

**COLLABORATION OF INDIGENOUS AFRICAN AND WESTERN
EUROPEAN MEDICINE: POLICY GUIDELINES**

BY

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DECLARATION

I declare that the thesis hereby submitted to the University of Limpopo, for the degree of Doctor of Philosophy (in Political Science) has not previously been submitted by me for a degree at this or any other university; that this is my own work in design and in execution, and that all material contained herein has been duly acknowledged.

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DEDICATION

This study is dedicated to my late beloved husband and best friend, Vernon, Leighton Mazwendoda. May the good Lord grant him eternal peace. It is also dedicated to my children Ntombizini, Bongumusa and Ntombizekhethelo.

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- The directorate of the Department of health Research Ethics Committee for granting me permission to carry out this study.

ABSTRACT

The primary aim of this study was to advocate for a collaborated health care delivery system that includes indigenous African medicine and is administered and controlled by the government. The objectives were:

- To demonstrate how apartheid disrupted the natural development of indigenous healing practices.
- To dispel the misconception about the use of indigenous African medicine in the treatment of diseases.
- To demonstrate the need to protect both indigenous African and western European medicine.
- To demonstrate that African patients consult both indigenous African and western European doctors for various aspects of their treatment in their health care choices.
- To demonstrate that patients expect the government to provide an effective health delivery system.

The main research question was: How can South Africa develop a collaborated health care delivery system using both indigenous African and biomedical health professionals that is effective and open to everyone on an equal basis?

The theoretical framework for this study was the Afro-centric worldview in which events and ideas are perceived from an African perspective with the African people as the main players rather than victims. At the centre of the study were the African people, their health, disease pattern and healing practices.

The Afro-centric qualitative research design was used. A sample size of 15 indigenous African doctors, 50 western European oriented health professionals and 84 patients participated in the study. The open coding method of data analysis was used to analyze data obtained from semi-structured in-depth interviews.

The major findings of the study are that:

- The belief of the African people in the existence of the ancestors and spirituality remains unshakeable. The strong belief in the ancestors make the diagnosis and treatment of diseases essentially religious practices.
- In the African culture, there are no preventative measures against natural illnesses, but there are preventative measures that are used against witchcraft/sorcery from entering a homestead and causing illness among members of a family.
- African people utilize both health care systems simultaneously and/or interchangeably depending on the seriousness of the illness and the knowledge and experiences that the illness can be effectively treated using indigenous African medicine or biomedicine.
- Both indigenous African doctors and biomedical health professionals play an important role in the provision of health.

Recommendations

The study recommends that when policy guidelines on the collaboration of indigenous African and western European medicine are drawn up, the following should be considered:

- Legislation to protect indigenous knowledge on African medicine
- Legislation that controls the qualification and registration of indigenous African doctors.
- Inclusion of indigenous African medicine in the curricula of all health professionals.

TABLE OF CONTENTS

DECLARATION	ii
DEDICATION	iii
ACKNOWLEDGEMENTS	iv
ABSTRACT	v
CHAPTER 1: GENERAL ORIENTATION TO THE STUDY	1
INTRODUCTION	1
RATIONALE AND BACKGROUND OF THE STUDY	1
PROBLEM STATEMENT	5
MOTIVATION FOR THE STUDY	6
SIGNIFICANCE OF THE STUDY	6
AIMS AND OBJECTIVES OF THE STUDY	9
HYPOTHESIS	10
RESEARCH QUESTIONS	10
THEORETICAL FRAMEWORK	11
DEFINITION OF CONCEPTS USED IN THIS STUDY	14
ORGANIZATION OF CHAPTERS	18
CHAPTER 2: REVIEW OF LITERATURE	20
Introduction	20
Indigenous knowledge	30
Aetiology and its philosophical basis /religion and indigenous healing	3
Natural causes of illness	35
Unnatural or supernatural causes of illness	35

Diseases caused by ancestors	37
Pollution as a cause of illness	38
The role of indigenous African medicine in Primary Health Care	39
Primary Health Care	39
Western and indigenous African medicine in the developing countries	41
Social and cultural relevance of indigenous African medicine	42
Practical and moral consideration of indigenous traditional medicine	43
The World Health Organization (WHO) Traditional Medicine Strategy	
2000-2005	43
Policy	44
Safety, efficacy and quality	45
Access: Making indigenous medicine available and affordable	46
Rational Use: Ensuring Appropriateness	48
The formal delivery health care system and indigenous African medicine in Africa	48
CHAPTER 3: RESEARCH METHODOLOGY	66
Qualitative research design	66
Population and sampling method	67
Population	67
Sampling	68
Inclusion criteria	69
Data collection	70

Community entry	70
Methods in data collection	70
Semi- structured one to one interviews	71
Focus groups	72
First session	72
Second session	72
Third session	73
Probing	73
Field notes	74
Tape recording interviews	74
Data presentation	74
Ethical considerations	76
Quality of research	76
Informed consent	76
Confidentiality and anonymity	77

CHAPTER 4: RESULTS OF INTERVIEWS WITH INDIGENOUS AFRICAN DOCTOR AND PATIENTS

INTRODUCTION	78
THEME: INDIGENOUS AFRICAN MEDICINE	82
Category A: The origin and nature of indigenous African healing practices	82
Category B: The belief system in the indigenous African healing practices	87
Category C: The influence of apartheid on the indigenous African healing practices	89

Category D: Health care system most people relied on ill	92
Category E: The health care system used in the prevention of diseases	98
Category F: Who should play a role in the provision of health care?	103
Faith healing	109

CHAPTER 5: RESULTS OF INTERVIEWS WITH HEALTH PROFESSIONALS 110

INTRODUCTION	110
Category A: The knowledge of the nature of indigenous African healing Practices	114
Category B: The scientific nature of the knowledge that IADs have about indigenous African medicine	117
Category C: Referral of patients to the indigenous African doctors	121
Category D: Collaboration of IAM and biomedicine in the provision of health	125
Category E: The view point of professional bodies towards the collaboration of IAM and biomedicine in the provision of health	130
Category F: The successes and challenges that may arise in the collaboration of IAM and biomedicine in the provision of health	132

CHAPTER 6	MAIN FINDINGS, CONCLUSION AND RECOMMENDATIONS	138
INTRODUCTION		138
OVERVIEW OF THE RESEARCH PROBLEM AND RESEARCH PROCESS		138
PROBLEM AND QUESTION INVESTIGATED		139
RESTATEMENT OF THE AIM AND OBJECTIVES OF THE STUDY		142
RESTATEMENT OF THE HYPOTHESIS		143
RESTATEMENT OF THE RESEARCH QUESTIONS		143
RESTATEMENT OF THE THEORETICAL FRAMEWORK		144
RESTATEMENT OF THE METHODOLOGY EMPLOYED IN THE STUDY		145
RESEARCH DESIGN AND METHODS OF DATA COLLECTION		145
Qualitative research design		145
Population and sampling method		146
Sampling		147
Inclusion criteria		148
Data collection		149
Data presentation		153
Ethical considerations		155

FINDINGS	156
Belief system	156
The attitude of health professionals towards indigenous African medicine	159
The influence of apartheid on the development of indigenous African medicine	160
Health system relied on for the treatment of diseases	161
Referral system	164
Health system used for the prevention of diseases	165
The use of amulets	167
Diseases caused by pollution	168
The collaboration of indigenous African and western European doctors in the provision of health	170
CHALLENGES IDENTIFIED	172
Intellectual property rights	172
Selfish ancestors	172
Power struggle and lack of mutual trust	174
Unsafe environment	174
Fees paid, deceitfulness and untrustworthiness of IADs	174
Different approaches used	175
Faith healing	175

RECOMMENDATIONS	176
The intellectual property rights	176
The selfish nature of ancestors	176
Indigenous knowledge is passed from one generation to the next through African religion or spirituality	176
Lack of mutual trust	177
Indigenous African medicine is expensive and IADs are deceitful and untrustworthy	177
Indigenous African medicine is unscientific	177
Curricular	178
Political will from the government	178
Institutionalization of indigenous African medicine	178
CONCLUSION	179
REFERENCES	186
APPENDIX A: Approval of research proposal: Ethics Research Committee	197
APPENDIX B: Approval letter Limpopo Provincial Government	198
APPENDIX C: Approval letter: sister in charge	199
APPENDIX D: Informed consent form	200
APPENDIX E: In-depth schedule: Indigenous African doctors	202
APPENDIX F: In-depths schedule: Health professionals	204
APPENDIX G: Focus group discussions schedule: patients	207

LIST OF FIGURES

Figure 4.1: Biographical data of the indigenous African doctors Ga- Dikgale village	79
Figure 4.2: Biographical data of the indigenous African doctors- Ga-Nchabeleng village	80
Figure 4.3: Biographical data of focus group –Ga-Dikgale village	81
Figure 4.4: Biographical data of focus group –Ga-Nchabeleng village	81
Figure 5.1: Age and gender of participants	111
Figure 5.2: Qualifications of participants	112
Figure 5.3: Church affiliation of participants	112
Figure 5.4: Years of experience in area of qualification	113

CHAPTER 1

GENERAL ORIENTATION TO THE STUDY

INTRODUCTION

The health care system in South Africa like other social systems is facing tremendous challenges. One of these challenges is that during the colonial and apartheid era only one health care system was formally recognized. Health care systems based on indigenous knowledge systems (IKS) that African people depended on for many centuries were not only deprived of recognition, but were also condemned as unscientific, primitive and barbaric. It must be remembered that any community or culture has its own ways and means of healing the sick, and if such ways remain uninterrupted, they evolve with the natural changes that take place among the community members.

RATIONALE AND BACKGROUND OF THE STUDY

Grenier (1998) defines indigenous knowledge (IK) as that knowledge that is kept in the minds of the people and is expressed in their daily activities. Such IK is part of their cultural heritage that has been accumulated over years and has been passed on from one generation to the next. An indigenous knowledge systems (IKS) is kept in the minds of the people of the community and is expressed in their daily lives, in their songs, stories, folklores, proverbs, dance, myths, cultural values, beliefs, rituals, community laws, local language, and plant species. It is also expressed in their indigenous healing practices (Grenier 1998; Semali and Kincheloe 1999).

In South Africa apartheid policies had a tremendous impact on the development of indigenous African medicine (IAM). Many laws that disrupted the natural development of indigenous healing practices were enacted. These laws include the Witchcraft and Suppression Act No.3 of 1957 amended by the Witchcraft Suppression Amendment Act No. 50 of 1970. This Act did not make any distinction between indigenous African healing practices and the practice of witchcraft. As a result indigenous African doctors (IADs) and herbalists were all classified as witchdoctors. The Homeopaths, Naturopaths, Osteopaths and Herbalist Act of 1974 and the Medical, Dental and Supplementary Act of 1974 made it illegal for IADs to practice their profession. As a result IAM became a backyard practice with no legal checks and balances or regulations.

