necessary for the attainment of its goals.

This act clearly makes traditional healers autonomous practitioners who are solely responsible for their own acts, omissions and commissions. South Africa identified the need to follow the Zimbabweans in the call to have an act legalizing the organization for traditional healers. A bill which is the Traditional Health Practitioners' Bill of 2003 was passed and the position of this bill was to authorize establishment of the traditional healers' council. The purpose of this council is to ensure the efficacy, safety, and quality of traditional health care services (SA, 2003:3-36). This bill is to enhance self regulation by the traditional healers and does not clarify their position in working with the biomedical personnel. The specific area of concern after the bill was passed was that there is a need for this bill to be an act of parliament, to fortify the position of this council so that traditional healers communicate with the government in one voice. Molaudzi (2001:19) explains that the process of tabling this bill to be an act of parliament is currently being explored.

3.3 Licensure as part of self organization

Neuman and Lauro (1982:1819); Chavunduka (1989:121) and Dunlop (1989:194) are the proponents of the model for licensing the traditional healers prior to incorporation because with self organization the process of licensure follows smoothly.

Daukstardt (1990:357) supported by Levitz (1992:25) states that it will be easy to encourage all license holders to conform to further educational requirements if they need to practice. Freeman and Motsei (1992:1123) follows on this by adding that in the light of having own council and they are licensed, they will then have the government to answer to. According to Steenkamp (1993:16) supported Knottenbelt (1993:241) self organization will afford the traditional healer an opportunity to be legal and work with the biomedical personnel. As Molaudzi (2001:19) further explains, that this will help protect the public against exploitation by unscrupulous traditional healers. Reciprocal education is discussed hereunder.

3.4 Reciprocal education and referral for traditional healers and the biomedical personnel

To effect working together between the traditional healers and the biomedical personnel, it is identified that reciprocal education about basic biomedical practices and traditional healing methods, is of value in the health care settings. This theme proposes that the traditional healer and the biomedical personnel should share information about each other's healing practices. Teaching the traditional healer basic biomedical therapies which are useful in events where biomedical personnel are not available. According to Holdstock (1979:123) the traditional healer once taught basic biomedical practices, can be used in primary health care settings and as Levitz (1992:23) explains, in rural areas the traditional healer can even refer some cases that are beyond his skills to biomedical personnel.

Knottenbelt (1993:241) states that this referral needs to be mutual because the best of both healing practices are used simultaneously. Christie (1991:551) explains that the more the referrals, the better the cooperative services for the patients because the traditional healer would have been made aware of cases that are beyond his skills during information sharing. Jilek (1994:249) supported by Mototo (1999:103) and Molaudzi (2001:19) further states that mutual referral will enhance to a great extend sharing and exchanging ideas, to strengthen the communication that is lacking between these two health practitioners. Abdool Karim *et al.,(*1994:15) indicates that this information sharing will be enhanced by training programmes, that structure integrated curricula where selected traditional medicines that are identified as useful in patient treatment are taught to biomedical students. Yangni Angate (1988:56); Gumede (1991:45) supported by Freeman and Motsei (1992:1123) refers to this model as a multidisciplinary approach where parties involved share information as availed during teachings. Neuman and Lauro (1982:1819) as well as Holsoe (1992) explain that a traditional healer excellent in the treatment of some cases, is identified and can be trained during which, an incentive can be given in the same fashion as with the biomedical students. After education they return back home, to implement what they have been taught, and training can be continuous for as long as there are new medicines in the health centre, or when there is loss of biomedical personnel.

As Karlsson and Molantoa (1983:1123) concur, that after training they may have their own health centre and treat amongst others, mental cases. South Africa is faced with a challenge of addressing loss of biomedical personnel, and President Thabo Mbeki has indicated that it is necessary to train more people to address this issue (Bhengu, 2003:6; Annon , 2004:5).

There is a primary health care hand book on traditional medicines which is published by Kagiso Publishers, and another one by Felhaber (Felhaber,1997:1-89), to enrich the knowledge of both traditional healers and biomedical personnel alike in South Africa. This approach is advocated by the WHO and applicable to all areas of need (WHO,1978:5; WHO,1987:1820).

4 SUMMARY

This article concludes a literature review discussing the models for the incorporation of traditional healers into the National Health Care Delivery Systems. The article also discussed the international and South African models for incorporation of the traditional healers into the health care system. From the preceding discussion it appears as if the challenge of having policy in South Africa to legalize the traditional healer is putting a lot of pressure on the National government. It is therefore evident that the WHO is encouraging countries to use its policy frame work to assist in legalizing the traditional healer and his practices.

The process of legalizing the traditional healer is an issue, identified necessary and can be realized by policy formulation. The passing of a bill in 2003 by the South Africa affords the traditional healer an opportunity to be self organized and form their own interim council. The licensing of traditional healers will help to weed out bogus traditional healers and at the same time give them an opportunity for their voices to be heard by government. Reciprocal teaching and learning is the cornerstone of information sharing.

This reciprocal education is aimed at fostering mutual understanding of each other's mode of healing and an agreement on what is useful for the patient to resolve identified problems.

5 BIBLIOGRAPHY

ABDOOL KARIM, S.S., ZIQUBU PAGE, T.T. & ARENDSE, R. (1994) Bridging the gap – potential for a health care partnership between African traditional healers and biomedicine in South Africa. *South African Medical Association Journal.* December, 84 (2): 1-16.

AKERELE, O. (1987) The best of both worlds: bringing traditional medicine up to date. *Social Science & Medicine*, 24 (2): 177-187.

ANDERSON, E., BEAUMONT, P., PRYER, H & ROBB, S. (1996) Attitudes towards reflexology held by the general practitioner's in Port Elizabeth. University of Port Elizabeth. 1-14. May. (Unpublished report).

ANON. (1994) Drugs and Backrubs. Science and technology. *The Economist,* 93-94. 10, December.

BERMAN, B. (2001) Complementary medicine and medical education, *British Medical Journal,* 322: 121- 122.

BHENGU, C. (2002) China and South Africa agree on traditional medicine. *Soweta,* 24, May. 10.

BODECKER, G. & KRONENBERG, F. (2002) A public health agenda for traditional, complementary and alternative medicine, *American Journal of Public Health,* 92(10): October. 1582- 1585.

CHAVUNDUKA, G.L. (1986) ZINATHA. The organization of traditional medicines in Zimbabwe (in LAST, M. & CHAVUNDUKA, G.L. *eds.* The professionalization of African medicine. Manchester: Manchester University Press for International African Institute. p. 45.)

CHRISTIE, V.M. (1991) A dialogue between practitioners of alternative medicine and modern medicine in Norway. *Social Science & Medicine*, 35 (5): 549- 552.

DAUSKARDT, R.P.A. (1990) Traditional medicine: *Perspectives and policies in health care development Southern Africa,* 7 (3): 351-357.

DEPARTMENT OF HEALTH. **see** SOUTH AFRICA. DEPARTMENT OF HEALTH.

DSAE **see** DICTIONARY OF SOUTH AFRICAN ENGLISH.

DICTIONARY OF SOUTH AFRICAN ENGLISH: on historical principles. (1996) Oxford, N. Y.: Oxford University Press.

ERNST, E. (2001). Possible danger of integrating CAM in medical education. *Arch Internal Medicine,* 161:1680 -1681.

FASSIN, D. & FASSIN, E. (1988) Traditional medicine and the stakes of legitimisation in Senegal. *Social Science & Medicine,* 27 (4): 353-357.

FREEMAN, M. (1992) Negotiating the future of traditional healers in South Africa. *Critical Health,* 40. 64-69.

FREEMAN, M. & MOTSEI, M. (1991) Is there a role for traditional healers in health care in South Africa: A proposal. Centre for Health Policy. Johannesburg: University of Witwatersrand. December. 1-5.

FREEMAN, M. & MOTSEI, M. (1992) Planning health care in South Africa: Is there a role for traditional healers? *Social Science & Medicine*, 34 (1):1183-1190.

FULDER, S. (1985) A new interest in complementary (alternative) medicine: towards pluralism in medicine? *Impact of Science on Society,* 143: 235-243.

GEEST, S. & VAN DER GEEST, S. (1997) Is there a role for traditional medicine in basic health services in Africa? A plea for a community perspective. *Tropical Medicine and International Health,* 2 (9): 903-911.

GLASSER, M. (1988) Accountability of Anthropologist, indigenous healers and their governments: A plea for reasonable medicine. *Social Science & Medicine,*27 (12):1461-1464.

GORTE,E. (1989) Changing traditional medicine in rural Swaziland. Effects on global system. *Social Science & Medicine,* 29 (9) :1099-1104.

GREEN, E. & MAKHUBU, L. (1984) Traditional healers in Swaziland: Towards improved cooperation between traditional healers and modern health sectors. *Social Science & Medicine*, 18(12): 1071-1074.

GREEN, E.C. (1988) Can collaborative programs between biomedical and African indigenous health practitioners succeed? *Social Science & Medicine*, 27(1): 1125-1130.

GUMEDE, M.V. (1990) Traditional healers: A medical doctor's perspective. Johannesburg: Vista University Press.

GUMEDE, M. (1992) Side by side. *Publico,* 24-25: October.

HAVEKORT, J., HIEMSTRA, W. HOOFT, T. (2000) Learning to enhance life forces. *Compass News Letter.* July.28.

HAUS, M. (1987) The contemporary romance of alternative medicine. *The South African Medical Journal,* 72 (7) 445, October.

HESS, D. J. (2002) Complementary or Alternative? Stronger *vs* weaker integration policies. *American Journal of Public Health,* 92 (10) 1579-1581. October.

HOLDSTOCK, T.L. (1979) Indigenous healing in South Africa: a neglected potential. *South African Journal of Psychology*, 9(1) :118-123.

HOPA, M., SIMBAYI, C.C. & DU TOIT, C.D. (1998) Perceptions on integration of traditional and Western healing in the new South Africa. *South African Journal of Psychology*, 28(1): 8-14.

INGSTAD, B. (1989) Healer, witch, prophet or modern health worker? The changing role of ngaka ya Setswana (*In* WILDING, A. J. & VESTERLUND, A. *eds.* Experience and pluralism: Essays on African ideas of illness and healing. Stockholm: Almqvist & Wikrell. 145 p.)

JEFFREY, R. (1982) Policies towards indigenous healers in independent India. *Social Science & Medicine,* 16 (1): 1835-1841.

JILEK, W. G. (1994) Traditional Healing in the Prevention and Treatment of alcohol and drug abuse. *Trans-cultural Psychiatric Research Review,* 31 : 219 –258.

JURG, A..M. & MARRATO, J. (1992) Mozambican experience – policy and developments since independence. Centre for Health policy. Johannesburg: University. of Witwatersrand. 14-18.

KARLSSON, E. L. & MOLANTOA, K. E. M. (1984) The traditional healer in Primary Health Care. *Continuing Medical Education,* 2 :43-47, April.

KING, M. (1983) Medical Care in developing countries. London: Oxford University Press.

KNOTTENBELT, J.D. (1993) Systems of alternative medicine. *South African Medical Journal,* 83(2): 241, April.

LAST, M. (1986) The proffessionalistion of African Medicine. Manchester University Press: Manchester.

LEVITZ. E. (1992) Traditional Medicine: friend or foe? *Publico*, 233-236. October.

MADDOCK, J. (1985). Alternative medicine. *The American Journal of Medicine,*142 13 May. 539- 547.

MARCUS, D. M. (2001) How should alternative medicines be taught to medical students and physicians? *Academic Medicine,* 76: 248-250.

MELATO S.R. (2000) Traditional healer's perception of the integration of their practices into the South African national health systems. University of Natal. (Dissertation – M.A.)

MOLAUDZI, F.M. (2001) Synergy between indigenous knowledge systems, modern health care system and scientific research- A vision for the 21st century. *Health SA Gesondheid,* 6 (4): 14-20.

MOTOTO. O. M. (1999) Willingness of traditional healers regarding collaboration with western psychiatrist in health care. Bloemfontein: UOFS Library (Dissertation- M. Soc).

MULLER, A & STEYN, M. (1999) Culture and the feasibility of a partnership between westernized medical practitioners and traditional healers. *Society in Transition,* 30 (2).

NORTHRIDGE, M. (2004) Integrating ethno-medicine into public health. *American Journal of Public Health,* 92 (10): 1565-1566. October.

NEUMAN, A.K. & LAURO, P. (1982) Ethno-medicine and biomedicine linking. *Social Science & Medicine*, 16 (210) :1817-1824.

NZIMA, D.R., EDWARDS, S.D & MAKUNGA, N.V. (1992) Professionalization of traditional healers in South Africa: A case study. *University of Zululand Journal of Psychology*, 8: 82-91.

OPPONG, A.C.K. (1989) Healers in transition. *Social Science & Medicine,* 28(6) : 605 – 612.

OYENEYE, O.Y. (1985) Mobilising indigenous resources for Primary Health Care in Nigeria. A note on the place of traditional medicine. *Social Science & Medicine,* 20 (1): 67-69.

OSKOWITZ, B. (1991) Bridging the communication gap between traditional healers and nurses. *Nursing RSA,* 6 (7): 20-22, July.

PARK, M.C. (2002). Diversity, the individual and proof of efficacy: complementary and alternative medicine in medical education. *American Journal of Public Health,* 92 (10): 1568- 1571, October.

PEARCE, T. (1986) Professional interests and the creation of medical knowledge in Nigeria. (*In* Last, M & Chavanduka, G.L. *eds.* The proffessionalization of African Medicine. Manchester University Press: Manchester. pp. 237-258.)

PEU, M.D., TROSKIE, R. & HATTING, S.P. (2001) Attitudes of community health nurses towards integration of traditional healers in Primary Health Care in the North West Province. *Curations,* 25 (1) 49-55.

PINKOANE, M.G., GREEFF, M. & WILLIAMS, M. (2001) Patient relationship and therapeutic techniques of the South Sotho traditional healer. Potchfestroom : PU vir CHO (Dissertation -M.Cur.)

PRETORIUS, E. 1991. Traditional healing and modern medicine working in tandem. *Curationis,* Dec. 14 (4): 10-12.

RAMOKGOPA, M.T. (1993) The role of traditional healer and his psychological function in the African Society. Pretoria: Medical University of Southern Africa. (Dissertation - M. Psych.)

RAPPAPORT, H. & RAPPAPORT, M. (1981) The integration of scientific and traditional medicine: a proposed model. *American Psychologist,* 367: 774-781, July.

REILLEY, D.T. (1983) Young doctor's views on alternative medicine. *British Medical Journal,* 287: 337 – 339, July. 30.

S.A **see** SOUTH AFRICA. Department of health.

SOUTH AFRICA. Department of health. (1996) Annual Report. Pretoria: Government Printers.

SOUTH AFRICA. Department of health. (1997) White Paper for the transformation of the health system in South Africa. (Notice 667). *Government Gazette*, 17:910-1. April 16.

SOUTH AFRICA. Department of health. (2003) The Traditional Health Practitioners Bill. (Notice 979). *Government Gazette*, 24704. April. 11. 3-36.

STAUGARD, F. (1985) Traditional medicine in Botswana: traditional healers. Gaborone: Ipelegeng Publishers.

STEENKAMP, C.S. (1987) Chiropraktyk en Homeopatie: 'n voorbeeld van die legitimering van 'n newe struktuur. *South African Journal of Sociology,* 18 (2): 66-74.

STRAKER, G. (1994) Integrating African and western healing practices in South Africa. *American Journal of Ppsychotherapy*, 48: 455 – 467.

TRACHTENBERG, D. (2002) Alternative therapies and public health: crisis or opportunity? *American Journal of Public Health* ,92 (10) October.

VAN EEDEN. A. (1993) The traditional healer and our future health system. *South African Medical Journal,* 83, June. 441- 442.

WELTZER, M. (2001) The Bristol Cancer Centre experience. *The South African Journal of Natural Medicines,* 3: 23-25.

WILTSCHER, A. (1989) Faith and doubt. *The New Statesman and Society,* July, 7.

WHO **see** WORLD HEALTH ORGANIZATION.

WORLD HEALTH ORGANIZATION. (1978) The promotion and development of traditional medicine. Technical report series 622. Geneva: WHO Publications.

WORLD HEALTH ORGANIZATION. (1987) Traditional healers as community health care workers. A review of projects using traditional healer as Community Health Care worker. Geneva :WHO publication.

YANGNI-ANGATE, A. (1981) Understanding traditional medicine. *World Health Forum,* 2 (3) :465-466.

YODER P.S. (1982) Biomedical and Ethno-medical practice in rural Zaire. *Social Science & Medicine,* 16 (2): 1851-1857.

ZUNGU CHIEF. (1992) Should traditional healers be recognized and registered/ If so, how should this occur? Centre for Health Policy. Johannesburg. University of Witwatersrand.

ARTICLE 2: THE TRADITIONAL HEALERS' PERCEPTIONS AND ATTITUDES REGARDING THEIR INCORPORATION INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

GUIDELINES FOR JOURNAL : ETHNICITY AND HEALTH

Instructions for Authors: Notes for Contributors

Submissions. *Ethnicity & Health* welcomes original contributions from all parts of the world on the understanding that their contents have not previously been published or submitted for publication elsewhere. Manuscripts should be sent as an e-mail attachment to: ethnicity.health@gerrish.org.uk. The manuscript should be in the form of a single word-processed file in

MS Word or rich text format. Any tables and figures should be positioned at the end of this document. In exceptional circumstances if e-mail is not available, hard copy will be acceptable. Four complete copies, together with a copy on disc conforming to the above specification should be sent to: Professor Kate Gerrish, School of Nursing and Midwifery, University c Sheffield, Samuel Fox House, Northern General Hospital, Herries Road, Sheffield, S5 7AU, UK. Full notes for contributors can also be found on the Taylor & Francis website at www.tandf.co.uk/journals.

Manuscripts. All submissions must be in the style of the *Uniform Requirements for Manuscripts Submitted to Biomedical Journals* (International Committee of Medical Journal Editors, 5th ed., *N Eng J Med* 1997; 356: 309-15). Papers should be

typed on one side of the paper, double spaced, with margins of at least 2.5 cm (1 inch). All pages must be numbered.

The first page should include the title of the paper, first name, middle initial(s) and last name of the author(s), for each author a short institutional address, and an abbreviated title (for running headlines within the article). At the bottom of the page give the

full name and address (including fax number and e-mail address if possible) of the author to whom all correspondence

(including proofs) should be sent. The second page should repeat the title and contain an abstract of not more than 300 words The third page should repeat the title as a heading to the main body of the text. The text should normally be divided into

sections with the headings: Introduction, Methods, Results and Discussion. Long articles may need subheadings within some sections to clarify their contents.

Authors are requested to nominate up to three independent reviewers. Please submit suggested reviewers with your manuscri together with their postal and e-mail addresses.

Abstracts. All papers must be summarized in an abstract, structured under the headings Objective(s), Design, Result(s) and Conclusion if appropriate. If they so wish, authors are welcome to prepare an abstract in a second language, where appropriat alongside the abstract in English.

References. The reference system preferred in this journal (Harvard style) uses within the text, the name of the author and th date of publication in chronological order, e.g. (Harvey 1997; Jackson 1998). Where there are three or more authors, the first author's name followed by *et al.* should be used, e.g. (Dear *et al* 1997), but all authors should be cited in the reference list.

Two or more works by one author in the same year should be distinguished by using 1980a, 1980b, etc. Page numbers shoul be given in the text for all quotations e.g. (Jackson 1998: 56).

References should be listed in alphabetical order according to first author. The content and form of the reference list should conform to the following examples.

Journal article: the reference should include authors' surnames and initials, date of publication, title of paper, name of journal, volume number (and issue number where volume pages do not run on) and first and last page numbers, e.g. James S.A., Strogatz D.S., Wing S.B. & Ramsey D.L. (1987) 'Socio-economic status, John Henryism and hypertension in blacks and

whites', *American Journal of Epidemiology*, vol. 126, pp. 664-673.

Book: the reference should include authors' surnames and initials, date of publication, title of book, place of publication and publisher, e.g. Fenton S. (1999) *Ethnicity: Racism, Class and Culture*, Basingstoke, MacMillan.

Chapter in an edited book: the reference should include details of the authors and editors together with the first and last pages e.g. Krieger N. (2000) 'Discrimination and Health', in *Social Epidemiology*, eds L. Berkman & I. Kawachi, Oxford, Oxford University Press, pp. 36-75.

Theses: the reference should include the type of degree and awarding institution, e.g. Currer C.M. (1986) *Health concepts anc illness behaviour: the case of Pathan women in Britain*. PhD thesis, University of Warwick.

Newspaper: the reference should include the title of the publication, the date of publication and the page number, e.g. Marr A. (1999) So what kind of England do we really stand for?, *Observer*, 31 Oct. 22-23.

Units of measurement must be cited in SI units.

Illustrations (including photographs, graphs and diagrams) should be referred to as Figures and their position indicated in the text (e.g. Figure 3). Each should be submitted on a separate page, numbered in Arabic numerals. The captions should also be submitted on a separate page, should include keys to symbols and should make interpretation possible without reference to th text. Figures should ideally be professionally drawn and designed with the format of the journal (248×175 mm) in mind and

should be capable of reduction.

Tables should be submitted on separate pages, numbered in Arabic numerals, and their position indicated in the text (e.g. Tat 1). Each table should have a short, self-explanatory title. Vertical rules should not be used to separate columns. Units should

not appear in the body of the table. Any explanatory notes should be given as a footnote at the bottom of the table.

Proofs are supplied for checking and making essential typographical corrections, not for general revision or alteration. Proof corrections must be returned (by e-mail or fax) within 72 hours of receipt.

Early Electronic Offprints. Corresponding authors can now receive their article by e-mail as a complete PDF. This allows the author to print up to 50 copies, free of charge, and disseminate them to colleagues. In many cases this facility will be available

up to two weeks prior to publication. Or, alternatively, corresponding authors will receive the traditional 50 offprints. A copy of

the journal will be sent by post to all corresponding authors after publication. Additional copies of the journal can be purchased

at the author's preferential rate of £15.00 per copy.

Copyright. It is a condition of publication that authors assign copyright or license the publication rights in their articles, includir abstracts, to Taylor & Francis. This enables us to ensure full copyright protection and to disseminate the article, and of course

the Journal, to the widest possible readership in print and electronic formats as appropriate. Authors may, of course, use the article elsewhere after publication without prior permission from Taylor & Francis, provided that acknowledgement is given to

the Journal as original source of publication, and that Taylor & Francis is notified so that our records show that its use is prope authorised. Authors retain a number of other rights under the Taylor & Francis rights policies documents. These policies are referred to at http://www.tandf.co.uk/journals/authorrights.pdf for full details. Authors are themselves responsible for obtaining permission to reproduce copyright material from other sources.

THE TRADITIONAL HEALERS' PERCEPTIONS AND ATTITUDES REGARDING THEIR INCORPORATION INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

Martha G. Pinkoane

***Ph. D. candidate** (Potchefstroom campus of the North-West University)

Private Bag X021, Vaal University of Technology

Vanderbijlpark, South Africa

email:martha@vut.ac.

***Promoter**

Prof. Dr. Minrie Greeff

School of Nursing Science

Potchefstroom campus of the North-West University

Potchefstroom, North West Province, South Africa

e-mail: vpkmg@puk.ac.za

***Co -promoter**

Prof. Dr.Magdalena P. Koen

School of Nursing Science

Potchefstroom campus of the North-West University

Potchefstroom, North West Province, South Africa

e-mail:vpkmpk@puk.ac.za

***Forwarding address**

Prof. Dr Minrie Greeff

School of Nursing Science

Potchefstroom Campus of the North-West University

Private Bag x 6001

Potchefstroom 2520

North West Province

South Africa

Fax number+27 18 299 1827

e-mail: vpkmg@puk.ac.za

ABSTRACT

THE TRADITIONAL HEALERS' PERCEPTIONS AND ATTITUDES REGARDING THEIR INCORPORATION INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

Traditional healing need to be part of the National Health Care Delivery System in South Africa, whether be it by incorporation, collaboration or integration. All the parties concerned, namely traditional healers, biomedical personnel, patients and the policy makers demonstrate an array of mixed perceptions and attitudes regarding approaches for the inclusion of traditional healers in health care provision. These perceptions and attitudes are an indication of the complexity of the situation because these three approaches all address the issue of having the two health care systems functioning together. Research has proved that the traditional healer is the health care choice of 80-90% of the black population, reason enough to investigate the manner in which the traditional healer can be utilized effectively to render services and resolve the patients' problems.

Objectives: Investigate the perceptions and attitudes of traditional healers regarding their incorporation, as well as how they think it should be achieved.

Design: A descriptive, exploratory and contextual qualitative research design was used, participants were selected by means of non probable purposive voluntary sampling. Data was collected by means of conducting semi- structured interviews using a tape recorder, and documenting field notes. Data analysis was achieved by transcriptions, followed by translating it from vernacular to English. Open coding was

done, and a co-coder and researcher analysed the data independently after which consensus discussions took place to finalise the data. Trustworthiness was ensured in this research. Ethical principles were applied according to the guidelines of the South African Department of Health and the Democratic Nurses Organisation.

The results reflect that government need to formulate policy to legalize traditional healers, after which they are to be self organized and licensed. Communication and reciprocal education need to exist between biomedical personnel and traditional healers. There are ways identified to facilitate working together and constraints which hinder working together are to be removed. In conclusion traditional healers are prepared to work with biomedical personnel.

THE TRADITIONAL HEALERS' PERCEPTIONS AND ATTITUDES REGARDING THEIR INCORPORATION INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

1 INTRODUCTION AND PROBLEM STATEMENT

Traditional healing needs to be part of the National Health Care Delivery System in South Africa, whether it be by incorporation, collaboration or integration. Underlying this debate is an array of mixed attitudes from all the parties concerned, namely the traditional healers, biomedical personnel, patients, and the policy makers. This array of mixed attitudes and perceptions is a barrier to the process of incorporating the traditional healer into the South African National Health Care Delivery System.

The possibility of traditional healers and biomedical personnel functioning together has been investigated since the eighties. The two groups met in Johannesburg in 1986 to discuss ways by which functioning together can be established (Zungu, 1992:24). A series of meetings and discussions followed after which came the promulgation of the Chiropractors Homeopaths and Allied Health Services Professionals Act of 1996. This Act gives the traditional healers their due recognition but does not include them as part of health care providers, based on the premise that traditional medicines need to be scientifically tested first, before the traditional healer can be allowed to work with the biomedical personnel (Department of Health, 1996:24).

The identified variety of approaches for inclusion of the traditional healers into the National Health Care Delivery System is an indication of the complexity of the

situation. The definitions and processes of the three approaches, namely, *incorporation, integration and collaboration* are the most commonly debated concepts because they all address the issue of having the two health care systems functioning together to increase health care resources and resolve the patients' health problems. The difference that has been identified lies in the interpretation and perceptions and has no bearing on which approach should be regarded as the most important to use when selecting a model for the traditional healers to work together with the biomedical personnel (Pinkoane, Greeff & Koen,2005: 7). Various authors utilise different words to indicate a process of functioning together as identified by the World Health Organisation (W.H.O, 1978:22), and it is really not possible to clearly separate the definitions and processes of the three approaches, namely, *incorporation, integration and collaboration.* The difficulty of not being able to separate the meaning attached to them is because they all address the issue of having the two health care systems functioning together to increase health care resources and resolve the patients' health problems (Pinkoane *et al.*, 2005:6).

Reviewing the past, incorporation was initiated in South Africa in 1947 when the traditional healers association then known as the Dingaka Association, took an initiative and had petitioned the South African Medical and Dental Council for registration as practitioners (Holdstock, 1979:122). The South African Medical Council had questions for the traditional healers, which by then could not be answered.

According to Gumede (1992:25) both the biomedical personnel and the traditional healers, retreated behind their sterile masks, gall bladder curtains, plastic and skin aprons respectively, and reached a stalemate. However, to address the health needs of the population, there is a need to take a giant leap into the future of health care provision.

In South Africa the traditional healer is identified as the health care choice of 80-90% for the black population (Abdool Karim *et al.*, 1994:2). If this large number of black people uses traditional healing, then it becomes necessary to investigate the manner in which the traditional healer can be utilized effectively in the National Health Care Delivery System to render the services that the patient needs for her culturally defined illnesses. Nzima, *et al.*, (1992:89) supports Abdool Karim *et al.*, (1994:5) by stating that it remains necessary to draw attention to the role the traditional healer plays in the life of black people, because the traditional healer is accessible and sometimes the only available health care service nearer to the people in event of illnesses. He is seen as a resource person, a teacher, a conserver of cultural practices, and a religious consultant who has the ability to mediate between the people and the ancestors. The people respect the traditional healer, and his traditional therapeutic techniques are used without any questions or comments (Pinkoane *et al.*, 2001:55). Reilly (1983:339) is of meaning that a whole person needs a whole doctor to resolve her problems holistically and if the biomedical personnel and traditional healers are to work together, then both health care systems can be utilised to effect the holistic approach to patient care.

If South Africa should opt for incorporation, then the process of legalising the traditional healer and his practice need to be in place. South of the Equator in Africa, the Zimbabwean method of legalisation as described by Chavunduka (1986:99) can be used as an example to follow. In this legalization the traditional healers practice is allowed by legislation, and they are required by law to form organizations. These organizations are responsible for the ethical control of the traditional healers' practices.

Bhengu (2002:10) mentions that South Africa and China are in the process of working together to develop and regulate traditional medicines using the Chinese model of regulation to protect the people against unscrupulous and bogus traditional healers. This move by the government to cooperate with China regarding the regulation of traditional medicines is a step forward to initiate the process of legalisation solely because to obtain these medicines, implies requesting the traditional healer to avail these medicines, so as to analyse those that can be identified to be beneficial and exclude those that are harmful for the patients (Van der Geest, 1997:905). According to Oyeneye (1985:68) the incorporation of the traditional healers need not to be viewed only as a means of increasing manpower, but also to give answers to the patients' social and mystical health problems, therefore the process of incorporating them legally need to be weighed seriously.

The opinions of those concerned with health care provision, namely, traditional healers, biomedical personnel, patients and policy makers, need to be known so as to be able to agree on a working relationship and how a way forward should be achieved.

Therefore, it remains imperative to investigate perceptions and attitudes of the traditional healers to get an understanding of how they feel about this incorporation process. Once these perceptions and attitudes have been explored, it will then be feasible to further review the best modality that can be used to pave the way forward to get the two health care systems to work together. This article focuses on the perceptions and attitudes of traditional healers regarding their incorporation into the National Health Care Delivery System of South Africa.

One of the guidelines that the researcher formulated in her previous study, indicates that for the incorporation of the traditional healers into the National Health Care Delivery System to be a reality, those involved in health care provision need to remove the barriers and interact so as to give attention to the needs of the community that far outweighs personal opinions (Pinkoane *et al.*,2001:121). For the reasons of resolving the health problems of the patients as well as increasing health care personnel it is imperative to answer the following questions:

What are the perceptions and attitudes of the traditional healers, regarding their incorporation into the South African National Health Care Delivery System, as well as their views on how this incorporation should be achieved?

2 RESEARCH OBJECTIVES

To be able to answer the above mentioned questions the following research objectives need to be attained:

2.1 Explore the perceptions and attitudes of the traditional healers, regarding the process for their incorporation into the South African National Health Care Delivery System.

2.2 Explore their views on how they think this incorporation should be achieved.

3 PARADIGMATIC PERSPECTIVE

The paradigmatic perspectives of this research encompass the metatheoretical assumptions, and theoretical statements and are subsequently discussed.

3.1 Metatheoretical assumptions

The metatheoretical assumptions for this research are persons, health, illness, nursing and environment and are subsequently described. **The person** is seen as man, a cultural being who has survived through time and place because of his ability to care for the physical, spiritual, psycho- social and cultural well being of other men, across the life span in a variety of environments and in different ways (Fitzpatrick & Whall, 1997:187). Within this context **health** refers to a state of well-being that is culturally defined, valued and practised, and reflects the ability of individuals, family and communities to perform their activities in a culturally expressed, beneficial and patterned ways. **Illness** is a state of not being well resulting from man's interaction with an external environment, and is believed to be intentionally caused by four possible agents: God, the ancestors, witches and "pollution". Within this context **nursing** is the facilitation of health care focusing on helping the patient to regain his physical, psychological and spiritual well being with in an environment that is dynamic and ecological, in which human, plant and animals life nurtures and unfolds. An **environment** is comprised of both internal and external environment. An individual's internal and external environment is to a great extent shaped and moulded by the family or community within which one is born, which, if not respected or

preserved in a meaningful way, may lead to a state of not being well, therefore to illness (Giger & Davidhizar, 1997:68; Pinkoane *et al.*, 2001:87).

3.2 Theoretical statements

The theoretical statements refer to the conceptual definitions which are used to construct the conceptual framework necessary for formulating the preliminary model (Walker & Avant,1995:30). They are as follows:

- **National Health Care System**

  The total network or system of services and provision of health care in a specific country, including all particular health care systems of whatever nature which occur in a country (World Health Organization,1990:16; van Rensburg, Fourie & Pretorius,1994:2).

- **Traditional Healer**

  A person who is recognised to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background, as well as 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, 1979:9).

  In this research, reference to the traditional healer implies both male and female traditional healers. Where HE or HIS is used in this article, it also refer to female traditional healers.

- **Traditional Healing**

  A sum total of all knowledge and practices, explicable or not, used in the diagnosis, prevention, promotion, curing and elimination of physical, psychosocial or spiritual illness caused by four agents, God, ancestors, witches pollution, and relying exclusively on practical experience and observation handed down from generation to generation whether verbally or in writing (WHO, 1987:8). In this research traditional healing focuses on the actions of the traditional healer to fend off illnesses caused by these four agents.

- **Biomedicine**

  An inclusive system of health care, based on scientific and empirical knowledge and methods of treatment that are scientifically tested (Anon, 1996:51; Peu, 2000:78) and substantiated by research results preserved in writing (Hammond-Tooke, 1989:1).

- **Incorporation**

  Incorporation refers to a process of combining or bringing about two separate entities or bodies to function as one. This functioning can be authorised to act as one legal body by passing a law to enhance and legalise its existence. This legal body can be made up of different professionals or practitioners who have the same aim and objective (WHO,1987:7; DSAE,1996:507). This research aims at obtaining the perceptions and attitudes of all the parties concerned with health care provision so as to be able to understand how they think this incorporation should be achieved after which a model will be formulated to facilitate this incorporation.

4 RESEARCH DESIGN

This outlay gives a short description of the research design and method, that was followed. This research used a qualitative design (Mouton & Marais, 1992:45), with the goal of exploring and describing the perceptions and attitudes of the traditional healers, regarding the process of their incorporation into the South African National Health Care Delivery System, as well as their views on how this should be achieved. Subsequently a model will be formulated for their incorporation into the South African National Health Care Delivery System once all the other stake holders namely, biomedical personnel, patients and policy makers, have been interviewed (Chinn & Jacobs, 1995: 45; Walker & Avant, 1995:12). The research was conducted in Gauteng, North West and the Free State provinces in South Africa.

5 RESEARCH METHOD

5.1 Permission to conduct research

Permission to conduct research in the regions or districts of Gauteng, North West and Free State provinces, was obtained through a letter written to each of the regional or district health services managers within each province.

5.2 Sampling

5.2.1 Population

The population consisted of traditional healers practising in three provinces of Gauteng, North West and Free State, as the provinces purposefully selected for conducting the research. These traditional healers practiced independently of each other within these three mentioned provinces.

5.2.2 Sample

A non-probable purposive voluntary sample (Rubin & Babbie, 1997:226) was used for all traditional healers according to a criteria that follows:

- were practising in any one of the three provinces namely Gauteng, North West and Free State;
- met the definition of traditional healer according to World Health Organisation's definition (WHO,1978:7);
- were willing to participate and give written or tape recorded informed consent, after having been informed about the purpose and procedure of the research;
- were able to understand, communicate openly and prepared to be interviewed by the researcher through the medium of North or South Sotho, Tswana, Zulu, Xhosa, English, Afrikaans while being recorded on tape which was to be erased after the research.

5.2.3 Choice of intermediators

Senior traditional healers in Gauteng, North West and Free State provinces were selected as intermediators for other traditional healers. Letters were taken to them to inform them about their roles both as participants and inter-mediators in the research. As inter-mediators they were to act as "go between" to identify other traditional healers who were willing to participate in the research. As participants they were to allow the researcher to conduct an interview with them in the same fashion as with the other traditional healers.

The letters of the senior and other traditional healers had two written consent forms which were to be filled in as an agreement to act as a participant and a "go between." A copy of a letter to the other traditional healers was also availed to the

senior traditional healers. Those who could not read or write had the information read to them by the researcher the day when she came to arrange for an appointment.

Once the traditional healers were identified by the senior traditional healers, their names, residential addresses, telephone numbers and language preference was availed to the researcher who contacted them to inform them about the purpose and the procedure of the research as well as the day when the interviews were to commence. Confidentiality and anonymity was also communicated.

5.2.4 Sample size

The size of the sample was determined by the number of participants available in each province. From Gauteng, three senior traditional healers and nine traditional healers; North West, four senior traditional healers and twelve traditional healers; Free State, four senior traditional healers and twelve traditional healers were accessible to take part in the research. Data saturation was experienced when the thirtieth interview was conducted (Burns and Grove,1997:302- 306), but a further fourteen were done to confirm the findings.

5.3 Data gathering

5.3.1 Pilot study

The interview schedules were first evaluated by experts for appropriateness and the open ended questions which were not clear were refined and adjusted accordingly (Burns & Grove, 1997:52-57; 302). The researcher then conducted a pilot study with three senior traditional healers, and six traditional healers from all three provinces, from the sample of those who met the criteria for inclusion in the research.

The pilot study further helped to determine whether the questions in the interview schedules were clear and understandable to ensure that data collected was according to the research objectives.

5.3.2 Accessing the participants

The researcher made contact with the senior traditional healers to obtain the necessary written informed consent forms as well as the names, residential address, telephone numbers and language preference of other traditional healers who participated in the research. After receiving the written informed consents, the researcher contacted them personally a day before commencing with the interviews, to arrange for time and place where the interviews were conducted. These discussions were used as an opportunity to clarify uncertainties regarding some aspects of the research including ethical aspects like, confidentiality, anonymity, privacy, risks, withdrawal and possible termination. The consent forms were detached from the letters and were kept as proof of voluntary participation in the research.

5.3.3 Conducting interviews

The semi-structured interviews were conducted with all traditional healers, using an audio tape. The interviewer (researcher) explained to all the participants what was expected of them during the interviewing sessions. Two types of tape recorders were used to record the interviews, one with batteries and the other with electricity. The purpose was to ensure that all information was captured, in case one failed. The tape recorders were placed in such a manner that they did not cause a distraction during the interview. The researcher endeavoured to build rapport with all the participants to keep the atmosphere relaxed.

The interview schedules were read out prior to commencing the interview, the purpose being to clarify any misunderstandings that could arise regarding the questions and what the interview was all about. The semi structured interviews were commenced by asking the following questions in the interview schedule:

1. "What are your views regarding the incorporation of traditional healers into the National Health Care Delivery System?"

"O bona jwang taba e ya hore dingaka tsa Setho di sebedisane mmoho le dingaka tsa sekgowa?"

2. "How do you feel about this incorporation process?"

"Maikutlo a hao ke afeng tabeng e ya hore dingaka tsee tse pedi di sebedisane mmoho?"

3. "How do you think this incorporation should be achieved?"