Colonialism viewed the African people as a *tabula rasa* that had to be filled with the necessary knowledge that would enable the colonizers to control them. Christianity, education and colonial culture were used as the instruments of control. The African worldview, history, identity and purpose were lost or distorted beyond recognition. The African people internalized the worldview of their oppressors and became alienated from their own health care practices; they began to look down upon their own heritage including the vast indigenous knowledge systems. The Apartheid policy also became the vehicle through which a European dominated culture was forced upon a conquered African people. What the colonizers did not understand they called it primitive and barbaric. As a result a vast amount of valid indigenous African knowledge was lost even though some African people continued using what they could from what remained intact. For many years

Africans hid their indigenous knowledge systems (IKS) because Europeans evaluated what they had learnt about them (Africans) in terms of their own preconceived ideas and against their own standards. The African people were also too afraid to reveal themselves (Odora Hoopers 2002).

The colonial and the apartheid policies disempowered the African people and the IKS that they had depended upon for centuries were marginalized and regarded as unscientific. European knowledge on the other hand was considered the only universal scientific knowledge. Similarly the natural development of the indigenous healing practices was marginalized and regarded as mystical and barbaric. Wreford (2005) states that indigenous African medicine was labelled a sum of fallacious beliefs. As a result of this development only one way of treating diseases was promoted.

Makgoba (1999) observes that the call for an African renaissance provides the African people with a platform that enables them to reclaim their lost history and their pride. It has come at a time when there is a dire need to explore all possibilities to find a cure for the many incurable diseases. It intends to provide opportunities to remove the veil of secrecy and suspicion behind which Africans had been forced to hide their indigenous healing practices from the rest of the world. He further asserts that the African renaissance provide a platform where Africans can explain themselves without fear of being ridiculed by the rest of the world. Such an exposure will enable African people to store in writing this valuable IK for future generations to use. It offers opportunities to understand the meaning behind the symbolism found in the African culture and thereby removing

misconceptions and overcoming the one sided approach to health and disease.

The African renaissance further provides an opportunity for investigating/exploring the possibility of establishing a national health care system that fosters collaboration and partnership between indigenous African medicine and the European Western health care systems. It provides a platform not only for debating the credibility of indigenous African medicine, but rather of looking at the possibilities of linking both the indigenous African and biomedical medicine into a unified national health care system that will be accessible to all (Bührmann 1984, Makgoba 1999, Folles & Folles 2000, Odora- Hoopers 2002).

Pretorius (1999) states that currently, there are about 150,000-200,000 indigenous African doctors in South Africa. The Minister of Health, Manto Tshabalala (2004) also indicates that in South Africa there are approximately 200,000 indigenous African doctors. It has been very difficult to establish a single statutory council that licenses and regulates indigenous healing practices because of the size of potential members. It has also been difficult to establish the number of bona fide members. Pretorius (1999) states that of the 80,000 practising indigenous African doctors, about 10% are bona fide practitioners.

Pretorius (1999) further asserts that prior 1994 there was little interest in IAM and after 1994 the government was faced with many challenges amongst which were the development, promotion and the protection of IKS and thereby enabling the African people to reclaim their lost identity. The

government's positive attitude towards IKS has led to the recognition of the role that IKS has in scientific medical development. He further states that currently IADs are licensed by 100 organizations that are registered under the Companies Act and not as health care providers. They are expected to follow certain ethical codes, but it is difficult for these associations to enforce these ethical codes. Thus, the practice is open to quakes and charlatans.

PROBLEM STATEMENT

One of the challenges facing the delivery of health care in South Africa is that during the apartheid government indigenous African medicine was suppressed, but African people continued to utilize the services of indigenous African doctors (IADs) in secret. Wreford (2005) states that access to health care is determined by the patient's ability to pay. This means that only the rich who are predominately white can only to afford to pay for the expensive and sophisticated health care services. She further says that the shortage of skilled health care professionals and the inadequate facilities particularly in the public health care services has also made it necessary that the government should consider collaborating with IADs in the provision of health care. Gumede (1990) found that 80% of Africans consult IADs before they visit a clinic or a hospital. Goldsberg (1997) states that a survey on IAM was conducted and the consumer satisfaction with IAM reached about 80%. The World Health Organization (2002) also estimates that more than 80% of people in the developing countries use IADs to meet their health needs. Ngubane (1977) and Gumede (1990) also state that African people continue to use both indigenous and the biomedical

health care systems simultaneously with the latter enjoying official recognition while, indigenous African medicine (IAM) is marginalized. Wreford (2005) states it differently when she says that South Africa has a pluralistic health care system where both biomedicine and indigenous African medicine operate parallel but always in a distance and in isolation. In South Africa the focus of the provision of health care has shifted from curative to promotive and preventative. IADS are also respected members of the community and are more attuned to prevention and fortification.

After the democratic elections of 1994 in South Africa, the attitude of the government and health care professionals towards IADS' became positive. However, there is no policy that ensures that collaboration and partnership between IADs and European Western medicine in the provision of health care is facilitated and protected.

MOTIVATION FOR THE STUDY

One was educated and trained in a western oriented system of health care and has worked for many years within such a system. As a result the inadequacies and conflicts of a one sided health care delivery system as it has affected African people has been observed and experienced.

SIGNIFICANCE OF THE STUDY

The health care system in South Africa faces many challenges ranging from the shortage of skilled personnel particularly in rural areas, limited public finances and poor management to the escalating cost of health care.

Technological and medical advancement also has an influence in the provision of health care requiring more skilled health care personnel. The 20-21st centuries have also exacerbated the health care crises with new diseases that are incurable for example cancer and HIV and AIDs.

Poverty, crime, the escalating prevalence of HIV and AIDS and the increasing level of violence especially among women and children are also major concerns in the country. It has become a matter of urgency that all available human resources are mobilised to tackle the health care crisis. The European Western medicine has contributed greatly to health. However, it has not been able to reach those that need it the most because of its rising costs, complex and expensive medical technology. Western medicine has become expensive because of its increasing reliance on sophisticated technology for both diagnostic and therapeutic purposes. These expenses benefit both the patients and the companies in terms of the profit made from the regular price increments. At the same time for the patient technology exacerbate the problem making doctors and nurses to be perceived as non carers (Downing 1991).

Western medicine focuses exclusively on the body and excludes the mind. This western worldview tends to ignore that the individual is a complex being made of infinite complex interactions. Wreford (2005) says that in biomedicine the body is seen as something that has to be worked on, altered adjusted and ultimately rebuilt. The hierarchical structure that is found in hospitals also tends to intimidate patients resulting in poor health care delivery service. Consequently the patient finds himself/herself lonely and isolated far away from the company of family members. On the other hand,

African people are spiritual in nature and they believe in the existence of the ancestors who play an important role in their treatment. Treatment is also in relation to the patients' family and community. African people also place emphasis in the establishment of equilibrium between the body, mind and environment. Thus, the strategy of the IADs is always seeking to restore balance and harmony between the body, mind and environment. Hence, IADs have continued to provide health care services for many centuries because they focus on promotion, prevention and management of diseases (Davies 2004; Wreford 2005).

The World Health Organization Alma Ata (1978) states it clearly that IADS form an integral part of African communities. They are deeply interwoven into the cultural and spiritual lives of the African people. They are the first people to be consulted when someone is ill and have considerable influence on the people. They are easily accessible and cheap particularly in rural areas where other services are not easily accessible.

It is ironic that IAM is not in partnership with western medicine when most of the western drugs are derived either directly or indirectly from herbal components and other natural compounds (Downing 1991).

In South Africa the focus of health care has shifted from being curative to the primary health care (PHC) approach. The government's emphasis on this approach is meant to make basic health care services accessible to all communities. Indigenous African doctors can play an important role in this regard because they are more attuned to prevention, protection and fortification. They are also well known members of their communities.

The need to formulate policies that will ensure that indigenous medicine is legally protected has become more urgent than before. It is therefore, important that all available resources are harnessed to meet the health care needs of communities. Collaboration and partnership between IADs and western oriented personnel will increase the scope of health care.

This study will deepen our insight into the indigenous knowledge systems, which can enhance medical knowledge in general by insights and practices from indigenous medicine. What will emerge are more family centred and acculturated medical practices in South Africa.

AIM AND OBJECTIVES OF THE STUDY

The aim of this study is to advocate for a complete and collaborated health care delivery system that include indigenous African medicine and administered and controlled by the government.

The following objectives were used to achieve the stated aim of the study:

- To demonstrate how apartheid disrupted the natural development of indigenous healing practices.
- To remove misconception in the use of indigenous African medicine in the treatment of diseases.

- To demonstrate the need to protect both indigenous African and western European medicine.
- To demonstrate that African patients use both indigenous African and western European doctors for various aspects of their treatment in their health care choices.
- To demonstrate that patients expect the government to provide an effective health delivery system.

HYPOTHESIS

The following hypothesis was tested:

Collaboration of indigenous African and Western European medicine can contribute to the prevention and treatment of diseases and improve the health status of communities in South Africa.

RESEARCH QUESTIONS

How can South Africa develop a collaborated health care delivery system using both indigenous African and biomedical doctors that is effective and open to everyone on an equal basis?

The following are the principal research questions:

- How did apartheid disrupt the natural development of indigenous African healing practices?

- How can indigenous African medicine contribute to the prevention and treatment of disease and the care of patients in a collaborated health care delivery system?
- Why should the South African Government administer and control a collaborative health care delivery system ensuring equal treatment for all?
- How do patients presently use both indigenous African and biomedical doctors in their health care choices?
- Do rural poor patients expect the government to provide an effective health care delivery system for them?
- Do rural poor patients want a government- administered and controlled collaborative health care delivery system?

THEORETICAL FRAMEWORK

The African worldview of human beings is one of an interrelated self with the body, mind and the environment. Africans do not see themselves as separate from their environment, but as completely integrated with the universe which is larger than them and yet centred on them. This philosophy is based on the African philosophical principle of unity of being. Ama Mazama (2002:220) explains the unity of being as the principle of “connectedness of all that is based on a common essence and the principle of harmony based on the organic solidarity and complementarity of all forms” with God being the source of energy that is identical to life itself. Ngubane (1977) explains the same notion that the individual has to maintain a balance with his/her environment. She defines balance as a “moral order in the

symmetrical sense in relation to the position of people, other people, the environment, the ancestors and other mystical forces that produce pollution.” (Ngubane 1977:27). Thus, good health does not only mean a healthy body, but it is all encompassing; it means the harmonious working and co-ordination of the environment with the self at the centre of events.

In the African worldview there is no difference between life and death. Death is viewed as a rite of passage from the world of the living to the world of the ancestors. It is a doorway to a noble and higher life as well as a transition for both the deceased and his/her relatives. There is also no separation between the world of the living and the spirit world because life is one. The only difference between the two worlds is essentially one of degree of visibility, the spiritual world being invisible but quite real. The ancestors are therefore, central in the African worldview, making the living and the dead to be interdependent. By virtue of being spiritual in nature the ancestors are considered closer to God and can therefore petition Him. They guide and protect us and communicate with us through dreams. Contact, communion and fellowship between the living and the dead are established and maintained by pouring libation, giving offerings, making sacrifices, appropriating, praying and fulfilling requests made by the ancestors (Mbiti 1992).

For many years colonialism and apartheid in South Africa removed us from our own philosophical, cultural, economical, religious, political and social worldview. Our minds have been entrapped in the Eurocentric way of thinking to the extent that, as Africans, we know little about our own heritage and nothing about our contribution to the world of knowledge. For

too long we have been marginalized and victimized to the extent that we have become apologetic to the Eurocentric viewpoint. Asante (2003) is of the opinion that our lifestyle, symbols, and manners have become contradictory and thus destructive to our personal growth and development. He continues to say that we are even unable to call our own ancestors because we do not know them and we despise them. Ama Mazama(2002) also refers to the same notion when he says that we have become dislocated and disoriented.

The Western scientific worldview that emphasizes objectivity in studying reality has dominated all spheres of research and has influence how we view, perceive and even conceptualize the universe. This scientific paradigm has quite often doubted the legitimacy of the spirit dimension as perceived in the African worldview. This approach to the study and understanding of phenomenon is called Afro-centricity. Ama Mazama (2002:385) defines Afro-centricity as the study of events and ideas from an African standpoint with Africans as the main players rather than victims. Asante (2003:6) contends that Afro-centricity is our history, mythology, motive and ethos. It is rooted in the cultural image and human interest of the African people. Its aim is to bring back to the Africans their victory and consciousness and as such, their liberation. The indigenous African communitarian values and their knowledge systems and practice, which many African people are abandoning, could be invaluable in the search for solutions to the many diseases that afflict our societies.

The approach in this study is Afro-centric. It is holistic and centred on the African worldview. At the centre of this study are the African people, their

health, disease pattern and healing practices. The aim with the employment of this approach is to empower indigenous African doctors as they provide health care. Also at the centre are the Africans and their culture, identity, values and experiences with regards to their history, belief system and their response to diseases and ill health. As the researcher establishes rapport, listens and also learns from participants she will also instil a sense of freedom and empowerment in them so that they can reclaim their own cultural heritage with pride as they explain, discuss, inform and share their knowledge and experiences on the indigenous knowledge system on indigenous medicinal herbs.

DEFINITIONS OF CONCEPTS USED IN THIS STUDY

- **Indigenous knowledge systems (IKS)**

According to Odora Hoppers (2002) indigenous knowledge systems refers to the body of knowledge and skills that African people have accumulated over the years which has been passed from generation to generation. According to Grenier (1998:1) indigenous knowledge systems are dynamic because new knowledge is continuously being added. They are also innovative and adapt to external knowledge to suit the local situation. In this study it will refer to a body of knowledge that has been accumulated over the years and is kept in the minds of the local people and is shared through culture.

Indigenous knowledge (IK) is defined as that “dynamic way in which the residents of an area have come to understand themselves in relationships to

their natural environment and how they organize that folk knowledge of flora and fauna, cultural beliefs and history to enhance their lives”(Semali & Kincheloe 1999:3) According to Grenier (1998) indigenous knowledge refers to “the unique tradition, local knowledge existing within and developed around the specific conditions of women and men indigenous to a particular geographic area.” In this research both definitions will be used to investigate the local knowledge that exist within a community as it pertains to the use of animal and plant preparations for protective, preventative and medicinal purposes.

Traditional healing according to Hammond-Tooke (1989) is the sum-total of all the knowledge and practices whether explicit or implicit used in the diagnosis, prevention and elimination of physical, mental or social imbalance relying exclusively on practical experience and observation handed down from generation to generation whether verbally or written. In this study traditional healing will refer to the local ways that members of a community used to deal with issues of illness and health.

Indigenous African doctor (IAD) will refer to someone recognized by his/her community as a competent person to provide health care using vegetable, plant animal and mineral products and other methods based on social, cultural and religious beliefs. Competence also includes the implementation of prevailing knowledge, attitudes and beliefs regarding physical, mental and social well-being and the causes of diseases in the community. It will include diviners, herbalist and traditional birth attendants.

Balance will refer to moral order in relation to the position of people, the environment, ancestors and other mystical forces (Ngubane: 1977).

Policy refers to the way in which a government addresses a social problem. This usually occurs through the development and implementation of a specific set of systems through programmes. In this study the researcher is concerned with health care policy.

Policy advocacy refers to the process by which an individual or a group actively supports a policy or actively supports a change in a policy. In this study the researcher is advocating a change in health care delivery system of South Africa.

Collaborative health care system will refer to a health care delivery system that has within it both indigenous African and biomedical doctors in private practice regulated and subsidized by the government. The model is considered in this research to be based upon a neo-liberal theoretical frame of reference.

Integrated health care system will refer to a health care delivery system that has within it both indigenous and biomedical doctors working for the government as equal partners within a direct government sponsored system. This model is considered in this research to be based upon a social democratic theoretical frame of reference.

Neo liberalism will refer to an ideology that emphasizes private ownership and control of all of the enterprises within a country. According to this

ideology it is the role of the government to regulate and facilitate private ownership of the businesses of the country. It dictates a certain policy approach

Social democracy will refer to an ideology that emphasizes direct state ownership, administration and control of the most essential enterprises within a country for the benefit of everyone. It dictates a particular policy approach.

Herbalist: According to Hill (2003) herbalist refers to specialists who have a wide knowledge of properties of indigenous plants and fauna. They often work closely with indigenous doctors and assist in the provision of treatment for the cure of diseases and the protection of individuals and their homestead. For this study a herbalist will be an individual who has a extensive knowledge of plants from which he/she can make medicinal preparations.

Dingaka (Sepedi) Izangoma (pl)isangoma/isanusi (isiZulu): This refers to people who have the power to interpret the causes of disease or misfortune and who are able to establish whether the illness or misfortune or has been caused by ancestral anger or witchcraft or sorcerer(Hammond-Tooke 1974:348) For this study *dingaka* will refer to people who are able to establish the causes of illnesses and are also able to treat some of the diseases.

ORGANIZATION OF THE STUDY

Chapter one: General orientation to the study. This chapter provides an overview of the study that includes the introduction, rationale and background of the study, the problem statement, the motivation for undertaking the study, significance of the study, aim and objectives of the study, the research question, the principal research questions, the hypothesis and the theoretical framework.

Chapter two: This chapter consist of the review of literature on indigenous knowledge medicine, aetiology of disease indigenous African medicine in Primary health care and the World health organization Traditional medicine Strategy 200-2005

Chapter three: Research methodology. This chapter presents the methodology of the study, the population and sampling method, methods of data collection, data presentation and ethical considerations.

Chapter four: This chapter deals with presentation, analysis and interpretation of data. This chapter strives to present, analyze and interpret the data that was gathered during the intervention research from IADs and patients in order to address the initial propositions of the study.

Chapter five: This chapter also deals with data presentation that was collected from health professionals in order to address the research question.

Chapter six: In this chapter a summary of the findings, conclusions and recommendations have been presented. This chapter, being the final one, reviews the study by providing a synopsis of the major aspects of the study. It gives a comprehensive view of the study ranging from the restatement of the problem and the aim and objectives. It also gives a summary of the findings and the literature that supports the findings. Finally conclusions are drawn and recommendations have been provided.

CHAPTER 2

REVIEW OF LITERATURE

INTRODUCTION

Western European medicine has contributed to health care globally. However, it has not been able to reach those that need it the most because of its rising cost, its complex medical technology and its hierarchical structure that tends to intimidate patients and thus resulting in poor delivery service.

Scholars such as Hopa, Simbayi and du Toit (1989) observe that in South Africa the apartheid policy exacerbated the discrepancy in the provision of health. This occurred along racial lines as stipulated in the racist legislation of the period. This led to a segregated health care system whereby the white minority enjoyed the best health services, while the African majority received the worst. While these writers emphasized the relative quality of health care available to white and African patients under apartheid, they did not look at the African people's response to the situation.

There is evidence to show that African people continued to use indigenous African medicine in what became a dual system of health care. Mönning (1983), Ngubane (1977), Gumede (1990), Peltzer (2001), Green (2001) indicated in their studies that in South Africa both the indigenous and the biomedical health care systems operated side by side. African people utilized them simultaneously with the latter enjoying official recognition while, indigenous medicine has been frowned upon, marginalized and operated as an informal sector of knowledge. Mönning (1983) found that IADS had a

strong psychological hold over the Bapedi. They had also survived the propaganda that was used against them. He further stated that some hospitals referred patients with psychosomatic complaints to the indigenous African doctors. Mabunda (1999) also found that in the then Northern Province, Africans visited indigenous doctors before visiting the hospital when they were ill. These patients stated that indigenous African doctors have knowledge of herbs that the biomedical doctors did not have. They also recommended that both the indigenous and the biomedical doctors should work together and share their expertise for the benefit of society and that they have a common goal of health for all. Gumede (1990) found that 80% of Africans visit IADS before they visit a clinic, a hospital or a doctor. He further stated that 50% of all childbirths occur outside the clinic or hospital. The Minister of Health, Manto Tshabalala (2004) also states that in South Africa about 80% of patients first consult IADS especially in the rural areas. Many African Christians also consult IADS in times of crises. Green (2001) found that IADs were consulted whether or not they have been educated in the prevention HIV and AIDS.

Odora Hoppers (2002) further states that both the Western and the indigenous knowledge systems are important natural resources. The local contextual expertise can compliment some of the mechanical technological capabilities of the Western knowledge systems for the benefit of all. For this to happen, there must be a shift of power; there must be the emancipation of IKS; there must be development of IKS are to co-operate with other knowledge systems on equal basis to achieve a holistic framework; there must be collaboration and partnership between indigenous African and

western medicine if IKS are to contribute to human and social development and protection of IKS against exploitation by dominant world forces.

These findings have been validated by World Health Organization (WHO) (1978) report stating that communities living in urban areas with adequate medical facilities still choose to use the services of IADS. Various reasons are given for this, namely, overcrowding in hospital and clinics, the hospital routine, impersonal communication of the staff, complicated medical procedures and shortages of staff.