"O nahana hore tshebedisano mmoho e e ka fihlellwa jwang?"

The participants were informed that they could converse freely as long as the conversation evolved around the objectives of the research. Enough time was given to each participant to answer questions as asked, and their level of education was taken into consideration. Communication techniques as described by Okun (1992:70-71) such as paraphrasing, reflecting, summarising, clarifying, and minimal verbal responses were applied during the interviews. Caution was exercised regarding giving personal perceptions, expectations, attitudes and meanings to reduce influencing the outcome of the interviews (Mouton & Marais, 1992:86). The interviews continued until all data was saturated.

5.3.4 Field Notes

The researcher took notes after conducting interviews with each of the participants and applied the guidelines of Talbot (1995:478) and Polit & Hungler (1997:307) to described the "what", "where", "who?" or "how?" of the situation. These field notes were documented immediately after each interview session and comprised of personal, observation and methodological notes. The dates, and places where field notes were taken were documented to facilitate an orderly and full description of data for analysis.

5.3.5 Physical Setting

Interviews were conducted at homes in the townships of Gauteng like Sebokeng, Orangefarm, Evaton, Sharpeville, Boipatong and Luipaardsvlei. In the Free State: Maokeng, Ramolotsi, Thabong, Mangaung, Qwaqwa and Deneysville. In the North West Province: Jouberton, Kanana, Khuma, Mmabatho,Tshing in Ventersdorp, Phokeng in Rustenburg and Leudoringstad were targeted. The settings where interviews were conducted were private, comfortable and pleasant, with minimal distractions. Telephones or cell phones were disconnected. The researcher made it clear to the traditional healers that during the interview there should be no disturbances or any consultations with any other person. The settings fostered physical and psychological freedom and enhanced participation. Ventilation was normal and the sitting place was arranged to facilitate eye contact and continuous rapport. All the homes were natural settings and did not conform to strict controlled or manipulated settings (Burns & Grove, 1997:42).

5.4 Data analysis

The audio taped interviews were transcribed verbatim by the researcher and translated from Tswana, South Sotho and Zulu/Xhosa and Afrikaans mix into English. Content analysis was used employing the method of open coding as described by Tesch *in* Cresswell, (1990:153-155). Transcriptions were presented in a manner that there was an area for notes, concepts were noted on the left and researchers perceptions on the right side. All the transcriptions were read through to get a sense of the whole. The most interesting or shortest transcription was read and words and themes were underlined as units of analysis. All the transcriptions were read underlining themes and words. Perceptions were written and spontaneous main categories and subcategories that came to mind were systemised in a table format. Perceptions and attitudes were used to help clarify these categories. The table was refined by translating it into scientific language. The use of double coding was employed whereby a nurse specialist or an expert co-coder decoded independently of the researcher. The co-coder received copies of the transcriptions, field notes, and a work protocol, that indicated the objectives of the research, the questions as asked to all the participants as well as the guide of steps as described above using a method of Tesch (*in* Creswell, 1994:153-157) of open coding. The researcher met the co-coder to discuss the findings so as to reach consensus and to finalise the tables.

5.5 Trustworthiness

Trustworthiness is described as a measure to ensure reliability and validity in qualitative research. For trustworthiness in this research a combination of the approach of Guba *(in* Krefting, 1991:214) and the model of Woods and Catanzaro (1988:136-137) for reliability and validity is used.

The model of Guba (*in* Krefting, 1991:214) using the criteria of credibility, applicability, consistency and neutrality, guided the outlay.

6 Ethical aspects

Ethical aspects specific to this research were taken into consideration as detailed in the Guidelines for the Democratic Nurses' Organisation of South Africa (DENOSA,1998:1-7) and the Department of Health (D.O.H, 2001:1-77).

These were:

- quality of the research was maintained by highest standards through thorough planning, implementation, documentation and the use of experts and a co-coder;
- confidentiality and anonymity was ensured by not revealing the identity of participants and areas where data was collected;
- privacy was ensured by recording interviews in total privacy of participants' homes, not divulging information to any other person and asked only research questions;
- informed consent obtained prior to conducting research, forms kept as proof thereof;
- risks minimised by little exposure to possible physical, psychological and social risks; and
- termination would have been undertaken, if relevant data could not be obtained.

7 Results, discussion and literature control

Five main themes emerged during the analysis of data, and these portrayed the traditional healers' perceptions and attitudes. The first main theme portrays the

perceptions and attitudes that reflects policy formulation as important for traditional healers. The second theme depicts the views for self organisation and licensure as necessary to effect incorporation. The third theme depicts communication and reciprocal education as a fact that need to be a reality between traditional healers and biomedical personnel. The fourth theme reflects ways identified to facilitate working together between the traditional healers and biomedical personnel and the last fifth theme portrays constraints which are seen as hindering the process of working together. These themes are discussed in detail followed by a literature control to validate the findings. To each theme is a sub-category which is indicated by a bullet and is given attention as the discussion of the research.

7.1 Theme one: Policy formulation is important for traditional healers

The first theme portray policy formulation as important for traditional healers. They saw that government need to formulate policy to legalize traditional healing so as to enhance their status and give them due authority to practice. This act or policy formulated by government should clearly spell out the role of traditional healers in health care settings. Policy makers and other stake holders should form part in this policy making process. This policy should allow government to building consulting rooms for traditional healers within the proximity of the hospital or clinic. Areas where consultation takes place to be inspected for safety and cleanliness.

- **Government to formulate policy to legalise traditional healing, so as to enhance their status and give them due authority to practice**

The following are their perceptions as expressed in words:

" It is the government which should pass a law that should give us legal power to work, people like Mr Mbeki "

" I see a way where the two groups to work together in harmony, all that you need is for the government to tell us in a form of a law that yes it is legal to work together then you will see another world"

Harrison (1974:13) and Dunlop (1984:194) confirm the results and indicates that there is a need for policy to be in place. Dauskardt (1990:352) supports the results and emphasises that the ball is in the court of the South African National Health Department to legalise the practice of the traditional healers. Freeman and Motsei (1992:1123); Abdool Karim *et al.*, (1994:6) and Peu *et al.*, 2001:124) confirm the research results with regard to formulation of policy to legalise traditional healing.

- **The act or policy formulated by government to clearly set out the role of traditional healers in health care settings**

These are the perceptions and attitudes that traditional healers expressed.

"When that law is passed the government should say what do they want us to do, do they want us to go to the clinics if so when, you know us healers have our way of doing things"

" It is something that needs to be laid down to be very clear, what should we do when we work together"

Melato (2000:27) and Peu *et al.,* (2001:45) supports these perceptions of the traditional healers that to be involved in patient care, it is necessary for the act to clearly spell out how they should function in health care settings. According to Mototo (1999:43) the services of the traditional healers can be used for psychiatric patients who are institutionalised.

- **Policy makers and other stake holders need to be part of this policy making process**

  Traditional healers want other stake holders to be involved in policy making since they will be the ones working with them. These views were said using the following words.

" The white doctors and some of our black doctors should be there where we will not be present to listen to the politicians when they make that law, that law is for the two of us"

"You know that we are not very educated in these things, it is only right that when that meeting of making this law is in place some of us should be there because our nurses and doctors who work with us should be present to talk for us all"

According to the WHO a National policy formulated in conjunction with health care providers to legalise traditional healing needs to be in place (WHO,1978:6). Melato (2001:56) confirm the results together with Molaudzi (2001:19).

- **Government to have policy for building consulting rooms for traditional healers which can be within the proximity of hospital or clinic**

These views of the traditional healers to have government build them their own consulting rooms, are as follows:

"I need you people to understand where we come from, when we work together we sort of need to have our own place to see patients, some of us are very poor therefore let the government help us, anybody with money is the government because the buildings will not be ours just like the hospitals."

"We need to have a building where we can be able to see our patients in private, a place that is build by our government so that we do not have to work from home, some of us stay in small places or shacks, so really we need to be helped in this regard"

Melato (2001:73) and Mototo (1999:35) support the findings regarding the need for the traditional healers to have their own places built within the area where their patients reside, or within the proximity of health services.

- **Areas where consultation takes place should be inspected for safety and cleanliness**

The need to have places where consultation takes place be evaluated for safety is identified by the traditional healers as necessary. These words reflect their views.

" *I feel it is important for us to work in clean places, the pots we use for boiling our medicines should be clean, they can come and see where we are and how we treat the patients"*

"Some of us stay in informal settlements but even then it does not mean our places should not be clean, we try to keep our areas clean so that when your people come they find that it is not so dirty as most people think"

Karlsson and Molantoa (1984: 47) and Peu *et al.,* (2001:152) supports the findings and explains that to enhance the cleanliness and safe hygienic practices the traditional healers need consulting rooms from where they can be able to see their patients (Bhengu, 2003: 8).

7.2 Theme two: Self organisation and licensure is viewed as necessary to effect incorporation

This is the second main theme and reflects the perceptions and attitudes of the traditional healers regarding formation of their own organisation as well as the necessity of licensure. The purpose of the organisation was seen as necessary to control the practice of traditional healers so as to effect unity among members, set

rules for ethical control, ensure that all traditional healers are licensed and to protect the knowledge of traditional healers.

- **Traditional healers need self organisation to control their practices**

The following words confirm the findings indicating that traditional healers' view self organisation as necessary to have self control over their practice.

"There are organisations something like associations and to tell the truth if these were like yours as nurses or like those of teachers I think we would be able to take care of ourselves as is the case with you people"

"It is something to really accept and appreciate for us to stand on our own and have our own group which is to act as our leaders, to talk for us and be our mouth piece"

Karlsson and Molantoa (1984:47) identifies this need for self organisation and mentions the Dingaka Association which ensured training and certification for traditional healers. Hopa *et al.*, (1998:10) and Peu *et al.*, (2001:125) mentions that there is an association called the Traditional healers' Association which is responsible for laying down rules as to how traditional healers should be trained, it has its headquarters in Hamanskraal. The Department of Health puts formation of an interim Traditional healers' Council in perspective, to provide a regulatory framework ensuring the efficacy, safety and quality of traditional health care practices (S.A, 2003:3- 36).

- **Organisation to effect unity by addressing rivalry and jealousy among members**

The presence of an organisation may help in neutralising rivalry and jealousy. The following quotations confirm these results.

" Actually I am worried that when we are busy fighting as local traditional healers how can we work with the nurses, so our association should call us and give us some advise on how to work together"

" We differ in our ancestors and this makes it difficult for us to reach an agreement on how to work with you people or doctors, if we can have some form of a person or whoever to help us resolve or act as a referee, we will be able to have a way forward"

Melato (2001:79) supports the research results by stating that different ancestors bring about difference in views about healing therapies therefore jealousy. Another form of disunity arises from the so called discrimination of males to female traditional healers, with male dominance over females. Peu *et al.*, (2001:120) and Bhengu (2003:8) supports the findings and states that their unity will be achieved much easier once organized.

- **Organization need to encourage traditional healers to identify and report bogus, immigrant traditional healers and ritual murders**

The traditional healers are perturbed by the actions of bogus traditional healers as well as insurgents of immigrant traditional healers.

The results are confirmed by the following statements.

" It is in fashion to be a bogus traditional healer who gives people things that are fake, so we are depending on organisations to help remove these people especially the immigrants"

" This is what is called ***"ngaka tjhitjha"*** *a healer who has not been to any training to be a healer, they do not know anything but pretend to be healers in order to make a living"*

According to Fassin and Fassin (1988:352) official recognition will assist in selecting quacks and charlatans from real healers. Abdool Karim *et al.,* (1994:15) and Melato (2001:78) supports the results by saying that a body or an association of traditional healers need to embark on a concerted effort to identify and eliminate undesirable health practices, including quacks and charlatans.

- **Organisation to set ethical rules for traditional healers to ensure that each one is accountable for own actions**

The research results show that the traditional healers see that there is a need for ethical control. The following words confirm these results.

"*When you have treated a person and you have made a mistake it is your own problem look for ways by which you can make that right"*

"Some people think they can get away with mistakes, the medicine does not work and then they send their person away after spending their money it is wrong and someone must stop such people"

Actions that are unbecoming are reported in the media and Melato (2000:32) supports the results that some traditional healers make mistakes and that they should report when something has gone wrong. Van Eeden (1993:441) and Bhengu (2003:24) supports the results that there are traditional healers who are involved in unscrupulous actions and are endangering the people's lives.

- **Each traditional healer to work according to how they are trained**

The traditional healers said that to overcome mistakes each traditional healer need to work according to how one is taught. The following words confirm these results.

"*We are all trained for a certain period of time and it is in the training that we get to know how to treat patients, how to do all things that concern care to the ill person, so one should do what you are taught unless you did not receive any form of training"*

" I really cannot remember how many times have I said to my students just do what I have taught you and if you do not know how come to me or phone, these things come to haunt you if they are not followed according to how the teachings have been done"

These words of the traditional healers are supported by Karlsson and Molantoa (1984:47) who states that traditional healers are taught at their own school and it is

therefore necessary to encourage formation of own school for their training. Molaudzi (2001:34) is of meaning that traditional healers should do what they have been taught to avoid unscrupulous actions that can put them into trouble.

- **Organisation to ensure that all traditional healers are licensed by their senior traditional healers and only the licensed ones work with biomedical personnel**

Traditional healers see organisations as responsible for encouraging senior traditional healers in each area to issue licenses to own students. The following quotations confirm these findings.

" We need licenses to be able to know that when we are to work with white doctors we are covered"

"We have talked amongst ourselves that we need to be licensed to practice, like Mme here, she went to get a license we do need to be licensed and these we can get from our masters they are the ones who taught us"

These research results are supported by Neuman and Lauro (1982: 1819); Chavunduka (1989:121) and Abdool Karim *et al.*, (1994:7) that traditional healers need to be licensed. Molaudzi (2001:19) states that the statutory body to be formed will have to control the practice of traditional healers.

- **Only licensed ones can work biomedical personnel.**

These are the words that they have expressed.

"The people with licenses are taught by seniors and they possess knowledge that is valuable to curing patients and when they have licenses the government will see that at least they are the people who can be among them"

" At times it is difficult to know a real healer from a fake unless you know from where that person has been trained, now when we talk of licenses let them be a sign of a person who has been taught and so to work with white doctors and nurses"

Neuman and Lauro (1982:1819) and Dauskardt (1990: 350) supports licenses by stating that those who have completed some known education should be licensed. Freeman and Motsei (1992:1120) and Abdool Karim *et al.*,(1994:5) refer to the need to license the traditional healer to enable him to function as a practitioner and to allow him to exercise his knowledge accordingly.

- **Organisation to ensure that the knowledge traditional healers possess is protected from being stolen by biomedical personnel**

From the research results the traditional healers said that they possess knowledge of traditional medicines and fear that the biomedical personnel may steal this from them.

These fears are verbalised below.

"There are some of us who have already given medicines to the white doctors to see if they work but then you never know the results, so we need to protect what we know"

"Sometimes I do not know what these associations do. We were called to a meeting where they told us that those of us who have any new herbs should bring them, when our medicines are good they do not tell us, when they are not right it is so easy for them to judge us"

Mototo (1999:37) and Moladzi (2001:16) states that the fear of property rights needs to be addressed to give them the opportunity to avail their herbs. Smetherham (2004:14) supports this availing of medicines to biomedical personnel as a step by the Human Science Research Council to continue with testing to find a cure for HIV/ AIDS.

7.3 Theme three: Communication and reciprocal education is to be a reality between traditional healers and biomedical personnel

These perceptions and attitudes emerged as the third main theme. They viewed having talks with biomedical personnel which should be in the form of meetings, discussions and information sharing. Reaching an agreement on identifying and availing the best treatment from each one to cure the patient. That best medicines are availed for testing and recognition should be received for useful medicines. Education and training of traditional healers about simple biomedical treatment should be undertaken. Biomedical personnel can be taught some traditional healing medicines. These discussions are as follows.

- **Having talks with biomedical personnel should be in the form of meetings, discussions and information sharing**

These perceptions of traditional healers having talks are expressed in the following words.

" When a person is enlightened and issues that are important are discussed, it is for them to truly see that traditional healers are also knowledgeable and need to be heard so that a way forward can be started"

" We need to have an agreement about how all of us is to work with the white doctors, therefore we must talk about it "

Haram (1991:173) and Oskowitz (1991:15) clarifies the necessity of these forums as a platform from which ideas can be exchanged and or fruitfully incorporated. Melato (2001:68) and Peu *et al.,* (2001:45) also mentions that these discussions can also be in the form of meetings.

The following words further confirm these findings about discussions and information sharing.

" It means as in the university we should have workshops, conferences where we look at all these issues, maybe when we know each other better we stand a chance to work together much easier than thought"

" When we meet and talk then it is easy for us to tell them what we are doing and so for them to tell"

Literature supports the results as Dauskardt (1990: 357) states that the lines of communication can be both formal and informal. Jilek (1994:249) and Abdool Karim *et al.,* (1994:11) mention the identified need to learn from each other as well as mutual exchange of ideas as the best way forward.

- **Reaching an agreement on identifying and availing the best medicines from each one to cure the patient**

The traditional healers' saw communication as necessary to both groups. The following words confirm these results.

"We need to come together and talk about treatment methods because there are those who are good with children, and those with women and so on, those who do things better than the others are the ones who should really be chosen to work with the doctors"

"If we agree it will be for the benefit of the patients' future because this person is helped by me while at the same time receiving treatment of the nurses"

Gumede (1990:235) supports the results and states that there is a necessity to use a multidisciplinary approach involving all specialist. Haram (1991:173); Knottenbelt (1993:241) and Melato (2001:68) confirm the results and explains this working together as bringing out the best from both worlds.

- **Avail best medicines for testing and receive recognition for useful medicines**

The traditional healers say those with best medicines can avail these for testing, and due recognition should be given to those whose medicines are useful.

These words support the findings.

"When we are together it will be easy for all of us to bring what we have so that the doctors can see what we have, I think even they can bring what they have to come and show us"

"Our medicines can be tested all that remains is that we should talk about f where can we do it, so that everybody knows that you have made a contribution for testing"

The results are supported by Fassin and Fassin (1988:354) and the World Health Organization that traditional medicines identified to be of value need to be availed for testing and this will give recognition to those who have contributed to tests and they can even be rewarded. The WHO has an encyclopaedia of traditional medicines in Congo Brazzaville (WHO, 1996:1). Molaudzi (2001:15) and Melato (2001:23) supports the results by stating that in communication both biomedical personnel and traditional healers can agree on the trial tests for these traditional medicines.

- **Education and training of traditional healers about some simple biomedical treatment**

This two way education and training is viewed by the traditional healers as necessary.

The following words portray these views.

" It does happen that when one is faced with problems that need some biomedical knowledge even though it does not have to be too much, but simple thing like treatment of wounds not using cow dung or other herbs, they can show us what they use"

" They called us the other day at the clinic to tell us about HIV/ AIDS and TB, to me it was an eye opener, we do need this information to help us know more about these two terrible diseases"

According to Oppong (1989:611) training traditional healers is a way seen as beneficial to increase their knowledge. Yoder (1982:1186) and Oskowitz (1990:32) supports the results and mention the need to teach the traditional healers fundamentals of biomedicine to identify problems and cases above their knowledge is a process that should be undertaken with earnestness.

- **Biomedical personnel can be taught some traditional healing medicines**

  The views of traditional healers indicating that the biomedical persons can learn some traditional medicines are confirmed by the following words.

"There is a lot that they can learn from us, just as we can learn from them even if it is more herbs than anything else, not that there is anything to hide"

"As of now teaching each other should be the order of the day if we are to work together they can come and in these meetings we teach them what we know, no one knows everything"

"They are getting from us all the herbs for testing, they can arrange that we teach them some ceremonies, why they are important to us as black people"

The results are supported by Neuman and Lauro (1982:1819) that biomedical personnel can be taught some traditional medicines where workshops and in-service education can be organized to effect these sessions (Abdool Karim *et al.*,1994:5 and Peu *et al.*, 2001:54).

7.4 Theme four: Identified ways to facilitate working together between traditional healers and the biomedical personnel

The traditional healers' perceptions and attitudes about ways identified to facilitate working together emerged as the fourth main theme. These reflect that the traditional healers are positive about working together but they need ancestral guidance to bless the process. Traditional healers should be given a chance to visit clinics and hospitals. Traditional healers can alternate with biomedical personnel for patient treatment. Referrals of patients to traditional healers by biomedical personnel is necessary and should not be one sided. Traditional healers do refer patients to clinic or hospital and yet biomedical personnel do not refer patients to them.

- **Traditional healers are positive about working together but need ancestral guidance to bless the process**

The following words confirm these results that traditional healers need ancestral guidance to bless working together.

"We have been healing people for a very long time before, all there is to do now is to ask from our ancestors if they approve of what you do if you do not ask for the light your things become dark"

" People do not believe when we tell them that working together is the right thing we are working together because in common sense the patient come here and go there, if this was wrong the ancestors would have long withdrawn their guidance"

Melato (2000:23) and Peu *et al.*, (2001:34) confirm the results that the traditional healers are now ready to work with biomedical personnel. Mototo (1999:45) mentions the positive notion expressed by traditional healers as an indication that they are ready to work with the biomedical personnel.

- **Traditional healers should be given a chance to visit hospitals and clinics**

The perceptions are expressed in the following words.

"We must have meetings to talk about how we can come and go in the clinics maybe a list of names of people who are to enter clinics and hospitals, make this list to say on which day who comes"

"The most important thing is to understand each other and from there to meet and finalise who should come to the clinic or hospital and when"

Zungu (1992:12) supports the research results and indicates that it is necessary to be given an opportunity to visit the patient in hospital but as yet nothing comes of the discussions. Oskowitz (1991:25) supports the findings that the traditional healers feel that they also need to accompany the patient to the clinic or hospital and that referral should be reciprocal.

- **Traditional healers can alternate with biomedical personnel for treatment of patients**

The following quotes confirm these results that treatment can be alternated.

"The times can be shared and that we give each other a chance to see our own patients"

" They can give their medicines at six in the morning and when I come at say nine then I give the patient mine, this is just an example, I know there can be a better solution to giving each other chance"

Green and Makhubu (1984:1078) supports the findings that the healing methods of one are identified and these are to be used to effect a cure. According to Freeman and Motsei (1992:1189); Knottenbelt (1993:241) and Abdool Karim *et al.*, (1994:10) there is a need to alternate treatment of patients to ensure positive results depending on the patient's diagnosis.

- **Referral of patients to traditional healers by biomedical personnel is necessary and should not to be one sided**

Mutual patient referral as means of ways to working together is viewed as important, and reflected by the following words.

" There is nothing that hurts a person more than when you know you have seen a patient and you indicate to him that he should go to the clinic or hospital, the only time you will know about that person is if he dies, then you carry the blame"

"To work with the doctors is not a problem, when I have seen a patient I will send him over for them to see what is wrong I am also expecting them to send over the ones that do not get better from their treatment"

Freeman and Motsei (1992:1141) and Abdool Karim *et al.*, (1994: 7) support the results that there should be mutual agreement on what needs to be referred one from the other.

- **Biomedical personnel do not refer patients to traditional healers**

The traditional healers indicated that no patients are sent to them by biomedical personnel. The following words confirm these findings.

" I think the big problem why we never get to hear about the patient again is because the nurses and doctors think we poison the people so why send them back to their death"

" They never send anyone to us it does not matter whether they see it is beyond their control or not, it has always been us sending patients to them not them to us"

These findings are supported by Oskowitz (1991: 34) that traditional healers do see the patients and send them to the biomedical personnel who never respond to sending cases to the traditional healers. Christie (1991:551) and Levitz (1992:25) states that for better services cross referrals are a necessity.

7.5 Theme five: Constraints which are seen as hindering the process of working together

The traditional healers identified constraints that hinder their way to work with biomedical personnel. They reflect that the biomedical personnel should respect, and not look down upon them. Traditional healers are receptive towards biomedical personnel and respect them. Biomedical personnel should trust traditional healers, treat them with dignity, and should understand their world.

- **Biomedical personnel should respect and not look down upon traditional healers**

The need for respect by biomedical personnel is quoted as:

" When they see you in these beads and clothes, they look at you as if you are nothing, sometimes it hurts badly because it is not by choice that we have this calling"

" Any way working together is good, but we need to sit and talk about why it is important to respect each other, we are adults, not children, when you want to know what I am doing, face me like an adults, I will tell you"

Oskowitz (1991:15); Melato (2001:23) and Peu *et al.*, (2001:56) and Pinkoane *et al.*, (2001:101) support the research results regarding the need for biomedical personnel to respect the traditional healer.

- **Traditional healers are receptive towards biomedical personnel and respect them**

The research results to support that the traditional healers are receptive towards the biomedical personnel, are reflected in these words.

" It does not mean that because some of us are not educated in lessons from a book, we are not wise to the on goings of the world, here in the Free State the Minister sends people to discuss important things with us and yes we feel like people"

"You send your patient to the hospital knowing that the person is going to be cared for, all these years that is what we have been doing"

Oskowitz (1991:15); Melato (2001:23) and Peu *et al.*, (2001:56) support the research results regarding the need for biomedical personnel to be receptive to the traditional healer who in return demonstrate that in health care provision they have always send their patients to them for treatment, in case where they were not successful.

- **Biomedical personnel need to trust the traditional healers and treat them with dignity**

These are the words that the traditional healers expressed to indicate the need to be trusted and treated with dignity.

" I did send a patient with a letter to explain what I did to the patient, and this very patient say that the nurses laughed at the letter, but one of them read it to the doctor because it was written in South Sotho, what does that mean"

"Why is it when you people are in the clinic that you feel we do wrong things to patients, I ask this because we do not think you believe the patient who is healed by us when you see him walk on his own"

Van Eeden (1993:441) supports the notion that traditional healers cannot be trusted with patients because some of their actions are questionable. According to Peu *et al.*, (2001:24) and Pinkoane *et al.*, (2001:56) it is necessary to build trust among health care providers for the patients to benefit from both health systems.

- **Biomedical personnel are to understand the traditional healers' world**

The following statements confirm these perceptions that biomedical personnel are to understand the traditional healers' world.

" When they see you with these beads on your head covered by red ochre, they look at you as if you are from out of here, sometimes it hurts so bad you start to wonder, but because it is not by choice that we have this calling, you keep to your people"

" All people who belong to the spirit world are seen to be somehow mad and yet it is not true, we understand the world of the living and the world where messages come in the form of dreams like in the Bible, so let us listen to each other"

These findings are supported by Abdool Karim *et al.*, (1994:4) and Arthur (1997:63) that the world of the traditional healer is of a different paradigm, but the need to understand them for what they are capable of achieving is necessary. According to Molaudzi (2001:23) the different world views need to be understood for what each stands for.

8 Conclusion

From the results and discussion it is noted that the traditional healers saw that there is a need for the government to be involved in the incorporation process. The government's involvement can be by way of formulating policy with involvement of all stake holders in health care provision, so as to legalise traditional healing. Policy can also be helpful in enabling the government to build consulting rooms for their practices to ensure patient safety. Once policy is formulated to effect this legalisation then traditional healers saw that it will be easy for them to organise themselves so as to be able to speak for themselves, be it with government or with biomedical personnel. The organisation will also be important in ensuring that its members practice with licenses, those without should not be allowed to work with biomedical personnel, and these

licenses will be a way of controlling all bogus and immigrant traditional healers. Punishment should be imposed by organisation to those traditional healers who perform illegal practices. Communication is seen as necessary between themselves and the biomedical personnel and in communication it will be feasible to learn and teach each other healing techniques and this can be achieved by meetings and discussion groups. Traditional healers have identified ways of working together, and are positive about this. They saw the ancestors' blessings as important for working together, which could be reached by an agreement of clinic or hospital visits. Treatment methods can be also be alternated and referral of patients can be done where if one method fails the other can take over the care of that patient. However constraints were identified and theses were related to lack of respect, dignity and trust, and were viewed as hindering the process of working together. These constraints could be resolved by the biomedical personnel being receptive to traditional healers and giving themselves an opportunity to learn to understand the traditional healers' world.

9 BIBLIOGRAPHY

ABDOOL KARIM, S.S., ZIQUBU- PAGE, T.T. & ARENDSE, R. (1994). Bridging the gap – potential for a health care partnership between African traditional healers and biomedicine in South Africa. *South African Medical Association Journal*, December.84(2):1-16.

AKERELE, O. (1987). The best of both worlds: bringing traditional medicine up to date. *Social Science & Medicine*, 24 (2): 177-187.

ANON. (1994). Drugs and Backrubs. *Science and Technology. The economist.* 93-94. December. 10.

ANON. (1996). Science versus tradition. *True Love:* 25, October. 51.

ARTHUR, M. (1997). The traditional biomedical dichotomy, in search of a common ground. *Curationis*, 20 (2): 63-65. July.

BHENGU, C. (2002). China and South Africa agree on traditional medicine. *Sowetan:* 24, May. 10.

BHENGU, R. (2003). Healers need nursing skills too. *Daily Sun*: 25, March. 8.

BOTES, A.C. (1995). The operationalization of research model in qualitative methodology. *RAUCUR*, 1(1): 1-9.

BURNS, N. & GROVE, S.K. (1997). The practice of nursing research: Conduct, Critique and Utilization. Philadelphia: W.B. Saunders.

CHAVUNDUKA, G.I. (1986). The Zimbabwe National Traditional Healers Association: ZINATHA. Harare. Zinatha Publication.

CHINN, P.L. & JACOBS, M.K. (1995). Theory and Nursing: A systematic approach. St. Louis. Mosby yearbook.

CHRISTIE, V.M. (1991). A dialogue between practitioners of alternative medicine and modern medicine in Norway. *Social Science & Medicine,* 35 (5) 549- 552.

DAUSKARDT, R.P.A. (1990). Traditional medicine: *Perspectives and policies in health care development Southern Africa,* 7 (3): 351-357.

DENOSA **see** DEMOCRATIC NURSES ORGANIZATION.

DEMOCRATIC NURSES ORGANIZATION. (1997). *Ethical standards for nurse researchers.* Pretoria: Denosa.

DEPARTMENT OF HEALTH **see** SOUTH AFRICA. DEPARTMENT OF HEALTH.

DSAE **see** DICTIONARY OF SOUTH AFRICAN ENGLISH

DICTIONARY OF SOUTH AFRICAN ENGLISH: on historical principles. (1996). NY., Oxford University Press.

DUNLOP, D.W. (1979). Alternatives to modern health care delivery systems in Africa: Public policy issues of traditional health systems (*in* ADEMUWAGUN, Z.A.A., AYOADE, J.A.A., HARRISON, T.E. & WARREN, D. M. *eds.* African therapeutic systems. Massachusetts : Crossroads.)

FASSIN, D & FASSIN, E. (1988). Traditional medicine and the stakes of legitimisation in Senegal. *Social Science & Medicine,* 27 (4): 353-357.

FITZPATRICK, J.J. & WHALL, A.L. (1996). Conceptual models of nursing: analyses and application. Connecticut: Appleton Lange.

FREEMAN, M. (1992). Negotiating the future of traditional healers in South Africa. *Critical health,* 40. 64-69.

FREEMAN, M. & MOTSEI, M. (1991). Is there a role for traditional healers in health care in South Africa: A proposal. Centre for Health Policy. Johannesburg: University of Witwatersrand. December. 1-5.

FULDER, S. (1985). A new interest in complementary (alternative medicine): towards pluralism in medicine. *Impact of Science on Society,* 143:235-243.

GLASSER, M. (1988). Accountability of Anthropologist, indigenous healers and their governments: A plea for reasonable medicine. *Social Science & Medicine,* 27(12):1461-1464.

GIGER, J. N. & DAVIDHIZAR, R. E. (1995). Trans- cultural nursing. Assessment and Intervention. St Louis: Mosby Year Book.

GORT, E. (1989). Changing traditional medicine in rural Swaziland. Effects on global system. *Social Science & Medicine,* 29 (9):1099-1104.

GREEN, E. & MAKHUBU, L. (1984). Traditional healers in Swaziland: Towards improved cooperation between traditional healers and modern health sectors. *Social Science & Medicine,* 18 (12): 1071-1074.

GUBA, E.G. *(in* Krefting, L. (1991) *Ed.* Rigor in qualitative research: the assessment of trustworthiness. *American Journal of Occupational therapy,* 45 (3): 214- 221. March.)

GUMEDE, M.V. (1990). Traditional healers: a medical doctor's perspective. Johannesburg: Vista University Press.

GUMEDE, M. (1992). Side by side. *Publico,* 24-25: October.

HARAM, L. (1991). Tswana medicine in interaction with biomedicine. *Social Science & Medicine,* 33 (2):167-175.

HOLDSTOCK, T.L. (1979). Indigenous healing in South Africa: a neglected potential. *South African Journal of Psychology,* 9 (1):118-123.

HOPA, M., SIMBAYI, C.C. & DU TOIT, C. D. (1998). Perceptions on integration of traditional and Western healing in the new South Africa. *South African Journal of Psychology,* 28 (2): 8-14.

INGSTAD, B. (1989). Healer, witch, prophet or modern health worker? The changing role of ngaka ya Setswana (*In* WILDING, A. J. & VESTERLUND, A. *eds.* Experience and pluralism: Essays on African ideas of illness and healing. Stockholm: Almqvist & Wikrell.)

JEFFREY, R. (1982). Policies towards indigenous healers in independent India. *Social Science & Medicine,* 16 (1): 1835-1841.

JILEK, W.G. (1994). Traditional Healing in the Prevention and Treatment of alcohol and drug abuse. *Trans-cultural Psychiatric Research Review,* 31 : 219 –258.

JURG, A. M. & MARRATO, J. (1992). Mozambican experience – policy and developments since independence. Centre for Health policy. Johannesburg. University. of Witwatersrand. 14-18.

KARLSSON, E.L & MOLANTOA, K. E. M. (1983). The traditional healer in Primary Health Care. *Continuing Medical Education,* 2 :43-47, April.

KNOTTENBELT, J. D. (1993). Systems of alternative medicine. *South African Medical Journal,* 83(2): 241.

LEVITZ. E. (1992). Traditional medicine: friend or foe? *Publico,* 233-236. October.

MELATO, S.R. (2000). Traditional healer's perception of the integration of their practices into the South African National Health Systems. University of Natal. (Dissertation- M. Psyche.)

MOLAUDZI, F. M. (2001). Synergy between indigenous knowledge systems, modern health care system and scientific research – A vision for the 21st century. *Health SA Gesondheid,* 6 (4) :14- 20.

MOUTON, J. & MARAIS, D. C. (1996). Basic concepts in the methodology of social sciences. Pretoria: R.G.N. Publishers.

MOTOTO, O.M. (1999). Willingness of traditional healers regarding collaboration with western psychologists health care. Bloemfontein: UOFS Library.(Dissertation- M Soc.)

MBURU, F.M. (1977). The duality of traditional and western medicine in Africa: Mystics, myths and reality. Essays in critique of medical anthropology. Rochester: Oakland University.

NEUMAN, A.K. & LAURO, P. (1982). Ethno-medicine and biomedicine linking. *Social Science & Medicine*, 16 (210) :1817-1824.

NGUBANE, H. (1977). Body and mind in Zulu medicine. London: Academic Press.

NZIMA, D.R., EDWARDS, S.D. & MAKUNGA, N.V. (1992). Professionalization of traditional healers in South Africa: A case study. *University of Zululand Journal of Psychology*, 8: 82-91.

OKUN, B.F. (1992). Effective helping: Interview and counselling techniques. California: Brookes/Cole.

OPPONG, A.C.K. (1989). Healers in transition. *Social Science & Medicine,* 28 (6) : 605 – 612.

OYENEYE, O.Y. (1985). Mobilising indigenous resources for Primary Health Care in Nigeria. A note on the place of traditional medicine. *Social Science & Medicine,* 20 (1): 67-69.

OSKOWITZ, B. (1991). Bridging the communication gap between traditional healers and nurses. *Nursing RSA,* 6 (7): 20-22. July.

PEARCE, T. (1986). Professional interests and the creation of medical knowledge in Nigeria. (*In* LAST, M & CHAVUNDUKA, G.L. *eds.* The proffessionalistion of African medicine. Manchester: University Press Manchester. p.237-258)

PEU, M.D., TROSKIE, R. & HATTING, S.P. (2001). Attitudes of community health nurses towards integration of traditional healers in Primary Health Care in North West Province. *Curations,* 25(1) 49-55.

PINKOANE, M.G., GREEFF, M & WILLIAMS, M. (2001). Patient relationship and therapeutic techniques of the South Sotho traditional healer. Potchfestroom: PU vir CHO. (Dissertation- M.Cur.)

PINKOANE, M.G., GREEFF, M. & KOEN, M.P. (2005). Models for the incorporation of traditional healers into the National Health Care Delivery System: A literature review. Potchefstroom. Potchefstroom campus of the North-West University. (Unpublished Ph. D thesis.)

POLIT, D. F. & HUNGLER, B.P. (1997). Nursing Research: Principles and Methods. Philadelphia: J.B. Lippincot Company.

RAPPAPORT, H & RAPPAPORT, M. (1981). The integration of scientific and traditional medicine: a proposed model. *American Psychologist,* 367, 774-781, July.

REILLEY, D.T. (1983). Young doctor's views on alternative medicine. *British Medical Journal,* 287: 337 – 339, 30 July.

RUBIN, A. & BABBIE, E. (1997). Research methods for social work. 3rd Ed. Pacific Grove: Brooks/Cole.

SMETHERHAM, J. A. (2004). Local flower power might be able to beat TB: Traditional medicine also show promise on AIDS. *The Star:* 15, Jan. 7.

S.A. **see** SOUTH AFRICA. Department of Health.

SOUTH AFRICA. Department of Health. (1996). Annual Report. Pretoria: Government Printers.

SOUTH AFRICA. Department of Health. (1997). White Paper for the transformation of the health system in South Africa. (Notice 667). *Government Gazette*, 17, 910-1. April 16. Cape Town: Government Publication.

SOUTH AFRICA. Department of Health. (2003). The Traditional Health Practitioners Bill. (Notice 979). Government Gazette, 24704. April. 11.3-36. Cape Town: Government Publication.

STAUGARD, F. (1985). Traditional medicine in Botswana: Traditional healers. Gaborone: Ipelegeng Publishers.

TALBOT, L. (1995). Principles and practice of nursing research. St Louis: C.V. Mosby.

TESCH, E. (1990). Research design: qualitative and quantitative approaches. (*In* CRESSWELL, J. *Ed.* A qualitative approach. *Library of congress catalogues in publication data.* p. 133-157)

VAN DER GEEST, S. (1997). Is there a role for traditional medicine in basic health services in Africa? A plea for a community perspective. *Tropical Medicine and International Health,* 2 (9): 903-911.

VAN EEDEN, A. (1993). The traditional healer and our future health system. *South African Medical Journal,* 83, June. 441- 442.

VAN RENSBURG, H.J.C., FOURIE, A. & PRETORIUS, E. (1994). Health care in South Africa: Structure and dynamics. Pretoria: Academica.

WALKER L.O. & AVANT, K.C. (1983). Strategies for theory construction in nursing. Norwalk. Connecticut. Appleton Century Croft.

WHO **see** WORLD HEALTH ORGANIZATION.

WORLD HEALTH ORGANIZATION. (1978). The promotion and development of traditional medicine. Technical report series 622. Geneva: WHO Publications.

WORLD HEALTH ORGANIZATION. (1987). Traditional healers as community health care workers. A review of projects using traditional healer as Community Health Care worker. Geneva. WHO publications.

WORLD HEALTH ORGANIZATION. (1996). Traditional medicine. Fact sheet 134. September. WHO (http://www.who.ch/).

WOODS, N.F. & CATANZARO. M. (1988). Nursing research. Theory and practice. St Louis: The C. V. Mosby Company.

YANGNI-ANGATE, A. (1981). Understanding traditional medicine. *World Health Forum,* 2(3):465-466.

YODER P.S. (1982). Biomedical and Ethno-medical Practice in rural Zaire. *Social Science & Medicine,* 16(2): 1851-1857.

ZUNGU CHIEF. (1992). Should traditional healers be recognised and registered: If so, how should this occur? Centre for Health Policy. Johannesburg: University of Witwatersrand.

ARTICLE 3: THE BIOMEDICAL PERSONNEL'S PERCEPTIONS AND ATTITUDES REGARDING THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

GUIDELINES FOR THE JOURNAL : SOCIAL SCIENCE & MEDICINE

SOCIAL SCIENCE & MEDICINE

Guide for Authors

Submission of Papers

Clickhere for Guidelines on Special Issues.

Social Science & Medicine is introducing a new online submission system, the Elsevier Editorial System (EES), with the aim of improving our editorial procedure for authors, editors and reviewers. The website address ishttp://www.ees.elsevier.com/ssm/

If this is your first time using the system you will need to go to the above page and register as a new author by clicking the 'Register' link. Once registered you may then submit your paper by clicking 'Submit New Manuscript' and following the instructions. All correspondence between editors and authors will be performed by e-mail and paper copies will not be required at the original submission stage.

The following types of contribution are welcomed:

1. Original research reports and critical or analytical reviews in any area of theory, policy or research relevant to health and illness. These may be up to 8000 words including abstract, tables, endnotes and references as well as the main text. Papers below this limit are preferred. The editors are prepared to consider longer papers in exceptional cases, though justification for this must be made at submission by the author.

2. Short research reports of research findings, "think pieces" or commentaries on topical issues. These papers should be no more than 2000 words.

3. Editorials or commentaries commissioned by the editors.

Submissions will be considered on the understanding that they comprise original, unpublished material and are not under consideration for publication elsewhere, and the studies on which they have been based have been subject to appropriate ethical review. A covering letter or e-mail to this effect should be enclosed with each submission, and it should be signed by all authors. This can be sent by post, electronically (i.e. as a scan), or by fax to the Managing Editor, Dr Ryan Mowat atrm158@le.ac.uk (Fax: +44 (0) 116 252 5259). *Social Science & Medicine* does not normally list more than six authors to a paper, and special justification must be provided for doing so. Further information on criteria for authorship can be found in *Social Science & Medicine*, 1997, 45(1), 1-2.

All submissions are subject to initial assessment by the senior editorial board to determine their suitability for consideration by *Social Science & Medicine*. Papers accepted for formal review will be sent anonymously to at least two independent

referees with *all identifiable details* removed. We are currently not considering companion pieces except in special instances. Authors should approach the Managing Editor if they wish to submit companion articles.

Manuscript Preparation

General: Submissions are acceptable in US or British English, but the use of either must be consistent throughout the manuscript. The editors reserve the right to adjust style to certain standards of uniformity. Authors should retain a copy of their manuscript since no responsibility can be accepted for damage or loss of papers. Original manuscripts and illustrations will be discarded one month after publication unless the publisher is asked to return original material after use. If hardcopies are submitted, they should be good quality single-sided printouts with a font size of 10 or 12pt on white paper.

Abstract and keywords: An abstract of up to 300 words must be included, as well as up to six keywords. The abstract should not be structured into subsections, and its word count should be provided.

Author details: This information is entered by following the instructions provided on the online submission system (EES).

Text: In the main body of the manuscript this order should be followed: abstract, abstract word count, keywords, full word count, main text, references, appendix, figure captions, tables and figures. Do not place tables or figures in the main text. As with author details, acknowledgements are entered separately during the online submission process. The full word-count must include all text, including that in the tables, figures, *references etc.* The use of endnotes and footnotes should be avoided if possible, though if necessary they should be listed separately at the end of the text and not at the bottom of each page. All endnotes (except for table footnotes) should be identified with superscript Arabic numbers. All pages must be numbered in the bottom right-hand corner.

References: *Social Science & Medicine* uses the APA referencing system, details of which can be found at http://www.apastyle.org/. All publications cited in the text should be presented in a list of references following the text of the manuscript. In the text refer to the author's name (without initials) and year of publication e.g. "Since Peterson (1993) has shown that..." or "This is in the agreement with results obtained later (Kramer, 1994)". *For 2-6 authors all authors are to be listed at first citation, with* "&" separating the last two authors, for more than six authors, use the first six authors followed by et al. In subsequent citations for three or more authors use et al. in the text. The list of references should be arranged alphabetically by authors' names. The manuscript should be carefully checked to ensure that the spelling of authors' names and dates are exactly the same in the text as in the reference list. References should be given in the following form:

Williams, S., & Calnan, M. (1996). Modern medicine: Lay perspectives and experiences. London: UCL Press.
Wethington, E., & Kessler, R.C. (1991). Situations and processes of coping. In J.

Eckenrode (Ed.), The social context of coping (pp.13-29). New York: Plenum Press.
Kanani, S. (1998). Towards quality of care in child health programmes: A challenge for the partnership in health and social sciences.*Social Science & Medicine*, 47(9). 1223-1230.

Referencing software such as Endnote® and Reference Manager® include the *Social Science & Medicine* style. If your current version of such software does not include the style it can be downloaded from the software website.

Illustrations: Details of the preferred file formats for electronically submitted illustrations can be found within the Artwork Instructions section of *Social Science & Medicine's* author gateway. All illustrations should be provided in camera-ready form, suitable for reproduction (which may include reduction) without retouching. Photographs, charts and diagrams are all to be referred to as "Figure(s)" and should be numbered consecutively in the order to which they are referred. They should accompany the manuscript, but should not be included within the text. All figures are to have a caption.

Line drawings: All lettering, graph lines and points on graphs should be sufficiently large and bold to permit reproduction when the diagram has been reduced to a size suitable for inclusion in the journal. Do not use any type of shading on computer-generated illustrations.

Photographs: Please access author gateway for more information on the file formats of photographs.

Colour: Where colour figures are required the author will be charged at the current colour printing costs. In cases where colour is paid for, authors will receive an additional one hundred offprints free of charge.

Tables: Tables should be numbered consecutively and given a suitable caption and each table provided in a separate file. Footnotes to tables should be typed below the table and should be referred to by superscript lowercase letters. No vertical rules should be used. Tables should not duplicate results presented elsewhere in the manuscript (e.g. in graphs).

Proofs: Proofs will be sent to the author (first-named author if no corresponding author is identified on multi-authored papers) by PDF wherever possible and should be returned within 48 hours of receipt, preferably by e-mail. Corrections should be restricted to typesetting errors; any other amendments made may be charged to the author. Any queries should be answered in full. Elsevier will do everything possible to get your article corrected and published as quickly and accurately as possible. Therefore, it is important to ensure that all of your corrections are returned to us in one all-inclusive e-mail or fax. Subsequent additional corrections will not be possible, so please ensure that your first communication is complete. Should you choose to mail your corrections, please return them to: Log-in Department, Elsevier Ltd, Stover court, Bampfylde Street, Exeter, Devon EX1 2AH, UK.

Offprints: Twenty-five offprints will be supplied free of charge. Additional offprints

and copies of the issue can be ordered at a specially reduced rate using the order form sent to the corresponding author after the manuscript has been accepted. Orders for reprints (produced after publication of an article) will incur a 50% surcharge.

Copyright: All authors must sign the "Transfer of Copyright" agreement before the article can be published. This transfer agreement enables Elsevier Ltd to protect the copyrighted material for the authors, without the author relinquishing his/her proprietary rights. The copyright transfer covers the exclusive rights to reproduce and distribute the article, including reprints, photographic reproductions, microfilm or any other reproductions of a similar nature, and translations. It also includes the right to adapt the article for use in conjunction with computer systems and programs, including reproduction or publication in machine-readable form and incorporation in retrieval systems. Authors are responsible for obtaining from the copyright holder permission to reproduce any material for which copyright already exists.

Author Services: For enquiries relating to the submission of articles (including electronic submission where available) please visit the Author Gateway from Elsevier Ltd at http://authors.elsevier.com. The Author Gateway also provides the facility to track accepted articles and set up email alerts to inform you of when an article's status has changed, as well as detailed artwork guidelines, copyright information, frequently asked questions and more. Contact details for questions arising after acceptance of an article, especially those relating to proofs, are provided after registration of an article for publication.

BIOMEDICAL PERSONNEL'S PERCEPTIONS AND ATTITUDES REGARDING THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

Martha G. Pinkoane Ms.
* **Ph. D. candidate** (Potchefstroom campus of the North-West University)
Vaal University of Technology
Private Bag x 021
Vanderbijlpark, 1900.Gauteng Province
e-mail:martha@vut.ac.za

Minrie Greeff Prof. Dr.
* **Supervisor: Professor in research**
School of Nursing Science
Potchestroom campus of the North-West University,
Private Bag x 6001
Potchefstroom 2520. North West Province. South Africa
e-mail: vpkmg@puk.ac.za

M.P Koen Prof. Dr.
***Co supervisor: Associate Professor**
School of Nursing Science
Potchefstroom campus of the North-West University,
Private Bag x6001
Potchefstroom, 2520. North West Province, South Africa
e-mail:vpkmpk@puk.ac.za
***Forwarding address**:
Minrie Greeff Prof. Dr.
School of Nursing Science
Private Bag x 6001.
Potchefstroom campus of the North-West University
Potchefstroom 2520.
North West Province, South Africa
e-mail: vpkmg@puk.ac.za

BIOMEDICAL PERSONNEL'S PERCEPTIONS AND ATTITUDES REGARDING INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM

ABSTRACT

The attitudes of biomedical personnel are a mixture of emotions varying from being negative to positive regarding the process of incorporating the traditional healers into the National Health Care Delivery System of South Africa. Negative notions were attributed to concerns like, financial gains and the prestige of being a biomedical person. The positive notions identified in those who were interested in establishing a working relationship, was mainly to avail health services to a large number of the population in rural and or urban settings. The only way seen as befitting to avail these services, was to involve the traditional healers in health care provision.

To be able to identify ways of working together the research focused on investigating the perceptions and attitudes of the biomedical personnel regarding the incorporation of traditional healers into the South African National Health Care Delivery System, as well as their views on how this incorporation should be achieved.

A descriptive, exploratory and contextual qualitative research design was used. Participants were selected by means of non probable purposive voluntary sampling. Data was collected by means of conducting semi- structured interviews using a tape recorder and documenting field notes. Data analysis was achieved by transcriptions and open coding. A co-coder and researcher analysed the data independently. Consensus discussions took place to finalise the data. Trustworthiness was ensured. Ethical principles were applied according to the guidelines of the South African Department of Health and the Democratic Nurses Organisation.

Results and conclusion: Government need to be involved in incorporation by passing an act. Traditional healers need to be self organized to control their practice, licensed, trained and educated. Communication is necessary to effect working together.

Key words:

National Health Care Delivery System, traditional healer, biomedical personnel, biomedicine, incorporation, patients.

1 INTRODUCTION AND PROBLEM STATEMENT

There is an identified array of mixed perceptions and attitudes which created a barrier to the process of incorporating the traditional healers into the South African National Health Care Delivery System. The parties concerned who demonstrate these mixed emotions were traditional healers, biomedical personnel, patients and policy makers, yet the need to have the traditional healer be part of the National Health Care Delivery System is a reality that needs to be addressed (Pinkoane, Greeff & Koen, 2005).

Pinkoane *et al.*, (2005) discussed a variety of approaches for inclusion of the traditional healers into the National Health Care Delivery System of South Africa, namely, *incorporation, integration and collaboration.* These commonly debated concepts all address the issue of having the two health care systems functioning together to increase health care resources and resolve the patients' health problems. The difference that has been identified lies in the interpretation and perceptions, and has no bearing on which approach should be regarded as the most important to use when selecting a model for the traditional healers to work together with the biomedical personnel.

According to Gort (1981) the mixed attitudes of biomedical personnel are better explained as being negative and positive regarding the process of incorporating the traditional healers into the National Health Care Delivery System. Green (1988) states that a factor which contributed to the negativity of the biomedical personnel towards the process of incorporation was that some of the traditional healers are making more money and this makes the competition for patients very strong for both groups when

they practice in the same neighbourhood (Schnaubelt,1990). According to Freeman and Motsei (1992) the negativity further results from fear regarding the reign over health care provision. All these years health care provision has been in the hands of biomedical personnel, therefore power sharing with the traditional healer who is regarded as a nobody is actually very offensive to them and affects their status as well as their exclusive wealth (Green,1988). The other aspect of unhappiness results from being deeply suspicious about the traditional healers' methods of healing, and to protect their domain the biomedical personnel claim that they have witnessed harmful treatment from the traditional healers and that traditional healing is a myth and primitive and renders no identified cure (Abdool Karim *et al.*, 1994). Freeman (1992) states that Dr Nthato Motlana, a medical practitioner based in Soweto argues that there is no reason why they should work with the traditional healers. He based his objection on the premise that traditional healing is not provision of proper medical care, it is nothing but 'mumbo jumbo' and that if primary health care should be provided to the people, it should be availed by trained nurses and not by traditional healers. This negativity is refuted by Levitz (1992) who positively states that there is a need to involve the traditional healers to improve primary health care services, and be able to reach and cure a large number of the population. To be able to attain this ideal goal, they need to have the compliance and involvement of the traditional healers for health care provision (Ingstad ,1989).

Neuman and Lauro (1982) indicates that even though incorporation may be viewed to be difficult between biomedical personnel and traditional healers, there are other biomedical personnel who are interested in establishing working together with the

traditional healers. Gumede (1990) postulates that there is a need to work together towards the process of incorporation to attain a joint goal of 'Health for all by the twenty first century' which is a strong request made by the World Health Organization (WHO, 1978). Freeman (1992) regards the process of incorporation as a fact that cannot be ignored, stating that even if the biomedical personnel can show these mixed perceptions, there are still some who nonetheless see a role for the incorporation of traditional healers into the National Health Care Delivery System. The Allied Health Professions and Chiropractors Act of 1996 (Department of Health,1996) and the White Paper for the Transformation of the National Health Care Systems of 1997 (Department of Health, 1997), have paved the way for their due recognition even though both do not clarify the traditional healers' role in health care provision explicitly.

It is for this reason of trying to get a way in which the biomedical personnel can work together with the traditional healers that it remains imperative to get an understanding of how traditional healers, biomedical personnel, patients and policy makers feel about this incorporation process. The guidelines that the researcher formulated in her previous study, indicates that for incorporation of the traditional healers into the South African National Health Care Delivery System to be a reality, those involved in health care provision need to remove the barriers and interact so as to give attention to the needs of the community that far outweighs personal opinions (Pinkoane *et al.*, 2001).

2 RESEARCH OBJECTIVES

The following research objectives were the focus of this research:

2.1 Explore the perceptions and attitudes of the biomedical personnel, regarding the process for the incorporation of traditional healers into the South African National Health Care Delivery System

2.2 Explore the biomedical personnel's views on how this incorporation should be achieved.

3 PARADIGMATIC PERSPECTIVE

The paradigmatic perspective of this research encompass the metatheoretical assumptions, theoretical statements, and are subsequently discussed (Pinkoane *et al.*, 2005).

3.1 Metatheoretical assumptions

The person is seen as man, a cultural being who has survived through time and place because of his ability to care for the physical, spiritual, psycho- social and cultural well being of other men, across the life span in a variety of environments and in different ways (Fitzpatrick & Whall, 1997). Within this context **health** refers to a state of well-being that is culturally defined, valued and practised, and reflects the ability of individuals, family and communities to perform their activities in a culturally expressed, beneficial and patterned ways. **Illness** is a state of not being well resulting from man's interaction with an external environment, and is believed to be intentionally caused by four possible agents: God, the ancestors, witches and "pollution". Within this context **nursing** is the facilitation of health care focusing on helping the patient to regain his physical, psychological and spiritual well being with in

an environment that is dynamic and ecological, in which human, plant and animals life nurtures and unfolds. An **environment** comprises of both internal and external environment. An individual's internal and external environment is to a great extent shaped and moulded by the family or community within which one is born, which, if not respected or preserved in a meaningful way, may lead to a state of not being well, therefore to illness (Giger & Davidhizar, 1997; Pinkoane e*t al.*, 2001 and Pinkoane *et al.*, 2005).

3.2 Theoretical statements

The theoretical statements refer to the conceptual definitions (Pinkoane *et al.*, 2005) which are to be used to construct the conceptual framework necessary for formulating the preliminary model (Walker & Avant,1995). These are as follows:

- **National Health Care System**

The total network or system of services and provision of health care in a specific country, including all particular health care systems of whatever nature which occur in a country (World Health Organization,1990; van Rensburg, Fourie & Pretorius,1994).

- **Traditional Healer**

A person who is recognized to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious

background, as well as 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).

In this research, reference to the traditional healer implies both male and female traditional healers. Where HE or HIS is used in this research, it also refers to female traditional healers.

- **Traditional Healing**

A sum total of all knowledge and practices, explicable or not, used in the diagnosis, prevention, promotion, curing and elimination of physical, psychosocial or spiritual illness caused by four agents, God, ancestors, witches pollution, and relying exclusively on practical experience and observation handed down from generation to generation whether verbally or in writing (WHO, 1978). In this research traditional healing focuses on the actions of the traditional healer to fend off illnesses caused by these four agents.

- **Biomedicine**

An inclusive system of health care, based on scientific and empirical knowledge and methods of treatment that are scientifically tested (Anon, 1996; Peu, *et al.*, 2001) and substantiated by research results preserved in writing (Hammond-Tooke, 1989).

- **Biomedical Personnel**

Doctors, nurses, pharmacists, psychologists/psychiatrists who have been scientifically trained for years as professionals at an institution of learning, university or college (Holdstock, 1979; Abdool Karim *et al.*, 1994; Arthur, 1997).In this research HE is used to refer to both male and female biomedical personnel.

- **Incorporation**

Incorporation refers to a process of combining or bringing about two separate entities or bodies to function as one. This functioning can be authorized by passing a law to enhance and legalize its existence. This legal body can be made up of different professionals or practitioners who have the same aim and objective (WHO,1987; DSAE,1996). This research aims at formulating a model to facilitate the incorporation of traditional healers to work with biomedical personnel to avail health care services.

4 RESEARCH DESIGN

This outlay gives a short description of the research design and method, that was followed in various articles. This research used a qualitative design (Mouton & Marais, 1992), with the goal of exploring and describing the perceptions and attitudes of the biomedical personnel, regarding the process for incorporation of the traditional healers into the South African National Health Care Delivery System, as well as their views on how this should be achieved. Subsequently a model will be formulated for the incorporation of traditional healers into the South African National Health Care

Delivery System (Chinn & Jacobs, 1995; Walker & Avant, 1995). The research is conducted in Gauteng, North West and Free State provinces in South Africa.

5 RESEARCH METHOD

5.1 Permission to conduct research

Permission to conduct research in the regions or districts of Gauteng, North West and Free State provinces, was obtained through a letter written to each of the regional or district health services managers within each province.

5.2 Sample

5.2.1 Population

The population consisted of biomedical personnel practicing in the three provinces of South Africa, namely, Gauteng, North West and Free State. The population of biomedical personnel consisted of professional nurses, medical doctors, psychologists, psychiatrists, and pharmacists some who practice independently and others in community health centres.

5.2.2 Sampling

A non probable purposive voluntary sample (Rubin & Babbie, 1997) was used. The selection for the various groups of biomedical personnel was done according to the specific criteria that follows.

5.2.2.1 Selection criteria for nurses:

- They were nurses from each of the different health care centres in the identified provinces of Gauteng, North West and the Free State;

- They were professional nurses registered with the South African Nursing Council under Act 50 of 1978;

- Have been practicing for more than five years in community health care centres;

- Were willing to participate in research and give written informed consent to participate in the research after receiving the reasons and the procedures of the research;

- They were able to communicate effectively and interact with the researcher through the medium of either English, Afrikaans, North and South Sotho, Tswana, Zulu and Xhosa; and

- Were prepared to participate in the semi structured interview whilst recording it on tape.

5.2.2.2 Selection criteria for medical doctors, psychiatrists and psychologists:

The were:

- registered with the Health Professionals Council;
- practicing for more than five years;

- attending to patients in health care centres availing primary health care and receives referrals from these centres;
- willing to participate in research and give written informed consent after receiving the reasons and procedures of the research ;
- prepared to participate in a semi structured interview whilst recording it on tape; and
- able to communicate effectively and interact with the researcher through English, and Afrikaans.

5.2.2.3 Selection criteria for pharmacists

Pharmacists were:

- registered with the Pharmacy Board;
- practicing and dispensing medicines and related substances under the Act 101 of 1965 as emended by Act 90 of 1997, for more than five years;
- practicing in the community health centres in Gauteng, North West and Free State;
- willing to participate in the research and give written informed consent after receiving the reasons and procedures for the research;
- prepared to participate in a semi structured interview whilst it is recorded on tape which were erased after the research; and
- able to communicate effectively and interact with the researcher through English and Afrikaans.

5.2.3 Choice of an intermediator

Senior regional district health services managers in Gauteng, North West and Free State provinces were selected as intermediators. Letters were taken to them to inform them about their roles both as participants and inter-mediators in the research. The letters of the senior district health services managers had two written consent forms which were to be filled in as an agreement to act as a participant and a "go between," a copy of a letter to the other biomedical personnel was also availed to the senior district health services managers. Once the biomedical personnel were identified by the senior district health services managers, they were contacted by the researcher to inform them about the day when the interviews were to commence.

5.2.4 Sample size

The following biomedical personnel were accessible and available to take part in the research, from Gauteng province three doctors, two clinical psychologists, two psychiatrists, two pharmacists, three nurses, total twelve; North West province, three doctors, three nurses, two psychiatrists, three pharmacists and one clinical psychologist, total twelve; Free State province fourteen interviews were conducted comprising of three doctors, four nurses, two psychiatrist, two clinical psychologists and three pharmacists. A further two interviews were conducted with the doctors to confirm the findings. Data saturation determined the size of sample for biomedical personnel and was experienced when the thirty sixth interview was conducted (Burns & Grove, 1997).

5.3 Data collection

5.3.1 Pilot study

The interview schedules were first evaluated by experts for appropriateness and the open ended questions which were not clear were refined and adjusted accordingly (Burns & Grove, 1997). The researcher then conducted a pilot study with two senior district health services managers and four biomedical personnel from three districts of each of the three provinces, from the sample of those who met the criteria for inclusion in the research. The pilot study further helped to determine whether the questions in the interview schedules were clear and understandable to ensure that data collected was according to the research objectives.

5.3.2 Accessing the participants

The researcher contacted the senior district health services manager to obtained the necessary written informed consent forms as well as the names, addresses and telephone numbers of the biomedical personnel who participated in the research. After receiving the written informed consents from all participants, the researcher contacted them personally a day before commencing with the interviews, to arrange for time and place where the interviews were conducted. These discussions were used as an opportunity to clarify uncertainties regarding some aspects of the research including ethical aspects like confidentiality, anonymity, privacy, risks, withdrawal and possible termination if the information wanted was not obtained.

5.3.3 Conducting interviews

The semi-structured interviews (Burns & Grove, 1997) were conducted with all biomedical personnel, using an audio tape. Prior to conducting the interviews the interviewer (researcher) explained to all the participants what was expected of them during the interviewing sessions. The tape recorders were placed in such a manner that they did not cause a distraction during the interview. The participants were reminded about all ethical aspects regarding the research, and the researcher endeavoured to build rapport with all the participants to keep the atmosphere relaxed. The semi structured interviews were commenced by asking the following questions in the interview schedule:

1. "What are your views regarding the incorporation of traditional healers into the National Health Care System?

2. How do you feel about this incorporation process?

3. How do you think this incorporation should be achieved?"

Communication techniques as described by Okun (1992) such as paraphrasing, reflecting, summarizing, clarifying, and minimal verbal responses were applied. Caution was exercised regarding giving personal perceptions, expectations, attitudes and meanings to reduce influencing the outcome of the interviews (Mouton & Marais, 1992). The interviews continued until all data was saturated.

5.3.4 Field Notes

The researcher took notes after conducting interviews with each of the participants. Talbot (1995) and Pilot and Hungler (1997) describes field notes as notes that describe the "what", "where", "who" or "how" of the situation, and are documented immediately after each interview session. They comprised of personal, observation and methodological notes and will serve as a guide or scheme for data analysis. The dates and places where field notes were taken were documented to facilitate an orderly and full description of data for analysis.

5.3.5 Physical setting

Interviews were conducted at different settings in Gauteng like Pretoria, Garankuwa, Vereeniging, Vanderbijlpark, Sebokeng, Sharpville, Boipatong, Germiston, Johannesburg, Alexandra and Luipaardsvlei. In the Free State; Kroonstad, Maokeng, Welkom, Thabong, Bloemfontein, Mangaung, Bethlehem, Qwaqwa, Sasolburg and Denneysville. In the North West Province; Klerksdorp, Jouberton, Stilfontein, Khuma, Mmabatho, Rustenburg Potchefstroom, Ikageng and Leudoringstad. The environment in these places was private, comfortable and pleasant, with minimal distractions. Telephones or cell phones were disconnected. All the places were natural settings and did not conform to strict controlled or manipulated settings (Burns & Grove, 1997).

5.4 Data analysis

Some audio taped interviews were conducted in English, but a few others were conducted in Afrikaans, Tswana, South Sotho and Zulu/ Xhosa mix and had to be transcribed verbatim and translated into English, by the researcher. Content analysis was used employing the method of open coding as described by Tesch (*in* Cresswell, 1990) that transcriptions be presented in a manner that there was an area for notes, concepts noted on the left and researchers perceptions on the right side. All the transcriptions were read through to get a sense of the whole. The most interesting or shortest transcription was read and words and themes were underlined as units of analysis. All the transcriptions were read underlining themes and words. Perceptions were written and any spontaneous main categories and subcategories that came to mind were systemised in a table format. The use of double coding was employed whereby a nurse specialist or an expert co-coder decoded independently of the researcher. The co-coder received copies of the transcriptions, field notes and a work protocol, that indicated the objectives of the research, the questions as asked to all the participants as well as the guide of steps as described above using a method of open- coding by Tesch (*in* Creswell, 1994).

The researcher met the co-coder to discuss the findings so as to reach consensus and to finalise the tables.

5.5 Trustworthiness

Trustworthiness is described as a measure to ensure reliability and validity in qualitative research. For trustworthiness in this research cognisance is given to the approach of Pinkoane *et al.,(*2005) where Guba *(in* Krefting, 1991) and the model of Woods and Catanzaro (1988) for reliability and validity was used, namely credibility, applicability, consistency and neutrality. This criteria is applied to this research and portrayed as tabled 1.

Table 1 Measures to ensure trustworthiness

Guba (*in* Krefting,1991:214-217) and Woods & Catanzaro (1988:136)		
Credibility	Truth value accurate reflection of the truth in this research	Literature review and control was undertaken. Field notes were taken after each interview. Independent data analysis was controlled by co-coder. (Cross validation)
	Research was conducted in the identified context of three provinces	Specific area for conducting research was appropriately Identified.

Applicability	Application to other situations	Dense description of data collection and analysis was given.
Consistency	Recording and reporting	Consistent reporting and recording was made to make it easy for critique or further studies. Gave a dense description of methodology and results. Used deductive, inductive and logical reasoning in the discussion.
	Regression and mortality	Data was collected once only for eight weeks. Similar interviews were conducted after obtaining consent forms.
Neutrality	Auditability to increase reliability and neutrality	Audited interviews, field notes. Raw data and records kept for peer review.
	Researcher's status	A trust relationship with participants was built. Emphasized value of participation to all. Decreased distractions, tape placed to blend with furniture.

		Used a co–coder to decode data. Used experts to evaluate findings.
	Choice and selection of participants	Used a purposive voluntary sample, set selection criteria, and described essential elements for participation of all samples. Build rapport with participants, and explained the value of their participation. Created a conducive relaxed atmosphere.

6 Ethical aspects

Ethical aspects specific to this research were taken into consideration as detailed in the Guidelines for Democratic Nurses' Organisation of South Africa, and the Department of Health, (*in* Pinkoane *et al.*,2005). These were:

- quality of the research maintained by highest standards through thorough planning, implementation, documentation and the use of experts and co-coder;
- confidentiality and anonymity ensured by not revealing identity of participants and areas where data was collected;

- privacy ensured by recording interviews in total privacy of participants' settings, not divulging information to any other person and asking only research questions;
- informed consent obtained prior to conducting research, forms kept as proof thereof;
- risks minimised by little exposure to possible physical, psychological and social risks;
- withdrawal and or termination would be allowed, if relevant data could not be obtained.

7 Results, discussion and literature control

The biomedical personnel's perceptions and attitudes are reflected under five main themes which emerged during data analysis. The first main theme portrays the perceptions and attitudes regarding the need for government to be involved in the incorporation process. The second main theme depicts the necessity for traditional healers to form their own organization. The third main theme, demonstrate education and training of traditional healers as important. The fourth theme reflects the importance of having traditional healers control their own practices. The last theme shows communication as necessary to effect working together between traditional healers and biomedical personnel. The themes are discussed in detail and followed by literature control to validate the findings. A bullet is used to indicate a subcategory under discussion.

7.1 Theme one: Government should be involved in incorporation process

The first main theme reflect the biomedical personnel as seeing it necessary for the government to formulate policy/act to legalise traditional healers, control traditional healers to decrease mal–practices and stipulate working together. Government should subsidize the building of consulting rooms for traditional healers and those in the rural areas can work from their own places which they are to be assisted in ensuring their structural safety and cleanliness.

- **Government to formulate act/policy to legalise traditional healers to conform with the recommendations of the World Health Organisation**

These views are expressed as follows.

"The government should take a leading role in getting an act of parliament in place because the WHO gives them a strong recommendation to facilitate this process"

Literature supports these findings and Green (1988) states that there is a need to formulate health policy geared towards legalizing the traditional healer. Steenkamp (1993) and Mthimkulu (1999) supports the findings that to legalize traditional healing is necessary to effect working together.

• Government to have an act/policy controlling traditional healers to decrease malpractice

These are the views as reflected in the following words:

"There are various associations out there that represents these traditional healers, I feel it should be mandatory that they should be controlled by legislation"

Pearce (1982); Freeman and Motsei (1992) as well as Molaudzi (2001) supports the findings that the traditional healers need a statutory body to ensure control of traditional healers' practice.

- **An act/policy should also stipulate how to work together with traditional healers, whether they are to visit clinics/ hospitals**

The biomedical personnel said.

"How this working together should evolve is something that needs clarity from the point of departure which should be addressed by the act that they will formulate, otherwise this working together should be clarified, to avoid any confusion"

Musi (1996) and Melato (2000) concur that working together need to be stipulated as part of policy to indicate whether they should visit hospitals and or clinics. The WHO (1978) supports the research findings, that this move of visitation is to enhance efficiency for patient care and thereby resolve their problems.

• Government should subsidize the building of consulting rooms for traditional healers in the urban areas within proximity of the clinic/hospital

The following quotations express these views.

"I think the only people with the money should invest in traditional healers is the government, they can facilitate this building project, like the RDP houses"

Karlsson and Molantoa (1984) support the findings that the government can erect a specific place for traditional healers which they can even use to train their initiates. Melato (2000) states that these consulting rooms should not be far from the clinic or hospital, to effect mutual referral.

- **Traditional healers who are in the rural areas can work from their own places which they are to be assisted in ensuring their structural safety and cleanliness**

The findings are supported by these words.

"Let them work from where they are, do what they want, and maybe be helped in a way about better living and working conditions, by government of course"

Literature is not clear regarding structural safety and cleanliness of the traditional healers' places but Muller and Steyn (1999) indicates that in the homes, urban or rural, the ancestors communicate better than anywhere else. Melato (2000) supports the findings that because of the socio economic status of the patients, working from within own area remains ideal. Pretorius (1990) further supports the findings and explain that modern medical facilities should be erected to ensure patients' comfort and safety.

7.2 Theme two: Traditional healers to form their own organization

The abovementioned second theme emerged as reflecting that traditional healers are to form their own organization which is to effect internal communication with own members and external communication with government and biomedical personnel. Organization should have its own register to record all members' names, their registration numbers, as well as issue licenses which are to be paid yearly and the unlicensed ones should not practice or be paid by medical schemes. Organization to build and engender trust relationship among its members and biomedical personnel.

- **Traditional healers are to form own organizations which should act as their spokesperson**

From the research results the following words are said by the biomedical personnel.

"If they can organize themselves meaningfully they will be able to talk with one voice, unlike now when one stands on his own when confronted with problems"

Setswe (1999) and Melato (2000) support the findings that once the traditional healers are organized, their way to reach decisions and participate in discussions on behalf of all other traditional healers is attained. Molaudzi (2001) confirms these and indicates that this will be feasible because of the on going process of getting the traditional healers' organization formalized.

- **Organization to effect internal communication with own members and external communication with government and biomedical personnel**

The need for an organization to effect internal communication is verbalized by the biomedical personnel.

"The decision that was taken to call them to a meeting to discuss this initiation school saga ended with some saying they did not know about it, others knew but did not come, once they have a statutory body it will be feasible for it to address such issues"

Muller and Steyn (2000) support the findings that traditional healers who belong to associations are already communicating among themselves as members. Nare (2004) states that associations are able to intervene when there are internal problems by resolving conflicting situations.

- **Organization need to effect external communication with government and biomedical personnel.**

The findings is supported by these quotes.

"The meeting that was due in February was called by the MEC for health and they were to discuss a way forward, even though I am not so sure about the contents thereof"

"The traditional healers cannot be taken for granted anymore, in their groups they are able to discuss their issues with nurses and us as doctors, this group came and wanted clarity regarding initiation in winter"

Literature supports the findings as Fenyves (1994) and Jilek (1994) explains that this stance of an organization is a way in which traditional healers are trying to gain recognition from the government and biomedical personnel. Morris (2001) explain that external communication of organization is important to forge links with biomedical personnel in the fight for HIV/ ADS.

• Organization should have its own register to record members' names and their registration numbers to practice

The following quotes express these views.

"It should be made compulsory that all of their members are in that register, so that they have existing living people like we do when you leave the country they know where you are"

These research findings are supported by Dauskardt (1990); Hopa, Simbayi and du Toit (1998:10) as well as Peu *et al.*,(2001:45), that once organizations exits then keeping names in their registers can be realized in the format that they will agree upon.

The need for a registration number to practice is supported as:
"It is their responsibility to have some form of a register just like us, where their members are known for them to be able to practice"

These findings are supported by Chavunduka (1989) that list of names makes it easy for the traditional healers practicing in that area to be known. Mthimkulu (1999) and Fenyves (1994) also supports the findings that a register should be kept to control traditional healers by a body similar to the Health Professionals Council.

- **Organization to be responsible for licensing its members and ensure that these licenses are paid yearly and the unlicensed should not practice**

These views are expressed as the research results with the following.

"I am of the opinion that once the traditional healers have organized themselves accordingly it will be in their best interest that all of their members carry licenses which logically are to be renewed yearly, like ours"

The research findings are verified by Freeman and Motsei (1992); Molepo (2000) and Molaudzi (2001) that organizations will control the practice of traditional healers who are license holders, because they will be professionals and this will be a measure of controlling the practice of traditional healing.

• **Organization to ensure that medical schemes pay only licensed traditional healers**

These research findings for payment of licensed traditional healers is verbalized like this.

"The medical scheme people know exactly where they stand regarding payment for patient treatment, if they get permission to practice and they have a license number it will be easy to claim"

The findings are supported by Straker (1994) that some medical schemes do not have a problem regarding payment of traditional healers. Peu *et al.*, (2001) supported by Keeton (2004) concurs that payment is finalized between the patient, traditional healer and the medical scheme concerned.

• Organization to build and engender trust relationship among its members and biomedical personnel

The findings of the research are reflected in the following as verbalized by the biomedical personnel.

"The function of say any organization is to make sure its members have a sense of security in any relationship, they know we are aware of these nasty feelings towards each other and we can only work together if we have trust in what each one of us is doing"

The research findings to highlight this rivalry as identified by biomedical personnel is supported by Mototo (1999); Melato (2000) and Molaudzi (2001) that it is necessary for organization to support members in getting to know and accept each others' ancestral guidance, so as to be able to function effectively in health care provision.

7.3 Theme 3: Training and education of traditional healers is important

These perceptions and attitudes regarding education and training emerged as theme three. The results reflect that traditional healers need to be responsible for own training and to sit for examinations which are to evaluate their competencies. Traditional healers who pass examinations and are competent should be allowed to work with the biomedical personnel. Traditional healers are to be educated about cases for their own treatment, identification of complications, immediate referral, dosages for administration of medicines, basic first aid and hygiene. They are to be made aware of nature conservation. Biomedical personnel should educate and assist traditional healers in compiling their own book of herbs. Biomedical personnel should receive basic education in some traditional medicines. Traditional healers should avail new medicines for further research and testing and to receive acknowledgement for tested useful medicines.

• Traditional healers to be responsible for own training and to sit for examinations which are to evaluate their competencies

The above view is supported by these quotes.

"Things should be left as they are, they continue to teach each other, they know the time frame here I feel very strong that none of us should interfere"

Karlsson and Molantoa (1984) supports the findings and clarifies the need for them to have their own training school. Melato (2000) and Molaudzi (2001) indicates that training is necessary and should be left to themselves.

To sit for own examinations to evaluate their competencies is confirmed hereby.

"If they are trained let them be examined just like everybody else, then they can give them certificates"

The research findings are supported by Neuman and Lauro (1982) that those who show some level of competencies should be commended. Knottenbelt (1993) explain that some form of clinical evaluation need to be done to ensure that they are knowledgeable to be accredited (Muller & Steyn, 2000).

• Traditional healers who pass examinations and are competent should be allowed to work with biomedical personnel

These views of biomedical personnel are expressed in the following.

"We are used to dictating terms even to the nurses, but here we need to give them an opportunity to decide on the best way to evaluate their students, all that we want is for them to give their best knowledgeable persons to work with us"

"Let it be both ways, if they know who is best, all the better, we will work with them"

Literature supports the findings as Holdstock (1979) and Gumede (1990) indicates that it will be bringing out the best of both worlds. Abdool Karim *et al.*, (1994) clarifies that it is necessary to draw strengths of both to effect patient care.

• Traditional healers are to be educated about cases for their own treatment

The following words capture these findings.

"Patients come here after they have been to them, it is time to teach them those that are seriously jeopardizing the patients' life, that these are cases for biomedicine"

Mototo (1999) and Muller and Steyn, (2000) support these findings for the need to educate the traditional healers about aspects of care that they are unable to comprehend. Molaudzi (2001) states that this education issue is a very important challenge for all biomedical personnel.

• Should be taught about identification of complications and immediate referral of cases beyond their understanding

The findings are as follows.

"I was devastated by this sight before me, please if they have doubts let the patients come to us, they can come too for us to help where necessary"

Morris (2001) and Aens (2004), support these research findings that traditional healers need to be taught identification of problems beyond their control and refer, before it is too late (Bateman, 2004).

• Traditional healers to be taught about dosages for administration of medicines, basic first aid and hygiene

These findings are supported by the following.

"The World Health Organization has made this recommendation, so let us teach them the properties of medicines and how much to give to avoid poisoning"

The results are supported by the World Health Organization (WHO,1978 & 1996) as well as Peu (2001) that traditional healers' potential need to be explored and taught simple basic biomedical procedures. Tabane (1995) affirms that traditional healers can be taught preparations, measurements of their own herbs which can be done in clean environments.