Interestingly, van Binsbergen (2000) and Katz (1982) were of the notion that there were more similarities between the two systems of health care than differences. They both agreed that the boundaries that existed between the seemingly unrelated health care systems were relative and porous. Makatu (2000) found that these similarities include the code of conduct. Both the indigenous and biomedical doctors were expected to conduct themselves in respectable manners and be kind and helpful to everyone regardless of their status; they were expected not to advertise or promote their competency; they may not discuss their qualifications; their reputation is determined only by the success of their treatment; they may not criticize or find fault with each other.

There are however, differences. Gumede (1990) states that African people are convinced that some diseases attack only African people and that IADS are the only health care providers able to treat these diseases and that it would be useless to visit a clinic or a hospital for such diseases. He further

asserts that in African culture the individual is explained in terms of his/her service to the group. This is different from the Western worldview and ideals of independence, ego development and the striving after ego development and gains. Bührmann (1984) asserts that the African worldview becomes important in the treatment of mental disorders where the co-operation of the patient's family is required. He further asserts that certain healing ceremonies cannot be performed without the relatives of the patient being present to carry out certain obligations. Also no ceremony can be successful without the guidance and co-operation of the ancestors.

Bührmann (1984) asserts that African people believe that there is a spiritual explanation to every human misfortune including illnesses. The cause of disease is interpreted in terms of who and why. This is in contrast with biomedical medicine in which the cause of disease is interpreted in terms of causality. In indigenous African medicine treatment is holistic because the individual is viewed as a total being with body, mind and soul. This is in contrast with biomedical medicine which divides illness into different categories and treatment is specific and individualized. With its objectivity, Western medicine therefore, becomes divorced from the African symbolic explanation of events (Bührmann 1984).

Pretorius (1999) asserts that the South African government has accepted the National Health Plan (NHP) and has committed itself to ensuring official recognition of the IADs in the delivery of health care services. This means that health care consumers would be allowed to choose whom they would like to consult for health care and legislation is to be promulgated to facilitate the regulation of IADS. Pretorius (1999) further observes that

presently, there is no single statutory body that regulates their practice. They are recognized by about 100 organizations in terms of the Companies Act but not as traditional health care practitioners.

Pretorius (1999) states that in 1995 public hearings were conducted on the viability of IADS and all provinces were in favour of a statutory control for IAM. Other recommendations were the standardization of IADS, their registration and that they should have access to medical Aid schemes. Pretorius (1999) further states that in 1998 public hearings were also conducted and all organizations were in favour of the incorporation of IADS into the formal health care system. He further asserts that however, there was disunity among the IADs to the extent that all attempts to unite them into a single body for registration purposes and control failed. Pretorius (1999) further asserts that some private companies recognized the need to involve IADS for example, Medscheme has limited indigenous African doctors' benefits and Eskom allow its employees to claim limited number of visits to the IADS on the company's plan.

In 2003 a bill was passed that allowed indigenous African doctors to issue medical certificates to a patient after a consultation. This is a move in the right direction. However, it does not address the issue of collaboration and partnership. Indigenous African doctors are now much more accepted but they are still marginalized even though the reality of the situation is that the majority of black South Africans continue to utilize their services. Peltzer (2001) in his study of the perceptions of biomedical doctors towards indigenous medicine found that 92% of the doctors favoured the integration

of indigenous healing practices into the national health care system with 75% being in favour of the integration of faith healing into the national health care system. These doctors also felt that such integration could bring about patient satisfaction and will ensure the provision of a more effective health care system.

In South Africa, the present health care system is based on the Primary Health Care (P.H.C) approach with the District Health System (D.H.S) being the essence. The focus of the D.H.S is to promote maximum community participation in the planning and the provision of health care services. It is also to include indigenous medicine in the official health care service so as to improve the health of communities in a meaningful way. Davies (2004) and Pretorius (1999) argue that the success of the P.H.C policy depends on the recognition that indigenous healing practices are deeply interwoven into the fabric of the cultural and spiritual lives of the people. As such they have a vital role to play in any health care delivery system.

For too long IADS have operated as private health care providers and have taken a heavy demand for the provision of health care that should have otherwise been taken up by the state. Collaboration and partnership with indigenous African doctors in a unified national health care delivery system will ensure that there is a more effective referral system, which has been one sided or at the most very ad hoc. Collaboration and partnership of the two health care systems into a single system will improve communication between the indigenous and biomedical doctors and thus foster a trusting relationship between the two health care providers. This will lead to exchange of knowledge and will thus give society renewed hope in the

treatment of many diseases that continue to inflict pain and misery upon everyone (Hill 2003).

Pretorius (1999) asserts that the delivery of health care in South Africa faces a variety of challenges ranging from the escalating cost of medical services to the shortage of well qualified personnel particularly in rural areas. The dawn of the 21st century has also heightened the health crisis with new diseases getting out of control. There is also poverty and the escalating violence that threatens to cripple communities. It has therefore become a matter of urgency to mobilize all the available resources to tackle the crisis. In spite of these challenges IADS and the potential contribution that they can make at different levels of health care delivery are often marginalized while western European doctors continue to enjoy official recognition.

Pretorius (1999) asserts that there is evidence that IADs can play a vital role in the delivery of cheap, affordable, equitable and culturally appropriate health to individuals and to communities especially when working in co-operation and in partnership with the western European doctors and other health workers. Chisala (2005) referring to Baquar also states that IADs play a vital role towards the wellbeing and the development of the rural population. She further adds that IADs are accessible and affordable especially to the poor. She further asserts that though IAM is still an unwritten science, it is well established in the culture and traditions and has become a way of life for almost 80% of the African people. WHO (1990) indicates that IAM should be accepted and recognized as an integral part of the cultural heritage of people. WHO (1978) states that IADS have a central role to play in the 21st century and with partnership with western European

doctors. They have great potential in areas of prevention and management of diseases.

There is well documented evidence that Africa was a cradle of civilization. Sawandi (undated) and Nantambu (2005) assert that the development of science and medicine began in Ancient Kemet (Egypt) by physicians and priests who associated magic with medicine. There was no separation between a physician, a priest and a magician. Quite often one person performed all these roles. The major concern of the physician priest was the welfare of the people and curing diseases. Dolan, Fitzpatrick and Herrmann (1983) assert that patients came to the temple to intercede with the gods and the physician- priests had to assist them. Sawandi (undated) and Nantambu (2005) further assert that it is from such origins that great physicians such as Imhotep, surgeons, and specialists came into being. It is from these great physicians that an ethical code that became known as the famous Hippocratic Oath was written (Sawandi undated).

Nantambu (2005) asserts that Imhotep the great African physician expanded many of the earlier theories of medicine. He also knew about the circulation of blood in the body long before it was known in Europe. He further promoted public health by establishing principle on public sanitation and male circumcision. Hence, he is regarded as the real father of medicine (Sawandi undated and Nantambu 2005).

Nantambu (2005) states that the work of the physician- priests ranged from embalming, faith healing and surgery. The medical papyri found in Ancient Kemet describe many diseases and injuries of the head, neck, face, chest and

spinal column and the appropriate treatment for these diseases and injuries. Imhotep together with his students diagnosed and treated many of these diseases. They also practised surgery and extracted medicines from various plants (Nantambu 2005).

Sawandi (undated) asserts that Ancient Kemet medicine was very advanced. Through careful observation, these Ancient Kemet physicians-priests developed one of the most advanced healing practices that contributed towards the advancement of medical science throughout the world. Treatment in Ancient Kemet was an integrated whole; it was an art that involved the body, mind and spirit. The physician priests also used magical spells to invoke the patient's ancestors because illness was also thought to be caused by the ancestors. Patients would also wear amulets and charms as preventive and curative measures. Their integrated healing methods therefore, centred on both religious and ritual methods. Dreams also played an important symbolic role in the treatment of diseases. Texts of various dreams and their interpretations were also found (Sawandi undated). Nantambu (2005) states that Ancient Kemet physicians were also advanced in surgery and orthopaedics. They successfully treated various fractures including fractures of the skull, ribs, limbs and nose. Patients with amputations were also fitted with prostheses. Ancient Kemet dentists also used gold wires to bind a loose tooth to a neighbouring tooth that was well. They also did filling of teeth using a type of mineral cement. Antiseptic, herbs and myrrh were also used to treat diseases of the gum. A tooth abscess was also drained by drilling.

(Nantambu (2005) and Sawandi (undated) assert that prescription for the various diseases involved the use of various substances such as plants, animal, mineral and even droppings and urine from a number of animals such as crocodiles and hippopotamus. They assert that these droppings were used probably because of their antibiotics properties.

Nantambu (2005) observes that medications such as honey, garlic and milk were also used for treating diseases of the respiratory system. Head injuries were successfully treated by trepanning, a procedure that involved an opening in the skull to relieve pressure. The Ancient Kemetic physician-priests kept detailed records of the various diseases and the treatment used. (Nantambu (2005) and Sawandi (undated) observe that there is considerable evidence that physicians in Kemet were extremely knowledgeable in gynaecology and obstetrics. They left medical records of the medical equipments that they used in the gynaecological operations and these include delivery chairs and forceps, knives, scissors and the origin of the modern day prescription symbol (Rx). They also left records on specializations such as surgery and ophthalmology. There are also had extensive texts on anatomy, physiology that clearly indicates a high degree of understanding of the human body. There is also written text indicating a high level of knowledge in Mathematics, Linguistics, Theology, Architecture and Astronomy (Nantambu 2005).

Nantambu (2005) asserts that Ancient Kemet had one of the greatest educational systems that were based on religion and famous well known Greeks (Europeans) scholars received their education from the African High Priests. These include Socrates, Hippocrates, Galen and Aristotle and Plato.

Plato also admired the Ancient Kemetic education system and he derived his four Cardinal Virtues from the original Egyptian spiritual belief system that contained ten virtues that each student had to study. His four Cardinal Virtues are: wisdom, fortitude, justice and temperance.

Indigenous Knowledge

Semali and Kincheloe (1999: 3) refer to indigenous knowledge (IK) as the “Dynamic way in which the residents of an area have come to understand themselves in relationship to their natural environment and how they organize that folk knowledge of flora and fauna, cultural beliefs, and history to enhance their lives”. Indigenous knowledge is part of African cultural heritage that has been accumulated over the years and shared through culture. It is transmitted orally from one generation to the next and is expressed in the people’s daily activities and is vulnerable to change. African people possess this vast amount of IK that also has an impact even to the 21st century.