• Traditional healers to be taught about nature conservation

The following confirm these findings.

"At certain seasons of the year there are plants that are growing so to take them at that time proves dangerous to the plant, then it stops growing, some are rare"

The findings are supported by Joubert (1987) and Palmer (1990) that traditional healers are being sensitized about the importance of proper harvesting. Molaudzi (2001) states that to teach them about nature conservation is a way to save nature from loosing all the important herbs that are need for the future.

• Biomedical personnel are to educate and assist traditional healers in compiling their own book of herbs

These findings are expressed like this.

"I feel it is the traditional healers who have a broad knowledge of herbs so it is in order to teach them how to take care of them so that they know they should document their existence, they will know that they must protect them from being totally harvested"

The research results are supported by the World Health Organization (WHO,1978) that formulating own drug book is the best thing to do to conserve the knowledge that exists (Felhaber, 1997; Cridland & Koonin,2001).

• Biomedical personnel to receive basic education in some traditional medicines

The biomedical personnel said that they can be taught some traditional herbs was expressed in the following words.

'It is a fact I personally do not know all the herbs, even as pharmacist at times it is necessary to learn more even from the traditional healers"

Mototo (1999); Melato (2000) as well as Steenkamp (2002) support the findings that it is necessary for traditional healers to teach biomedical personnel some traditional medicines to learn and enrich their knowledge.

• Traditional healers should avail new medicines for testing

These findings are verbalized by the following.

"The Department of Health need new tests to identify good herbs for patient treatment"

"Anybody with knowledge of any unknown good herbs are encouraged to bring them forth for testing"

These findings are supported by the call made by the Department of Health (Molaudzi, 2001). Neuman and Lauro (1982) as well as Abdool Karim *et al.*, (1994)

concur that all traditional healers should come forth if they are having new herbs for these to be put on trial.

• Traditional healers to receive acknowledgement for tested useful medicines

The research results are reflected by the by biomedical personnel as:

"A lot is written about doctors, pharmacists who requested for the traditional healers' medicines, hut once these are successful do not give credit to the person who gave him that medicine, take the story of the African potato on the market, it is bringing in money"

Traditional healers are robbed of their knowledge by unscrupulous biomedical personnel, this findings are supported by Freeman and Motsei (1992) and Melato (2001). Morris (2001) concurs by stating that those who receive medicines from traditional healers should give them the necessary acknowledgement .

7.4 Theme 4: The perceptions and attitudes of traditional healers regarding control of traditional healing practices

The above perceptions and attitudes emerged as theme four indicating the need for traditional healers to set their own standards, have ethical rules, identify bogus traditional healers and deal with them accordingly. They are to ensure that patients are not overcharged, payments are standardized, with separate payment for biomedicine and traditional medicines.

• **Traditional healers to set their own standards that outline guidelines for traditional healing practice**

These verbalized as:

"For the sake of the recipients of health care safety of patients is ensured by carrying out actions according to the expected norm, I cannot do anything at all that is not within my categorical expectations"

These findings are supported by Pretorius (1991) that traditional healers are aware of the need to work according to guidelines, but a problem identified by Muller and Steyn (1999) supported by Molaudzi (2001) is that each one operates according to the directions of the ancestors therefore guidance is sought from them before they can do anything.

• **Traditional healers are to have ethical rules to stop ritual killings and patient molestation**

The quotations to support the findings.

"This is an act of ruthlessness that has been part of their way of getting charm and trying to gain richness, it must be stopped"

These findings are supported by Van Eeden (1993) that there are atrocities that traditional healers perform. According to the Ngubane (1981) ritual killers are bogus traditional healers who are in traditional healing as a money making racket. Ncaca (2004) supports these findings and indicates that the police are expected to intervene in such cases.

- **They are to ensure that patients are not overcharged and payments are standardized**

The following are said by the biomedical personnel to confirm the findings.

"A cow is almost like more or less say R1500 to R2000. So it is a lot of money for consultation and treatment, but well patients do pay"

The findings of exorbitant payments are supported by Nare (2004) that the traditional healers do charge more than what the patient can afford. Pinkoane *et al.,* (2001) states that the fees charged vary from one traditional healer to the other and usually payment is determined by the type of treatment the patients get, and this makes similar payments problematic.

- **They are to ensure that patients to pay separate fees for traditional medicine and biomedicine**

These views are expressed to confirm these findings.

"I do not know where the patients got this from but if she consults me and I treat her then it means that I should be paid my own money for treating her ,if she goes somewhere else she still remains accountable for paying those people"

Musi (1996) and Pinkoane *et al.*, (2001) support payment of traditional medicines as negotiable between the traditional healer and the patient. Nare (2004) affirms the

findings and say that payments need to be separated as an agreement between the provider and the recipient.

7.5 Theme 5: Communication between traditional healers and biomedical personnel is necessary to effect working together

This theme demonstrate that there is a need for mutual communication to enable an understanding of each other, form new partnerships and enhance existing relationships. Traditional healers are to openly communicate their fears of being undermined by biomedical personnel, and are concerned about their future. Traditional healers should not work in isolation or have secretes but to share ideas to reduce the notion of suspicion about witchcraft.

- **Mutual communication will enable traditional healers and biomedical personnel to have an understanding of each other**

These research findings that two way communication is necessary is expressed in these quotes.

"Traditional healers are not open people they keep what they do to themselves"

Literature supports these findings as Pinkoane *et al.*, (2001) and Molaudzi (2001) affirms that when talks are held both groups can communicate in a meaningful way and reach and understanding about each other (Peu *et al.*, 2001).

- **Communication will help to form new partnerships and enhance existing relationships**

These sentiments are verbalized by the following.

"In the days gone by I would say but this is ridiculous, but now things have taken a new turn and we must bring him in our lives, let them also accept that we should work as partners"

These research findings are supported by Freeman and Motsei (1992) and Abdool Karim *et al.*, (1994) that it is necessary to work as partners. Pantanowitz (1994) further states that it is necessary to harness each other's mode of healing so as to work in harmony together.

- **Traditional healers are to openly communicate their fears to biomedical personnel that they are being undermined and concerned about their future**

The findings of these views are said in the following.

"If one of them talks and has not been given permission to disclose it is an offense, a serious one, it means you must give some money to gain permission to be talked to"

These findings are supported by Pinkoane *et al.*, (2001) that before the traditional healer can talk *'vula mlomo'* should first be paid to effect any two way communication.

The traditional healers are now vocal and are communicating with government and biomedical personnel (Gumede, 1990; Pinkoane *et al.*, 2005).

• **Traditional healers should not work in isolation or have secretes but to share ideas to reduce the notion of suspicion about witchcraft**

The research findings to support these views of biomedical personnel are expressed in these.

"Look at what happened when they revealed their herbs we are able to hear of tests and more tests, let them remove the cloak of secrecy"

Staugardt (1985:32) and Last (1989:23) explain that the reasons why traditional healers operated in secrecy was because of the laws that prohibited their practice. Mburu (1977:56) says it remained necessary not to disclose because what was done, was for the knowledge of the recipient only.

8. Conclusion

From the results it was identified that the biomedical personnel feel that it is imperative that the government should be involved in the incorporation process by formulating policy to, legalize traditional healing and control the traditional healers' practices. Furthermore self organization by traditional healers was viewed as necessary, based on the need for it to organize, register and license members, unlicensed members not to practice, or be paid by medical schemes. Training and education of traditional healers was viewed as important, achieved by sitting for examinations, those who pass and are competent should work with biomedical personnel. Regarding traditional healers' self control about own practice, achieved by setting standards, ethical rules, to identify bogus traditional healers. Lastly,

communication was seen as essential for understanding each other, and an avenue for traditional healers to be open about their fears and concerns regarding their future, as well as decreasing the existing secrecy.

9 BIBLIOGRAPHY

AAKSTER, C.W. (1989). Assumptions governing approaches to diagnosis and treatment. *Social Science & Medicine*, 29(3):293-300.

ABDOOL KARIM, S.S., ZIQUGU PAGE, T.T., & ARENDSE, R. (1994). Bridging the gap – potential for a health care partnership between African traditional healers and biomedicine in South Africa. *South African Medical Association Journal*, December. 84 (2):1-16.

AENS. (2004). Awards for initiation schools. *Daily Sun*: 13, April.5.

ANC **see** AFRICAN NATIONAL CONGRESS.

AFRICAN NATIONAL CONGRESS. (1994). A national health plan for South Africa. Maseru : Bahr Mapping & Printing.

ANDERSON, E., BEAUMONT, P., PRYER, H., & ROBB, S. (1996). Attitudes towards reflexology held by general practitioners in Port Elizabeth. Port Elizabeth: University of Port Elizabeth. (Unpublished report). 1-14.

ANON. (2004). Brain drain. *Today's Doctor*, March. 9.

ANON. (1996). Science versus tradition. *True Love:* 25, October. 51.

ARTHUR, M. (1997). The traditional biomedical dichotomy, in search of a common ground. *Curationis*, 20 (2): 63-65. July.

BATEMAN, C. (2004). HIV training of traditional healers limp along. *South African Medical Journal*, 94 (10): October.

BERMAN, B. (2001). Complementary medicine and medical education. *British Medical Journal,* 322.121-122.

BHENGU, R. (2003). Healers need nursing skills too. *Daily Sun:* 25, March. 8.

BODECKER, G. & KRONENBERG, F. (2002). A public health agenda for traditional, complementary, and alternative medicine. *American Journal of Public Health,* 92 (10):1582- 1589. October.

BURNS, N. & GROVE, S.K. (1997). The practice of nursing research: Conduct, Critique and Utilization. Philadelphia: W.B. Saunders.

CHAVUNDUKA, G.L. (1986). ZINATHA. The organization of traditional medicines in Zimbabwe (*in* LAST, M. & CHAVUNDUKA, G. L. *eds.* The professionalization of African medicine. Manchester: Manchester University Press.)

CHINN, P.L. & JACOBS, N. (1991). Theory and Nursing: A systematic approach. St. Louis. Mosby yearbook.

CRIDLAND, J.S. & KOONIN, S. (2001). Use of traditional medicine - towards a classification. *South African Medical Journal,* 91, 6. June.

DAUSKARDT, R.P.A. (1990). Traditional medicine: *Perspectives and policies in health care development Southern Africa.* 7 (3): 351-357.

DAVIDS, N. & KEETON, C. (2004). Doctors who bring shame to their profession. *Sunday Times*: 9, May. 6.

DENOSA **see** DEMOCRATIC NURSES ORGANIZATION.

DEMOCRATIC NURSES ORGANIZATION. 1997. *Ethical standards for nurse researchers.* Pretoria: Denosa.

DEPARTMENT OF HEALTH **see** SOUTH AFRICA. Department of health.

DSAE see DICTIONARY OF SOUTH AFRICAN ENGLISH.

DICTIONARY OF SOUTH AFRICAN ENGLISH: on historical principles. (1996). NY: .Oxford University Press.

DLAMINI, M.P. (2000). Attitudes of health workers towards integration of traditional healers in primary health care. Pretoria: UNISA.(Dissertation- M. Cur).

DUNLOP, D. (1984). Alternatives to 'modern' health delivery systems in Africa: Public policy issues of traditional health systems. *Social Science & Medicine*, 9 (1):581-586.

ERNEST, E. (2001). A possible danger of intergrating complementary medicine in medical education (A letter, comment). *Arch internal medicine,* 161:1680- 1681.

FASSIN, D AND FASSIN, E. (1988). Traditional medicine and the stakes of legitimisation in Senegal. *Social Science & Medicine,* 27 (4) : 353-357.

FELHABER, T. (1997). South African Primary Health Care Book. Pretoria. Kagiso Publishers.

FENYVES, K. (1994). South African traditional healers organizations in the context of traditionalism and modernity. Johannesburg: University of Witwatersrand (Dissertation M.A.)

FITZPATRICK, J.J. & WHALL, A.L. (1996). Conceptual models of nursing: analyses and application. Connecticut: Appleton Lange.

FREEMAN, M. (1992). Negotiating the future of traditional healers in South Africa. *Critical health,* 40. 64-69.

FREEMAN, M. & MOTSEI, M. (1992). Planning health care in South Africa: Is there a role for traditional healers? *Social Science & Medicine*, 34 (1):1183-1190.

FREEMAN, M. & MOTSEI, M. (1991). Is there a role for traditional healers in health care in South Africa: A proposal. Centre for Health Policy. Johannesburg: University of Witwatersrand. December. 1-5.

GIGER, J. N. AND DAVIDHIZAR, R.E. (1995). Trans- cultural Nursing. Assessment and Intervention. St Louis: Mosby Year Book.

GORT, E. (1989). Changing traditional medicine in rural Swaziland. Effects on global system. *Social Science & Medicine,* 29 (9) :1099-1104.

GREEN, E. & MAKHUBU, L. (1984). Traditional healers in Swaziland: Towards improved cooperation between traditional healers and modern health sectors. *Social Science & Medicine*, 18(12): 1071-1074.

GREEN, E.C. (1988). Can collaborative programs between biomedical and African indigenous health practitioners succeed? *Social Science & Medicine*, 27(1): 1125-1130.

GUMEDE, M.V. (1990). Traditional healers: a medical doctor's perspective. Johannesburg: Vista University Press.

GUMEDE, M. (1992). Side by side. *Publico,* 24-25: October.

HAMMOND-TOOKE, D. (1989). Rituals and Medicine. Johannesburg: A. D. Donker Publisher.

HARRISON, I.E. (1974). Traditional healers a neglected source of manpower. *Rural Africana.* 26:5-16.

HIEMSTRA, W., HOOFT, B. & ANDEWEG, H. (2000). Learning to enhance life forces. *Compass News letter,* July. 28.

HOLDSTOCK, T.L. (1979). Indigenous healing in South Africa: a neglected potential. *South African Journal of Psychology,* 9:118-123. May.

HOPA, M., SIMBAYI, C.C. & DU TOIT, C.D. (1998). Perceptions on integration of traditional and Western healing in the new South Africa. *South African Journal of Psychology,* 28(1): 8-14.

INGSTAD, B. (1989). Healer, witch, prophet or modern health worker? The changing role of ngaka ya Setswana (*In* WILDING, A. J. & VESTERLUND, A. *eds.* Experience and pluralism: Essays on African ideas of illness and healing. Stockholm: Almqvist & Wikrell).

JEFFREY, R. (1982). Policies towards indigenous healers in independent India. *Social Science & medicine,* 16 (1): 1835-1841.

JILEK, W.G. (1994). Traditional Healing in the Prevention and Treatment of alcohol and drug abuse. *Trans-cultural Psychiatric Research Review,* 31 : 219 –258.

JOUBERT, H. (1995). Conservation, traditional medicines. *Vuka SA,* 77, November.

KNOTTENBELT, J.D. (1993). Systems of alternative medicine. *South African Medical Journal,* 83(2): 241, April.

KARLSSON, E.L AND MOLANTOA, K.E.M. (1984). The traditional healer in Primary Health Care. *Continuing Medical Education,* 2 :43-47, April.

LAST, M & CHAVUNDUKA, G. L. *eds.* (1986). The proffessionalistion of African Medicine. Manchester: Manchester University Press.

LEVITZ. E. (1992). Traditional Medicine: friend or foe? *Publico,* 233-236. October.

LINCOLN, Y.S. & GUBA, G. E. (1985). Naturalistic inquiry. London: Sage Publications.

LOUW, J. (2003). Help your best friend: Complementary health. *Farmers' weekly:* 30, May.29.

MARCUS, D.M. (2001). How should alternative medicine be taught to medical students and physicians? *Academic Medicine*,76: 248-250.

MBURU, F.M. (1977). The duality of traditional and western medicine in Africa: Mystics, myths and reality. Essays in critique of medical anthropology. Rochester: Oakland University.

MELATO S.R. (2000). Traditional healer's perception of the integration of their practices into the South African national health systems. University of Natal (Dissertation- M. Psyche)

MOLAUDZI, F.M. (2001). Synergy between indigenous knowledge systems, modern health care system and scientific research- A vision for the 21st century. *Health SA Gesondheid,* 6 (4) 14-20.

MOLEPO, E.R. (2000). The effectiveness of the referral system in primary health care in the West rand region: a normative – ethical study with special emphasis on traditional healers. Stellenbosch: University of Stellenbosch (Dissertation- M. A.)

MORRIS, K. (2001). Treating HIV in South Africa- A tale of two systems. *The Lancet,* 357. 14, April. 1190.

MOTOTO. O.M. (1999). Willingness of traditional healers regarding collaboration with western psychiatrist in health care. Bloemfotein: UOFS Library (Dissertation- M. A.)

MOUTON, J. & MARAIS, D.C. (1996). Basic concepts in the methodology of social sciences. Pretoria: R.G.N. Publishers.

MTHIMKULU, J. (1999). The need to register traditional healers in post apartheid health system. Bloemfontein: Vista University Bloemfontein. (Article non qualification.)

MULLER, A. & STEYN, M. (1999). Culture and the feasibility of a partnership between westernized medical practitioners and traditional healers. *Society in transition,*30 (2).

MUSI, O. (1996). To allow Sangomas with patients. *City Press*: 24, Nov. 31.

NARE, S. (2004). Inyanga cuts fees and set captives free. *Daily Sun:* 25, Feb.1.

NCACA, N. (2004). Botched operations prompt search for solutions. *City Pres:* 30,May. 27.

NEUMAN, A.K. & LAURO, P. (1982). Ethno medicine and biomedicine linking. *Social Science & Medicine*, 16(210) :1817-1824.

NGUBANE, H. (1977). Body and mind in Zulu medicine. London: Academic Press.

NGUBANE, H. (1981). Aspects of clinical practice and traditional organization of indigenous healers in South Africa. *Social Science & Medicine*, 15(210) :361-365.

NZIMA, D.R., EDWARDS, S.D & MAKUNGA, N.V. (1992). Professionalization of traditional healers in South Africa: A case study. *University of Zululand Journal of Psychology*, 8:82-91.

OKUN, B.F. (1992). Effective helping: Interview and counselling techniques. California: Brookes/Cole.

OSKOWITZ, B. (1991). Bridging the communication gap between traditional healers and nurses. *Nursing RSA*, 6(7): 20-22. July.

PALMER, R. (1987) Witchdoctors for conservation. *The Naturalistic Inquirer*. 31(3): November. 31-33.

PANTANOWITZ. D. (1993). Alternative medicine – A rational viewpoint is necessary. *South African Medical Journal*, 83(1): 638.

PEARCE, T. (1986). Professional interests and the creation of medical knowledge in Nigeria. (*In* LAST, M. & CHAVUNDUKA, G. L. *eds.* The proffessionalistion of African Medicine. Manchester: Manchester University Press.)

PEU, M.D., TROSKIE, R. & HATTING, S.P. (2001). Attitude of community health nurses towards integration of traditional healers in Primary Health Care in North West Province. *Curations*, 25(1) 49-55.

PINKOANE, M.G. (2001). Patients relationship and therapeutic techniques of the South Sotho traditional healer. Potchfestroom.:PU vir CHO (Dissertation -M.Cur.)

PINKOANE, M.G., GREEFF, M. & KOEN, M.P. (2005). Models for the incorporation of traditional healers into the National Health Care Delivery System: A literature review. Potchefstroom campus of the North-West University. (Unpublished thesis - Ph. D.)

POLIT, D. F. & HUNGLER, B.P. (1997). Nursing Research: Principles and Methods. Philadelphia: J.B. Lippincot Company

PRETORIUS, E. (1998). Traditional healing and modern medicine working in tandem. *Curationis*, Dec 14 (4) 10-12.

RUBIN, A. & BABBIE, E. (1997). Research methods for social work. 3rd Ed. Pacific Grove: Brooks/Cole.

S.A. **see** SOUTH AFRICA

SETSWE, G. (1999). The role of traditional healers in primary health care in South Africa. *Health South Africa,* 4 (2)55-60.

SMETHERHAM, J.A. (2004). Local flower poer might be able to beat TB: Traditional medicine also show promise on AIDS. *The Star*: 15. January.7.

SOUTH AFRICA. Department of health. (1996). Annual Report. Pretoria: Government Printers.

SOUTH AFRICA. Department of health. (1997). White Paper for the transformation of the health system in South Africa. (Notice 667). *Government Gazette*, 17:910-1. April 16.

SOUTH AFRICA. Department of health. (2003). The Traditional Health Practitioners Bill. (Notice 979). Government Gazette,24704. April. 11.3-36.

SOUTH AFRICA. Department of health. (2000). Guidelines for Good Practise in the Conduct of the Clinical Trials in Human participants in South Africa. Pretoria: Government Printers.

SOUTH AFRICAN NURSING COUNCIL. (1978). *The Nursing Act 50 of 1978 as amended.* Pretoria: Government Printers. Membership for the profession. 1998. 13. 31.

STAUGARD, F. (1985). Traditional medicine in Botswana: traditional healers. Gaborone: Ipelegeng Publishers.

STEENKAMP, C. S. (1987). Chiropraktyk en homeopatie: 'n voorbeeld van die legimetiseering van 'n nuwe struktuur. *South African journal of sociology,* 18(2):66-74.

STEENKAMP, V., VON ARB & STEWART, M. (2002). Herbal remedies traditional medicine- toxic or therapeutic? *Laboratory marketing spectrum,* 4 (21)4. 4-5

STRAKER, G. (1994). Integrating African and western healing practices in South Africa. *American Journal of Psychotherapy*, 48: 455 – 467.

TABANE, E.M. (1995). Opinions of African caretakers of children at the Red Cross War Memorial Childrens Hospital regarding the linking of traditional healers to western health settings. Cape Town: University of Cape Town. (Dissertation- M. A.)

TALBOT, L. (1995). Principles and practice of nursing research. St Louis: C.V. Mosby.

TESCH, G. (1990). Research design: qualitative and quantitative approaches. (*In* CRESSWELL, J. *Ed.* A qualitative approach. *Library of congress catalogues in publication data.* 133-157.)

VAN EEDEN. A. (1993). The traditional healer and our future health system. *South African Medical Journal,* 83, June. 441- 442.

WALKER L.O. & AVANT, K.C. (1983). Strategies for theory construction in nursing. Norwalk, Connecticut. Appleton Century Croft.

WHO **see** WORLD HEALTH ORGANIZATION.

WORLD HEALTH ORGANIZATION. (1978). The promotion and development of traditional medicine. Technical report series 622. Geneva: WHO Publications.

WORLD HEALTH ORGANIZATION. (1987). Traditional healers as community health care workers. A review of projects using traditional healer as Community Health Care worker. Geneva. WHO publications.

WORLD HEALTH ORGANIZATION. (1996). Traditional medicine. *Fact sheet 134.* Geneva. WHO publications. September.

WOODS, N.F. & CATANZARO, M. (1988). Nursing research: Theory and practice. St Louis: C.V. Mosby.

ARTICLE 4: THE PATIENTS PERCEPTIONS AND ATTITUDES REGARDING THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

Guidelines for the Journal: South African Family Practice, incorporating Geneeskunde

Information for Authors and Readers - 2003

Editorial Policy

South African Family Practice, incorporating Geneeskunde (SAFP/G) is a peer-reviewed scientific journal, which strives to provide primary care physicians and researchers with a broad range of scholarly work in the disciplines of Family Medicine, Primary Health Care, Rural Medicine, District Health and other related fields. The Journal publishes original research, clinical reviews, and pertinent commentary that advance the knowledge base of these disciplines. The content of *SAFP/G* is designed to reflect and support further development of the broad basis of general medical practice through original research and critical review of evidence in important clinical areas; as well as to provide practitioners with continuing professional development material.

All manuscripts will be subject to peer-review and the decision of the Editor will be final. Articles submitted for consideration by the editor should not have been published before, either in total or in part, nor be currently submitted to any other publisher. The Editor retains the right to stylise and shorten any material accepted for publication. Accepted manuscripts will be copy edited and galley proofs will be sent to the author for approval. Preference is given to articles presenting the results of original research or evidence-based clinical reviews, relevant to family medicine, primary health care, district health or rural medicine. Opinions expressed in the Journal should not be taken to represent the policies of the SA Academy of Family Practice/Primary Care, the Family Medicine Education Consortium (FaMEC), or the Publisher. Submissions in any official language of South Africa will be considered for publication within the framework of the SAFP/G mission to appeal to the widest possible readership.

Manuscript presentation

Authors are encouraged to consult the "Guidelines for Articles" of the Canadian Family Physician (http://www.cfpc.ca/cfp/authors/guidelines.asp) before finalising their manuscripts. Authors should prepare their manuscripts in accordance with the "Uniform Requirements for Manuscripts Submitted to Biomedical Journals" prepared by the International Committee of Medical Journal Editors (http://www.icmje.org/). Abbreviations and acronyms must be kept to a minimum and spelled out when first introduced in the manuscript. Generic drug names should generally be used. When proprietary brands are used in research, include the brand name in parentheses in the Methods section when first mentioned.

Contributions are accepted in one of the following categories:
(The illustrative maximum word counts *exclude* the Abstract, Tables, Figures and References):

Research: Reports on original research. Quantitative studies and surveys, 1800 words, qualitative studies, 2400 words. Mixed quantitative and qualitative studies, 2400 words.
Short reports: Limited research findings, e.g. the findings of a pilot study or limited survey, may be presented as a short report (800 words, including no more than two tables or figures and not more than 8 references).
Systematic reviews: Reviews on the best available evidence from research, focusing on a clinical question, 1800 words.
CME Updates: Full reviews of clinical topics aimed at updating the knowledge of practitioners, 1800 words. Shorter CME reports, 800 words.

Case Reports: A report on one or more cases illustrating an important lesson for family physicians/primary care doctors, 800 words.
Discussion papers: An **opinion** on a topic relevant to family medicine, a **commentary** on a paper published in the Journal, or a **reflection** on any aspect of family medicine (1200 words).
Practice Tips: A new clinical idea, educational programme, or practical solutions to everyday practice problems can be presented as a brief report (600 words, with no more than one table or illustration).
Letters to the Editor. (300 words) Brief comments on articles published in the Journal or other information of interest to readers. Letters selected for publication that comment on published articles would be forwarded to the original authors of those articles.

Manuscript format

All manuscripts must be submitted in **electronic format**, as an e-mail attachment or on computer disk, preferably in MS Word®(or RTF) format using Times New Roman font size 11 and double-spacing. The author must always retain a copy. A covering letter should make it clear that all the named authors have approved the final manuscript. All sections of the manuscript should be double-spaced with 20mm margins left and right. Begin each section on a separate page in the following order: title page, abstract, text, acknowledgements, references, tables, and figures.

The **title page** should include from top to bottom: manuscript-title; name of author with all the qualifications of author, and institutional affiliation of each author; name, address/telephone/fax/E-mail of the author to whom reprint requests should be addressed; and up to 5 keywords. Pages should be numbered consecutively in the lower right corner beginning with the title page.

Abstract. The structured abstract for a Research article should be no longer than 250 words and should consist of four paragraphs labelled Background, Methods, Results, and Conclusions. It should briefly describe the problem or issue being addressed in the study, how the study was performed, the major results, and what the authors conclude from these results. The abstracts for other types of articles should be no longer than 150 words and need not follow the structured abstract format.

Keywords. Up to five words or short phrases should be added to the bottom of the title page. Use terms from the Medical Subject Headings (MeSH) of Index Medicus when available and appropriate. Key words are used to index the article and may be published with the abstract.

Acknowledgements. In a separate section, acknowledge any financial support received or possible conflict of interest. This section may also be used to acknowledge substantial contributions to the research or preparation of the manuscript made by persons other than the authors.

References. Cite references in numerical order in the text, in superscript format. Do not use brackets. In the References section, references must be typed double-spaced and numbered consecutively in the order in which they are cited, not alphabetically. The style for references should follow the format set forth in the "Uniform Requirements for Manuscripts Submitted to Biomedical Journals" prepared by the International Committee of Medical Journal Editors (http://www.icmje.org/). Abbreviations for journal titles should follow Index Medicus format. Authors are responsible for the accuracy of all references. Personal communications and unpublished data should not be referenced. If essential, such material should be incorporated in the appropriate place in the text. . List all authors when there are six or fewer; when there are seven or more, list the first three, then "et al." When citing URLs to web documents, place in

the reference list, and use following format: Authors of document (if available). Title of document (if available). URL. (Accessed [date]).

The following are sample references:

1. London L, Baillie R. Notification of Pesticide Poisoning: Knowledge, Attitudes and Practices of Doctors in the Rural Western Cape. *S Afr Fam Pract* 1999;20(1):117-20.

2. FDA Talk Paper: http://www.fda.gov/bbs/topics/ANSWERS/2002/ANS01151.html (Accessed 04/10/2002).

Tables. Tables should be self-explanatory, clearly organised, and supplemental to the text of the manuscript. Each table should include a title on top, be typed on a separate page, and be numbered in *Roman* numerals (I, II, etc) in order of its appearance as called out in text. Indicate clearly in the text where each table needs to be inserted (e.g. INSERT Table III HERE). Tables must have clear descriptive titles.

Figures. All figures must be submitted in electronic format, preferably inserted at the end of the electronic document. Alternatively, attach as electronic files in the format of the original software program in which it was created. Symbols, lettering, and numbering (in *Arabic* numerals e.g. 1, 2, etc. in order of appearance in the text) should be placed below the figure, clear and large enough to remain legible after the figure has been reduced. Indicate clearly in the text where each figure needs to be inserted (e.g. INSERT Figure 3 HERE). Figures must have clear descriptive titles.

Photographs and images: If photographs of patients are used, either the subject should not be identifiable or use of the picture should be authorised by an enclosed written permission from the subject. Photographs and images should be submitted electronically as far as possible. Save them as a 300 dpi JPEG, and send it by e-mail (preferred) or on a CD or floppy disk. Photographs in print must be glossy and unmounted. On the back of each photograph, use a self-adhesive label to indicate the figure number, author's last name, and figure orientation ("top"). Please do not write on the back of the photograph itself.

Permission. Permission should be obtained from the author and publisher for the use of quotes, illustrations, tables, and other materials taken from previously published works, which are not in the public domain. The author is responsible for the payment of any copyright fee(s) if these have not been waived. The letters of permission should accompany the manuscript. The original source(s) should be mentioned in the figure legend or as a footnote to a table.

Review and action. Manuscripts are initially examined by the editorial staff and are usually sent to independent reviewers who are not informed of the identity of the author(s). When publication in its original form is not recommended, the reviewers' comments (without the identity of the reviewer being disclosed) may be passed to the first author and may include suggested revisions. Manuscripts not approved for publication will not be returned.

Ethical considerations. Papers based on original research must adhere to the current version of the Declaration of Helsinki on "Ethical Principles for Medical Research Involving Human Subjects" and must specify from which recognised ethics committee approval for the research was obtained.

Conflict of interest. Authors must declare all financial contributions to their work or other forms of conflict of interest, which may prevent them from executing and publishing unbiased research. [*Conflict of interest exists when an author (or the author's institution), has financial or personal relationships with other persons or organizations that inappropriately influence (bias) his or her opinions or actions.*]*

*Modified from: Davidoff F, et al. Sponsorship, Authorship, and Accountability. (Editorial) JAMA 2001: 286(10)

The following declaration may be used if appropriate:
"Using the following broad definition of conflict of interest, I declare that I have no financial or personal relationship(s) which may have inappropriately influenced me in writing this paper."

Copyright. Authors of all articles are required to assign copyright to the SA Academy of Family Practice/Primary Care. Authors may use their own work after publication without written permission, provided they acknowledge the original source. Individuals and academic institutions may freely copy and distribute articles published in SAFP for educational and research purposes without obtaining permission.

Submissions and correspondence. All submissions and correspondence regarding manuscripts should be addressed to: The Editor, South African Family Practice inc. Geneeskunde, PO Box
19063, Tygerberg, 7505. Tel: (office hours) +27 (0)21 938 9449. Fax: (24 hours) +27 (0)21 938 9153. E-mail: pjtdv@sun.ac.za

THE PATIENTS' PERCEPTIONS AND ATTITUDES REGARDING THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

Ms. Martha G. Pinkoane
* **Ph. D.** candidate (Potchefstroom Campus of the North-West University)
M. Cur (Community Nursing)
Vaal University of Technology
e-mail:martha@vut.ac.za

Prof. Dr. M. Greeff
***Supervisor**
Ph. D. (Psychiatric Nursing)
School of Nursing Science
Potchefstroom Campus of the North-West University
e-mail: vpkmg@puk.ac.za

Prof. Dr. M. .P. Koen
***Co supervisor**
Ph. D. (Professional Nursing)
School of Nursing Science
Potchefstroom Campus of the North-West University
e-mail:vpkmpk@puk.ac.za
***Forwarding address:**
Prof. Dr. M. Greeff
School of Nursing Science
Potchefstroom Campus of the North-West University
Private Bag x 6001
Potchefstroom 2520
North West Province, South Africa.
e-mail: vpkmg@puk.ac.za
Tel: +27 18 299 1830
Fax: +27 18 299 1827

THE PATIENTS' PERCEPTIONS AND ATTITUDES REGARDING THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

ABSTRACT

Background

The majority of patients use traditional medicines to resolve their health problems. On getting no expected results from the traditional healer, they move to biomedical personnel, in a way of shunting to and from, between the two service providers. It is for this reason of using these services at the same time that it is imperative to find out what their perceptions and attitudes are regarding the incorporation of traditional healers into the South African National Health Care Delivery System as well as their views on how this incorporation should be achieved.

Methods:

Objectives: To explore the perceptions and attitudes of the patients, regarding the incorporation of traditional healers into the National Health Care Delivery System. To explore their views on how they think this incorporation should be achieved.

Design: An exploratory, descriptive, and contextual qualitative research design was followed.

Sample selection was non probable purposive voluntary sampling using a set criteria.

Setting: Nine identified regions within the provinces of Gauteng, North West and Free State provinces were utilized.

Data collection was achieved by conducting semi- structured interviews using a tape recorder, and documenting field notes.

Data analysis was achieved by making transcriptions of interviews which were translated from the vernacular to English. Analysis was done by open coding. A co - coder and researcher analysed the data independently. Two consensus discussions took place to finalise the analysis of data.

Trustworthiness was used to ensure rigor of the research. Ethical principles were applied according to the guidelines of the South African Department of Health and the Democratic Nurses Organisation.

Results: The patients perceived the traditional healer as gifted to heal and that he/she has a role in health care provision. They saw that there was a need for mutual respect and trust between traditional healers and biomedical personnel, so as to learn from and teach each other. The government's role in incorporation was seen as important to formulate policy. Traditional healers were to form their own organization and both biomedical personnel and traditional healers were to sit and communicate ways of working together.

Conclusion: The study indicated that the patients perceived the incorporation of traditional healers as important to avail the health services necessary to resolve their problems

KEY WORDS: National Health Care Delivery System; incorporation; biomedical personnel, traditional healer; patients

1 INTRODUCTION AND PROBLEM STATEMENT

Traditional healing need to be made part of the National Health Care Delivery System in South Africa, be it by integration, collaboration or incorporation.[1] Underlying this debate is an array of mixed attitudes from the providers and consumers of health care, and this creates a barrier for the process of incorporating the traditional healer to avail health care services.

The majority of patients use the services of the traditional healer because they believe in his ability to communicate and intermediates between the people and the ancestors.[2] Of the other reasons for the patients to use the traditional healer could be the method of payment which is an agreement that is easily negotiable between the two parties, whereas in biomedicine upfront payment is the order of the day and is not negotiable. [3,4]

When the patients shunt to and from, it is out of sheer desperation as to who will ultimately resolve their health problems.[6] The patients have a right to choose the treatment method available,[7] that the choice to consult any of the two health care providers is his/hers to make, and the one available and accessible to them whenever they need care is the traditional healer.[8] Accordingly incorporation will give them an opportunity to use the services of the traditional healers without any fear or intimidation from the biomedical personnel.[9]

However another view of patients is that they are not in favor of incorporation because traditional healers make them to perform unhealthy practices.[10] These are some of the allegations facing traditional healers who are involved in atrocities which can affect the incorporation process.[11,12] It is however refuted that it is not only traditional healing that creates consumer disenchantment, but biomedicine as well.[5] Cases of patients waiting for long periods, absence of medicines, absconding and even dying, are problems often identified as related to lack of resources, human and or material.[13,14] When biomedical personnel are available, not only do they take their time in resuming the work as scheduled, they also use their rights and refuse to treat patients based on their religious convictions.[15] These inhumane treatment gives reason enough to seek the help of the traditional healer, based on their seriousness because ultimately the patients are the ones who suffer. For resolving health problems of the patients as well as increasing health care personnel it was imperative to explore the perceptions and attitudes of the traditional healers, biomedical personnel, patients and policy makers, regarding the process for the incorporation of traditional healers into the South African National Health Care Delivery System as well as their views on how this incorporation should be achieved. This article however focuses on the patients perceptions and attitudes to get an understanding of how they feel about this incorporation process.

2 RESEARCH DESIGN

This research used a qualitative design, [16] with the goal of exploring and describing the perceptions and attitudes of the patients regarding the incorporation of traditional healers into National Health Care Delivery System as well as their views on how they

think this incorporation should be achieved. Subsequently a model will be formulated for this incorporation once all the other stake holders namely, traditional healers, biomedical personnel and policy makers have been interviewed. [17,18] The research was conducted in the nine regions of Gauteng, North West and the Free State provinces in South Africa.

3 RESEARCH METHOD

3.1 Permission to conduct research

Permission to conduct research was obtained through a letter written to each of the regional or district health services managers within each province.

3.2 Sampling

3.2.1 Population and sample

The population consisted of thirty patients, ten from each province, who gave written informed consent,[20, 21] selected by non-probable purposive voluntary sampling and ensured that data saturation was achieved.[19] These patients were identified by Senior traditional healers and traditional healers according to a set criteria. The traditional healers acted as inter-mediators, and availed the names, residential addresses, telephone numbers and language preferences of patients to the researcher, who personally contacted them to arrange for the interviews.

3.3 Data gathering

3.3.1 Pilot study

A pilot study was conducted with three patients from each of the nine regions of the three provinces from the sample of those who met the criteria for inclusion in the research. It was conducted to ensure that the questions were clear and appropriate after they were evaluated by experts.

3.3.2 Conducting interviews

The semi-structured interviews were conducted in the homes of the participants using both battery operated and electric tape recorders to ensure that all the information was captured, in case one failed. The researcher endeavoured to build rapport with all the participants to keep the atmosphere relaxed.

The following questions were asked in South Sotho:

1. **"What are your views regarding the incorporation of traditional healers into the National Health Care Delivery System?**

2. **How do you feel about this incorporation process system?**

3. **How do you think this incorporation should be achieved?"**

Communication techniques such as paraphrasing, reflecting, summarizing, clarifying and minimal verbal responses were applied during the interviews.

Field notes were taken after conducting interviews with each of the participant. Trustworthiness was ensured by giving attention to credibility, applicability, consistency and neutrality. Ethical aspects were considered using the Guidelines for the Democratic Nurses' Organisation of South Africa (DENOSA,1998:1-7) and the Department of Health (S.A, 2001:1-77). Permission for conducting the research was granted by the ethics committee of the North-West University.

3.4 Data analysis

The audio taped interviews were transcribed verbatim by the researcher and translated into English. Content analysis was used employing a method of open coding.

4 RESULTS, DISCUSSION AND LITERATURE CONTROL

Five main themes emerged during the analysis of data and serves as the discussion of the findings.

4.1 Theme 1: The traditional healer is seen as gifted to heal and has a role to play in health care provision.

The patients viewed the traditional healer as having powers to heal them and that they should be allowed to use traditional medicines, based on being accessible and he/she has an understanding of their illness.

4.1.1 Traditional healers are gifted, need ancestral guidance and blessings to work with biomedical personnel

The following words confirm these results:

"I go to the traditional healer because he is a spiritual person, who has a gift from those below and from God, it is something that has been around for a very long time, it is only that the very doctors do not want to let anybody know they have something to do with the traditional healers, they feel it is a disgrace, our great grand parents knew about this gift of healing".

"Already there are those traditional healers who work with the white doctors here in our town there is one, it is because they are aware that these people are ancestors people with great healing powers".

"All of us to work with another person you need to get blessings from above, the traditional healers must speak with the ancestors and hear what they have to say in this regard".

Literature supports the findings that the traditional healer is seen to avail a cure even though each one operates according to the directions of the ancestors, therefore they need ancestral guidance and support to work with biomedical personnel. [2, 22, 23]

4.1.2 Patients need to be allowed to use traditional medicines because the traditional healers understand their illnesses, he is near and gives them treatment immediately.

The following words complete these views.

"Now when you have a problem the doctor is at the shopping center it is not near, I must take a taxi to that side, and only when my pension money is available, no money no treatment from him, I go to the traditional healer now I get what I want".

"The old man lives down the road so before I say anything else even at night, he saw my grand child and asked for nothing, if I go to the clinic it is worse these days there are no medications".

" He is a man of ancestors who lives with us from our own world that is why it is easy for him to see things the way I see them"

The findings that the traditional healer plays a role in the life of black people, accessible and sometimes the only available health care service near is seen by patients as reason to consult him/ her for treatment.[5,2, 24]

4.1.3 Biomedical personnel need to recognize and respect the efficacy of traditional medicines, that they should be allowed to use both healing methods without one ridiculing the other.

These are the words of one patient.

"When I get no cure from one I use the other, so why should I be penalized for doing that in the hospital they like telling us not to use traditional medicines, but I am the one who is ill."

"The nurses and doctors should realize that now when you are desperately ill you need something to make you better, at times even when a person say eat this you do because you are in need of cure."

"The problem that we all know exists is that all people who are educated look down upon the uneducated, so you nurses find it hard to even talk with them, their medicines work, and we go to them ,you must realize that even if we go secretly you must let us see him"

From the results it is evident that the patients need the two health care systems to meet their health problems, so the need for biomedical personnel to respect and not underestimate the treatment of traditional medicines is seen as important, where if one fails the other takes over to resolve the patients' problems. [25,6, 3]

4.1.4 Biomedical personnel to realize that they as patients may decide or choose whom to consult because the traditional healer knows herbs.

The following quotation is from a patient.

"These people know medicines and know what to give, even when the doctors have doubts , they should leave us to choose, I can go to the clinic, they should leave me alone, the traditional healer does not stop me from going to the clinic"

"The time is now when the nurses are cheeky I tell them where to get off, they cannot force us like before, of now we talk about our rights where we want to go where we want and do what we want to do with our lives, years before it would not be like this"

" It is important to realize that as much as I come to the clinic for my high blood pills, I may also go to my sangoma and truly no one can stop me"

The findings that the patient has a right to treatment of his her choice is supported by the literature and is an issue that needs biomedical personnel to consider because the patients view the treatment as used to effect a cure. [7, 8]

4.1.5 The traditional healer should identify the medicines known to produce a cure and be rewarded for these.

The following quote is from a patient.

"Every weekend it is a family upon family at the grave yard, our children do not bury us we bury them, if they find something good they must give them money to encourage them to look for more, that will be good".

"I cannot talk for them, their medicines talk them because they go to the veld to cut and dig I can only say they should come and show the doctors what they have found, the nation is dying"

" It hurts you so bad when you know you have found something and yet when it works nobody comes to say you have done well, they are people too let them be given due if they get a cure"

Literature supports the findings that traditional medicines identified to be of value need to be availed for testing and recognition and rewards need to be given accordingly to those who use and avail these herbs. [1,23,35]

4.2 Theme 2: Mutual respect and trust is necessary between the traditional healers and the biomedical personnel so as to learn from and teach each other

The patients' perceptions regarding the need for mutual respect and trust between the traditional healers and the biomedical personnel need to exist in order that they should teach and learn from each other, and not blame one another for complications.

4.2.1 Biomedical personnel and traditional healers need to understand, respect, and trust each other regarding patient treatment.

The patients had this to say.

"From long ago the doctors never saw them as anything, is it because some are white, others are black, it stands to be questioned, they must look at each other with the same eyes so that they can give us what we want from them"

"I have a feeling that the white doctors even you nurses do not trust the traditional healers and how can they work or see us with you when you can just see that they are not on the same level"

The results demonstrate traditional healers need to be treated as professionals and be respected for the treatment given. It is also seen as necessary by the biomedical personnel to respect the traditional healer in return. [6, 12,26]

4.2.2 Biomedical personnel should not to be boss over traditional healers and blame them in event of failures or complications.

The following are expressed by the patients.

"Nurses and doctors are very up front they like telling people what to do let it end with us patients because the traditional healer has nothing to be blamed for."

"When things go wrongs someone looks for another to blame, and surely the poor traditional healers will carry the blame, but when we are cured the doctors wants to get the credit, when are they going to stop the blame and baas play".

"This thing of who tells who what to do has been in the minds of you people because you are learned, and yet the truth is they go to the veld to get what the ancestors tell them they can only listen to those below and their Gods not you".

The findings are supported by literature that biomedical personnel want to rule traditional healers and blame them for complications and deaths among users is an area of concern for the patients as well biomedical personnel. [11, 22, 27]

4.2.3 Biomedicine also fail to effect a cure at times reason enough to teaching and educate each other about methods of healing.

These are the words as expressed by patients.

"You go for a small operation they remove the whole hand and yet that was not the agreement, you can read in the news papers every day there is something new, even

for our traditional healers there are mistakes so it is time for them to come and show each other and meet half way"

"The things that are happening now are terrible, they once said it is the traditional healers what about them when people die and you get no answers, in hospital where you are supposed to be safe, so everyone should come clean"

The results are supported by concerned patients who also indicate that medical doctors are also producing no cure at times. In communication both groups can agree on teaching each other about healing therapies. [25, 28]

4.2.4 Clinic nurses are to teach traditional healers information that will help the patient in case they are not available

The patients say:

"It is very easy for them to teach the traditional healers new things to help us when we go to see him for our own problems, I also saw it in the news the other day."

"What are they teaching them now and then when they call them to the clinic let it be something that adds to what they already know so that they can help us".

From the results supported by the literature, it is found that traditional healers were seen to be going in to clinics for some form of education, viewed as a beneficial way to increase their knowledge.[2, 6, 28]

4.2.5 The knowledge the traditional healers posses should not be stolen by the biomedical personnel, or be used without their permission.

These are the views of the patients.

"These days the people, traditional healers who are gifted and they make some medicines that are really working, and the government says they should try to get a cure for this terrible AIDS thing, so they must at least give them something in return"

"The whole world is fighting to get a cure for cancer, tuberculosis so if they are getting it, it should not be taken away from them, but let them be paid well, otherwise they will not be bringing it for anybody to see at all".

Literature supports availing of medicines for testing to biomedical personnel and that patency and ownership issues needs a process and steps to be in motion, encouraged by the government. [23, 29]

4.3 Theme 3: Government's role in incorporation is important so as to formulate policy

This is the third theme and demonstrate that the patient want the government to have a role in incorporation by formulating policy to clarify the role of the traditional healers in health care provision, build consulting rooms for the traditional healers and avail security for patients as protection against criminals.

4.3.1 Government has a duty of formulating policy to enable traditional healers to work with biomedical personnel

These are the words.

"In any country in the world there is nothing that can happen without the involvement of the government, why are they delaying to get involved, it is their country, they make the laws for everything now its time to have law to make sure these two groups work together"

"Last year we heard that they have been working with government to have a law so as to work with the doctors, let us see that law now"

Literature supports the results that there is a need for policy to be in place which will give clarity regarding the role of the traditional healer in health care provision, is regarded as necessary. [30, 31]

4.3.2 In the policy the role of the traditional healers in health care provision should be clearly set out by the government

The above views are expressed in these words.

"Amongst them there are those that think they know a lot, so now I feel that to be sure who does what let the government say there is a law, it should not come from the doctors or nurses"

"We are all concerned about that, they will say he should go into the hospital or clinic, to be sure of this at least they must write down what he should do, to make us all aware and to cover them too"

These views are supported by literature that traditional healers who are to be involved in patient care, need an act to clearly spell out how should they function in health care settings. [12, 25, 32]

4.3.3 The government through its policy should build consulting rooms for traditional healers which they should keep clean, near clinic or taxi rank

The patients expressed themselves in the following words.

"The government knows that these people have nothing, some of their houses are really shabby, some RDP places will be appreciated anywhere where we can reach them easily for example at the rank."

"I heard someone saying that it is impossible but it is not, they deserve better like their white counter parts who use beautiful suites in hospitals, let it be the government who help them, as is with all other health facilities, even in the same surroundings"

"Somehow their places are often not very clean and not too shabby but if they have these RDP like rooms to keep it clean will not be too much of a problem, remember some live in shacks"

Literature supports the results about traditional healers having their own medical centres which could be built within the proximity of a clinic or hospital. [12, 25, 33,

4.3.4 Government should help traditional healers working from home with protection from criminals when patients come late for consultation

These fears are expressed by the patients as follows.

"The tsotsis are now targeting the traditional healers in the locations, they are robbing patients whom they see as well off. It is not safe at night. Last week they burgled his house but I understand they took nothing maybe they became scared"

"The government is not doing enough to make us feel safe now it is worse because they now attack traditional healers at their own homes for money, let there be some form of protection coming from government".

Even though there is no substantial literature supporting these results, these feelings as expressed by the patients demonstrate concern for their safety as well as the safety of traditional healers in the wake of crime rates.

4.4 Theme 4: Traditional healers are to have their own organization and be licensed

Theme four portray traditional healers as needing to have its own organization who can act on their behalf, and would be recognized by the government. The traditional healers' organization must control their practices, control bogus traditional healers, initiation schools, ensure training, stop rivalry and in-fighting, issue licenses, allow them to sell their medicines, and ensure that those without licenses are punished.

4.4.1 Traditional healers are to have their own organization with own leaders who can act on their behalf before meeting with biomedical personnel.

The following words are expressed by the patients.

"It is a long time coming now for the traditional healers to group themselves, stand on their own be heard, and this can be by choosing own leaders from among themselves, they can do it"

"For them to be able to talk with the government and the doctors they must speak for themselves by clubbing together, not some there others here, they can have a strong voice"

Literature support this need for self organization and the results indicate that traditional healers must have their own controlling body like other health professions to be able present their problems as an organization. [12,33, 34]

4.4.2 The government must recognize the existence of the traditional healers' organization.

These are the words as said by the patients.

"In the days gone by people were not allowed to organize themselves, but ever since unions then government listens to the people, in other words the traditional healers will be heard by the government"

"I really see them as a force to take note of they must just put their heads together then the government is surely to hear them, especially now that they the government want AIDS drugs".

The results that government need to consider traditional healers organization like workers union are supported by the media and literature, so that they are better able to be heard by government. [8,12]

4.4.3 It is the duty of the organization to control the practice of traditional healers to safeguard the patients against bogus traditional healers.

These are the words.

"As patients we are now afraid because when now the government realizes the importance of the traditional healer, then suddenly everyone else is one, we need to be protected and only if they have leaders who should look for these fakes can we know who is real."

"There are so many traditional healers out there something must be done to control each person from claiming to be a traditional healer, therefore this society or association will help to check them out"

Literature supports the fact that bogus traditional healers are a fact for traditional healing moreover their due recognition is tabled in parliament. If they organize themselves then its easy to identify these fakes. [12, 25, 35]

4.4.4 Organizations should investigate and identify bogus traditional healers and check whether they have received any training or not, they should be jailed for ritual killings.

These are the words as verbalized by patients:

"Some of these traditional healers are not even known, today a person is a prophet tomorrow a traditional healer it is so confusing, nobody knows who taught them, it is time their leaders know them, and where they received their knowledge"

"They call them "ngaka motwana" meaning fakes, they know them but are afraid at times to point them out, some are ruthless killers, they are self made all in a venture to make a living, they need a very strong hand to control them"

There is a growing concern about bogus traditional healers and official recognition will assist in this regard. [5,25] Ritual killers are bogus traditional healers and are money making racketeers who should be jailed. [10, 27, 36]

- **Initiation schools to be controlled by organization, training is undertaken under the supervision of senior traditional healers.**

The patients had this to say.

"Our country is caught by a mad disease of initiation schools, they take young boys who are still at school, what kind of parents are these, the leaders of traditional healers must stop this thing by having an organization to train these teachers of initiation schools "

"What is going to happen ultimately is that those who kill should go to jail, even if they are medical doctors, the leaders should be very strict about these fakes, we are at risk, our children as well"

"They make huge amounts of money from these schools that is why they are kidnapping young boys who die, loose their manhood, where are their leaders teach them this old art and to stop this madness, the schools have lost their meaning now".

Literature support the results for an association of traditional healers needed to embark on a concerted effort to identify and teach these teachers of initiation schools and eliminate undesirable health practices including deaths of young men from these initiation schools. [11, 27, 32]

4.4.6 Organization must ensure that traditional healers are united, stop rivalry and in fighting.

These concerns are verbalized by the patients.

"The difference in training maybe the reason for these personal differences and jealousy, or other things maybe one's ancestors stronger than yours, we never know, but what is important is that some of form of control should come from those who lead"

"We know that even white doctors fight about this and that of patients, so the traditional healers fight for so many things, the doctors are disciplined by their council, so should it be with them, their leaders are to sort of discipline them one way or another".

Literature supports the differences in healing therapies, different ancestors, discrimination and dominance of males to females which creates rivalry that needs to be controlled by own organization of traditional healers. These differences are identified as causes of disunity, so organization to control its members. [12,28,35]

4..4.7 Organization must issue out licenses to make traditional healers responsible, enable them to sell their medicines, and ensure that those without licenses are punished.

The patients verbalized their views as:

"The permits are to make them know the right from wrong when they do wrong they will take them away, when they want to sell herbs in the streets, they should be having permits, we will all know those who do not have permits are fakes".

"Now even the government is saying to them they should be having leaders who are to make sure all their practices are not shady any more so they should license them, as are nurses who work in clinics, they have their certificates on the wall"

Literature supports these research results that the issuing of licenses need to be a reality and those without licenses should not even sell in the streets but to be punished. [23,37,38]

4.5 Theme 5: Traditional healers and biomedical personnel are to sit and communicate ways of working together.

The patients said that traditional healers and biomedical personnel are to sit and communicate ways of working together, not to rush, but reach an agreement on how to work together. They should meet and discuss a way in which rules must be applied, and that biomedical personnel should refer them to traditional healers or grant them permission to see the traditional healer.

4.5.1 Biomedical personnel and traditional healers need not rush to reach an agreement on how to work together, they must meet and discuss a way forward.

These are views as verbalized.

"The way life is moving each one of us must be given a chance at doing what you know best, so let them all sit down invite the government to look at ways in which our needs can be met".

"At times it looks like it is going to be easy to work together, yet change is very difficult to accept, they all need to talk, about who is going to do what when, it is really important for own good and our good too"

The need of not rushing for incorporation, that meetings are a necessity and a platform from which ideas can be exchanged are supported. Furthermore ideas about how best working together can be realized are indicated as findings. [22, 39]

4.5.2 Rules for working together should be agreed upon and applied in the same way where a daily list or register with the names of attending traditional healers is written down.

The patients had this to say:

"I have seen in the hospital that some doctors come and go according to who is a specialist to see special patients, traditional healers should be controlled in the hospital or when they go to the clinic, they are of different ancestors and this must be remembered.

"They must be reminded that they cannot just come any time, there are rules even for them, like for the doctors, the TB doctor comes three times a week, it is a rule, so they must have rules to".

"Their names should be known by all, I have never seen a clinic without rules, and with so many of them in one place it can be a mad house, let the nurses make a way of accommodating them".

The findings that the patients feel that traditional healers can come to the clinics is supported by literature and a point raised to avail both services simultaneously, but should be done in accordance with stipulated way agreed about visitation. [6, 39]

4.5.3 Biomedical personnel should agree on referrals to the traditional healers and if necessary grant them permission to go to the traditional healer.

The following quotation is from a patient.

"Here is something surprising the very black nurses pretend as if they do not know that we go there, instead of understanding our situation they make it worse, why? They must give us chance to go see the traditional healer"

"When you are in the hospital no one want to hear you speak about the traditional healers its as if you talk of witchcraft, now they must understand that some of these diseases one needs confirmation of the traditional healer, we should be allowed to go there"

Literature supports the findings that traditional healers do see the patients and send these to the biomedical personnel. That it is necessary for patients to be allowed to go and see the traditional healer, instead of faking reasons for a pass out. [9, 12, 25,]

5 CONCLUSION

The conclusion of this article show the patients as having feelings that portray the traditional healer as being gifted to heal and having a role in health care provision and can work with the biomedical personnel. That they need ancestral guidance for blessings to work together furthermore they should be allowed to use traditional medicines because the traditional healers understand their illness, is near and gives out medicines immediately. The biomedical personnel are to recognize and respect the efficacy of traditional medicines as able to cure, and that they should be allowed to use both healing methods simultaneously.

It was also identified that the patients feel that it was necessary that the biomedical personnel and traditional healers should have mutual respect, understanding and trust

so as to teach and learn from each other. Biomedical personnel should not be boss over traditional healers and blame them in event of failures or complications because biomedicine also fail to effect a cure at times, reason enough to teach and learn from each other about methods of healing and herbs. That the knowledge the traditional healers posses should not be stolen by the biomedical personnel, or be used without their permission.

The patient saw the government as having a role in the incorporation process by policy formulation to enable the traditional healers to work with biomedical personnel. In this policy the role of the traditional healers should be clarified, and be made to help traditional healers have consulting rooms. Those working from home need to be protected against criminals at night. Another area of concern was that traditional healers should have their own organizations, which is to be recognized by government, as well as communicate with the biomedical personnel. The patients feel that this organization has a duty to control the practice of traditional healers and get rid of bogus traditional healers and that these should be investigated for any training and if not, they should not be part of incorporation. Ritual killings and initiation schools are another area of concern for the patients who felt that organization is to ensure that traditional healers are trained and initiation schools are under the supervision of senior traditional healers who do not overcharge people. Ritual killers are to be jailed and the organization is to ensure that there is unity among traditional healers. Furthermore the organization must issue licenses to make traditional healers responsible and enable them to sell their medicines, those without licenses should be punished.

6 ACKNOWLEDGEMENTS:

The participants, patients and traditional healers; the district health services managers for consent to undertake the study; the co coder; the two institutions, Vaal University of Technology for study support throughout, and the North-West University, Potchefstroom campus for facilitating, and assisting the research process; the

Automobile Association in Vanderbijlpark and the Cartography Department of North-West University for assisting with accessing places where the research was undertaken and lastly, my two study promoters.

7 CONFLICT OF INTEREST: None declared

FOOT NOTE: The complete information for this research is available on request.

8 BIBLIOGRAPHY

1. PINKOANE, M.G., GREEFF, M & WILLIAMS, M.J. 2001. Patient relationship and therapeutic techniques of the South Sotho traditional healer. Potchfestroom: PU vir CHO. Dissertation -M.Cur. 207p.

2. FREEMAN, M. & MOTSEI, M. 1991. Is there a role for traditional healers in health care in South Africa: A proposal. Centre for Health Policy. Johannesburg: University of Witwatersrand. December. 1-5.

3. GUMEDE, M.V. 1990. Traditional healers: a medical doctor's perspective. Johannesburg: Vista University Press. 238 p.

4. MUSI, O. 1996. To allow Sangomas with patients. *City Press*: 24 Nov. p 31.

5. ABDOOL KARIM, S.S., ZIQUGU PAGE, T.T. & ARENDSE, R. 1994. Bridging the gap – potential for a health care partnership between African traditional healers and biomedicine in South Africa. *South African Medical Association Journal,* December. 84 (2) 1-16.

6. OSKOWITZ, B. 1991. Bridging the communication gap between traditional healers and nurses. *Nursing RSA,* 6(7): July. 20-22.

7. FULDER, S. 1985. A new interest in complementary (alternative medicine): towards pluralism in medicine. *Impact of Science on Society,* 143:235-243.

8. TOM, M.E. 1994. The reasons given by patients for visiting the traditional healers. Johannesburg: University of Witwatersrand. (Dissertation- M.A)

9. CHRISTIE, V.M. 1991. A dialogue between practitioners of alternative medicine and modern medicine in Norway. *Social Science & Medicine.* 35 (5) 549- 552.

10. VAN EEDEN, A. 1993. The traditional healer and our future health system. *South African Medical Journal,* 83, June. 441- 442.

11. NARE, S. 2004. Inyanga cuts fees and set captives free. *Daily Sun:25* Feb. 1.

12. PEU, M.D., TROSKIE, R. & HATTING, S.P. 2001. Attitudes of community health nurses towards integration of traditional healers in Primary Health Care in North West Province. *Curations,*25(1) 49-55.

13. DE VILLIERS, M.R., & DE VILLIERS, P.J.T. 2004. Doctors' views of working conditions in rural hospitals in the Western Cape. *SA Family Practice,* 46 (3):21-26.

14. NAIDOO,P. 2004. A critical look at health. *SA Family Practice, 46 (7):5-7.*

15. BATEMAN, C. 2004. HIV training of traditional healers limp along. *South African Medical Journal,* 94(10) October.

16. MOUTON, J. & MARAIS, D.C. 1996. Basic concepts in the methodology of social sciences. Pretoria: R.G.N. Publishers. 310 p.

17. CHINN, P.L & JACOBS, M.K. 1991. Theory and Nursing: A systematic approach. St. Louis. Mosby yearbook. 238 p.

18. WALKER L.O. & AVANT, K.C. 1983. Strategies for theory construction in nursing. Norwalk. Connecticut. Appleton Century Croft. 150 p.

19. RUBIN, A. & BABBIE, E. 1997. Research methods for social work. 3rd Ed. Pacific Grove: Brooks/Cole. 758 p.

20. DEMOCRATIC NURSES ORGANIZATION. 1997. *Ethical standards for nurse researchers.* Pretoria: Denosa. p 8.

21. SOUTH AFRICA. Department of health. 2000. Guidelines for Good Practise in the Conduct of the Clinical Trials in Human participants in South Africa. Government Printers. 100 p.

22. MULLER,A & STEYN, M. 1999. Culture and the feasibility of a partnership between westernized medical practitioners and traditional healers. *Society in transition,* 30 (2).

23. MOLAUDZI, F.M. 2001. Synergy between indigenous knowledge systems, modern health care system and scientific research- A vision for the 21st century. *Health SA Gesondheid,* 6(4) 14-20.

24. NZIMA, D.R., EDWARDS, S.D & MAKUNGA, N.V. 1992. Professionalization of traditional healers in South Africa: a case study. *University of Zululand Journal of Psychology,* 8:82-91.

25. GORT, E. 1989. Changing traditional medicine in rural Swaziland. Effects on global system. *Social Science & Medicine,* 29 (9) :1099-1104.

26. MELATO S.R. 2000. Traditional healer's perception of the integration of their practices into the South African national health systems. Pietermaritzburg: University of Natal. (Dissertation- M.Soc)

27. NCACA, N. 2004. Botched operations prompt search for solutions. *City Press:* 30, May. 27.

28. DAVIDS, N.& KEETON, C. 2004. Doctors who bring shame to their profession. *Sunday Times:* 9, May. 6.

29. SMETHERHAM, J. A. 2004. Local flower power might be able to beat TB: Traditional medicine also show promise on AIDS. *The Star:* 15, Jan. 7.

30. YODER P.S. 1982. Biomedical and Ethnomedical Practice in rural Zaire. *Social Science & Medicine,* 16(2): 1851-1857.

31. DAUSKARDT, R.P.A. 1990. Traditional medicine: *Perspectives and policies in health care development Southern Africa,* 7 (3): 351-357.

32. MOTOTO. O.M. 1999. Willingness of traditional healers regarding collaboration with western psychiatrist in health care. Bloemfontein: UOFS Library.(Dissertation M. Soc).

33. KARLSSON, E.L AND MOLANTOA, K.E.M. 1998. The traditional healer in Primary Health Care. *Continuing Medical Education,* 2 :43-47, April.

34. HOPA, M., SIMBAYI, C.C. & DU TOIT, C.D. 1998. Perceptions on integration of traditional and Western healing in the new South Africa. *South African Journal of Psychology*, 28(1): 8-14.

35. BHENGU, R. 2003. Healers need nursing skills too. *Daily Sun:* 25, March.8.

36. NGUBANE, H. 1981. Aspects of clinical practice and traditional organization of indigenous healers in South Africa. *Social Science &Medicine*, 15:361-365.

37. NEUMAN, A.K. & LAURO, P. 1982. Ethno medicine and biomedicine linking. *Social Science& Medicine,* 16(210) :1817-1824.

38. CHAVUNDUKA, G.L. ZINATHA. 1986. The organization of traditional medicines in Zimbabwe (*in* LAST, M. & CHAVUNDUKA, G.L. *eds*. The

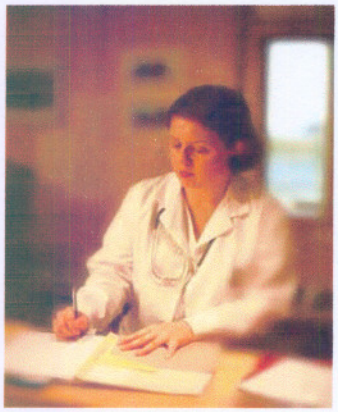
professionalization of African medicine. Manchester: Manchester University Press for International African Institute. 45 p.)

39. ZUNGU CHIEF. 1992. Should traditional healers be recognized and registered/ If so, how should this occur? Centre for Health Policy. Johannesburg: University of Witwatersrand. 17 p.

ARTICLE 5: THE POLICY MAKERS' PERCEPTIONS AND ATTITUDES REGARDING THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

GUIDELINES FOR THE JOURNAL : CURATIONIS

INSTRUCTIONS FOR PROSPECTIVE AUTHORS



Please read the instructions carefully. Publication of articles is often delayed because they have been poorly prepared. Publication will be expedited if you comply with the following specifications.

Preparation of manuscript

Print the manuscript in double spacing throughout and with side margins of at least 2.5cm.

- Word processors, at least WordPerfect 0, must be used. Please ensure that the typeface is clear and legible.
- The manuscript must be submitted in triplicate. A further copy of the manuscript should be kept by the author.

Each completed manuscript should contain the following:

Title page

The title page must contain:

- The title of the article.This should be concise and informative;
- The first name, other initials and last name of each author;
- Highest academic qualification and other applicable qualifications;
- Name of department or institution; and
- Name and address of author to whom galley proofs should be sent.

Abstract

On a separate page give an abstract of the article in both English and Afrikaans.

The length of the article

The length of the article should not be more than approximately 5000 words, unless exceptional circumstances make greater length desirable.

Headings in text

Please make ranking of headings and sub-headings clear by marking them 1, 2, or 3 etc (in pencil) in the margin.

Abbreviations

Please use abbreviations sparingly, if at all.

All measurements must be given in accordance with the Systeme International d'Unites (SI) using the correct unit and symbol.

Illustrations

Tables

Please keep their number and size to a minimum. Large tables are difficult to read and often impossible to print. Give each table a descriptive title. Indicate their position in the text. Do not use ditto signs. Tables should be intelligible without reference to the text.

References

The abbreviated Harvard System must be used.

Reproduction of previously published material

Articles submitted for publication in Curationis are considered on the assumption that they have not been published before. It is the author's responsibility to obtain the copyright holder's written permission for material (whether text, tables or illustrations) to be reproduced in this journal. The written permission should accompany the manuscript.

Proofs

For research articles submitted for publication in Curationis, the author will receive one set of galley proofs of an accepted article. Write essential corrections clearly in ink in the margins of the proofs, with corresponding marks in the body of the text. Do not add any new material. Please make sure that co-authors (if any) approve of any changes. Return one marked set of corrected proofs to the Editor within one week. Failure to do so will result in the article being printed in a later volume.

Referees

Research articles for Curationis will be submitted to two independent referees for appraisal before the manuscript is accepted for publication. These referees are appointed on the recommendations of the editorial board.

Letters to the Editor

Manuscripts must be accompanied by a letter to the Editor giving the following information:

- Full names, initial(s), title, qualifications, place of work, position, full address, list of previous publications. The Editor should be notified immediately of any change of address.
- Summary of requirements on checklist
- Letter to the Editor.
- Manuscript:
    - Title page
    - Abstracts in two languages
    - Text
    - References and acknowledgements
    - Illustrations; tables, labels and legends
- Written permission, if applicable, from copyright holders.
- Submit three copies of the manuscript in a heavy envelope.
- The article must be on a 'stiffy' disk and in WordPerfect 6.0.

Articles in other languages

If an article is published in an official language, other than English, an English translation of the title of the article must be provided as part of the summary. The summary of 300-500 words must follow at the end of the article. The summary must cover (where applicable): statement of problem; research methodology; main findings; and reccomen-dations. An English translation of the full title of the article must also be furnished.

THE POLICY MAKERS' PERCEPTIONS AND ATTITUDES REGARDING THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH FRICA

Martha G. Pinkoane

*** Ph.D. candidate** (Potchefstroomnt Campus of the North-West University)

M. Cur. Community Nursing; B. Cur I *et* A

Vaal University of Technology, Vandebijlpark. 1900.

e-mail:martha@vut.ac.za

Minrie Greeff

***Supervisor**

Ph.D. Psychiatric Nursing Science, M. Cur

School of Nursing Science

Potchefstroom campus of the North-West University

e-mail: vpkmg@puk.ac.za

Magdalena P. Koen

***Co - supervisor**

Ph.D. Professional Nursing Science, M. Cur

School of Nursing Science

Potchefstroom campus of the North-West University

e-mail:vpkmpk@puk.ac.za

***Forwarding address**

Prof. Dr Minrie Greeff

Private Bag x 6001

Potchefstroom Campus of the North-West University

Potchefstroom 2520. North West Province.

South Africa

e-mail: vpkmg@puk.ac.za

Tel: 018 299 1901

Fax: 018 299 1827

THE POLICY MAKERS' PERCEPTIONS AND ATTITUDES REGARDING THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

ABSTRACT:

The policy makers have not been vocal about the process to incorporate traditional healers into the National Health Care Delivery System of South Africa, based on mixed perceptions, which were both negative and positive. The negative views were related to the denial that traditional healing does provide a cure and the positive views were identified in the passing of policies from 1994. These policies passed initiated recognition of the existence of traditional healers, but failed to address the important aspect of incorporating the traditional healers into the National Health Care Delivery System. It is these mixed perceptions as well as lack of appropriate policy to facilitate incorporation of traditional healers that urged the researcher to explore the perceptions and attitudes of policy makers regarding this incorporation process, as well as their views on how it should be achieved.

An exploratory, descriptive and contextual qualitative research design was followed. Participants were selected by non-probable, purposive voluntary sample. Data was collected by means of conducting semi-structured interviews, as well as taking field notes. Data analysis was achieved by analysing transcriptions through open coding involving a co-coder until consensus was achieved. Results reflect that policy makers are in favour of incorporation.

In conclusion incorporation was seen as a process that need to be undertaken by both traditional healers and biomedical personnel through communication. That government should be responsible for this process by policy formulation, which should clarify terms and conditions for incorporation.

1 INTRODUCTION AND PROBLEM STATEMENT

The policy makers were not vocal about the incorporation of the traditional healers into the National Health Care Delivery System of South Africa. The stance that the government took on traditional healing was associated with the fact that traditional medicine was seen as creating complications based on its raw nature when used by the patients (Levitz:1992:25). There were often reported cases of mortality arising from use of these medicinal herbs. Even in cases like these the patient continued to use the traditional healers' services out of the reality that he understands their problems and is always available in times of need (Pinkoane *et al.*, 2001:78). It is from this premise of availing health services to the people, that the government resolved not to be vocal about the traditional healer' practices because his/her services partially relieved the overburdened health sector (Meisner, 2004:901). All this time the policy makers were aware that the patients use the services of the traditional healer simultaneously with those of biomedical personnel because Morris (2001:1190) and Oskowitz (1991;15) identified projects that have been initiated in South Africa by biomedical personnel, to try working together with traditional healers. According to Freeman and Motsei (1992:1189) in spite of these attempts made by the biomedical personnel to try and work together with the traditional healers, the government seemed unperturbed to officially pave a way for an official agreement to have incorporation in place.

From a neutral stance of non committal but with due consideration for the problem at hand, came the promulgation of the National Health Plan (ANC,1994:55); the Homeopaths and Allied Health Professions Act of 1996 (S.A, 1996:25) and the White Paper for the Transformation of Health Systems (S.A, 1997:47) which gave the traditional healers their due recognition but does not specify or describe any type of working together between them and the biomedical personnel.

The problem that the herbs the traditional healers use seem to be an issue and to ameliorate this problem of toxicity Peu (2001:21) and Meisner (2004:902) indicates that traditional healers received an invitation from government to come forward and bring these herbs for scientific testing.

This move by government is a way of acknowledging the contribution of traditional medicines regarding solving the patient's health problems. The second positive move was the indication to form a partnership with the Chinese government to investigate the way in which ideas can be exchanged with regard to traditional medicines (Bhengu, 2002:6). According to Morris (2001:1190) the South African government was aware that the Nigerian government is conducting a pilot trial of traditional medicine from South Africa. To add to these trials by Nigeria, Dr Matsabisa was mandated by the Human Science Research Council to initiate research into traditional medicines even though the government is still hesitant to come forward and officially pave the way for incorporation to be in place.

South Africa however faces problems with its availability of human resources in health care delivers services. This problem arises from various sources of dissatisfaction among others being the serving of community services after completion of training. The dissatisfaction of health professionals evokes in them feelings of rebellion (Prinsloo,2004:3), coupled with poor working conditions, and this gives them reason enough to continue leaving the country to go overseas (De Vries and Marincowitz 2004:27). It is this exodus that needs the government to realize that there is a human resource potential that is being neglected and not used to its best in the traditional healer. Morris (2001:1190) and Pinkoane *et al.*,(2001:78) states that many experts now support the use of traditional healing knowledge that is why the WHO is supporting its member countries to utilize the traditional healer if his therapies are the source of health care provision for that community (WHO, 1985:10).

The traditional healers however also need to be more controlled and organized as a group of health care providers. The Traditional health Practitioners Bill formulated in 2003, enables traditional healers to form their own organization which is to control their practices (DOH, 2003:), but it does not afford them the legal authority to work with biomedical personnel. The ball is in the court of the South African government to come up with an act or policy guidelines on the issue to incorporate traditional healers in the Republic of South Africa.

From the preceding discussion it remains imperative to investigate perceptions and attitudes of the policy makers regarding incorporation of traditional healers into the National Health Care Delivery System of South Africa, as well as how they feel this incorporation should be achieved?

2 RESEARCH OBJECTIVES

2.1 Explore the perceptions and attitudes of policy makers regarding the incorporation of traditional healers into the National Health Care Delivery System of South Africa.

2.2 Explore their views on how they think this incorporation should be achieved.

3 PARADIGMATIC PERSPECTIVE

The paradigmatic perspective of this research encompass the metatheoretical assumptions and theoretical statements.

3.1 Metatheoretical assumptions

The metatheoretical assumptions for this research are persons, health, illness, nursing and environment and are subsequently described. **The person** is seen as man, a cultural being who has survived through time and place because of his ability to care for the physical, spiritual, psycho- social and cultural well being of other men, across the life span in a variety of environments and in different ways (Fitzpatrick and Whall, 1997:187). Within this context **health** refers to a state of well-being that is culturally defined, valued and practised, and reflects the ability of individuals, family and communities to perform their activities in a culturally expressed, beneficial and patterned ways. **Illness** is a state of not being well resulting from man's interaction with an external environment, and is believed to be intentionally caused by four

possible agents: God, the ancestors, witches and "pollution". Within this context **nursing** is the facilitation of health care focusing on helping the patient to regain his physical, psychological and spiritual well being with in an environment that is dynamic and ecological, in which human, plant and animals life nurtures and unfolds. An **environment** is comprised of both internal and external environment. An individual's internal and external environment is to a great extent shaped and moulded by the family or community within which one is born, which, if not respected or preserved in a meaningful way, may lead to a state of not being well, therefore to illness (Giger & Davidhizar, 1997:68; Pinkoane *et al.*, 2001:87).

3.2 Theoretical statements

The theoretical statements refer to the conceptual definitions used to construct the conceptual framework of the preliminary model (Chinn & Jacobs,1995:20;Walker & Avant,1995:30). They are as follows:

- **National Health Care System**

The total network or system of services and provision of health care in a specific country, including all particular health care systems of whatever nature which occur in a country (World Health Organization,1990:16; van Rensburg, Fourie & Pretorius,1994:3).

- **Traditional Healer**

A person who is recognized to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background, as well as 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, 1979:9).

In this research, reference to the traditional healer implies both male and female traditional healers.

- **Biomedical Personnel**

Doctors, nurses, pharmacists, psychologists/psychiatrists who have been scientifically trained for years as professionals at an institution of learning, university or college (Holdstock, 1979:121; Abdool Karim *et al.*, 1994:2; Arthur, 1997:65).

In this article HE is used to refer to both male and female biomedical personnel

- **Incorporation**

Incorporation refers to a process of combining or bringing about two separate entities or bodies to function as one. This functioning can be authorised to act as one legal body by passing a law to enhance and legalise its existence. This legal body can be made up of different professionals or practitioners who have the same aim and objective (WHO,1987:7; DSAE,1996:507).

- **Policy makers**

The persons or appointed officials assigned with decision making for administration, management and research of health care provision within health services (Andrews,1990:34; du Toit, van der Walt & Cheminais, 1998:80).

In this article policy makers are Regional or District Health Services Managers

4 RESEARCH DESIGN AND METHOD

This research used a qualitative design (Mouton & Marais, 1992:45), to explore and describe the perceptions and attitudes of policy makers, regarding the process of incorporation, as well as their views on how this should be achieved, with the goal of formulating a model to make this process a reality (Chinn & Jacobs, 1995: 45; Walker

& Avant, 1995:12). The research was conducted in Gauteng, North West and the Free State provinces of South Africa.

4.1 Permission to conduct research

Permission to conduct research in the regions or districts of the three provinces was obtained through a letter written to each of the regional or district health services managers within each province.

4.2 Sampling and Population

A non-probable purposive voluntary sample (Rubin & Babbie, 1997:226) was used according to set criteria to select a population which consisted of three policy makers out of each province who gave written informed consent. Data saturation was experienced when the ninth interview was conducted.

4.3 Data gathering

4.3.1 Accessing the participants

The researcher made contact with the participants a day before to arrange for the time and place where the interviews were conducted. Confidentiality, anonymity, privacy, risks, withdrawal and possible termination were discussed.

4.3.2 Physical Setting

The settings were different places where the policy makers worked in the towns of Gauteng, North West and Free State provinces. All the places were natural settings, private, with no distractions (Burns & Grove, 1997:42).

4.3.3 Conducting interviews

The semi-structured interviews were conducted with all policy makers using an audio-tape, one with batteries and the other with electricity. The purpose was to ensure that all information was captured, in case one failed, and the following questions were asked:

1. "What are your views regarding the incorporation of traditional healers into the National Health Care System?