Grenier (1998:1) and Odora-Hoppers (2002) define indigenous knowledge systems (IKS) as knowledge that is not documented but is indigenous and is kept in the minds of the people and is expressed in their daily activities-in stories, songs, folklores, proverbs, dances and myths, rituals, beliefs, values, local language and plant species. The characteristic of IKS are that they are embedded in the cultural web and history of the people. It forms the backbone of the social, economic, scientific and technological identity of the people (Odora- Hoppers 2002).

Odora- Hoppers (2002) asserts that colonialism viewed African people as having black bodies with dim minds that needed healing. Africans were regarded as filthy, thought to be behaving like animals and they were thought to lack self-determination. As such, they had to be domesticated. They had to be taught to read and to reason in order to become self-reflective and self-disciplined. In the name of decency, cleanliness and health, they had to be moulded by the cultural norms of the white man because their way of life was regarded as inferior. African people had to change not only their names but also their way of life.

Odora- Hoppers (2002) further asserts Indigenous African healing practices were also regarded as superstitions and a hindrance to receiving the ‘word of God’. Any association of Christians (believers in the western God, baptised into Christian faith) with the IADs was regarded as moving backward to paganism (a belief system other than Christian). Through a planned system of education Africans in turn, internalized the norms and value of their colonizers and began to perpetuate the state of affairs even in the absence of the colonizers. Many Africans became evangelists and bearers of the European worldview. The African people were brainwashed with no regard to their own culture. They became alienated from their own culture having been convinced of its backwardness. Their IKS was rendered non scientific and irrelevant and the Africans became an “inverted mirror of western identity, a mirror that belittled them and sent them to the back of the queue” (Odora- Hoppers 2002).

In recent years there has been a movement towards a better understanding of IKS because of its effectiveness. Africans are also demanding their right to be heard. For example, they are demanding their right to land and other resources. Governments worldwide are responding to African demands for justice by surrendering to a political climate that supports dialogue on IK (Grenier 1998).

Africa in general and South Africa in particular face many challenges relating to weak health infrastructure, limited tools inadequate human resources, limited public finances, poor management and planning and lack of integrated health systems and misapplication of human, technical and financial resources poverty, famine and disease (Gawanas undated). The IKS therefore, provide the much needed alternative to the western approach. There is also a realization among the scientists that western knowledge invaluable as it is, cannot alone respond adequately to today's complex social, economical, political and environmental challenges. The IKS provides a needed paradigm shift. It provides a different approach to problem solving because it examines a problem in its totality. Medicine and nursing are realizing the importance of considering the physical, psychological, social and cultural aspect of a person when considering his/her health. This holistic approach forms the basis of IKS of health care (Grenier 1998).

South Africa as a new democracy has several laws that provide a framework for democracy and transformation. These among others include the Reconstruction and Development Programme (RDP), the Growth, Equity

and Reconstruction policy (GEAR) and the African Renaissance. The African Renaissance in particular aims at the development of a deeper understanding of Africa and South Africa in particular, including her languages and methods of development. It allows the African people to regain their lost identity and pride.

Aetiology and its philosophical basis/ religion and indigenous healing

It is practically impossible to understand the indigenous African health care system without first understanding African religion. There is a distinct interrelationship between African religion and their indigenous healing practices. Mbiti (1992:12) defines African religion as “the product of the thinking and experiences of our forefathers”. He further states that “one cannot understand the African heritage without understanding its religious part.” Mbiti 1992:12). He further asserts that African religion gives the African people their identity, security in life, how to act in different situations and how to solve problems. It is part of the African heritage and it is the result of the thinking and experiences of our forefathers who developed religious beliefs and observed religious ceremonies and rituals. These rituals are performed not only to appease and appropriate angry ancestors, but they are performed to learn their wishes, to be guided by their wisdom and to have communion with them. Ancestors are central in African religion; they intercede between God and man. They keep in touch with their families and the symbiotic relationship that exists between the living and the ancestors is important for the success of the art of healing. The IADS are central to African religion because they control every human activity and

they are very close to the ancestors. They communicate with them to ensure good health, happiness, fertility and rain. Thus, it is very important to maintain this bond of friendship between the living and the dead (Mbiti 1975; Mönnig 1983; Gumede 1990).

Mbiti (1992) observes that health is a major concern in all societies and authors such as Ngubane (1977) and Gumede (1990) indicate that good health and illness are viewed in terms of the intricate relationship that exists between the living and the ancestors. Thus, in the African context health is a state in which the individual is in harmony with him/herself, with those around him/her and the environment. Ill health on the other hand, is viewed as a state of disharmony that occurs because of bad or evil spirits entering the body. The individual is understood in relation to his/her family, community and environment. Ngubane (1977) further asserts that the environment is viewed as having undesirable elements which make the individual to be in a state of vulnerability. Treatment therefore, involves the restoration of harmony by re-establishing balance between the individual and the environment.

Authors such Gumede (1990) and Mbiti (1992) assert that in African culture nothing occurs by chance. Every illness has an intention and a specific cause. Hence Africans will ask questions such as “why me?” and “who?” because they believe that there is a spiritual explanation to every human misfortune including illness. Wreford (2005) says that many African people continue to consult IADs before, during and after receiving biomedical treatment because biomedicine cannot offer an explanation for the onset of illness-‘the why me and why now’” which she says forms a critical part in the

understanding of health and healing. Wreford (2005) further states that without explanations to these questions, any treatment is unlikely to ensure complete healing because it does not deal with the ultimate cause of illness.

Natural causes of illness

African people also believe in the natural causes of diseases. These diseases are commonly classified as *imikhuhlane* (isiZulu), *mokhuhlwane* (Sepedi). Some of the diseases in this category include diseases associated with the stages of the development of an infant and these include measles, whooping cough, chickenpox, mumps and teething. Seasonal changes also bring diseases that are found in this category and these include diseases such as diarrhoea, hay fever and many others. Hereditary diseases such as epilepsy, asthma, mental illness and others are also included in this category. A speedy recovery from these diseases is usually expected with no need to consult an IAD. Instead, a variety of medicinal herbs are usually used to treat them. There is also a tendency to use western medicine to treat these diseases (Ngubane 1977; Gumede 1990; Bührmann 1984).

Unnatural or supernatural causes of illness.

Diseases caused by unnatural factors include those diseases that are associated with witchcraft and sorcery. Hammond- Tooke (1989) states that witches cause illness by making the environment dangerous and thus disturbing the balance between the individual and the environment.

This may occur because of conflict, jealousy and unhealthy competition among members of a community.

Ngubane (1977) and Gumede (1990) state that it is believed that these evil spirits are placed in the environment and can be picked up through inhalation or through contact where the sorcerer smears harmful substances on objects that the victim is likely to touch or by “stepping over” (*ukweqa imikhondo*) something that is dangerous to health. All such diseases are collectively known as *umeqo*.

Ngubane (1977) and Gumede (1990) also state that individuals have to protect themselves and their families against these forces by strengthening their resistance thereby maintaining a state of balance with the environment. It is important that people who live together must be strengthened at the same time to keep balance among them. They further state that various rituals are performed to maintain the balance at a symbolic or conceptual level. Various medicinal herbs are also used to fortify the homestead and also strengthen family members against environmental hazards. These rituals are performed yearly in spring before summer rains and thunderstorms because the strengthening treatment also includes protection against lightning. The unquestionable belief in the presence of the ancestors in the treatment of such diseases has a therapeutic effect as well. Joints of the bones are also believed to be the most vulnerable parts of the body through which the evil elements enter the body. Thus, for prophylactic purposes, incisions are made on the joint introducing the medicine directly at the point where the body is most vulnerable

Some people are considered vulnerable to illnesses and these include infants who have fragile bone structures and wide joints such as the fontanelles

(ukhakhayi) which is considered a weak point against environmental hazards. To survive these environmental hazards the infant must be protected even before birth. The mother too must also observe certain behaviours that will minimize contact with these hazards (Ngubane 1977).

Diseases caused by ancestors

Authors such as Ngubane (1977, Gumede 1990 and Bührmann 1984) assert that the belief in the ancestors among the African people is very strong because they are considered givers of life. They are also honoured, loved, respected and sometimes feared. They are loved because it is believed that their primary concern is the welfare and the protection of their descendants. They form an invisible permanent defence against evil spirits and witches. Without the protection of the ancestors their descendants become vulnerable to misfortune and illnesses. Good health and good fortune are rewards from the ancestors for good behaviour and constant sacrifices.

Gumede (1977) further asserts that ill health is considered as a punishment for sins of commission and omission or as a reminder to sacrifice to the ancestors. Such illnesses are believed to be treatable and are without any complications particularly if the individual concerned complies with the expected norms. When ancestors cause illness, it is only to make the individual aware of his/her errors and to urge him/her to correct his/her ways. But, if he/she fails to comply with the expected norm, the ancestors withdraw their protection and illness will set in and even death.

Pollution as a cause of illness

African people believe that illness can also be caused by certain everyday crises such as birth, death, menstruation, abortion, handling of a corpse and widowhood particularly widows who have not been cleansed. These life crises cause the individual (particularly women) to be in a state of pollution or impurity (*isinyama-IsiZulu and sefifi-Sepedi*). Ngubane (1977) states that Africans consider the world hitherto and the world hereafter as separate worlds. She further says that notionally there is an area of overlap between these two worlds that is considered marginal and dangerous and is expressed literally as darkness (*umnyama*). Ngubane (1977) refers to pollution as “a mystical force which diminishes resistance to disease and creates conditions of poor luck, misfortune (*amashwa*), disagreeableness and repulsiveness (*isidina*)”. Pollution cannot be explained in terms of cause and effect. The correction of these crises also involves mystical means expressed in symbolic medicine.

Ngubane (1977) says that people who are in a state of pollution are expected to adopt a certain behavioural pattern known as (*ukuzila*). She further states that this is a state of withdrawal from social life, quarrelling and fighting, shouting, wearing of fancy clothes and any form of pleasure. People who are in this state are considered to be vulnerable to misfortunes and diseases and they are therefore, expected to avoid any risky and dangerous undertakings. Individuals who do not conform to the expected behavioural pattern are believed to suffer from a certain form of neurosis. The IADS play important roles in this regard because they are consulted to establish balance between body, mind and environment (Ngubane 1977).

The role of indigenous African medicine in primary health care.

Primary Health Care

The 1978 World Health Organization (WHO) Alma-Ata Conference defined Primary Health Care (PHC) “as essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part of the country’s health system of which it is the nucleus and of the overall social and economic development of the community”.

Primary health care provides comprehensive service to all that is promotive, preventive, protective, restorative, curative and rehabilitative. It is a practical approach that makes health care universally acceptable to the community.

The WHO Alma Ata declaration (1978) also recognized PHC as a means of achieving the goal of “health for all by 2000”. The decision to adopt PHC was reached because it became evident that to provide effective health care it was necessary to take into consideration the social and environmental causes of ill health, the communities within which it operates and their belief systems. The main focus of PHC is making health care accessible, affordable and acceptable. It also encourages community participation and maximum self-reliance.