2. How do you feel about this incorporation process ?

3. How do you think this incorporation should be achieved?"

Communication techniques as described by Okun (1992:70-71) such as paraphrasing, reflecting, summarizing, clarifying, and minimal verbal responses were applied during the interviews.

The researcher took field notes after conducting interviews with each of the participants and applied the guidelines of Talbot (1995:478) and Polit and Hungler (1997:307) to described the "what", "where", "who?" or "how?" of the situation.

4.4 Trustworthiness

To ensure trustworthiness in this research the approach of Guba *(in* Krefting, 1991:214) regarding credibility, applicability, consistency and neutrality was used (see table 1).

Table 1 : Measures to ensure trustworthiness

Credibility Guba (*in* Krefting,1991:214-217)	Truth value to give accurate reflection of the truth in this research	Literature review/control was undertaken. Field notes were taken after each interview. Independent data analysis controlled by co coder was done. (Cross validation)
	Research was conducted in the identified context of three provinces	Specific area for conducting research was appropriately identified.
Applicability	Application to other situations	Dense description of data collection and analysis was done.
Consistency	Recording and reporting	Consistent reporting and recording was done to make it easy for critique or further studies. Dense description of methodology and results was given. Used deductive, inductive and logical reasoning in the discussion.
	Regression and mortality	Data was collected once only for eight weeks. Similar interviews were conducted after obtaining consent forms.

Neutrality	Auditability to increase reliability and neutrality	Audited interviews, field notes, and raw data. Kept records for peer review.
	Researcher's status	A trust relationship was built with participants. Emphasized value of participation to all. Decreased distractions, the tape recorder was placed to blend with furniture. Used a co–coder to decode data. Used external experts to evaluate the findings
	Choice and selection of participants	Used of purposive voluntary sample, set selection criteria, described essential elements for participation of all samples. Rapport was built with all participants, and value of their participation was explained Created a conducive relaxed atmosphere during interviews.

4.5 Ethical aspects

Ethical aspects specific to this research were taken into consideration as detailed in the Guidelines for the Democratic Nurses' Organisation of South Africa (DENOSA, 1998:1-7) and the Department of Health (S.A, 2001:1-77):

- quality of the research was maintained by highest standards through thorough planning, implementation, documentation and the use of experts and a co- coder;
- confidentiality and anonymity was ensured by not revealing the identity of participants and areas where data was collected;
- privacy was ensured by recording interviews in total privacy of participants' homes, not divulging information to any other person and asked only research questions;
- informed consent obtained prior to conducting research, forms kept as proof thereof;
- risks minimised by little exposure to possible physical, psychological and social risks; and
- termination would have been undertaken, if relevant data could not be obtained.

4.6 Data analysis

The audio taped interviews were transcribed verbatim by the researcher. Content analysis was used employing the method of open coding as described by Tesch *in* Cresswell, (1990:153-155). Double coding was employed whereby a nurse specialist independently coded the data after which the findings of the researcher and co-coder were discussed, and consensus was reached to finalise the data.

5 RESULTS, DISCUSSION AND LITERATURE CONTROL

The policy makers' perceptions and attitudes are discussed under five main themes, which are, theme one, communication is important between traditional healers and biomedical personnel to reach consensus about incorporation. The second main theme reflects that traditional healers need to be taken seriously and used as resource persons in health care delivery. The third main theme indicates that government should facilitate incorporation by formulating policy to effect this process. The fourth theme portrays the need for traditional healers to be clarified about terms and conditions necessary to effect incorporation, and lastly the fifth theme indicates that two way education and training is important between traditional healers and the biomedical personnel. A bullet is used to indicate a subcategory .

5.1 THEME 1: COMMUNICATION IS IMPORTANT TO REACH CONCENSUS ABOUT INCORPORATION

Policy makers feel communication is important to reach consensus about incorporation and should be between biomedical personnel and traditional healers.

- **Communication is necessary to explore a realistic approach regarding incorporation**

These words sum up these views.

"When you meet the traditional healers they are chirpy about going forward, but the doctors are rather not so open, but I know of some who feel the time for a way forward is here let us meet to talk of the way forward"

These results are supported by Tabane (1995:37) and Selinzio (2002:1563) who states that it is now the time to move forward and all ideas of working together should be summed up into a meaningful whole.

- **Discussions to be an effort of both traditional healers and biomedical personnel who should accelerate them regarding how incorporation should be attained**

The policy makers had this to say.

"It is felt as though it is difficult to come with the way traditional healers are to allowed to work with doctors, but look at what is happening in the clinics with the nurses calling them to teach them new things"

Muller and Steyn (1999:142) as well as Pretorius, de Klerk and van Rensburg (1993:52) support the findings and are of meaning that it is imperative for both to sit and agree on how best this incorporation can be achieved.

- **Both groups need to engage mutually to understand each other's world and work in order that existing relationships can be enhanced**

The quotations of policy makers to support the results are:

"To know each other is to open up, I can never know you or your work unless you give it to me for me to read it, like what you did in your previous work, from now I will be able to relate with you in more understanding way, so let them have insight and build a positive relationship"

Mafalo (1997:2) support the findings and states that it is the best for both groups to build a relationship where one knows what is happening in the other's world. Peu *et al.*, (2001:45) and Brom (2003:9) support the findings.

- **The traditional healer is not old fashioned, is enlightened and need to be involved at levels of meetings and discussions**

The knowledge of the traditional healer is acknowledged in these words of policy makers.

"The old fashioned traditional healer who hid during the day is not here anymore, now they are young, go to school and even clean, why not talk directly with him not for him"

The findings are supported by Melato (2000:45) and Pinkoane *et al.*,(2001:90) that the modern traditional healer rural or urban is younger and need to be acknowledged.

- **An existing link between traditional healers, local authorities and biomedical personnel is established in the provinces which enables discussions to resolve the identified problems of initiation schools**

These words reflect the policy makers' views.

"Here in our local clinics the nurses call them for teaching, so it is a way forward because children die in initiation schools, I am sure you saw the news, so we are trying to teach them basics of sterility"

The findings are supported by Molaudzi (2001:16), Ncaca (2004: 27) and Nare (2004:5) that the traditional healer is having a link with the clinics and doctors.

- **Discussions should also focus on how best reciprocal referral can be realized whereby biomedical personnel refer to traditional healers and it should not only be traditional healers referring to biomedical personnel**

These views are expressed by the policy makers like this:

"They leave the hospital under the pretence of attending to family problems and yet go to the traditional healer, it shows how much they value his cures, so why do they allow the very patient to come to clinics, and yet they biomedical people do not send them to him for help, it does not work really"

The findings are supported by Oskowitz (1991:7); Thabede (1991:12) and Tiba (1990:19) that when one consults the patient this process of referral should flow between the traditional healers and the biomedical personnel.

5.2 THEME 2: TRADITIONAL HEALER TO BE TAKEN SERIOUSLY AND USED AS A RESOURCE PERSON

The second theme reflects the process of incorporation as long overdue because the WHO advocated for it. The Chinese or Zimbabwean method of incorporation can be used as examples in health care provision. The traditional healer exists parallel to biomedicine as informal and should not be left aside, and yet to remain autonomous. The policy makers see the traditional healer sharing the culture and believe system of the people. The traditional healer works more on the mind of people therefore useful in solving community problems. There are however problems for both biomedicine and traditional healing because of fakes, and practitioners who do not live up to their professional expectations. More research should be undertaken on herbs and due recognition to be given to the traditional healer whose herbs are found to be useful.

- **The process of incorporation is long overdue and should not be delayed as the WHO advocates for the use of traditional healer whose actions should be viewed positively**

These are the words of policy makers:

"This is a thing that especially us in South Africa, with all our resources should have accomplished. WHO is interested in the traditional healer and his practice, we need to use their guidelines for him to be beneficial to us, more so in the outlying areas"

Freeman and Motsei (1992:1182) and Bengu (2003:5) advocate for the use of the traditional healer based on the patients needs. The World Health Organization in Alma Ata proposed that the traditional healer be used in areas identified as in need (WHO,1978:5).

- **The Chinese or Zimbabwean method as examples can be applied to use the traditional healer in health care provision**

The views of policymakers are expressed with these words:

"We left here as a delegate to attend a conference in Beijing ,the one for HIV/AIDS, to our shocking surprise they use their healers who use traditional methods like acupuncture, so it would be good to copy what is already applied"

" In Zimbabwe the are allowed into the health centers but only if they are known in that area"

Bengu (2002:5) states that the government is in the process of looking for a working relationship with China. Abdool Karim, *et al.*, (1994:7) support the findings with the application in Zimbabwe.

- **Traditional healing exists parallel to biomedicine as informal part of health care provision and should not to be left aside but to remain autonomous**

The words of the policy makers are expressed as:

"From as far back as time can tell even before biomedicine evolved the traditional healer was in place, now they function along side each other, they serve the patient from different worlds but achieve the goal of giving the patient what he wants"

Fenyves (1994:37) and Molepo (2000:47) supports the findings and explain that the traditional healer can avail the services, but should remain in his practice area.

- **The traditional healer shares the culture and belief system of the people and can be used in the treatment of HIV/AIDS**

The following words portray these views.

"These people have been here from Biblical times, they are in the culture of the people, religion is the same, the people of the East have the traditional Shaman presiding over every ritual and ceremony"

Ramogopa (1993:23), Bateman (2004:804) and Keeton (2004:4) support the findings that the traditional healer is from the people and for ailments like HIV/AIDS the traditional healer should be used as the people believe that they do have a cure.

- **The people go to the traditional healer before going to the biomedical personnel because they are bound to him by belief and culture**

Policy makers had this to say.

"This peculiar practice has been going but we all ignored it because when I still practiced I would see that this person is from the traditional healer, but then keep quiet about it, it is part of cultural practice for black people'

The findings are supported by Gumede (1990:23) and Peltzer (2001:13) that patients consult the traditional healer in secrecy.

- **The traditional healer works more on the mind of the people therefore he is useful in solving community problems**

These are the words:

"This comes as no wonder because he approaches the person in the context of his family and where he live, so it is only sensible to involve him in community matters,

go to the rural areas and see this thing practically, the chief calls him to assist in decision making over community matters"

Thabede (1991:13); Setswe (1999:56) and Melato (1999:23) supports the findings that traditional healing has a potential to be used in community projects as well as in mental heath care.

- **Problems identified for traditional medicine are no different from those of biomedicine where both sides have fakes, faults and practitioners do not live up to professional expectations**

These results are confirmed by the following quote from a policy maker.

"We want to blame foreign doctors, it may be so yes, but what about our own local doctors, the nurses do terrible things, reports come in and we need to take serious steps, just as we say the traditional healers should correct their practices so should we"

Ncaca (2004:5) and Dlamini and Hlongwane (2003: 1) concur about the findings regarding botched operations leading to mortal complications. It is an issue facing provinces that these initiation ceremonies should be controlled.

- **Scientific testing of medicines is necessary to conduct more research on herbs and due recognition to be given for herbs already identified as useful in patient treatment**

The above views are verbalized like this:
"We should not sit in our offices and expect them to give us their medicines, let us in a decent way request each one who have something new to bring it for testing, some of these herbs are useful beyond reasonable doubt"

Mototo (1999:23) and Brom (2003:10) supports these findings regarding scientific testing of medicines and that those traditional healers who brought useful medicines should be given their due recognition (Smetherham,2004:7).

5.3 THEME 3: GOVERNMENT TO FACILITATE INCORPORATION BY POLICY FORMULATION

Theme three reflect the need for government to facilitate incorporation by policy formulation . They see this policy or act as a way to legalize and regulate traditional healing according to the same principles applied to biomedical personnel. Policy to further clarify the role the traditional healers should play in health care settings.

- **Policy or act to be formulated by government to legalize traditional healing so that traditional healers are regulated according to the same principles applied to biomedical personnel**

These are the words of policy makers.

"We need a frame of reference as of now the clinic sisters are calling them intermittently to reduce the problem of initiation schools, but it is still not clear what way forward is to be because nothing is on black and white"

The findings are supported by Molepo (2000:13); Molaudzi (2001:12) as well as Bodecker and Kronenberg (2002:1583) that traditional healing need to be regulated to reduce problems associated with their practices.

- **Policy to clarify the role of the traditional healer in health care provision and ensure that traditional healing and biomedicine function under one umbrella body**

  These are the words as verbalized by policy makers.

"It is the responsibility of government that this whole process should be made clear by an act, they are practicing more or less like private practitioners, therefore they should be told what is expected of them"

Muller and Steyn (1999:23); Mototo (1999:32) and Molaudzi (2001:15) support the importance of policy to spell out what actions are to be undertaken by the traditional healers.

5.4 THEME 4: TRADITIONAL HEALERS TO BE CLARIFIED ABOUT TERMS AND CONDITIONS NECESSARY TO EFFECT INCORPORATION

The results in this theme show the need to clarify traditional healers about terms and conditions necessary to effect incorporation. That self organization is necessary by traditional healers according to their own categories. That this organization is to control them, be answerable to the government, and all members are licensed which are to be renewed yearly. The organization is to set standards and guidelines which are to be maintained and enforced to assist in evaluating their practice and to have ethical control to help them identify bogus traditional healers. Traditional healers should continue to work from their own homes, and rural traditional healers are nearer, easily accessible and more receptive in their own places.

- **Traditional healers are to organize themselves according to their own categories as a requirement for incorporation**

These are the words as said by policy makers.

"They know each other, so like us in this area we all have names of those doctor, let them have an independent body"

"We want to go to them and ask for their area representative, you do know of VAIPA, so any new person should be known by us, let them organize themselves as in their localities, form a body, for those who know herbs, babies and so forth'

Mototo (1999:27); Bodecker and Kronenberg (2002:1583) including Peltzer (2002:17) concur that it is necessary for them to have representation in the form of an organization.

- **Organization to be in control of traditional healers and be answerable to the government**

These are expressed in this way:

"In as much as they should form an organization or association whatever case maybe, they are too many and the only way to control them is this body to be answerable to the government"

Molepo (2000:23); Moladzi (2001:14) and Peu (2001:32) confirm the findings that organization is to be answerable to the government for their actions.

- **Organization to ensure that members have licenses which are renewed yearly**

This is the quotation.
"Like all people belonging to organizations theirs should be known by government so that they should also pay licenses to work and time and again say yearly or so renew them"

Pretorius (1993:52) and Mototo (1999:45) support the findings regarding licensure of traditional healers which are to be paid as an individual responsibility.

- **The organization needs to set standards which are to form guidelines that are to be the framework regarding traditional healing practices**

These are verbalized by a policy maker.
"The most crucial part is for them to follow a patterned way to work with the doctors, I think if we look at what the WHO proposes it becomes meaningful to follow that pattern but someone must teach them"

The findings are supported by Mthimkulu (1999:31); Muller and Steyn (1999:79) as well as Molaudzi (2001:14) regarding standards and guidelines to follow when treating patients.

- **The guidelines that the organization set are to be maintained and enforced to assist in evaluating their practice**

The views of policy makers are expressed like this.

"To be sure we work with safe traditional healers there is a definite way that should be followed, but I feel it will only serve everybody's interest if the same could be done by the very traditional healers self because we cannot set guidelines for evaluation over the practice that is alien to us"

Molaudzi (2001:15) and Keeton (2004:4) support the findings and explains that this evaluation is to help with compliance and exclude all atrocities on their part.

- **Traditional healers are to have ethical control over their practice to help them identify bogus traditional healers who are to be excluded from incorporation, but are to be punished**

This is a quotation for ethical control.

" You know there are so many of them some good others involved in terrible things, fakes of all kinds, and truly and honestly they need some form of strong control about their work, we can call it ethics, discipline or whatever, but their code of practice should be ensured"

The findings are confirmed by Muller and Steyn (1999:79) supported by Bodecker and Kronenberg (2002:1582) that there is a need for control over traditional healing practice, based on the premise that they are so many and some are not well vested with healing therapies.

- **Traditional healers' can work from their own homes**

These are the words of a policy maker.
"It will be more becoming if they still worked from their homes, it is only that some stay a little far, but what is important is that they are able to do whatever they want when they are there, no constraints"

Mototo (1999:25); Molepo (2000:32) and Melato (2000:43) see it as necessary that the traditional healer works from their own places where there is privacy.

- **Rural traditional healers are nearer to the people and are easily accessible and more receptive in their own places**

These are policy maker's quotation.

"The traditional healer who is in the rural area is like the one in informal settlement, so his presence there is a bonus for health care, let him operate from there"

Mototo (1999:23) and Jordan (2001:23) support these findings that the traditional healer is accessible when operating near the people.

5.5 THEME 5: TWO WAY EDUCATION AND TRAINING IS IMPORTANT BETWEEN TRADITIONAL HEALERS AND BIOMEDICAL PERSONNEL

This theme emerged portraying the policy makers as perceiving education and training as important for both traditional healers and biomedical personnel regarding healing therapies, and that traditional healers will need training to be taught identification of complications and cases above their scope of practice. Traditional healers who are knowledgeable about herbs are to be selected to work with biomedical personnel, further they should be more open about own actions and remove the veil of secrecy.

- **Education and training is important for both traditional healers and biomedical personnel regarding healing therapies**

These quote the views.

"There is no doubt in my mind that when the two groups meet they should engage in mutual education which is to focus on all aspects of health care"

Molaudzi (2001:12) and Pinkoane *et al.*, (2005:3) support the findings that it is necessary to avoid hazards by two way teaching and learning.

- **Traditional healers need training to be taught identification of complications and cases above their scope of practice**

These words are said by the policy makers.

"This is a long standing issue, but I am happy that the clinic sisters are already on this education for the traditional healers it would be so good to have them understanding what they can do and what need to be seen by the clinic sister or doctor for that matter"

Molepo (2000:45) and Molaudzi (2001:14) support the findings that education is to enable them to detect early conditions beyond their knowledge. Peltzer (2001:9) concedes that this learning is always necessary for traditional healers.

- **Select traditional healers who are knowledgeable about herbs to work with biomedical personnel**

These are the results.

" As of now all are encouraged to participate in getting new medicines tested, and surely they who bring them up must forge a web in that area, with the testers in the laboratories to know the results"

The findings are supported by Mototo (1999:40); Peltzer (2001:10) and Molaudzi (2001:15) that it is necessary to identify those who know and open doors for them to work with the biomedical personnel.

- **Traditional healers are to be more open about own actions and remove the veil of secrecy**

The results portray the views of policy makers as:
"The time has come for them to show what they have, it does not help in any way for them to keep on saying the ancestors will remove their protection, if they don't come out who will trust what they do, no one, except of course their patients"

About removing the secrecy Melato (2000:23) and Pinkoane *et al.*, (2005:67) support the results that the traditional healers are now prepared to show what they have. Brom (2003:9) also supports the findings.

6 CONCLUSION

It is identified that policy makers view communication between traditional healers and the biomedical personnel as important to reach an agreement about incorporation. That the traditional healer need to be taken seriously and be used as a resource person, because he shares the same world view with the patient. It is the government who should facilitate incorporation by policy formulation so as to identify the way in which both groups should function together in health care settings. Traditional healers are to be clarified about self organization and licensure as some of the terms and conditions necessary to effect incorporation and lastly, two way education and training is important between traditional healers and the biomedical personnel regarding each other' s mode of treatment.

7 REFERENCES

1. Complete book by one author

ANDREWS, Y.1990. Medical Practitioners and Nursing Professionals as Public Managers. Pretoria. HAUM Publishers.178p

GUMEDE, M.V. 1990. Traditional healers: a medical doctor's perspective. Johannesburg: Vista University Press. 238 p.

NGUBANE, H. 1977. Body and mind in Zulu medicine. London: Academic Press. 158p

OKUN, B.F. 1992. Effective helping: Interview and counselling techniques. California: Brookes/Cole. 283 p.

TALBOT, L. 1995. Principles and practice of nursing research. St Louis: C.V. Mosby. 700 p.

2. Complete book by two authors

BURNS, N. & GROVE, S.K. 1997. The practice of nursing research: Conduct, Critique and Utilization. Philadelphia: W.B. Saunders. 798 p.

CHINN, P.L & JACOBS, M.. 1995: Theory and Nursing: A systematic approach. St. Louis. Mosby yearbook.238p

GIGER, J. N. & DAVIDHIZAR, R.E.1995. Trans- cultural Nursing. Assessment and Intervention. St Louis: Mosby Year Book.575p.

MOUTON, J. & MARAIS, D.C. 1996. Basic concepts in the methodology of social sciences. Pretoria: R.G.N. Publishers. 310 p.

POLIT, D. F. & HUNGLER, B.P. 1997. Nursing Research: Principles and Methods. Philadelphia: J.B. Lippincot Company. 694 p.

RUBIN, A. & BABBIE, E. 1997. Research methods for social work. 3rd Ed. Pacific Grove: Brooks/Cole. 758p.

WALKER L.O. & AVANT, K.C. 1995. Strategies for theory construction in nursing. Norwalk. Connecticut. Appleton Century Croft.127 p.

WOODS, N.F. & CATANZARO, M. 1988. Nursing research: Theory and practice. St Louis: C.V. Mosby.142 p.

3. Complete book by two or more authors

DU TOIT, D.F.P., VAN DER WALT,G.,BAYAT, MS.& CHEMINALS, J. 1997. Public Administration and management for effective governance. Kenwyn. Juta & Co, 271p.

4. Publication with an institution, organization or association as author

AFRICAN NATIONAL CCONGRESS.1994. A National Health Plan for South Africa. Johannesburg. ANC. 90 p.

DENOSA **see** DEMOCRATIC NURSES ORGANIZATION

DEMOCRATIC NURSES ORGANIZATION. 1997. *Ethical standards for nurse researchers.* Pretoria: Denosa. p8.

DSAE **see** DICTIONARY OF SOUTH AFRICAN ENGLISH

DICTIONARY OF SOUTH AFRICAN ENGLISH : on Historical Principles. 1996. Cape Town:Oxford University Press. 825 p.

WHO see WORLD HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION. 1978. The promotion and development of traditional medicine. Technical report series 622. Geneva: WHO Publications. 21 p.

WORLD HEALTH ORGANIZATION. 1987. Traditional healers as community health care workers. A review of projects using traditional healer as Community Health Care worker. Geneva.

5. Government publication

S.A. **see** SOUTH AFRICA. DEPARTMENT OF HEALTH

SOUTH AFRICA. Department of health. 1996. Annual Report. Pretoria: Government Printers. 60 p.

SOUTH AFRICA. Department of health. 1997. White Paper for the transformation of the health system in South Africa. (Notice 667). *Government Gazette*, 17:910-1. April 16. 232 p.

6. Work of author (s) representative of an organization

FREEMAN, M. & MOTSEI, M. 1992. Is there a role for traditional healers in health care in South Africa: A proposal. Centre for Health Policy. Johannesburg: University of Witwatersrand. December. 1-5.

7. An anthology with person(s) as editor(s)

ZUNGU CHIEF. 1992. Should traditional healers be recognized and registered/ If so, how should this occur? Centre for Health Policy. University of Witwatersrand.17 p.

MBURU, F.M. 1977. The duality of traditional and western medicine in Africa: Mystics, myths and reality. Essays in critique of medical anthropology. Rochester: Oakland University. 210p

8. An anthology published by an institution

THABEDE, D.G. 1991. The relevance of traditional healer in provision of mental health.
Social Work Practice. Pretoria. Department of Social Welfare. Pp11-14.

9. A contribution in an anthology

GUBA, E. G. *(in* Krefting, L. 1991. *Ed.* Rigor in qualitative research: the assessment of trustworthiness. *American Journal of Occupational Therapy,* 45(3): 214- 221. March.

INGSTAD, B. 1989. Healer,witch, prophet or modern health worker? The changing role of ngaka ya Setswana (*In* WIDING, A. J. & VESTERLUND, A. *eds.* Experience and pluralism: Essays on African ideas of illness and healing). Stockholm: Almqvist & Wikrell. 308p

TESCH, 1990. Research design: qualitative and quantitative approaches. (*In* CRESSWELL, J. *Ed.* A qualitative approach. *Library of congress catalogues in publication data.* 133-157.)

10. Journal articles

10.1 Author known

ABDOOL KARIM, S.S., ZIQUBU- PAGE, T.T. & ARENDSE, R. 1994. Bridging the gap – potential for a health care partnership between African traditional healers and biomedicine in South Africa. *South African Medical Association Journal*, 84(2) 1-16. December.

ARTHUR, M. 1997. The traditional biomedical dichotomy, in search of a common ground. *Curationis,* 20 (2): 63-65. July.

BATEMAN, C. 2004. HIV training of traditional healers limp along. *South African Medical Journal, 94(10).* October.

BODECKER, G. & KRONENBERG, F. 2002. A public health agenda for traditional, complementary and alternative medicine. *American Journal of Complementary Medicines.* 1582-1585.

BROM, B. 2003.Opening doors to integrative medicine. *South African Medical Journal of Natural Medicines.* (10). 9-10.

DE VRIES, E.M & MARINCOWITZ, G.M. 2004. The perceptions of rural women doctors about their work. *South African Family Practice*; 46 (3). 27 -29.

DAUSKARDT, R.P.A. 1990. Traditional medicine: perspectives and policies in health care. *Development Southern Africa.* 7 (3): 351-357.

HOLDSTOCK, T.L. 1979. Indigenous healing in South Africa: a neglected potential. *South African Journal of Psychology*, 9:118-123. May.

JILEK, W.G. 1994. Traditional Healing in the Prevention and Treatment of alcohol and drug abuse. *Trans-cultural Psychiatric Research Review,* 31 : 219 –258.

LEVITZ. E. 1992. Traditional Medicine: friend or foe? *Publico,* 233-236. October.

MOLAUDZI, F.M. 2001. Synergy between indigenous knowledge systems, modern health care system and scientific research- A vision for the 21st century. *Health SA Gesondheid* 6(4); 14-20.

MORRIS, K. 2001. Treating HIV in South Africa- A tale of two systems. *The Lancet*, 357. 14, April. 1190-1191.

MULLER,A & STEYN, M. 1999. Culture and the feasibility of a partnership between westernized medical practitioners and traditional healers. *Society in transition*,30 (2).

NGUBANE, H. 1981. Aspects of clinical practice and traditional organisation of indigenous healers in South Africa. *Social Science & Medicine*, 15B:361-365.

OSKOWITZ, B. 1991. Bridging the communication gap between traditional healers and nurses. *Nursing RSA*, 6(7): 20-22. July.

PELTZER, K. 1998. A community survey of traditional healers in South Africa(Northern Province). *South African Journal of Ethnology*. 21(4). 191-197.

PELTZER, K. 2001. An investigation into the practices of the traditional healer and faith healer in an urban setting in South Africa. *Health SA Gesondheid*. 6 (2) 10- 12.

PEU, M.D., TROSKIE, R. & HATTING, S.P. 2001. Attitude of community health nurses towards integration of traditional healers in Primary Health Care in North West Province. *Curations*, 25(1) 49-55.

PRETORIUS, E. 1991. Traditional healing and modern medicine working in tandem. *Curationis* 14 (4) 10-12, December.

SELINZIO, V.B.M. 2002. What is the role of complementary and alternative medicine in public health. *American Journal of Public Health.*, 92 (1) October.

SETSWE, G. 1999. The role of traditional healers in primary health care in South Africa. *Health South Africa* 4 (2)55-60.

10.2 Weekly /daily paper with author known

BHENGU, R. 2003. Healers need nursing skills too. *Daily Sun*: 25, March. p8.

BHENGU, C. 2002. China and South Africa agree on traditional medicine. *Sowetan*: 24 May. p10.

DAVIDS, N.& KEETON, C. 2004. Doctors who bring shame to their profession. *Sunday Times*: 9, May. p 6.

NCACA, N. 2004. Botched operations prompt search for solutions. *City Pres:* 30, May. p 27.

NARE, S. 2004. Inyanga cuts fees and set captives free. *Daily Sun*: 25, Feb. p1.

JORDAN, B. 2001. One woman's health service atop a lonely hill. *Sunday Times:* 30, September. 23.

SMETHERHAM, J. A. 2004. Local flower power might be able to beat TB: Traditional medicine also show promise on AIDS. *The Star*: 15, Jan. p7.

10.3 Article with unknown author

AENS. 2004. Awards for initiation schools. *Daily Sun*: April 13.p5

11. Legislation

SOUTH AFRICA. DEPARTMENT OF HEALTH. 2003. The Traditional Health Practitioners Bill. (Notice 979). Government Gazette, 24704. April. 11.3-36.

12. Unpublished thesis and dissertations

BODIBE. W.J.M. 1989. The inclusion of traditional healers into mental health team-Asocial work perspective. Pretoria: University of South Africa. (Dissertation- M.A).

DHLAMINI, M.P. 2000. The attitudes of health care workers towards the integration of traditional healers in primary health care. Cape Town: University of Cape Town. (Dissertation. M- Cur).

FENYVES, K. 1994. South African traditional healers organizations in the context of traditionalism and modernity. Johannesburg: University of Witwatersrand (Dissertation M.A).

MEISSNER, O. 1997. The legal status of traditional healers in South Africa.. Pretoria: University of South Africa. (Thesis- LLD).

MELATO S.R. 2000. Traditional healer's perception of the integration of their practices into the South African national health systems. Pietermaritzburg: University of Natal (Dissertation MA).

MOLEPO, E.R. 2000. The effectiveness of the referral system in primary health care in the West rand region: a normative – ethical study with special emphasis on traditional healers. Stellenbosch: University of Stellenbosch. (Dissertation –M. Phil).

MOTOTO. O.M. 1999. Willingness of traditional healers regarding collaboration with western psychiatrist in health care. (Dissertation, M. Soc. Science). University Orange Free State Library.

MTHIMKULU, J. 2000. The need to register traditional healers in post apartheid health system. Bloemfontein: Vista University Bloemfontein. (Article, non qualification).

PINKOANE, M.G, GREEFF. M. & WILLIAMS, M.J. 2001. Patient relationship and therapeutic techniques of the South Sotho traditional healer. Potchefstroom.:PU vir CHO (Dissertation -M.Cur.)

PINKOANE , M.G., GREEFF, M & KOEN, M. 2005. The traditional healers' perceptions and attitudes regarding their incorporation into the National Health Care Delivery System of South Africa. Potchefstroom: North-West University.(Article 2. Ph. D thesis).

RAMOKGOPA, M.T. 1993. The role of traditional healer and his psychological function in the African Society. Pretoria: Medical University of Southern Africa. (Dissertation - M. Psyche).

TABANE, E. M. 1995. Opinions of African caretakers of children at the Red Cross War Memorial Children's Hospital regarding the linking of traditional healers to western health settings. Cape Town: University of Cape Town. (Dissertation- M. Soc Science).

ARTICLE 6: A MODEL FOR THE INCORPORATION OF TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

GUIDELINES FOR THE JOURNAL : SOCIAL SCIENCE AND MEDICINE

SOCIAL SCIENCE & MEDICINE

Guide for Authors

Submission of Papers

Clickhere for Guidelines on Special Issues.

Social Science & Medicine is introducing a new online submission system, the Elsevier Editorial System (EES), with the aim of improving our editorial procedure for authors, editors and reviewers. The website address ishttp://www.ees.elsevier.com/ssm/

If this is your first time using the system you will need to go to the above page and register as a new author by clicking the 'Register' link. Once registered you may then submit your paper by clicking 'Submit New Manuscript' and following the instructions. All correspondence between editors and authors will be performed by e-mail and paper copies will not be required at the original submission stage.

The following types of contribution are welcomed:

1. Original research reports and critical or analytical reviews in any area of theory, policy or research relevant to health and illness. These may be up to 8000 words including abstract, tables, endnotes and references as well as the main text. Papers below this limit are preferred. The editors are prepared to consider longer papers in exceptional cases, though justification for this must be made at submission by the author.

2. Short research reports of research findings, "think pieces" or commentaries on topical issues. These papers should be no more than 2000 words.

3. Editorials or commentaries commissioned by the editors.

Submissions will be considered on the understanding that they comprise original, unpublished material and are not under consideration for publication elsewhere, and the studies on which they have been based have been subject to appropriate ethical review. A covering letter or e-mail to this effect should be enclosed with each submission, and it should be signed by all authors. This can be sent by post, electronically (i.e. as a scan), or by fax to the Managing Editor, Dr Ryan Mowat atrm158@le.ac.uk (Fax: +44 (0) 116 252 5259). *Social Science & Medicine* does not normally list more than six authors to a paper, and special justification must be provided for doing so. Further information on criteria for authorship can be found in *Social Science & Medicine*, 1997, 45(1), 1-2.

All submissions are subject to initial assessment by the senior editorial board to determine their suitability for consideration by *Social Science & Medicine*. Papers accepted for formal review will be sent anonymously to at least two independent referees with all identifiable details removed. We are currently not considering

companion pieces except in special instances. Authors should approach the Managing Editor if they wish to submit companion articles.

Manuscript Preparation

General: Submissions are acceptable in US or British English, but the use of either must be consistent throughout the manuscript. The editors reserve the right to adjust style to certain standards of uniformity. Authors should retain a copy of their manuscript since no responsibility can be accepted for damage or loss of papers. Original manuscripts and illustrations will be discarded one month after publication unless the publisher is asked to return original material after use. If hardcopies are submitted, they should be good quality single-sided printouts with a font size of 10 or 12pt on white paper.

Abstract and keywords: An abstract of up to 300 words must be included, as well as up to six keywords. The abstract should not be structured into subsections, and its word count should be provided.

Author details: This information is entered by following the instructions provided on the online submission system (EES).

Text: In the main body of the manuscipt this order should be followed: abstract, abstract word count, keywords, full word count, main text, references, appendix, figure captions, tables and figures. Do not place tables or figures in the main text. As with author details, acknowledgements are entered separately during the online submission process. The full word-count must include all text, including that in the tables, figures, references etc. The use of endnotes and footnotes should be avoided if possible, though if necessary they should be listed separately at the end of the text and not at the bottom of each page. All endnotes (except for table footnotes) should be identified with superscript Arabic numbers. All pages must be numbered in the bottom right-hand corner.

References: *Social Science & Medicine* uses the APA referencing system, details of which can be found at http://www.apastyle.org/. All publications cited in the text should be presented in a list of references following the text of the manuscript. In the text refer to the author's name (without initials) and year of publication e.g. "Since Peterson (1993) has shown that..." or "This is in the agreement with results obtained later (Kramer, 1994)". For 2-6 authors all authors are to be listed at first citation, with "&" separating the last two authors, for more than six authors, use the first six authors followed by et al. In subsequent citations for three or more authors use et al. in the text. The list of references should be arranged alphabetically by authors' names. The manuscript should be carefully checked to ensure that the spelling of authors' names and dates are exactly the same in the text as in the reference list. References should be given in the following form:

Williams, S., & Calnan, M. (1996). Modern medicine: Lay perspectives and experiences. London: UCL Press.
Wethington, E., & Kessler, R.C. (1991). Situations and processes of coping. In J. Eckenrode (Ed.), The social context of coping (pp.13-29). New York: Plenum Press.

Kanani, S. (1998). Towards quality of care in child health programmes: A challenge for the partnership in health and social sciences. *Social Science & Medicine*, 47(9), 1223-1230.

Referencing software such as Endnote® and Reference Manager® include the *Social Science & Medicine* style. If your current version of such software does not include the style it can be downloaded from the software website.

Illustrations: Details of the preferred file formats for electronically submitted illustrations can be found within the Artwork Instructions section of *Social Science & Medicine's* author gateway. All illustrations should be provided in camera-ready form, suitable for reproduction (which may include reduction) without retouching. Photographs, charts and diagrams are all to be referred to as "Figure(s)" and should be numbered consecutively in the order to which they are referred. They should accompany the manuscript, but should not be included within the text. All figures are to have a caption.

Line drawings: All lettering, graph lines and points on graphs should be sufficiently large and bold to permit reproduction when the diagram has been reduced to a size suitable for inclusion in the journal. Do not use any type of shading on computer-generated illustrations.

Photographs: Please access author gateway for more information on the file formats of photographs.

Colour: Where colour figures are required the author will be charged at the current colour printing costs. In cases where colour is paid for, authors will receive an additional one hundred offprints free of charge.

Tables: Tables should be numbered consecutively and given a suitable caption and each table provided in a separate file. Footnotes to tables should be typed below the table and should be referred to by superscript lowercase letters. No vertical rules should be used. Tables should not duplicate results presented elsewhere in the manuscript (e.g. in graphs).

Proofs: Proofs will be sent to the author (first-named author if no corresponding author is identified on multi-authored papers) by PDF wherever possible and should be returned within 48 hours of receipt, preferably by e-mail. Corrections should be restricted to typesetting errors; any other amendments made may be charged to the author. Any queries should be answered in full. Elsevier will do everything possible to get your article corrected and published as quickly and accurately as possible. Therefore, it is important to ensure that all of your corrections are returned to us in one all-inclusive e-mail or fax. Subsequent additional corrections will not be possible, so please ensure that your first communication is complete. Should you choose to mail your corrections, please return them to: Log-in Department, Elsevier Ltd, Stover court, Bampfylde Street, Exeter, Devon EX1 2AH, UK.

Offprints: Twenty-five offprints will be supplied free of charge. Additional offprints and copies of the issue can be ordered at a specially reduced rate using the order form

sent to the corresponding author after the manuscript has been accepted. Orders for reprints (produced after publication of an article) will incur a 50% surcharge.

Copyright: All authors must sign the "Transfer of Copyright" agreement before the article can be published. This transfer agreement enables Elsevier Ltd to protect the copyrighted material for the authors, without the author relinquishing his/her proprietary rights. The copyright transfer covers the exclusive rights to reproduce and distribute the article, including reprints, photographic reproductions, microfilm or any other reproductions of a similar nature, and translations. It also includes the right to adapt the article for use in conjunction with computer systems and programs, including reproduction or publication in machine-readable form and incorporation in retrieval systems. Authors are responsible for obtaining from the copyright holder permission to reproduce any material for which copyright already exists.

Author Services: For enquiries relating to the submission of articles (including electronic submission where available) please visit the Author Gateway from Elsevier Ltd at http://authors.elsevier.com. The Author Gateway also provides the facility to track accepted articles and set up email alerts to inform you of when an article's status has changed, as well as detailed artwork guidelines, copyright information, frequently asked questions and more. Contact details for questions arising after acceptance of an article, especially those relating to proofs, are provided after registration of an article for publication.

A MODEL FOR THE INCORPORATION OF THE TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

Martha G. Pinkoane

M. Cur Community Nursing Science; B. Cur I *et* A

***Ph.D Candidate** (Potchefstroom campus of the North-West University)

Vaal University of Technology

Vanderbijlpark

e-mail:martha@vut.ac.za

***Supervisor**

Minrie Greeff

Ph.D Psychiatric Nursing Science, M. Cur

School of Nursing Science

Potchefstroom campus of the North-West University

Potchefstroom

***Co - supervisor**

Magdalena P. Koen

Ph. D Professional Nursing; M. Cur

School of Nursing Science

Potchefstroom campus of the North-West University

Potchefstroom

e-mail:vpkmpk@puk.ac.za

***Forwarding address**

Prof. Dr. Minrie Greeff

School of Nursing Science

Potchefstroom campus of the North-West University

Private Bag x 6001

Potchefstroom

2520

North West Province, South Africa

e-mail: vpkmg@puk.ac.za

Tel: +27 18 299 1829
Fax:+ 27 18 299 1827

A MODEL FOR THE INCORPORATION OF THE TRADITIONAL HEALERS INTO THE NATIONAL HEALTH CARE DELIVERY SYSTEM OF SOUTH AFRICA

ABSTRACT

In South Africa the patient uses both the traditional healers and biomedical personnel's services out of need for the best healing therapy to fulfil his/ her health needs. When one service does not yield expected results the patient uses the other, creating a motion of shunting to and from between the two health care providers. The two systems quite often stand in conflict with one another and the patient finds himself/herself in the middle of these two service providers. It is from the need of the patient to get the best service to fulfil her/his health needs that the researcher was prompted to undertake research on how incorporation of traditional healers into the National Health Care Delivery System of South Africa can be realized.