The WHO Alma Ata Declaration (1978) also recognized the contributions of IADs and traditional birth attendants (TBA) in meeting the goal of health for

all through PHC. To achieve this goal it is imperative that all available resources are harnessed. PHC is suitable for IAM because the IADS are well known and respected within their communities; they provide health care service that is culturally acceptable to the local population and effective in dealing with a variety of health problems within the community. They are the first and the last to be consulted in any matters. PHC is also suitable for IADs because it is based on the holistic approach to life and the achievement of balance between body, mind and environment is central (Davies1994). Davies (1994) asserts that many developing countries will be unable to attain the goal for health by 2000 unless collaboration with IADs through PHC is adopted. Richter (2003) states that in 1977 the WHO also recognized the collaboration of IAM with western medicine.

Davies (1994) further asserts that many developing countries face many challenges including high mortality rates, low life expectancies and high maternal mortality rates at 700:100,000 live births. These problems are due to the unavailability of resources. The limited resources are often not properly allocated leading to under utilization. The rapid population growth in Africa also makes it almost impossible to provide adequate and equitable health for all because of financial constraints. The gap between supply and demand continues to widen making it impossible for the majority of the population to have access to health care. This is also exacerbated by the high debt, rapid population growth, and political instability (Davies 1994; Aregbeyen 1996). Richter (2003) asserts that the escalating HIV prevalence rate in Sub-Saharan African communities also means that the IADS are carrying the load of treating HIV and AIDS patients. Thus, they need the support, education and co-operation from the formal health care system.

Western and indigenous African medicine in the developing countries.

The World Health Organization (WHO) (1978) states that 80% of the population in the developing world in Africa use indigenous African medicine (IAM) to meet their health care needs because of its many positive features. It is cheap, accessible, affordable, diverse, flexible and broadly accepted among the population. It also forms part of the African belief system. There is also increasing evidence that over the last two decades, about 70-90% of the population of the developed countries use IAM to treat chronic diseases. It is popular for its diverse and individualized approach to ill health.

Richter (2003) states that in Sub-Saharan Africa the ratio of IAD to the population is about 1:500 while, that of biomedical doctors to the population is about 1:40,000 ratio to the rest of the population. In Uganda for example, the ratio of IAD to the population is between 1:200 and 1:400. While that of western doctors is 1:20,000 or less. This clearly indicates the accessibility of IADs and the shortage of western trained doctors particularly in the rural areas. Most of these doctors are found in the urban areas and cities. WHO (1978) states that quite often in the remote rural areas IAM is sometime the only affordable source of health care available for the majority of the population. For too long IADS and biomedical doctors have remained pursuing their own separate ways though they both aim at improving health and thereby improving the quality of life of all the citizens of the country (Ndaki 2004; Bodeker 2001; Bodeker 2003; Zhang 2004; Davies 1994).

The popularity of IAM is due to its approach to health; it is holistic in approach to illness treating the spiritual and physical wellbeing of patients and also allowing for the interdependence of the body, mind and the environment. While the western approach to health focuses only on the body and excludes the mind. It addresses the symptoms but not the root cause of the health problem (Davies 1994; Richter 2003; Chisala 2005).

Social and cultural relevance of Indigenous African Medicine

Indigenous African doctors play a significant role in the daily lives of the local people within their communities. They are also well known, respected, trusted and culturally accepted within their communities. They also possess more knowledge on IAM. As such, they are socially sanctioned authorities of health care who are less likely to overlook important cultural factors in health care. They can therefore, play a significant role in the provision of PHC services if they are given the recognition they deserve as legitimate caregivers (Davies1994). Richter (2003) further states that in many countries IADS have been drawn in the provision of PHC.

Patients use various health care systems even for the same illness. There is no single health care system that addresses all aspects of health care. Each health care system is strong in some aspect and weak in other aspects of care. It is therefore, essential to collaborate and have partnership with other forms of health care for the benefit of patients. Indigenous African medicine and western medicine can also compliment each other. For example, the holistic approach to health care can work to calm a patient and facilitate

healing through the elimination of stress and the fear of the unknown as well as alleviate pain and suffering and thus facilitates healing (Davies 1994).

Practical and moral consideration of indigenous traditional medicine

Davies (1994) states that one of the arguments for the use of IAM is the cost of medicine. In the rural areas people use IAM to treat diseases and if it does not work they then seek help from western doctors. This may in fact be dangerous. Thus, partnership with IADS in the provision of PHC within the national health care system will assist PHC planners to monitor and eliminate some of the dangerous practices of IADS. Health planners have a moral obligation to collaborate and work in partnership with IAM for monitoring purposes. IAM is also cost-effective for example, indigenous medicine *nwin* is known to be effective in the treatment of malaria and many other diseases. In India it is used to make soap used for skin problems and in Africa it is chewed and used to clean teeth. Collaboration and partnership with IADS in the provision of PHC will also enable them to act as change agents with regards to some of the dangerous practices rather than antagonizing them and thereby allowing them to continue using approaches that will have disastrous consequences (Davies 1994).

The World Health Organization (WHO) Traditional Medicine Strategy 2000-2005.

The accessibility and affordability of Indigenous African Medicine (IAM) to the majority of the population in Africa makes it logical that it should be integrated into the national health care delivery system. Many countries are

developing national policies, regulatory guidelines and are also defining the roles of Indigenous African Doctors (IADS) in the national delivery health care system. The increasing use of IAM has also made it imperative that there should be policy regarding the licensing of the practice of the IADS and also assuring the quality of the drugs used. However, WHO (2002) estimates that one- third of the population in the world still has no regular access to essential drugs and in the poorest parts of Africa and Asia the figures are rising to over 50%.

In response to these challenges WHO has developed a strategy to enable IAM to contribute to the health care delivery system. The widespread use of IADS has also created challenges relating to policy, safety, efficacy and quality, access and rational use. The WHO in its Traditional Medicine Strategy 2002-2005 identified the following areas as challenges that needed to be addressed to ensure the success of the integration of IAM into the national health care system:

Policy

WHO (2002) noted that in year 2000 only 25% of 191 Member States in Africa had policies on Indigenous Traditional Medicine (IAM). It further stated that a national policy is urgently needed particularly in the developing countries where the majority of people depend on IAM for their health care needs. The integration of IAM into the national health care system will enable the two systems to work effectively together for the benefit of the consumers of health care.

We argue that the development of policy will:

- Provide a sound basis for defining the role of IAD in the national health care system,
- Ensure that the necessary regulatory and legal mechanisms are developed for the promotion and the maintenance of good practice,
- Promote access that is equitable and
- Ensure the authenticity, safety and efficacy of any therapy that is being used.

Furthermore, the policy should cover issues such as education and training, licensing, research and allocation of financial and other resources and indicate the model of integration to be used. The appropriation and adaptation of indigenous knowledge in African medicine is growing at a fast rate. It is therefore, important that there should be policy on the Intellectual Property Rights.

Safety, Efficacy and Quality.

WHO ((2002) noted that the practice of the development of IAM is largely influenced by the culture, the social and historical circumstances from which it evolved. The holistic approach, the establishment of equilibrium between body, mind and environment and the emphasis on health rather than disease are central in the African belief system. Thus, the IAD focuses on the overall condition of the patient rather than on the disease that the individual is suffering from. For centuries many of the indigenous practices and products have been used with success and the efficacy of some of these herbs have

already been established. At the same time many reports have been written indicating some of the fatal adverse effects of misuse of IAM and the use of therapies with no information on the safety of these therapies. This indicates clearly the absence of standards and methods to evaluate these practices. The development of regulation and legislation for the IAM has been slowed down by the lack of research resulting in lack of data and inadequate development of methodology. However, the growing number of national research institutions on indigenous medicine in developing countries indicates the growing importance of IAM.

ACCESS: Making indigenous medicine available and affordable

The World Health Organization (2002) estimates that 1/3 of world population have no regular access to essential chemical drugs. In the developing world, the IADS live and work within the communities. They are thus, available and can provide cheap and effective treatment for common diseases. For many rural patients IADS are the only available source of health care.

In Ghana, Mali and Zambia more than 60% of children with high fevers are treated at home with herbal medicine. People also have confidence in the ability of the IAD to manage debilitating, incurable diseases and this explains why Africans with HIV use herbal medicine to relieve symptoms and to manage opportunistic infections. The role of the IADS should be recognized and the integration of IAM into the national health care system should be strengthened and in this way making IAM accessible to all (WHO 2002).

In some countries, the relationship between the TBAs and PHC providers is being strengthened. But, in many other countries each still continues to work in isolation within his/her own sphere. Access should therefore mean creating opportunities to improve communication and co-operation between IAM and western medicine to enable patients to benefit from both practitioners to meet their needs. At the same time some IADS have no knowledge of PHC and thus carry out practices that are dangerous to the community. The challenge is to ensure that the knowledge and skills of the IADs are enhanced. It is therefore, imperative that appropriate education and training programmes on the proper use of indigenous African medicine are provided both to the health care providers and to the public. It also includes qualification and the licensing of all health care providers (WHO 2002).

Another challenge relates to the issue of intellectual property rights and patient rights. The large-scale use of IAM can lead to economic benefits. However, a critical issue relates to how best these economic benefits could be shared between the holders of the indigenous traditional knowledge and the innovators. WHO (2002) states that reliable standards indicators to measure levels of access should be developed. The safest and most effective therapies must be identified to provide the basis to increase the use of IAM. Access also relates to the protection of indigenous knowledge in medicine and sustainable use of natural resources. A variety of strategies could be used to protect the indigenous African knowledge in medicine. These can include the creation a national inventory of medicinal plants, documentation of indigenous knowledge on medicinal plants and the development of a

national policy on the protection of indigenous knowledge on traditional medicine.

Rational Use: Ensuring Appropriateness

This includes issues of education and training, qualification and licensing of all health care providers. This means that all health care providers must be well trained and educated. They must also be qualified and licensed to practice. Training programmes should be modified for IADS to include basic elements of PHC and Public Health. All curricula for health care providers should also include a component of IAM. The education of all health care providers will also ensure that both IADS and biomedical doctors understand and appreciate the complimentary nature of health care they are providing. It involves proper use of good quality products, good communication between IADS, biomedical doctors, patients and providing information to the public (WHO 2002).

The formal delivery health care system and indigenous African medicine in Africa

There are four broad forms of co-operation between indigenous African medicine and western medicine and it is essential that government policy should articulate clearly the model of choice. These models are:

- Monopolistic model where the western doctors have the sole right to practice medicine.
- A tolerant/ co-existence model where indigenous traditional doctors are permitted to practice in an unofficial capacity.