The research objective was to investigate the perceptions and attitudes of traditional healers, biomedical personnel, patients and policy makers regarding the incorporation of traditional healers into the National Health Care Delivery System of South Africa and how they think this should be achieved. This data was used to formulate a model for the incorporation of the traditional healers into the National Health Care Delivery System of South Africa.

The research used a theory generating design with the purpose of formulating a model according to the approach of Dickoff, James and Wiedenbach (1968:435). A qualitative approach was used to investigate the perceptions and attitudes of the traditional healers, biomedical personnel, patients and policy makers. A conceptual framework for the incorporation of traditional healers was formulated from the initial critical literature review and the qualitative research, through concept identification and classification. The main concept identified was *incorporation of traditional healers*, and the associated concepts were identified as, *policy and organization: policy formulation by government, self organization by traditional healers, licensure of*

traditional healers, and availing structures for consultation; professional relationship: effective communication, mutual respect and trust; reciprocal education and training; two way referral; scientific testing of traditional medicines; patients' choice of services, health needs fulfilled, and quality health care services. The use of experts in model formulation and traditional healing were employed to refine the conceptual framework through dialogue. A systematic, logical and consistent approach lead to the conceptualization of the model for the incorporation of traditional healers into the National Health Care Delivery System of South Africa. Further dialogue followed with experts for the final description of the constructed model, which was evaluated on the basis of predetermined criteria. Guidelines for the implementation of the model were formulated.

1 INTRODUCTION AND PROBLEM STATEMENT

In South Africa 80-90% of black patients uses both the traditional healers and the biomedical personnel's services out of the need for the best healing therapy to fulfil his/her health needs (Abdool Karim, Ziqubu- Page & Arendse, 1994:5). This use creates a motion of shunting to and from between the two health care providers, where both systems stand in conflict with one another and the patient find himself caught in the middle (Peu, Hatting & Troskie, 2001:22).

The possibility of traditional healers and biomedical personnel functioning together existed since the eighties. The two groups met in Johannesburg in 1986 to discuss ways by which functioning together can be established (Zungu, 1992:24). A series of meetings and discussions followed after which, came the promulgation of the Chiropractors, Homeopaths, and Allied Health Services Professionals Act of 1996. This Act gives the traditional healers their due recognition but does not include them as part of health care providers, based on the premise that traditional medicines need to be scientifically tested first, before traditional healers can be allowed to work with the biomedical personnel (Department of Health, 1996:24).

In a critical literature review it became evident that various approaches were used internationally and nationally for the incorporation of the traditional healers into the National Health Care Delivery System (Pinkoane, Greeff & Koen, 2005:8 a). Three main concepts describing this process were identified, namely, incorporation, integration and collaboration. They all address the same issue of having the two health care systems functioning together to increase health care resources and fulfil the patients' health needs (Pinkoane, *et al.*, 2005:4 b). The difference that has been identified in the concepts, are in the specific interpretation and perceptions of the various authors and has no bearing on which approach should be regarded as the most important or effective to use when selecting an approach for the traditional healers to work together with the biomedical personnel. For the purpose of this research the word

incorporation was used as it seemed to be the most suitable to use to get the two health care systems to function together to decrease or eliminate the simultaneous use of both services by the patient.

To gain a richer understanding of the incorporation process and to be able to formulate a model for the incorporation that could work within the South African National Health Care Delivery System, the researcher undertook a qualitative research design with the purpose of investigating the perceptions and attitudes of traditional healers, biomedical personnel, patients and policy makers, regarding the incorporation of traditional healers into the National Health Care Delivery System (Pinkoane *et al.*, 2005: b, c, d, e). From the results obtained after the perceptions and attitudes were explored it seemed that all four groups had differences in focus but agreed that the incorporation of traditional healers is a process that needs to be in place. Even though the traditional healers, biomedical personnel, patients and policy makers agreed about incorporation, all perceived it as imperative first to get the government involved in the incorporation process by way of policy formulation to officially legalize traditional healing in the country. This legalization process was seen as a way of ensuring that whatever way of working together is envisaged traditional healing should be part of the legal health care delivery system, like the biomedical personnel.

All the parties were of meaning that both the traditional healers and the biomedical personnel had an important role to play, commencing with the traditional healers who should organize themselves meaningfully to be able to get representation when communicating amongst themselves as well as with government. This organization should also be a machinery for self control, licensing, and to weed out bogus traditional healers. On the other hand it was indicated that the biomedical personnel as formal health service providers need to change their perceptions and attitudes towards the traditional healers to be able to engage in positive talks about the incorporation process. It became evident in this research that the biomedical personnel need to accept, and acknowledge the contribution of the traditional healer to health care provision, as well as respect and trust the traditional healers' world view and their healing therapies. They identified the need to focus on the area where the traditional healers would provide their services. If it should be from home, safe structures are to

be availed for consultation. If it should be at the hospital or through a clinic visit, a list of names should be availed of all traditional healers who would be involved. Traditional healers should also avail their healing therapies for testing after which they would receive acknowledgement for useful medicines. Reciprocal education and training was seen as necessary where biomedical personnel could be taught some traditional healing therapies and they in turn could teach traditional healers some basic biomedical procedures. This relationship was to foster two way referral between the two groups, based on the premise that where one fail to yield positive results the other takes over to fulfil the patient' s health needs. The question was then asked:
How can incorporation of traditional healers into the National Health Care Delivery System of South Africa best be achieved?

2 RESEARCH OBJECTIVE

The objective was to formulate a model for the incorporation of the traditional healers into the National Health Care Delivery System of South Africa.

3 RESEARCH DESIGN

This research was qualitative, exploratory, descriptive, (Burns & Grove 1997:230) and contextual in nature for the purpose of theory generation. The use of this approach was identified as ideal for this research based on the premise that no model has been formulated for the incorporation of traditional healers into the National Health Care Delivery System of South Africa.

4 METHODOLOGY

In formulating the model the first three levels of the approach of Dickoff, James and Wiedenbach (1968:236) were utilized, namely, factor isolating theory, factor relating theory and situation relating theory. To be able to meet the objective of this research it was necessary to dynamically move from level one factor isolating theory, where concepts were identified, classified, defined and analysed, to level two, factor relating

theory, where relationships between concepts was delineated, up to level three situation relating theory, where the structure and process of the model were discussed. See figure 1 for the brief outlay of the research process.

Figure 1: A schematic diagram to illustrate the flow of the research process

Level one: Factor Isolating theory

Step 1: Identify and classify concepts from the critical literature review and qualitative research on perceptions and attitudes of the traditional healers, biomedical personnel, patients and policy makers, regarding incorporation of traditional healers into the National Health Care Delivery System of South Africa.

↓

Step 2 : Construct a tentative conceptual framework

↓

Step 3: Dialogue between the researcher and experts in model formulation, to review and refine the constructed conceptual framework.

↓

Step 4: Finalize the conceptual framework

↓

Step 5: Main and associated concepts:

* Identification and analysis of the main concept: *incorporation of the traditional healer*

* Identification and defining of the associated concepts:

- policy and organization: policy formulation by government, self organization by traditional healers, licensure of traditional healers, and availing structures for consultation;

- professional relationship: effective communication, mutual respect and trust;

- reciprocal education and training;

- *two way referral;*
- *scientific testing of traditional medicines;*
- *patients' choice of services, and health needs fulfilled;*
- *quality health care service.*

↓

Level two: Factor Relating theory

Step 6: Formulating relationship statements between main and associated concepts

↓

Step 7: Construct a tentative visual model for the incorporation of the traditional healers into the National Health Care Delivery System of South Africa

↓

Step 8: Dialogue with experts in model formulation and the field of traditional healing to: * review the main and associated concepts and;

* the tentative visual model ↓

Step 9: Refine and finalize the visual model

↓

Level three: Situation Relating theory

Step 10: Describe the structure and process of the model for the incorporation of traditional healers into the National Health Care Delivery System of South Africa

↓

Step 11: Evaluation of the conceptualized model

4.1 Level One : Factor Isolating theory

In factor isolating theory the concepts were identified, classified, analysed and defined using the approach of Dickoff *et al.*, (1968:420) and Walker and Avant (1995:29). Concepts are the most critical elements to consider when undertaking theory generation, based on the premise that they guide the process of investigation, which give direction to theory generation. Greeff (1991:31) postulates that it is of utmost importance that this level should be attended to with care as concepts differ in nature, and they can be primitive, concrete or abstract.

4.1.1 Identification of concepts

Concept identification is a process described by Chinn and Kramer (1995:93) as identifying those concepts that form the basic fabric of theory. Dickoff *et al.*,(1968:420) explains that theory at this level is a naming theory and that most of the time words are meant to express concepts. In this case the words to identify concepts were effected by employing a critical literature review and a qualitative research that was exploratory, descriptive and contextual in nature (Burns & Grove,1997: 140). The critical literature review investigated international and national approaches for the incorporation process. The qualitative research method was used to gain enough knowledge about the perceptions and attitudes of the traditional healers, biomedical personnel, patients and policy makers regarding the incorporation of the traditional healers into the National Health Care Delivery System of South Africa. These perceptions and attitudes were obtained by conducting semi-structured interviews and verified by literature to identify the similarities and the differences between the present findings and the previous research.

A mental map was constructed with the purpose of formulating through a thought process ideas, expose, or bring elements to mind, and to name them. This process of naming was thus a theoretical activity and serve as verbal attachment for the discovery of a conceptual unit (Greeff, 1991:30). It is therefore essential that in naming a concept it should be such that it can be communicated. The essential components during the naming process, according to Chinn and Kramer (1995:79), is a word or symbolic

label, the object or event itself, feelings, values and attitudes associated with the perception of the concept. These concepts can come from life, personal experiences and literature. Experience is considered empiric if it can be shared and verified by others using sensory evidence as is the case in this research where concepts were derived from the perceptions and attitudes of traditional healers, biomedical personnel, patients and policy makers.

4.1.2 Concept classification

Dickoff *et al.,* (1968:422) describes concept classification as sorting, categorizing, assigning names in terms of belonging to one kind as opposed to another, but in such a way that a total collection of kinds constitute all the factors of the one given kind. In concept classification concepts were sorted, put together and related one to the other according to their affinity. The approach of Greeff (1991:33) which used the survey list of level four theory from Dickoff *et al.,(*1968:423), to classify the concepts was employed. The survey list includes the following: agency referring to the who or what that performs the activity; recipient referring to who or what receives the activity; framework means, the context within which the activity is performed; terminus refers to the end point of the activity; procedures of the activity refer to the actions undertaken; and dynamics as the energy source of the activity.
The survey list, were thus used to construct the tentative conceptual framework.

4.1.3 Tentative conceptual framework for the incorporation of traditional healers into the National Health Care Delivery System of South Africa

The tentative conceptual framework was formulated from the classified concepts derived from this research. Dickoff *et al.*, (1968:428) makes mention of viewing activities in relation to other things, persons, or activities and to see the interrelation of these "other factors" as constituting a total context of activities. Wilson (1989:281) describes a framework as postulating relationships among concepts and permits empirical testing. Furthermore concepts can be bounded, in a specific way and explicitly interrelated. In this research even though the process of concept

identification, classification, analysis and definition occurred individually, each of these steps influenced the other, and lead to obtaining main and associated concepts. Concepts were therefore placed under headings of the survey list of Dickoff *et al.*, (1968:428) to construct the framework. The activity incorporation was viewed as produced by the agent, which was the traditional healers and biomedical personnel and received by a recipient which was the patient. The path that leads the activity from agent to recipient, were procedures which were undertaken to lead the activity to the terminus, which is quality health care. Dickoff *et al.*, (1968:428) further states that these activities are intimately related by pathways from one to another, as cited.

Dialogue was carried out between the researcher and the experts in model formulation to reach an agreement about the identified concepts used for the tentative conceptual framework.

4.1.3 Finalization of the conceptual framework for the incorporation of traditional healers into the National Health Care Deliver System of South Africa

The final conceptual framework was refined and finalized for the incorporation of traditional healers into the National Health Care Delivery System of South Africa after dialogue was carried out. See table 1 on the next page.

Table 1: Final conceptual framework for the incorporation of traditional healers into the National Health Care Deliver System of South Africa

Agency	Biomedical personnel and traditional healers
Recipient	Patients
Context	The National Health Care Delivery System of South Africa
Terminus	Availing quality health services by incorporation of traditional healers
Procedures	• Policy and organization - Policy formulation by government - Self organization by traditional healers - Licensing of traditional healers - Structures for consultation • Professional relationship - Mutual respect and trust - Effective communication • Reciprocal education and training • Two way referral • Scientific testing of traditional medicines • Patients' choice of services and health needs fulfilled • Quality health care services
Dynamics	Patients shunt to and from between biomedical personnel and traditional healers, and have no choice. Biomedical personnel lack respect for traditional healers and do not trust their healing therapies. Traditional healers are secretive and need ethical control.

4.1.4 Main and associated concepts of the model for the incorporation of traditional healers

The main and associated concepts are derived from the conceptual framework. Dialogue was carried out with experts to agree on these concepts. The main concept is incorporation of traditional healers and the associated concepts are:

- Policy and organization

- Policy formulation by government
- Self organization by traditional healers
- Licensing of traditional healers
- Structures for consultation

- Professional relationship

- Mutual respect and trust
- Effective communication

- Reciprocal education and training
- Two way referral
- Scientific testing of traditional medicines
- Patients' choice of services health needs fulfilled
- Quality health care services

4.1.5.1 Concept analysis and definition of the main concept: Incorporation of traditional healers

Concept analysis is described by Walker and Avant (1995:28) as a process where one clarifies, refines or sharpens concepts to better understand them. Wilson (1989:285) describes concept analysis as essentially a thinking process, where relevant variables or concepts are explored. The concepts are analysed, and investigated for differences and similarities in elements of the phenomena of interest within a theory. Some concepts are abstract in nature (Chinn & Kramer, 1995:75), as is the main concept of the model

for the incorporation of traditional healers into the National Health Care Delivery System of South Africa, namely "incorporation of traditional healers." Every researcher makes use of scientific language to be able to find the meanings attributed to the main concept within the theory. At least concepts get their meaning partially from within a determined conceptual framework, therefore it is self explanatory that followers of the same framework find it easy to communicate with each other (Greeff, 1991:35). The following steps of concept analysis as approached by Greeff (1991:36) were applied, namely, investigating dictionary and subject definition, deriving the main elements from the various definitions, and lastly, defining the concept "incorporation of traditional healers."

*** Investigation of dictionary and subject definitions**

Defining the concept specify the ideas on which the theory is built. Chinn and Kramer (1995:93) is of meaning that concepts should clearly and concisely identify the theoretical meaning of important concepts within a theory and can be borrowed from other theories or other multiple sources. Wilson (1989: 279) supports concept definition by stating that concepts may have theoretical or operational definition and are linguistic labels that are assigned to objects or events.

The first step was to obtain dictionary and subject definitions from dictionaries and literature about *incorporation*. The concepts *integration and collaboration* were investigated as synonyms of incorporation. See table 2 on the next page for an outlay of various definitions.

Table 2: Dictionary and subject definitions for incorporation and its synonyms

Word	Definition	Reference
Incorporation	Refer to a process of: • combining or; • bringing two separate entities or bodies to function as one; • authorised to act as one legal body.	Dictionary of South African English, (1996:507)
	• Include; • form part of.	Oxford Advanced Learners' Dictionary (2000:606)
	• To be made up of different professionals or practitioners who have the same aims and objectives, a multi-disciplinary approach involving all specialists.	Gumede (1990:185)
	• The traditional healers function with biomedical personnel under one health department, as two separate bodies.	Pinkoane *et al.*, (2001:59).
	• Using the best of both traditional healing and biomedicine, under one department with different bodies.	WHO (1987:7)
	• Traditional healers to function in their own settings, autonomous, but with official endorsement and recognition to treat cases.	Rappaport and Rappaport (1981:775)

	• Incorporate the best of traditional healing and biomedicine with one controlling authority for standards and control.	Knottenbelt (1993:241)
	• Two sided cooperation with government involvement, identify healing techniques that are of value that can be used as means of cooperation.	Green and Makhubu (1984:1078)
	• Fuse two ideas to suit cultural /health needs	Pearce (1982:1612)
	• Traditional healers and biomedical personnel remain autonomous and each retains own methods of practices by operating through recognition of what is valuable from each side.	Freeman and Motsei (1992:1189)
	• Two sectors act autonomously, not controlling, but respecting each other's existence.	Staugardt (1985: 200)
Integration	• A process whereby the two different parts or systems function together.	DSAE, (1996:521)
	• Combine two or more things so that they work together. • Many different parts work together.	Oxford Advanced Learners Dictionary (2001:623)
	• A combination of diverse elements of perceptions.	Hopa, Simbayi and du Toit (1998:10).

	• Different view points identified for their differences and similarities and yet be seen to attain the desired goal.	World Health Organization, (1978:12)
	• Blending the two where the patient receives a combination of both treatment methods depending on the diagnosis.	Freeman and Motsei (1991:5)
	• The traditional healers functions alongside biomedical personnel within government controlling their activities using laws and regulations.	Staugardt (1985:202)
	• Integration of the two health care systems means blending them, where the patient receives a combination of both treatment methods depending on the diagnosis.	WHO (1987:9)
Collaboration	• A joint effort of working together.	DSAE, (1996:664).
	• The act of working with another person or group. • Involving several people.	Oxford Dictionary (2001:215)
	• A two sided effort whereby the healing methods of one are brought to fore.	WHO (1978:7)
	• Choosing the most effective one to cure the patient's identified problem at that time.	Abdool-Karim *et al.*, (1994:4)

	• In collaboration only to those who have completed some recognised education and had shown some level of competencies should be involved.	Green and Makhubu (1984:1078)
	• Collaboration efforts should involve traditional healers who show level of competency biomedical personnel and political office bearers.	Neuman and Lauro (1982:1819)
	• Traditional healers, biomedical personnel and policy makers to exchange ideas to promote legislative changes for working together.	Jilek (1994:249)
	• An effort not to displace or replace, but combine the best features of both.	Green (1988:1129)

*** Deriving the main elements for the concept "incorporation of traditional healers"**

These main elements are the essential words of the definition " incorporation of traditional healers" and are derived from the various definition of the concepts incorporation, integration and collaboration. They are as follows:

- Bringing two separate bodies to function as one;

- Multi-professional approach;
- Different practitioners having the same aims and objectives;
- Legally authorised;
- Two sided effort;
- Partnership;
- Exchanging of ideas;
- To remain autonomous;
- Using the best practices of both the traditional healers and biomedical personnel under one department;
- Fuse two ideas to suit cultural/health needs;
- Combine diverse perceptions;
- Blending the two where the patient receives a combination of both treatment methods depending on diagnosis

*** Concept definition of the main concept "incorporation of the traditional healers"**

The definition formulated from the analysis and derived main elements is as follows:
Incorporation of traditional healers refers to a legally authorised process of bringing about the functioning of traditional healers and the biomedical personnel as two separate bodies made up of professionals and practitioners to work together under one health department in a multi-professional approach. They share the same aims and objectives focussed at fulfilling the patients' identified health and cultural needs. It is a two sided effort combining both treatment methods and best practices to form partnership in which each remain autonomous.
The definition described above give the concept "incorporation of traditional healers" a different connotation from the initial definition used prior to the process of concept analysis and definition.

4.1.5.2 Concept definition of associated concepts

- Policy and organization

Policy and organization as an associated concept refers to four aspects to ensure a well defined and organized system for the traditional healers to function within the National Health Care Delivery System. The latter is obtained through policy formulation by government, self organization by traditional healers, licensing of traditional healers and lastly by availing structures for consultation.

- Policy formulation by government

Policy formulation is a process undertaken by government whereby an act of parliament is passed and involve legal experts in policy formulation, traditional healers, biomedical personnel and policy makers. The essence is to give the traditional healers legal authority to practice as is the case with all health care providers in the country.

- Self organization by traditional healers

In the process of self organization, the traditional healers organize themselves meaningfully and have representatives at regional, provincial and national level, who act as their spokesperson, to communicate internally with own members and externally with government, and biomedical personnel. The organization effects ethical control to decrease malpractices, punish fakes and ritual murderers, as well as diminish rivalry and infighting amongst its members.

- Licensing of traditional healers

Licensing of traditional healers is a procedure undertaken by senior traditional healers responsible for training the initiates. The licenses are issued to the students who completes training in traditional healing, and affords a license holder an opportunity to have a practice number and sell his/her medicines.

- Availing structures for consultation

Structures for consultation are places where traditional healers practice and are provided by the government in urban and rural areas. The structures provide for physical safety in the form of Reconstruction Development Programme houses.

- Professional relationship

Professional relationship is a process evolving around effective communication, mutual respect and trust.

- Communication is an activity of expressing ideas or feelings about each other's world, healing methods, and takes place between traditional healers and biomedical personnel to engender and enhance mutual respect and trust.
- Mutual respect and trust is a two way activity of exploring feelings about each other to restore negative perceptions and attitudes with positive ones. Respect and trust of each other contribute to positive relationships and establish rapport.

- Reciprocal education and training

Reciprocal education and training is a two way process occurring between the traditional healers and the biomedical personnel whereby knowledge and skills are imparted to teach and learn from each other healing methods effective for patient care.

- Scientific testing of traditional medicines

Scientific testing of traditional medicines is research undertaken to any substance used in the treatment of ailments whereby experiments are done on herbs used for curative, preventive, protective and maintenance purposes. The traditional healers avail their useful herbs to be tested and those traditional healers whose herbs have been identified to effect a cure are given their due recognition and acknowledgement. Their knowledge is not be stolen or used without their permission and this information is

prepared as their own book of herbs (Pinkoane *et al.*,2001:80 and Pinkoane *et al.*, 2005b:7).

- Two way referral

Two way referral is an act of sending a patient who needs his/ her health needs to be fulfilled, from the traditional healers to biomedical personnel or *vice versa* for either one of them to treat the patient according to the prevailing problem, with a verbal or written information about his/ her condition. This process is to effect exchange of information regarding the patient's progress (Pinkoane *et al.*,2001:150).

- Patients choice of services and health needs fulfilled

Choice implies a unanimous act undertaken by the patient based on the right to decide and choose between the traditional healers and the biomedical personnel, health care services best suited to fulfil his/her health needs. The patient's choice is to be respected, as a consumer of health services and a citizen of the country (SA, 1994:23).

- Quality health care services

Quality health care services are services availed to patients by incorporating the services of the traditional healers and the biomedical personnel to fulfil the patients' health needs. Where either one of both practitioners fails to effect a cure, the other takes over the treatment and the patient is attended by both practitioners who are available, accessible, affordable, and meets the principles of primary health care as well as address the "Batho pele" principle of compassion and caring.

4.2 Level two -Factor Relating theory: formulation of the visual model for the incorporation of the traditional healers into the National Health Care Delivery System of South Africa

Factor relating theory is described by Dickoff *et al.*, (1968:421) as a level of theory where concepts are not seen in isolation but are linked in relation of one to the other. Hardy (1978:16) mention that to link concepts it becomes necessary to examine the relationship between their logical structure, because several relationships can exist between concepts in a theory and are better expressed in a form of a model. Chinn and Kramer (1995:115) is of meaning that in factor relating, concepts are correlated or associated in such a way that they become part of a larger meaningful situation. In a meaningful situation relationships are explored, and the overall structure of a theory and its components begin to emerge and take shape. The main relationships between concepts were formulated and a visual model created.

4.2.1 Formation of relationships

Formation of relationships was identified as a way in which two, three or more complex concepts relate to each other in a constant way, revolving between and among each other providing substance for construction of a framework (Chinn and Kramer (1995:115). The relationship between the identified main and associated concepts were delineated to make explicit the theoretical statements and to decide which variables were more important and which relationships most suitable. The following relationship statements are at the centre of the model for incorporation of the traditional healers into the National Health Care Delivery System of South Africa:

- A well formulated and executed policy for the incorporation of traditional healers into the National Health Care Delivery System by government enables the involvement of both traditional healers and biomedical personnel to provide quality health care delivery service.
- A meaningful relationship between the traditional healers and the biomedical personnel will provide an opportunity for the patient to make an informed choice of the health care delivery system to fulfil his/her health and cultural needs.

- Incorporation of the traditional healers into the National Health Care Delivery System based on a professional relationship between traditional healers and biomedical personnel will lead to the provision of best practices through partnerships.

4.2.2 Tentative visual model for the incorporation of traditional healers into the National Health Care Delivery System of South Africa

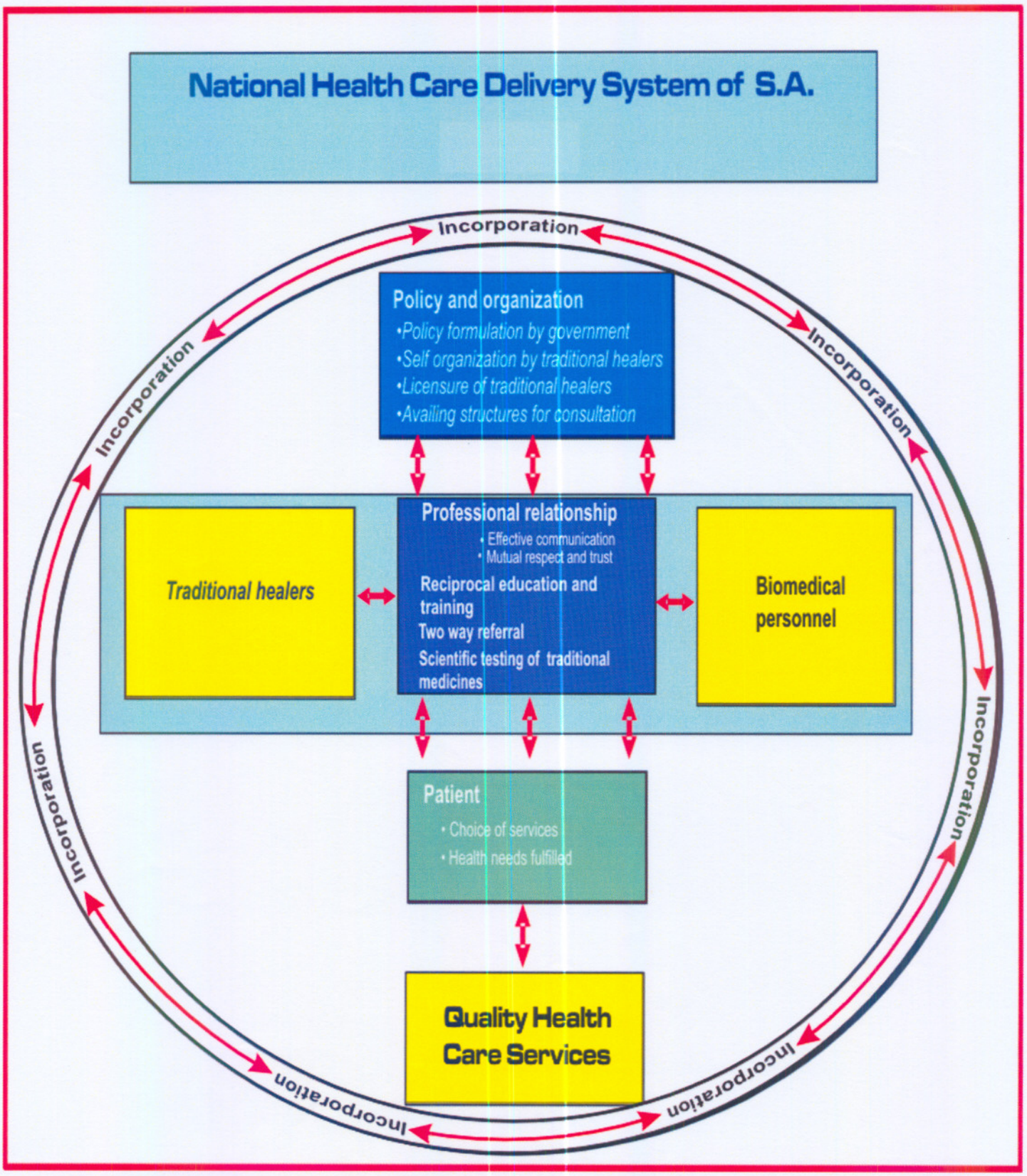
A tentative visual model was constructed after the main and associated concepts were identified. The importance of such a visual model is to give the researcher a diagram for discussion with experts (Greeff, 1991:39). The model was constructed in such a manner as to relate to the process and structure for the incorporation of traditional healers into the National Health Care Delivery System of South Africa.

Dialogue was carried out with experts in model formulation and traditional healing, to agree on the delineated relationships as well as the tentative visual model. The purpose and value of the dialogue was not to invite objection and opposing views but to communicate ideas, knowledge, and through a medium of critical evaluation, review a better approach that could be used. Furthermore expert involvement allowed for engaging in dialectic thinking where thoughts are supplemental and augmenting. Greeff (1991:39) explain dialectic thinking as application of thoughts that are not moving in a directed way, but moves to and from between sets and concepts.

4.2.3 The final visual model for the incorporation of traditional healers into the National Health Care Delivery System of South Africa

After dialogue with experts, there was an endeavour to effect changes in the visual model and weave in new ideas to finalize the model for the incorporation of traditional healers into the National Health Care Delivery System of South Africa. This final visual model serves as a basis for illustrating how relationships were formed as well as a description of the model (see figure 2 on the next page for the illustration of the model).

Fig 2: The model for the incorporation of traditional healers into the National Health Care Delivery System of South Africa



4.3 Level 3- Situation Relating Theory: Description of the structure and process of the model for incorporation of traditional healers into the National Health Care System of South Africa

Dickoff *et al.*, (1968:421) refer to situation relating theory as a level where predictions are made. Chinn and Kramer (1995:69) follows up on situation relating by explaining it as predicting how situations relate, and concepts and statements are consolidated to form an overall picture of what the model should consist of. In situation relating theory the structure and process are used to describe the model.

4.3.1 Structure of the model

Chinn and Kramer (1995:91) states that structuring theory involves forming schematic linkages between concepts which should result in a formal theoretic structure. The structure of the model for the incorporation of traditional healers into the National health Care Delivery System of South Africa demonstrate consistency and logic in the use of different structural forms. The structure of the model need to give a global overall form for the conceptual relationships within and it becomes necessary to start with the most central relationships that are self explanatory. The most central relationships is between the traditional healer and the biomedical personnel who have a professional relationship which evolves around effective communication, mutual respect and trust, reciprocal education and training, two way referral, scientific testing of traditional medicines, necessary to enhance working together. Between the traditional healers and biomedical personnel the structures are interactive and coalesce in the middle and form relationships evolving around procedures. Concepts are further linked in a linear fashion flowing from policy and organization, to the relationship between traditional healers and biomedical personnel affording the patient a chance to make a choice of a health care delivery system. The patient changes from being ill to attaining a healthy status fulfilling his/ her health needs, where the two health care systems are used simultaneously. The totality of the theoretical description for the process of incorporation, demonstrate a circular structure that encompass all the components within the model, the agent, procedures, recipient, dynamics and

terminus. The structure takes multiple forms and fit in this model based on the premise that they all link by arrows which portray the interdependence, strength and viability of the relationship between the concepts.

4.3.2 The Process of the model for the incorporation of traditional healers into the National Health Care Delivery System of South Africa

The process of the model for incorporation of the traditional healers into the National Health Care Delivery System of South Africa indicates that policy and organization are the first point of departure for the realization of the incorporation process. Policy in this instance is an act to be formulated by government, stake holders as traditional healers, biomedical personnel, and policy makers. This act is to legalize traditional healing and afford the traditional healers authority and legal status to practice, as is the case with all other health professionals in South Africa. The act is to stipulate clearly the role of the traditional healers in health care settings, indicating their position regarding patient treatment. Further the formulated policy is to make provision for the traditional healers to organize themselves meaningfully.

Self organization means self control and autonomy for the purpose of effecting internal and external communication. Internal communication is with members, whereby ethical rules and control measures are communicated to them. External communication means the organization act as a spokesperson for its members when communicating with government and or the biomedical personnel. The organization is to ensure that rivalry and jealousy remain under control and engender a feeling of trust among own members and the biomedical personnel. It is the organization that sets standards and guidelines for the practice of traditional healing according to their own frame of reference. The guidelines that are set are to be maintained and used as a yard stick to evaluate traditional practices. Furthermore the organization ensures that members are licensed.

Licensing implies that all practicing members are to be in rolls or registers with each member having a registration number to practice. The new initiates are licensed by their master traditional healers who train them. The purpose of licensing is to identify

fakes, and enforce ethical control over the practice of traditional healing, and give each member an opportunity to sell his/her medicines. The organization should communicate mandatory yearly renewal of licenses and that failure to update membership means no practice for that year. All other traditional healers without licenses should face harsh sentencing if no one is answerable for their existence as traditional healers.

Traditional healers need to have safe structures from where consultation should take place. Policy should make provision for building of these structures that are to be near the taxi rank for easy access to transport as well as near the clinics/hospital to enhance the process of referral between the traditional healers and the biomedical personnel. The traditional healer who is in the rural areas need their structures to be reinforced to withstand the elements, and these should be maintained by government in the same fashion as for the urban traditional healers.

In incorporation it is important to foster a professional relationship between traditional healers and biomedical personnel. This professional relationship is strengthened by effective communication where information is shared to understand each other's world, share ideas about each other's treatment methods and agree on modus operandi to effect incorporation. Effective communication is a cornerstone for building rapport between the traditional healers and the biomedical personnel. Opening up to each other enhances mutual respect and trust and reduce the notion of witchcraft associated with traditional healing.

Reciprocal education and training takes place through workshops and information sharing sessions whereby traditional healers teach biomedical personnel some traditional healing therapies, and traditional healers are taught some basic biomedical practices. In training the traditional healers simple biomedical procedures, include basic personal and environmental hygiene, treatment of cases within their scope, identification and referral of complications, doses for administration of herbal medicines, nature conservation and compiling their own book of herbal remedies. Traditional healers need to be evaluated to determine their level of competency and those who pass are given an opportunity to work in health care settings. Biomedical

personnel are taught some traditional techniques like home protection, removal of bad luck or repugnancy, steam bathing and performance of some rituals and ceremonies. In this whole process of two way education and training, the biomedical personnel acknowledge the contribution of the traditional healers to health care provision and trust the therapeutic techniques because the veil of secrecy is removed.

A two way referral system is facilitated based on shared information regarding the progress of the patient. The biomedical personnel reciprocate the referral by identifying cases which fail to respond to biomedical treatment and send patients to traditional healers. To effect referral a letter informing one to the other, treatment initiated and the progress or regress noted. During referral the patient is allowed to take the prescribed treatment and show the referred practitioner to avoid problems of toxicity or duplication of regime.

Traditional healers are to avail their new and untested medicines for scientific testing. A list of all tested traditional medicines is to be availed in all health care settings. Each tested medicine should have an information leaflet which makes the user know effects and side effects and signs of over dosage, toxic reactions and emergency interventions. These medicines are to be dispensed by traditional healers or biomedical personnel who received training in traditional therapeutic techniques. Traditional healers who bring useful medicines are to be acknowledged duly and their ownership right remains protected.

The patient as the consumer of health services should have a choice in deciding on whom to consult to fulfil his/her health needs. The patients are to be treated with respect, human dignity, tolerance, acceptance, empathy, patience and are to be supported when deciding to consult the traditional healers. The patients should be more open to biomedical personnel regarding consulting the traditional healers and are not to exhibit any fear or inhibitions regarding availing developments and progress of his/her health to biomedical personnel as well as to the traditional healers.

In incorporation the traditional healers work with biomedical personnel to avail quality health care service to the patients using the following principles of primary health care, accessibility, acceptability, affordability, sustainability and intersectoral collaboration. Accessibility implies that the traditional healer has consulting rooms near the taxi rank, clinic or hospital, so that when his services are needed he is within reach or when complications arise he/she is able to ferry the patient to the clinic or hospital with ease. Acceptability is reflected by accepting and acknowledging the services rendered by both practitioners under the aura of respect and trust engendered by effective communication, where the patient exercises his/her right to choose which of the two service providers to use at that time. Affordability means payments to both practitioners should be reasonable, the traditional healers to standardize payments, with and reach an agreement about the amount and the manner of payment. Sustainability is ensured by safeguarding the practice of traditional healers against fakes, whereby those in practice are licensed and the areas where they render their services are known, safe and protected against criminal elements. Inter-sectoral collaboration is maintained by involving the traditional healers when consulting with other sectors and biomedical personnel regarding all health matters.

5 Evaluation of the Model for the incorporation of traditional healers into the National Health Care Delivery System of South Africa

The description and evaluation of a model takes place to determine whether the objective for the formulation of the model has been attained. A combination of the criteria of Hardy (1973:18-20); Greeff (1991:47-49) and Chinn and Kramer (1995:118) was used to structure the evaluation using the following, clarity, simplicity, accessibility, generality and importance.

5.1 Clarity

For evaluating clarity it is necessary to look for both semantic and structural clarity as is the case with this research.

5.1.1 Semantic clarity

Semantic implies the meaning of words, and clarity means quality of being expressed meaningfully. In this research semantic clarity evaluates important aspects related to clarity in the definition of the main concept incorporation of traditional healers, as well as the associated concepts namely policy and organization, professional relationship, scientific testing of traditional medicines, two way referral and quality health care services. Definitions bring out the relationship between empirical indicators and the concepts of the theory to light as is the case with the main and associated concepts. The main concept was analysed and defined according to dictionaries and subject definitions. No terms were borrowed from other disciplines which are without definitions, because they would affect clarity, and the reader would end up attaching his/her own definition to that term. The model can be understood regarding how ideas were conceptualized and those that were not clear were identified and redefined to enable the researcher to make the model easy to understand.

5.1.2 Structural clarity

Structural clarity is closely associated with semantic clarity because it addresses the way in which logic and reasoning was applied in the theory. The descriptive elements of the structure and relationships are very important for evaluation. Concepts are arranged and organized meaningfully in a linear, horizontal, and vertical upwards and downwards fashion. The relationships between the traditional healers, biomedical personnel evolve around the activities that are interactive which are to be undertaken to effect incorporation and avail quality health services to the patient. These are the aspects that are important and the relationships are clearly set and all concepts are included in the structure. The theory flowed logically from policy and organization and progressed without breaks to availing quality health services with no lost relationships or unclear attachments.

5.2 Simplicity

Evaluating simplicity means that the number of elements within each descriptive category, particularly concepts and their relationship should be minimal, with fewer relational components. This model is very simple and the concepts identified and classified show their relationship one to the other and are not standing in isolation. Simplicity can further be ensured by checking on the number of concepts and their structural organization. This theory has one main concept, incorporation of traditional healers, and relate to a number of associated concepts with ease, like, policy and organization; professional relationships; reciprocal education and training; two way referral; scientific testing of traditional medicines and quality health care services. Therefore the model is simple to understand as reflected in the illustrated diagram.