- A parallel model where both systems are separate components of the national health care system for example India
- Integrated model where both systems of health care are integrated at the level of medical education and practice such as in China and Viet Nam.

The WHO (2002) states that the use of IAM and TCM in America is still informal. In some instances it is used under the monopolistic model where IAM falls under the control of western medicine. Hesketh and Zhu (1997) and Bodeker (2001) state that Asian countries have made major progress in incorporating the traditional health system in the national policy. Bodeker (2001) further states that in China and Vietnam the parallel approach is used, where modern and traditional medicines are separate within the national health care system. Akerele, Heywood and Synge (1991) also indicate that China with a population of more than a billion, IAM forms the main type of treatment. Bodeker (2001) further asserts that in China, alternate medicine accounts for about 40% of all health care and 20% of hospital beds are reserved for practising traditional medicine. Akerele et al (1991) also indicate that even in the United States of America where synthetics dominate, plant products still form an important source of prescription drugs.

Bodeker (2001) states that India recognizes both western oriented and alternate medicine and patients are allowed to choose whom they wish to be treated except in an emergency where patients are only attended by western oriented doctors. India's referral system is very good and patients are referred to the traditional doctor and visa versa. Bodeker (2001) further

states that the curriculum for traditional doctors is standardized and includes both theory and practice. He further states that India has a pharmacopoeia data for all drugs and this is an advantage for the country because it provides the scientific data on all medicines. The Indian government actively promotes traditional medicine by establishing and subsidizing public institutions for teaching and research (Bodeker 2001).

Research conducted indicates that IADs are willing to collaborate with the formal sector and to establish joint training. For example, in Zambia 94% of IADs and 52% of the formal health workers were keen to collaborate in training and patient care relating to HIV and AIDS. However, in South Africa 1% of nurses are IADS and in Swaziland rural nurses perceived themselves as being teachers to the IADs but not learning from them. They view themselves only as sources of referral for the IADS. In Swaziland IADS are also taking care of patients suffering from HIV and AIDS. It is therefore, important that they receive the much needed support, co-operation and education that the formal health care system might be able to provide (Richter 2003)

Sharma (2004) asserts that the Zimbabwean population like many African countries depends on African medicine and the IADs play an important role in the delivery of health care service and rehabilitation. Currently, there is only one Act (Traditional Medicine Practitioners Act). The Act and the Council only deal with administrative matters such as registration of practice of African doctors. Chavunduka (1994) suggested that the parallel model could be adopted in Zimbabwe with each system recognizing and respecting the character of the other. In Botswana the parallel model has been adopted

because it is felt that one or the other system might be absorbed in the process of integration (WHO 2002).

Clarke (1998) says that in Mozambique, the ministry of health officially recognizes IADS and they form part of the parallel self regulating health care service which collaborates with the government. Richter (2003) states that in Africa, IADS are taking care of patients suffering from the HIV and AIDS epidemic. It is therefore, important that IADs receive the much needed support, co-operation and education that the formal system of health care might be able to provide.

In Uganda, about 80% of the population rely on the IADs for their health care needs. There is at least 1 IAD for every: 200-400 people as compared to one western trained doctor for every 10,000 in urban areas and 50,000 people in rural areas. IADS are an integral part of the local culture and are respected as people who are knowledgeable about disease and illness (Bodeker 2001).

Bodeker (2001) further state that The Ugandan Government has supportive environment in promoting IAM. By 2000 Uganda had established a task force that co-ordinated the wide spread use of IAM by people suffering from HIV and AIDS and the role of IADS in the prevention of AIDS. Bodeker (2001) further assert that Uganda managed to bring down the number of HIV infections because of the establishment of the Traditional and Modern Health Practitioners Together Against Aids (THETA) which is a non-government organization that promotes collaboration between IADS and modern health practitioners in the fight against HIV and AIDS. Its activities

also include the training of IADS as community counsellors and educators on sexually transmitted infections including HIV and AIDS. Indigenous African doctors are also trained in the care and support of patients who are HIV positive (WHO2002). Bodeker (2001) and Richter (2003) further assert that in Uganda IAM has been effective in the treatment of *herpes zooster* and HIV associated chronic diarrhoea and weight loss. THETA has also taken the lead in Africa in developing collaboration and partnership between biomedical and IADs.

There is also legislation that ensures that the IAD have a role to play in the health care system. The Ministry of Health Strategy and Policy has recognized IAM and has developed regulations for integrating it into the PHC programme. The Ugandan National Council for Science and Technology (UNCST) has a project on indigenous knowledge and institutional development (WHO2002).

Tsey (1997) says that in Ghana like in most African countries, the rising cost of western medicine means that individuals are increasingly using IAM as an affordable and accessible alternative. He further states that WHO and other international organizations promote the use of IAM throughout the developing world. He further asserts that in Ghana diseases that are frequently mentioned as being treated by IADS include jaundice, fever and malaria, menstrual pains, snake bite, asthma, boil, piles and infertility. Less frequently mentioned diseases include hypertension. He further states that in Ghana once a patient has started treatment with an IAD the patient remains under the care of the practitioner even long after active treatment has been completed and that can take one to two years. This means that practitioners

can have clients who are attached to them as either under treatment or under care depending on patients' conditions. Some IADS refer their patients to the hospital especially if they do not know what is wrong with the patient,

Tsey (1997) further asserts that mental illnesses belong to the speciality of the spiritually based practitioners. The practitioners provide accommodation to their patients and the majority of patients that require residential care are those with mental illness and other psychosocial problems. Tsey (1997) further asserts that western oriented doctors are least able to treat mental illnesses and psychosocial problems. He asserts further that in Ghana IADS that are acceptable are the non-spiritually based. The spiritually based IADS seem to have no role and are perceived to be unable to sit comfortably within a "rational" health care environment.

The system of payment for IADS has undergone tremendous change in Ghana. Initially IADS regarded payment as a token of appreciation after recovery. But due to the cost of living and the introduction of licence fees, IADS are increasingly demanding monetary payments for their services. A general perception is that IAM is another trade from which to make a living (Tsey (1997)).

Tsey (1997) also asserts that in Ghana a Council that regulates and controls the practice of IAM has also been established under the Traditional Medicine Practice Act 2000, Act 595. The primary draft of this Act originated from the IADS themselves. In 1991 the Ministry of health incorporated a Traditional Medicine Unit and in 1999 the status of the unit was upgraded to that of a Directorate. The Ministry of health has also

collaborated with the Ghana Federation of Traditional Medicine Practitioners Association (GHAFTRAM) and other stakeholders to develop a five-year strategic plan for IAM. The plan outlined the activities to be carried out from 2002 to 2004, and was to be reviewed every two years. The plan also proposed among other issues the need to develop a comprehensive training programme in IAM from basic to tertiary levels. Ghana is about to introduce a diploma course in IAM at the medical school to formally train doctors and other health professionals.

A Ghana Herbal Pharmacopoeia containing scientific information on 50 medicinal plants has been established and a second volume is currently being prepared. It is also expected that by 2004 certified and efficacious herbal medicine was to be prescribed and dispensed in hospitals and pharmacies. Since 2000, the third week of March is celebrated as a Traditional Medicine Week. The Centre for Scientific Research into Herbal Medicine that was established in 1972 and it focuses mainly on biochemical and pharmacological analysis of medicinal plants with the aim of establishing efficacy. It also offers both western and herbal treatment. Patients have the opportunity to choose either of the system or a combination of the two systems depending on the patient's ability to pay. Tsey (1997) further states that the hospital in Ghana has a separate ward where patients on herbal treatment are admitted and monitored (World Bank March 2003.No.54; Tsey 1997).

Tsey (1997) mentions that the Ghanaian government has made stride with the collaboration and partnership with IAM in the national health care system. However, there are pitfalls and these are:

- There is little contact with the IADs once the Centre for Scientific Research has collected the samples.
- There is lack of resources for the IADS and that may hinder any genuine attempt to collaborate on an equal footing.
- The daily functions of the centre are beyond the worldview of the IADS. Thus, the danger is that the western trained Ghanaian doctors may appropriate intellectual property from the herbalists with no benefits for the IADS in the form of results from the researcher's financial return accrued from the commercialization of herbal medicine.

Tsey (1997) further states that other challenges include the lack of resources by IADs may hinder any attempt by the government to collaborate with IAM on equal footing. Another challenge with the collaboration is the tendency of the product becoming more expensive and therefore, becoming unable to be attained by the ordinary people. This undermines the ease of access that is normally associated with IAM. Tsey (1997) further asserts that the issue of property rights should be addressed before any attempt of collaboration is attempted.

Tsey (1997) also states that the legal and ethical issues pertaining to the relationship between IADS and western trained doctors should be thoroughly examined particularly that the relationship between the two becomes unequal and it is also an interracial relationship particularly in South Africa where the western trained practitioners are mainly white and the IADS are black. He further states that policy makers and western trained health practitioners should have a clear understanding of the African notion

of the causation of illness and preventive measures which could have great benefits for primary health care.

Bodeker (2001) asserts that challenges facing IAM also include the lack of standardization, poor documentation and the lack of regulatory mechanisms. He further asserts that these challenges should be overcome if IAM is to be more included in the treatment of Aids prevention and care.

WHO (2002) states that in Nigeria, the National Agency for Food and Drug Administration and control (NAFDAC) has taken steps to regulate and control IAM products with the aim of ensuring safety, efficacy and quality. In consultation with IADs and researchers, NAFDAC has established guidelines on regulating herbal medicines. The government has also approved a national policy on a Traditional Medicine Code of Ethics. WHO (2002) also states that in Nigeria legislation has been drafted relating to the establishment of national and state Traditional Medicine Boards to enhance the regulation and the practice of IAM and also to promote co-operation and research in IAM. Bodeker (2001) also states that there is a herbal medicine that seem to boost the immune system by increasing the CD4 cell count leading to improvement on HIV related illnesses.

Chisala (2005) asserts that in Malawi there is National co-ordination body on IAM (an association of traditional medicine and a training programme in traditional medicine for health workers). She further asserts that there is still no legislative framework to regulate IAM. She further indicates that even though the majority of the African population use IAM, in many African nations IAM technically remains illegal.

In South Africa the present health care system is based on the PHC model with the District Health System (DHS) being the essence of PHC. The main focus of the DHS is to promote maximum community participation in the planning and the provision of health care services. It is also to involve indigenous healing practices in the official health care services so as to improve the health of communities in a meaningful way. Pelzer (2001) in his study of the perceptions of western trained doctors towards indigenous African medicine found that 92% of the doctors were in favour of the integration of indigenous African medicine into the national health care system with 75% being in favour of the integration of faith healing into the national health care system. Clarke (1998) argues that the success of PHC policy depends on the recognition that indigenous African healing practices are deeply interwoven into the fabric of the cultural and spiritual lives of the people. She further asserts that IADS are accessible even in the most rural and remote areas where other health services are not. As such, IADs have a vital role to play in proving health of the majority of South Africans (Clarke 1998).