5.3 Accessibility

Accessibility addresses identified concepts within the model as well as attainable research outcomes. The research is in six articles which are to be availed, making the attained objectives a reality. Furthermore the grounding of this model for incorporation of the traditional healers is clear and repetition was omitted, because the main and associated concepts are empirically identifiable. This model is for incorporation of traditional healers, and is to be accessed by health departments for availing the services of both the traditional healers and biomedical personnel to fulfil the patients health needs.

5.3 Generality

Being generalizeable means that a theory covers a broad spectrum of concepts but is still relatively simple and valid. This theory has a potential for generalization as it can be converted from its contextual nature as undertaken in three of the nine provinces in South Africa. The reason being that in each province there is a mixture of both urban and rural environments. The researcher was able to obtain the perceptions of both rural and urban people and got an opportunity to review the application of this research to other provinces thus applying the principle of generality. The breadth and

breadth and scope of the theory, need to be considered for it to be generalizeable to other six provinces. Further the model has a breadth and scope to be used for urban and rural environment because patients remain as recipients and consumers of services from both the traditional healers and biomedical personnel.

5.5 Importance

The importance addresses the extend to which the theory leads to valued nursing goals. In this research the National Health Care Delivery System of South Africa needs to increase health care resources and fulfil the patients' health needs, therefore the model is important to address this problem. This model is unique based on the premise that no model has ever been formulated for incorporation of traditional healers into the South African National Health Care Delivery System. Furthermore the patient has an opportunity to make a choice regarding whom to consult for his/ her health needs. Another area of importance is because the model to incorporate the traditional healers, is to avail the services of both health care providers simultaneously, thereby ensuring quality health care services using the principles of primary health care.

6 GUIDELINES FOR THE IMPLEMENTATION OF THE MODEL

The guidelines for the implementation of this model are formulated to facilitate the process of incorporation of the traditional healers into the National Health Care Delivery System of South Africa.

6.1 The researcher is to initiate discussions within the three provinces where the research was undertaken for the purpose of communicating the proceeds of the research. Permission to communicate these proceeds would be obtained from the District Health Services Manager as the first line of communication. The role players in these discussions are experts in traditional healing, biomedical personnel, traditional healers and policy makers who would form a forum where deliberations and debates are held to discuss issues pertinent to incorporation. They are to evaluate the model, review its strengths, limitations and the possibility of its application. Consensus would be reached at districts and the

deliberations agreed upon would be tabled to the provincial health department for their review and discussion.

6.2 The provinces are to establish similar forums, which are to be made up of all stake holders as cited above and should also include experts in traditional healing located as provincial representatives.

6.3 After a process of consultation at provincial level it becomes necessary to finalize the discussion of the model, its feasibility for application and involve government.

6.4 Government involvement should take place and ensure that:

- A task force of officials are appointed for dealing with all aspects regarding traditional healing;
- Establish a body consisting of legal experts and traditional healers' representatives to be part of task force;
- The Human Science Research Council to be involved and discuss pharmacology of traditional medicines;
- National Health Information System of South Africa is involved to publish information pamphlets for informing communities about progress in traditional healing and its therapeutic techniques;
- An environment conducive to harvesting medicines without the destruction of extinct herbs is created, this should be done in consultation with the Department of tourism and nature conservation;
- Arts and culture affirm cultural awareness in communities.

7 CONCLUSION

This is the conclusion of the research where the final objective to formulate a model for the incorporation of traditional healers into the National Health Care Delivery System of South Africa is attained. The formulated model shows the government formulating policy to legalize traditional healing and affords the traditional healers legal authority and an opportunity to be an official partner to the biomedical personnel and avail the quality health care services that fulfils the patients health needs using the primary health care approach.

8 BIBLIOGRAPHY

ABDOOL KARIM, S.S; ZIQUBU –PAGE, T.T & ARENDSE, R. (1994). Bridging the gap: Potential for health care partnership between African traditional healers and biomedical personnel in South Africa. *South African Medical Journal,* December, 84 (2) 1-16

BURNS, N. & GROVE, S.K. (1997). The practice of nursing research: Conduct, Critique and Utilization. Philadelphia: W.B. Saunders.

CHINN, P.L & KRAMER, M.K. (1995) Theory and Nursing: A systematic approach. St. Louis: Mosby Year book.

DEPARTMENT OF HEALTH. **see** SOUTH AFRICA. DEPARTMENT OF HEALTH.

DICKOFF, S., JAMES, P. & WIEDEBACH, E . (1968). Theory in a practice discipline. Part 1. Practice orientated theory. *Nursing Research,* 17 (5) Sept – Oct 1968: 415 –435.

DSAE **see** DICTIONARY OF SOUTH AFRICAN ENGLISH

DICTIONARY OF SOUTH AFRICAN ENGLISH ON HISTORICAL PRINCIPLES. (1996). NY: .Oxford University Press.

DAUSKARDT, R.P.A. (1990). Traditional medicine*: Perspectives and policies in health care development Southern Africa.* 7 (3): 351-357

FASSIN, D AND FASSIN, E. (1988). Traditional medicine and the stakes of legitimisation in Senegal. *Social Science & Medicine,* 27 (4): 353-357.

FREEMAN, M. & MOTSEI, M. (1991). Is there a role for traditional healers in health care in South Africa: A proposal. Centre for Health Policy. Johannesburg: University of Witwatersrand. December. 1-5.

FREEMAN, M. & MOTSEI, M. (1992). Planning health care in South Africa: Is there a role for traditional healers? *Social Science & Medicine*, 34 (1):1183-1190.

GREEFF, M. (1991). 'n Model vir psigiatriese verpleegkundige begeleiding van die pasiente met geestesongemaak. Johannesburg: RAU.(A doctoral theses.)

GREEN, E.C. (1988). Can collaborative programs between biomedical and African indigenous health practitioners succeed? *Social Science & Medicine*, 27(1): 1125-1130.

GREEN, E. & MAKHUBU, L. (1984). Traditional healers in Swaziland: Towards improved cooperation between traditional healers and modern health sectors. *Social Science & Medicine*, 18(12): 1071-1074.

GUMEDE, M.V. (1990). Traditional healers: a medical doctor's perspective. Johannesburg: Vista University Press.

HARDY, M.E. (1978). Theoretical Foundations For Nursing. New York: MSS Information corporation.

HOPA, M., SIMBAYI, C.C. & DU TOIT, C. D. (1998). Perceptions on integration of traditional and Western healing in the new South Africa. *South African journal of psychology*, 28 (2): 8-14.

HOLDSTOCK, T.L. (1979). Indigenous healing in South Africa: a neglected potential. *South African Journal of Psychology*, 9(1):118-123.

JILEK, W.G. (1994). Traditional Healing in the Prevention and Treatment of alcohol and drug abuse. *Trans-cultural Psychiatric Research Review*, 31 : 219 –258.

KNOTTENBELT, J.D. (1993). Systems of alternative medicine. *South African Medical Journal,* 83(2): 241, April.

MELATO S.R. (2000). Traditional healer's perception of the integration of their practices into the South African national health systems. University of Natal. (Dissertation- M. Soc)

MOUTON, J. & MARAIS, D.C. (1996). Basic concepts in the methodology of social sciences. Pretoria: R.G.N. Publishers.

NEUMAN, A.K. & LAURO, P. (1982). Ethnomedicine and biomedicine linking. *Social science medicine*, 16(210) :1817-1824.

OXFORD ADVANCED LEARNERS DICTIONARY. (2000). NY: Oxford University Press.

PEARCE, T. (1986). Professional interests and the creation of medical knowledge in Nigeria. (*In* LAST, M. & CHAVUNDUKA, G. L. *eds.* The proffessionalization of African Medicine. Manchester: University Press Manchester.)

PEU, M.D., TROSKIE, R. & HATTING, S.P. (2001). Attitude of community health nurses towards integration of traditional healers in Primary Health Care in North West Province. *Curations*, 25(1) 49-55.

PINKOANE, M.G. GREEFF,M & WILLIAMS, M.S.J. (2001). Patients relationship and therapeutic techniques of the South Sotho traditional healer. Potchfestroom: PU vir CHO (Dissertation -M.Cur.)

PINKOANE, M.G., GREEFF, M. & KOEN, M.P. (2005 a). Models for the incorporation of traditional healers into the National Health Care Delivery System: A literature review. Potchefstroom campus of the North-West University (Ph. D- thesis).

PINKOANE, M.G., GREEFF, M. & KOEN, M.P. (2005 b). Traditional healers' perceptions and attitudes regarding their incorporation into the National Health Care Delivery System of South Africa. Potchefstroom: Potchefstroom campus of the North–West University (Ph. D- thesis).

PINKOANE, M.G., GREEFF, M. & KOEN, M.P. (2005 c). Biomedical personnel's perceptions and attitudes regarding the incorporation of traditional healers into the National Health Care Delivery System of South Africa. Potchefstroom: Potchefstroom campus of the North–West University (Ph. D- thesis).

PINKOANE, M.G., GREEFF, M. & KOEN, M.P. (2005 d). Patients' perceptions and attitudes regarding the incorporation of traditional healers into the National Health Care Delivery System of South Africa. Potchefstroom: Potchefstroom campus of the North–West University (Ph. D- thesis).

PINKOANE, M.G., GREEFF, M. & KOEN, M.P. (2005 e). Policy makers' perceptions and attitudes regarding the incorporation of traditional healers into the National Health Care Delivery System of South Africa. Potchefstroom: Potchefstroom campus of the North–West University (Ph. D- thesis).

S.A. **see** SOUTH AFRICA.

SOUTH AFRICA. Department of health. (1996). Annual Report. Pretoria: Government Printers.

SOUTH AFRICA. Department of health. (1997). White Paper for the transformation of the health system in South Africa. (Notice 667). *Government Gazette*, 17:910-1. April 16.

SOUTH AFRICA. Department of health. (1998). Traditional healers: A report by the National Assembly Portfolio Committee on health NCOP select committee on social service. Cape Town: Government printers.

SOUTH AFRICA. Department of health. (2003). Traditional Health Practitioners' Bill. Cape Town: Government printers.

STAUGARD, F. (1985). Traditional medicine in Botswana: traditional healers. Gaborone: Ipelegeng Publishers.

WALKER L.O. & AVANT, K.C. (1995). Strategies for theory construction in nursing. Norwalk. Connecticut: Appleton Century Croft.

WILSON, H. S. (1989). Research in nursing. California : Addison Wesley.

WHO **see** WORLD HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION. (1978). The promotion and development of traditional medicine. Technical report series 622. Geneva: WHO Publications.

WORLD HEALTH ORGANIZATION. (1987). Traditional healers as community health care workers. A review of projects using traditional healer as Community Health Care worker. Geneva: WHO publications.

YODER P.S. (1982). Biomedical and Ethnomedical Practice in rural Zaire. *Social Science & Medicine*, 16(2): 1851-1857.

ZUNGU CHIEF. (1992). Should traditional healers be recognised and registered/ If so, how should this occur? Centre for Health Policy. Johannesburg: University of Witwatersrand.

CONCLUSIONS, SHORTCOMINGS AND RECOMMENDATIONS

CONCLUSIONS , SHORTCOMINGS AND RECOMMENDATIONS

1 INTRODUCTION

This research report was initiated with an overview of the whole research process which gave the outlay of how the research was conducted in two stages. In the first stage, the perceptions and attitudes of traditional healers, biomedical personnel, patients and policy makers regarding the incorporation of traditional healers into the National Health Care Delivery System of South Africa, and their views on how they thought this incorporation could be achieved, were explored. A qualitative research approach was followed which produced six articles that are submitted for publication to various journals as indicated.

The second stage of the research dealt with model formulation for the incorporation of the traditional healers into the National Health Care Delivery System of South Africa. From the results of stage one, a model was formulated utilizing Dickoff, James and Wiedenbach's (1968:420) approach to theory generation. Only level one, factor isolating theory, level two factor relating theory and level three situation relating theory, were used. The model formulation part was detailed as the sixth article of this research and was submitted for publication.
Conclusions, shortcomings and recommendations of the research are discussed.

2 CONCLUSIONS

The conclusions described here are for the total research, which are the conclusions for the perceptions and attitudes of traditional healers, biomedical personnel, policy makers, and the patients as well as for the model for the incorporation of the traditional healers into the National Health Care Delivery System of South Africa.

2.1 Conclusions regarding traditional healers' perceptions about their incorporation into the National Health Care Delivery System of South Africa

The perceptions and attitudes of traditional healers about their incorporation into the National Health Care Deliver System of South Africa portrayed the need for the government to be involved in the incorporation process by way of formulating policy to legalize traditional healing so as to give them due authority to practice. Policy formulation was the central issue which they saw as necessary for self organization and could only be accomplished if the government formulates this policy. The organisation was also viewed as important to introduce licensing of traditional healers which was seen as a way to limit the practice of bogus traditional healers.

Furthermore traditional healers viewed communication between themselves and the biomedical personnel as a means of availing best medicines in practice. An openness existed for testing of traditional medicines. Guidance of ancestors remained important to traditional healers and they were open for working together as long as ancestral blessings was considered. There was also an agreement to work with the biomedical personnel, but more trust and respect would be required to enhance professional relationship. Traditional healers exhibited fear for their future and this was verbalized as a real concern.

2.2 Conclusions regarding biomedical personnel's perceptions and attitudes regarding the incorporation of traditional healers into the National Health Care Delivery System of South Africa

The biomedical personnel's perceptions and attitudes yielded the same views as was identified with the traditional healers, that it was also imperative for the government to be involved in the incorporation process by formulating policy to legalize and control traditional healing to decrease malpractices. Safe areas for consultation was suggested whereby government could provide these structures. They suggested a format of self organization by traditional healers similar to that of the medical model.

Training and education of traditional healers was seen as an important tool to uplift the standards of practice. Interest was shown in traditional medicines and a book of herbs could be compiled. Biomedical personnel could be taught by traditional healers and traditional healers would avail medicines for testing. Lastly, communication was seen as essential for understanding each other, formulating new partnerships and enhancing existing ones.

2.3 Conclusions regarding patients' perceptions and attitudes about the incorporation of traditional healers into the National Health Care Delivery System of South Africa

The conclusions showed the patients as having views that portray the traditional healer as a person who is gifted to heal, sharing their world view, accessible and available to them whenever he/she was needed. The patients wanted to be allowed to have a choice and make a decision about whom to consult regarding their illnesses. The biomedical personnel were to respect the efficacy of traditional medicines and should not be blamed in event of failures or complications. The patient saw the government's role in incorporation as policy formulation to authorise working together, and this policy should also provide for building consulting rooms. Traditional healers should have their own organization to control their practice and bring unity amongst its members.

2.4 Conclusions regarding policy makers' perceptions and attitudes regarding the incorporation of the traditional healers into the National Health Care Delivery System of South Africa

The policy makers' perceptions and attitudes regarding the incorporation of traditional healers into the National Health Care Delivery System of South Africa, indicated that communication was the essence upon which all efforts regarding this process should evolve. Communication should be an effort of both traditional healers and biomedical personnel to accelerate the process of incorporation. An existing link

was identified between traditional healers, local authorities and biomedical personnel about discussions to resolve the problem of initiation schools.

The policy makers acknowledged contribution of the traditional healers in health care provision as well as the issue of abiding by ownership rights for their herbs. Involvement of traditional healers could be according to the recommendations of the World Health Organization, applying the Chinese or Zimbabwean methods as model cases. Policy to effect working together should be formulated and traditional healers to be informed about the conditions that they have to meet, to effect incorporation.

2.5 General conclusions on perceptions and attitudes of traditional healers, biomedical personnel, patients and policy makers.

All four groups agreed that the traditional healer is a resource person and should be incorporated based on the need for them to meet up to the expected conditions as set out. That it is necessary for government to formulate policy legalizing the existence of the traditional healers, and that communication is central to effect interaction between the traditional healers and the biomedical personnel. The differences in opinion was from traditional healers who had fears and concerns about their future and the of lack of respect for them exhibited by biomedical personnel. The biomedical personnel's concerns revolved around the secretive activities of the traditional healers which still gives them the feeling that witchcraft still exist in traditional healing. The patients' concerns were more towards autonomy, and the choice to make own decisions about consultation. As for the policy makers, it was evident that the conditions set out by biomedical personnel are the way to go coupled with the recommendations of the World Health Organization. They saw it as necessary for South Africa to use China and Zimbabwe as model cases.

2.6 Conclusions regarding the formulated model for incorporation of the traditional healers into the National Health Care Delivery System of South Africa.

The formulated model for the incorporation of traditional healers into the National Health Care Delivery System of South Africa demonstrate incorporation as a process that is undertaken within the context of the South African National Health Care Department. It shows the government formulating policy for legalizing traditional healing and affording traditional healers and opportunity to be self organized and licensed. The same policy allows for building structures for traditional healers to use as consulting rooms. In incorporation the traditional healers and the biomedical personnel have a professional relationship engendered by effective communication which embrace mutual trust and respect for each other. Effective communication further engenders reciprocal education and training and affords traditional healers an avenue to open up and avail their medicines for testing. Two way referral is undertaken to avail quality health care services using the principles of primary health care, for the patient who has a choice in selecting the service best suitable to fulfil his/her needs.

3 SHORTCOMINGS

The following shortcomings were identified:

- Some patients who had already given informed consent, relocated to unknown places and new participants had to be selected according to the set criteria.
- Long distances between the various participants was time consuming and costly.
- Some of the biomedical personnel's responses were directed only at answering the questions, and they avoided elaborating on the answers. The possibility of time constraints was observed.

4 RECOMMENDATIONS

Recommendations are made from this research for education, research and practice. The recommendations for practice are in the form of guidelines to incorporate the traditional healers into the National Health Care Delivery System of South Africa.

4.1 Recommendations for education

Recommendations for education are for the biomedical personnel and traditional healers.

4.1.1 Education for the biomedical personnel

Education courses for the basic course nurses (general, psychiatry, community health) and midwifery (SANC,1985:45), post basic courses, as well as those of the doctors, psychiatrists, pharmacists, psychologists. This education should include the following as part of their curriculum.

- The use of traditional therapeutic techniques whereby representatives from the traditional healers are invited to address and demonstrate traditional healing therapies as well as medicines.
- Respect and acknowledgement of the traditional healer and his therapeutic techniques so that traditional healers can be viewed as part of the health care team.
- Compassionate approach to patient care as demonstrated by traditional healers to assist them in eradicating negative attitudes towards patients who utilizes the services of the traditional healers.
- Respecting the patients' rights to self determination including the choice for selecting the services that he/ she feels fulfils his/ her health needs.
- Referral methods that are culture sensitive, including referral to the traditional healers' services.

4.1.2 Education for traditional healers

- The traditional healers could be taught hygiene, first aid, aseptic methods of circumcision and incision making, basic wound care, home health care for terminal patients, assisting patients in self administration of medicines at home;
- Educating them in proper methods of harvesting herbs necessary for nature conservation;
- Teaching traditional healers how to compile their own books of herbs for new medicines that have been scientifically tested, proper methods of dispensing prepared medicines;
- Teaching them early recognition and identification of complications, and of cases beyond their scope for immediate referral.
- Traditional healers to be encouraged to keep abreast with recent developments in patient treatment and those who cannot read or write can have this information made available to them through continuous teachings in the clinic or hospitals. Those in the rural areas can have their school going children can read and write for them.

4.1.3 Education for both traditional healers and biomedical personnel

- Building a professional relationship by:

- Forging a link to work together as a team, achieved by sharing the patients' health problems;
- discussing the best possible solution for fulfil the identified health needs;
- availing to each other a written report about the patient's progress;
- encouraging the patient to view his/ her treatment as an effort of both practitioners to enable the patient to open up to both practitioners without fear or inhibitions;
- forging a strong referral base to create a healthy environment.

- Effective communication

Effective communication should be facilitated by understanding each other's world in an atmosphere or environment conducive to patient recovery. Effective communication can be facilitated by:

- holding workshops to communicate new medicines and correct any misgivings regarding patient treatment;
- having regular discussions in the clinic or ward about the patient's progress;
- sharing amenities like tea rooms to hold informal talks;
- availing to each other new information from journals and publications that discusses patient treatment.

4.2 Recommendations for research

The following research can enrich the knowledge of traditional healing:

- Research into diseases which have been successfully treated by traditional healers;
- Investigating the modalities which can be used for dispensing and availing traditional medicines to patients in clinics and hospitals;
- Identifying appropriate methods for storing and using traditional medicines in primary health care settings;
- Investigating the existing relationship between the traditional healers and biomedical personnel;
- Exploring existing models for registration and licensure of the traditional healers as well as the criteria for being a license provider;
- Formulating, implementing and evaluating standards and practical guidelines for the traditional healers to ensure quality assurance in traditional healing.

4.3 Recommendations for practice

The recommendations for practice are reflected in the form of guidelines that are formulated to facilitate the incorporation of traditional healers into the National Health Care Delivery System of South Africa.

The specific process for incorporation of traditional healers are used as a point of departure and is as follows:

4.3.1 Policy and organization

4.3.1.1 Policy formulation by government

4.3.1.2 Self organization by traditional healers

4.3.1.3 Licensure of traditional healers

4.3.1.4 Availing structures for consultation

4.3.2 Professional relationship

4.3.2.1 Effective communication

4.3.2.2 Mutual respect and trust

4.3.3 Reciprocal education and training.

4.3.4. Two way referral

4.3.5 Scientific testing of traditional medicines

4.3.6 Patients choice of services and health needs fulfilled

4.3.7 A quality health care service

Guidelines with regard to facilitate the incorporation of traditional healers into the National Health Care Delivery System of South Africa are hereby reflected and what needs to be noted is that these components even though described independently of each other, augment and complement each other.

4.3.1 Guidelines for policy and organization

Guidelines for policy and organization show the need for government to formulate policy to legalize traditional healing, give the traditional healers an opportunity to be self organized, be licensed as well as avail structures for their consultation.

4.3.1.1 Policy formulation by government

Traditional healers have been given due recognition by government in the form of various policy frameworks like the National Health Plan of 1994, The Homeopaths Chiropractors and Allied Health Services Act of 1996, as well as the White paper for the transformation of Health Care Systems of 1997(ANC,1994:27; S.A, 1996:23; S.A, 1997:45). This recognition is a clear point of departure to illustrate that the government is aware of the contribution the traditional healer has on health care provision, but still does not explicitly indicate his legal status as is the case with all other health professionals in South Africa. The policy authorising his existence as a health care provider, is to be a regulation reflecting their professional competency and integrity which should characterise traditional healing.

The following are guidelines to have government formulate policy.

- Government needs to embark on a concerted effort to get legal experts who are knowledgeable about all aspects of traditional healing and policy formulation, to formulate an act which is to focus on the legal position of traditional healing within the framework of the National Health Department of South Africa,

- The act need to make provision for the following:
  - clarify licensing as a criteria for selecting traditional healers who are to work with biomedical personnel;
  - places for patient consultation should be indicated as at the traditional healers' place or at structures near clinic or hospital and exposed to a system of evaluation for safety;
  - visitation to clinics and or hospitals, to be verified;
  - names of selected traditional healers who should be part of this process should be availed by their organization;
  - identification cards to be availed and worn by all traditional healers during visitation to clinics and hospitals;
  - the times for consultation of patients should be spelled out and written for every one to be conversant with them;

- The act to follow a model similar to that of the health professions, but for traditional healers only the following aspects are to be included:
- clear standards and guidelines for practice;
- work procedures for the use of therapeutic techniques should be formulated;
- dispensing methods as well as prescriptions of traditional medicines to be stipulated;
- uniform or protective clothing to be similar for all traditional healers attending patients in clinics and hospitals.

4.3.1.2 Guidelines for self organization

The guidelines for self organization are explicit in the Traditional Health Practitioners' Bill of 2003 (Pinkoane *et al.*, 2005:9). The Bill makes provision for establishment of an interim traditional health practitioners' council of the Republic of South Africa; to provide for a regulatory framework to ensure the efficacy, safety and quality of traditional health care services; to provide for control over the registration, training and practice of traditional health practitioners and to provide for matters incidental thereto (S.A , 2003: 3- 36).

4.3.1.3 Guidelines for licensure of traditional healers

The process to have traditional healers licensed is imperative to get them aligned in a almost the same way as biomedical personnel (Zungu, 1992:13; S.A, 2003: 17). The purpose of licensing can be achieved by the organization which has regional office bearers. Licensing can be achieved in the following way for all new learners:

- all senior traditional healers in a specific region should avail the names of all his/ her students who are training;
- on completion of training the senior traditional healers should avail their names to the regional senior traditional healers;
- the regional senior traditional healer should enter the names of all new traditional healers of the district in the register kept in his/ her office;

- certificates should be issued by the senior regional traditional healers with the senior traditional healers who trained the students whose names are in the register;

Registration of old trained traditional healers

- enlist all traditional healers who had trained at his/ her school;
- avail this list to the senior regional traditional healers;
- inform old trainees about the process of registration and certification;
- each certificate must have:

- individualized registration number;
- names of the bearer;
- his/ her identity number;
- any speciality for example childrens' diseases;
- date of issue, signatures of both the regional and training senior traditional healer;
- and bear the region's stamp of approval.

- each traditional healer should be informed of:

- the registration number on each certificate which reflect proof of being a qualified member;
- the importance of yearly registration payments;
- removal of name from the register in case of failure to keep payments updated;
- this constituting illegal practice whereby offenders face mandatory jail sentence;
- restoration done only after penalty fee has been paid and name restored in register.

- lists are kept by the organization's provincial representatives who are to presents these to the National Health Department as and when required to do so.

4.3.1.4 Guidelines for availing structures for consultation

As part of quality health care provision, it remains imperative that patient care should be undertaken in an environment which is clean and safe. The following guidelines are to ensure this environment for traditional healers:

- government to formulate policy to avail structures for patient consultation;
- urban areas consulting rooms should be erected within the proximity of the taxi rank for easy access to transport or near the clinic or hospital to enable easy transfer of patients in cases of emergencies;
- rural traditional healers should have the same safe structures, where existing ones can be maintained by government or if dilapidated new buildings can replace old ones;
- senior traditional healers from organization remain responsible to intermittently evaluate these places for cleanliness;
- traditional healers should be informed about avoiding consulting patients late evenings to avoid exposure to criminal attacks.

4.3.2 Guidelines for professional relationship

Professional relationship should be maintained between the traditional healers and by effective communication, mutual respect and trust which need to exist between the biomedical personnel and the traditional healers. The following are the guidelines to engender effective communication.

4.3.2.1 Guidelines for effective communication between traditional healers and the biomedical personnel

In order to develop a professional relationship effective communication can be realized by the following:

- Opportunities for open discussions through workshops and forums should be undertaken to enhance an understanding of each other's world and enable formation of new partnerships and enhance existing ones;
- A rapport and good interpersonal relations between the traditional healers and the biomedical personnel are effected by providing new ideas to each other through information leaflets and pamphlets to inform each other about unfolding events;
- Undertake a joint venture by both traditional healers and biomedical personnel to address communities through radios and television to demonstrate partnership;
- Hold meetings at regional or provincial level where traditional healers should openly verbalize their concerns regarding on going events in patient treatment that needs clarity;
- Using meetings as an avenue for sharing ideas to reduce the notion of secrecy associated with witchcraft and encouraging members to report bogus traditional healers;
- The most recent factual data to be availed about activities in both parties through:
  - Organising workshops for both groups;
  - Avail training programmes and strategies about common pharmacology, further testing of useful herbs;
  - Introduction of public educational forums to keep the community informed about progress made in tested traditional herbs and which ones could be available for use, and where these could be obtained;

4.3.2.2 Guidelines for mutual respect and trust

For mutual respect and trust to prevail traditional healers and the biomedical personnel should change their perceptions and attitudes towards the each other, as well as treatment of the patient's perceived illness. The following should be done:

- Traditional healer should not act in isolation when attending to cultural problems (Abool-Karim *et al.*, 1994:2). They should involve biomedical personnel by way of referral to understand traditional healing techniques;
- Biomedical personnel should not monopolize patient care based on the premise that their therapies are scientifically tested and yield expected results. They should also refer and communicate the treatment given to patients who come with cultural problems who do not respond to their treatment to traditional healers;
- Biomedical personnel should treat patients holistically, with compassion and not treat symptoms only;
- Acceptance of the contribution by the traditional healer in health care provision by inviting then for open discussions.
- Trusting each other's mode of health care, recognising the efficacy and the limitations of own system as well as those of the others.
- Accepting that either treatment offered to the patient may or may not be effective therefore the modalities that can be employed to resolve the patient's problem can come from either one of them;
- Identifying no cure from prescribed treatment request and or recommendations to be made to the patient to consult either one of the two health care providers;

Communication to be the basis of mutual trust and respect and contribute to working together for the community to see the traditional healer as a recognised, independent, respected and acceptable health care provider;

4.3.3 Guidelines for reciprocal education and training

Reciprocal education and training need to be undertaken by both traditional healers and biomedical personnel where each one avails to the other therapeutic techniques used in treating the patient.

4.3.3.1 Traditional healers should be taught:

- patients for their own treatment some of which are referred by biomedical personnel;
- measurement of dosages for administration of own herbs;
- home health care for terminal patients;
- assisting patients with self administration of medicines at home;
- early identification of complications;
- early referral of patients who are not responding to traditional medicines;
- basic first aid;
- aseptic technique for basic wound care, incisions and circumcision;
- personal and environmental hygiene;
- compiling own book of herbs and availing it for reading and encourage more inputs from traditional healers who are knowledgeable about herbs.

4.3.3.2 Biomedical personnel should be taught:

- traditional healing therapies like steam bathing;
- bathing for removal of bad luck;
- home protection; and
- performance of rituals and ceremonies.

4.3.4 Guidelines for two way referral

A process of two way referral is to be undertaken by both traditional healers and the biomedical personnel to give a patient an opportunity to be treated by the best therapy according to the prevailing health problem (Molaudzi,2001:19 and Pinkoane *et al.*, 2001:123).

The following are the guidelines for two way referral:

- traditional healers are to be educated to identify cases beyond their scope of treatment and refer patients to biomedical personnel;
- biomedical personnel are to reciprocate the referral by identifying cases which fail to respond to biomedical treatment and send patients to traditional healers;
- communication can effect referral using a letter informing one the treatment initiated and what progress or regress noted;
- the patient is allowed to take the prescribed treatment used and show to the referred practitioner to avoid problems of toxicity or duplication of regime.

4.3.5 Guidelines for scientific testing of traditional medicines

It appears that traditional healers are availing their medicines for testing based on the need to ensure patients' safety. According to Pinkoane *et al.*, (2005:8) all tested medicines are to be availed for use in health care settings. The following guidelines can ensure availability of these herbs:

4.3.5.1 Compile a list of all tested traditional medicines and avail this in all health care settings;

4.3.5.2 Avail identified new herbs from the traditional healers to be tested by the National Human Science Research Council;

- tested herbs that are useful and ready need to be placed in containers and labelled accordingly;
- these medicines are to be availed to health centres in containers or trolleys that are identified as traditional medicines;
- the medicines are to be dispensed by traditional healers or biomedical personnel taught traditional therapeutic techniques;
- all herbs are to have an information leaflet which makes the user know effects and side effects and signs of over dosage;
- toxic reactions and interventions thereof are to be indicated on same leaflet.

4.3.6 Guidelines for the patients' choice of services to fulfil his/her health needs

The majority of patients consult the traditional healer while using biomedicine and need to be given an opportunity to make a unanimous decision about whom to consult without any fear of reprimand or rebuke. The following guidelines should enable this choice:

4.3.6.1 Biomedical personnel need to understand, accept and acknowledge the patients' choice when using these herbs;

4.3.6.2 Patients are to be:

- treated with respect, human dignity, tolerance, acceptance, empathy and patience;
- supported in circumstances where biomedical personnel attend to the symptoms of illness based on the diagnosis and the traditional healers on culturally perceived illnesses;

4.3.6.3 Patients should be more open to biomedical personnel regarding consulting the traditional healers;

4.3.6.4 Patients are not to exhibit any fear or inhibitions regarding availing developments and progress of his/her health to biomedical personnel as well as to the traditional healers.

4.3.7 Guidelines for facilitating a quality health care service

The identified way in which the treatment of the patient can be managed to avail quality health care service to fulfil the patient's health needs, should be by availability, accessibility, acceptability, affordability, sustainability and inter-sect oral collaboration.

The following guidelines are to be in place:

- Health care services to comply with the principles of primary health care as indicated by the National Health Department regarding availability, implies the

reach or when complications arise he/she is able to ferry the patient to the clinic or hospital with ease;

- Acceptability, reflected by accepting and acknowledging the services rendered by both practitioners under the aura of respect and trust engendered by effective communication, where the patient exercises his/her right to choose which of the two service providers to use at that time;
- Affordability means payments to both should be reasonable, the traditional healers to standardize payments, with an agreement reached about the amount and the manner of payment;
- Sustainability ensured by safeguarding the practice of traditional healers against fakes, whereby those in practice are licensed and the areas where they render their services are known, safe and protected against criminal elements;
- Inter-sect oral collaboration maintained by involving the traditional healers when consulting with all the other health professionals regarding health matters.

4.3.8 In conclusion

My aspirations are that we need to live with the reality of an African world view, and it was from these perceptions and attitudes of the participants towards the process of incorporation that it became evident that we need to understand and accept different world views and their meaning as embraced by their own people. These positive perceptions and attitudes towards the incorporation of the traditional healers, give me hope that these guidelines could be followed and applied with success in the clinical area and my prayer is for the patients health needs to be fulfilled so that they attain the highest level of health by having these two health care providers working together to enrich human resources for health care provision in South Africa.

5 SUMMARY

This research was initiated with the purpose of formulating a model for the incorporation of the traditional healers into the National Health Care Delivery System of South Africa. The researcher divided the research into two stages, namely, first stage, qualitative and second stage theory generating. In the first stage of qualitative research there were three objectives to be achieved, and these were attained based on the fact that the research questions as set out, were answered using the following research objectives, one, investigate the existing models for the incorporation of traditional healers into National Health Care Delivery Systems. This was attained by conducting a critical literature review which revealed that traditional healers are used in health care settings. In the West the traditional healer is regarded as the complementary or alternative health practitioner and in the East and Africa he/ she is still the traditional healer whose services are used simultaneously with those of the biomedical personnel. South Africa recognizes the traditional healer but he/ she is not used as an official health care provider except for in projects which had been initiated to explore the potential of a working relationship.

Objective two was to explore the perceptions and attitudes of the traditional healers, biomedical, personnel, patients and policy makers regarding the process for the incorporation of traditional healers into the National Health Care Delivery System of South Africa, as well as their views on how this incorporation should be achieved. This objective was also attained because the results demonstrated an agreement of all the stake holders that the traditional healers are available to provide services for the patients.

To the third objective, formulating a model for the realization of the incorporation of traditional healers into the National Health Care Delivery System of South Africa, this objective was also attained using the approach of both Dickoff, James and Wiedenbach (1968:236). A visual model for the incorporation of traditional healers into the National Health Care Delivery System of South Africa, was constructed to demonstrate how in incorporation the government is involved by formulating policy to legalize traditional healing. Policy also affords traditional healers an opportunity to

be self organized, and licensed. Structures for consultation are availed to ensure patient safety. In incorporation the biomedical personnel and traditional healers have a professional relationship, which foster effective communication, mutual respect and trust. Reciprocal education and training takes place to teach and learn from each other. Two way referral is a process used to let the patient be seen by both practitioners, where one fails the other takes over. The traditional healers avail their medicines for scientific testing and the patient has a choice about the service fulfilling his/ her health needs. A quality health care service is rendered applying the principles of primary health care. The model was evaluated for clarity, simplicity, accessibility, generality and importance.Guidelines for the implementation of the model were formulated.

6 BIBLIOGRAPHY

ABDOOL KARIM, S.S., ZIQUGU PAGE, T.T. & ARENDSE, R. 1994. Bridging the gap – potential for a health care partnership between African traditional healers and biomedicine in South Africa. *South African medical association journal*, 84(2):1-16 December.

DEPARTMENT OF HEALTH. **see** SOUTH AFRICA. DEPARTMENT OF HEALTH.

DICKOFF, S., JAMES, P. & WIEDEBACH, E. 1968. Theory in a practice discipline. Part 1. Practice orientated theory. *Nursing Research*, 17 (5) Sept – Oct 1968: 415 –435.

FREEMAN, M. & MOTSEI, M. 1991. Is there a role for traditional healers in health care in South Africa: A proposal. Centre for Health Policy. Johannesburg: University of Witwatersrand. December. 1-5.

MOLAUDZI, F.M. 2001. Synergy between indigenous knowledge systems, modern health care system and scientific research – A vision for the 21st century. *Health SA Gesondheid,* 6 (4); 14 – 20.

PINKOANE, M.G., GREEFF, M & WILLIAMS, M.S.J. 2001. Patients relationship and therapeutic techniques of the South Sotho traditional healer. Potchfestroom.:PU vir CHO (Dissertation -M.Cur.)

PINKOANE, M.G., GREEFF, M. & KOEN, M.P. 2005. Traditional healers' perceptions and attitudes regarding their incorporation into the National Health Care Delivery System of South Africa. Potchfestroom: Potchefstroom Campus of the North-West University. (Unpublished Ph. D- thesis.)

S.A. **see** SOUTH AFRICA.

S.A. **see** SOUTH AFRICA.

SOUTH AFRICA. DEPARTMENT OF HEALTH. 1996. Annual Report. Pretoria: Government Printers.

SOUTH AFRICA. DEPARTMENT OF HEALTH. 1997. White Paper for the transformation of the health system in South Africa. (Notice 667). *Government Gazette*, 17:910-1. April 16.

SOUTH AFRICA. DEPARTMENT OF HEALTH. 2003. The Traditional Health Practitioners Bill. (Notice 979). *Government Gazette*, 24704. April. 11.3-36.

SOUTH AFRICAN NURSING COUNCIL. 1985. *The Nursing Act 50 of 1978 as amended.* Membership for the profession. Pretoria: Government Printers. 13. 31.

WHO **see** WORLD HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION. 1978. The promotion and development of traditional medicine. Technical report series 622. Geneva: WHO Publications.

WORLD HEALTH ORGANIZATION. 1987. Traditional healers as community health care workers. A review of projects using traditional healer as Community Health Care worker. Geneva: WHO publications.

ZUNGU CHIEF. 1992. Should traditional healers be recognised and registered/If so, how should this occur? Centre for Health Policy. Johannesburg: University of Witwatersrand.

S.A. **see** SOUTH AFRICA.

SOUTH AFRICA. DEPARTMENT OF HEALTH. 1996. Annual Report. Pretoria: Government Printers.

SOUTH AFRICA. DEPARTMENT OF HEALTH. 1997. White Paper for the transformation of the health system in South Africa. (Notice 667). *Government Gazette*, 17:910-1. April 16.

SOUTH AFRICA. DEPARTMENT OF HEALTH. 2003. The Traditional Health Practitioners Bill. (Notice 979). *Government Gazette*, 24704. April. 11.3-36.

SOUTH AFRICAN NURSING COUNCIL. 1985. *The Nursing Act 50 of 1978 as amended.* Membership for the profession. Pretoria: Government Printers. 13. 31.

WHO **see** WORLD HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION. 1978. The promotion and development of traditional medicine. Technical report series 622. Geneva: WHO Publications.

WORLD HEALTH ORGANIZATION. 1987. Traditional healers as community health care workers. A review of projects using traditional healer as Community Health Care worker. Geneva: WHO publications.

ZUNGU CHIEF. 1992. Should traditional healers be recognised and registered/If so, how should this occur? Centre for Health Policy. Johannesburg: University of Witwatersrand.