Richter (2003) states that in 1970 the Traditional Healers Organization (THO) was established and estimates its membership to 69,000 indigenous African healers in Southern Africa with 25,000 of those coming from South Africa. He further asserts that currently, there are about 150, 00-200,000 IADS in South Africa. Mulaudzi (2001) indicates that there are approximately 350,000 IADS who provide health services. Richter (2003) further asserts that any IAD who wants to be a member of the THO has to attend a one day's workshop on traditional primary health care and has to have reference of good character. Richter (2003) further adds that the THO

has provincial branches in Mpumalanga, Limpopo, KwaZulu-Natal and the North West Provinces. Its headquarters is in Gauteng.

Richter (2003) also states that another umbrella body of IADs in South Africa that has branches through out the country is the Traditional Healers Health Care Group. This body focuses on home based care, Direct Observation Treatment (DOT), support for the people with TB, Voluntary Counselling and Testing (VCT), education on HIV and AIDS and street counselling.

Richter (2003) further asserts that it has been very difficult to establish a single statutory council because of the size of potential members. It has also been difficult to establish the number of bona fide members. Pretorius (1999) states that of the 80,000 practicing IADs only about 10% are bona fide doctors. Pretorius (1999) asserts that the licensing of IADs in South Africa poses many challenges. There is no single statutory body that regulates their practice. Presently they are licensed by about 100 organizations in terms of the Companies Act and not as health practitioners. Members are expected to abide by certain ethical codes but these associations are unable to enforce these ethical codes because they lack the mechanism to do so. Thus, the practice becomes open to mismanagement and corruption.

Adele (1998) asserts that in 1997 public hearings were conducted on the viability of the IADS in South Africa. The report stated that all nine Provinces were in favour of the establishment of a statutory council that regulated the behaviour of IADS. Also recommended was the

standardization of the practice of IADS, their registration and that they should have access to medical aids schemes.

In 1998 the Portfolio Committee conducted public hearings on issues relating to the establishment of a council for IADS, their training and code of conduct. The majority of South Africans were in favour of the integration of IADS into the formal health care system. To date there is no single association that has been established for their registration. Whatever the case may be, the reality of the situation is that the majority of South Africans continue to use IAM though it remains poorly regulated and subsidized (Adele 1998).

Pretorius (1999) asserts that indigenous African medicine remains untapped resources that have enormous potential in the treatment of many illnesses. Indigenous African doctors are able to treat ailments that are culture bound and that usually do not respond to western medicine. He further asserts that it has also been well documented that educated Africans consult IADS in secret. Peltzer (2001) also found that IADS continue to provide health care services though not officially recognized. He further asserts that in South Africa IADs and Western doctors have operated side by side since the beginning of western medicine. Wreford (2005) also supports this notion and says that IAM operated as a parallel or complimentary health service for many years in South Africa. Steyn and Muller (2000) and Hess (1998) found that IADs are consulted whether or not they have been educated in HIV and AIDS prevention and that IADS also want to learn about western ideas of healing and were also keen to learn more about cancer and were willing to

provide health education. It is for this reason that collaboration would be most beneficial for health in South Africa (Clarke 1998).

In KwaZulu Natal at the Valley of Thousand Hills, IADs and western trained doctors have been providing health care services side by side since the 1980s. Many of IADS received training and have been certificated to function as qualified community health workers. They are also members of the tuberculosis control programme and they are involved in administering and in the dispensing of oral hydration fluids, running health posts and nutritional programmes. Some of them have also been trained to conduct HIV and AIDS awareness campaigns and issue condoms. They have proven beneficial in spreading the message of prevention, which is well accepted within the African perspective. They are also encouraged to bring patients to the hospital when western medicine is needed. In turn, the clinic reports back to the IADS and in some instances refer those patients with African diseases to the IADS. (Pitt 1998; Clarke 1998; Kelly 2001).

Kelly (2001) observes that at the Ngwelezane hospital in KwaZulu Natal there are about 400 HIV patients that are benefiting from plants that are scientifically researched and from supplements supplied by the University of Zululand ethnobotanists. Some of these plants include *Sutherlandia frutescens* (*unwele*), which is an herbal immunomodular that has many proven anti-cachexia and anti-HIV actions. Many experts concur that many HIV and AIDS patients are being taken care of by IAD who use the IK of plants and remedies. Richter (2003) adds that *Sutherlandia* has a positive impact in improving the quality of life of people living with HIV by

improving appetite, mood and the sense of well-being and weight gain within 6 weeks of treatment.

Richter (2003) states that the Medical Research Council (MRC) established A South African Traditional Medicines Research Unit whose activity include registration of provisional patents, research into various medicinal plants and research training of postgraduate students. In 1997 the MRC produced a first practical guide book for IADS in PHC and in 2000, it had a joint venture in the creation of a Medicinal Database called TRAMED III. In 2003 Medical Control Council (MCC) established a reference centre for IAM called the National Reference Centre for Africa Traditional Medicine (NRCATM) and is managed by a Management Board.

Additionally, Green (2001), Steyn and Muller (2000) and Hess (1998) found that IADS were keen to learn more about cancer and were willing to provide health education. These authors recommended the training of IADS to enable them to attain professionalization leading to full recognition within the health care milieu. Such training could lead to accreditation with the South African Qualification Authority (SAQA) and the National Qualification Framework (NQF). Wreford (2005) also says that IADS are generally interested in being in partnership with biomedicine but, their enthusiasm is not reciprocated. She further argues that IADS are expected to learn from and adapt their practices to the principles of biomedicine while, there is no reciprocal learning by biomedical doctors. She further asserts that biomedical doctors continue to look down on the IADS and are not interested in the professional skills, knowledge, wisdom and insight that the IADS have.

Steyn and Muller (2000) further state that a study conducted at Atteridgeville South Africa revealed that generally IADs stated that they could treat any disease if ancestors agreed. They could treat sexually transmitted infections, infertility and infant illnesses and to a lesser extent home problems, mental illnesses and swollen legs.

Clarke (1998) asserts that what is controversial is whether IADs should be part of the National Department of Health or that they should have their own association that is affiliated with the National Department of Health. Clarke (1998) further asserts that some of the IADS are in favour of some form of partnership with the Department of Health and that they see it beneficial to them and their patients. However, Hess (1998) is of the opinion that IADS play an important role in the provision of health for the majority of South Africans but, their role is still not clearly defined and there is great disparity between the IADS and the western oriented doctors. He further asserts that some of the IADS are in favour of maintaining IAM and are therefore, in favour of the parallel system of partnership. These IADs argue that western medicine is well established and recognized while, IAM is not accorded similar recognition.

Hess (1998) further states that proponents of the parallel system of health care argue that IAM should be upgraded to the rank equal with modern medicine as they serve a far greater number of clients than western oriented doctors especially in the rural areas. They want to see both systems operating equally with both sectors referring patients to each other. Some of the IADS want to see IAM incorporated into the South African Medical Council (SAMC) because they argue that this will give them more benefits

for example recognition by their counterparts. They also want to have schools for the training of IADS similar to a western medical school.

Hess (1998) further asserts that the Department of Health wants IADs to establish a formal council to conduct their affairs and this will make management easier. Richter (2003) asserts that other African countries have made tremendous strides in formally recognizing IAM and in establishing structures for IADS. Currently in South African the medicines and related Act does not make provision for complimentary medicine. Despite the growing number of people using IAM for their ailments, neither the Department of Health nor the Medical Council has come up with a definite policy regarding IAM (Hess1998). It was in 1999 that the Traditional Healers Council was established and in 2003 the Traditional Health Practitioners Bill was passed.

Wreford (2005) states that the Traditional Health Practitioners Act 35 of 2004 was gazetted in Parliament in May 2005 and is designed to formalize the structure and organization of IAM. She further asserts that the Act appears to be conservative in the establishment of a parallel health care system. Instead it promotes for the training of inspired IADS. The Act enables the Minister of Health together with a Council to regulate on the standards of education that is required for trainee IADS, set minimum requirements for training. Wreford (2005) asserts that such an approach addresses the fears and anxieties of biomedical doctors about certification and training. She further sates that the training of IADS possess a challenges regarding their modus operandi because their knowledge is transmitted in

dreams and the training in the western educational framework means that the subtlety of IAM will be displaced.

Kelly (2001) asserts that in South Africa there are many stakeholders with conflicting agendas for example, the Parliamentary Portfolio Committee on Arts, Culture, Science and Technology aims at ratifying the destruction of indigenous African knowledge during apartheid while, the Ministry of Health seems to be more concerned about curbing unsafe practices and toxicity. Indigenous African doctors themselves are concerned that regulation will bring about their restriction, their skills will not be recognised and that they will be exploited.

Bodeker (2001) argues that the marginalization of IAM in Africa is due to the misunderstanding between IADs and western trained practitioners. Many governments and international agencies call for the recognition of IAM. However, there is lack of commitment and action by many governments and this is a key issue that delays the identification of effective, indigenous approaches to AIDS prevention and care and to building strong partnerships for an integrated strategy against AIDS. As a result many medicinal plants that Africans use daily which are effective against opportunistic infections or HIV remain unknown or not investigated while most HIV and AIDS patients can not afford modern drugs with proven effectiveness. Katz (1982) agrees against the use of western standards of health care for official recognition of IAM. He is of the opinion that if these western standards are used, they must be used with due care or else the unique contribution of IAM and IADS will be lost. It will also lead to the devaluation and deterioration of the indigenous African health care system.

Katz (1982) argues that to resolve the conflict the consumers should make their own choices. He argues that consumers make pragmatic decisions that include the combination of both health care systems. He further asserts that they tend to ignore or de-emphasize the theoretical conflicts that seemingly exist. He further states that consumers are able to put together a treatment package that satisfies their own needs. Katz further asserts that the guidelines policy that are developed should recognize the different assumptions of the two systems, respect of each other, understanding of each other's limitations and strengths and a greater understanding and tolerance of the patients' beliefs and practices.

Clearly, the collaboration of both health care systems in the provision of health care in South Africa requires among other issues political will, availability of monetary resources, training infrastructure and a suitable model the country, the indigenous African doctors and the public prefers (WHO 2002).

CHAPTER 3

RESEARCH METHDOLOGY

RESEARCH DESIGN AND METHODS OF DATA COLLECTION

The purpose of this chapter is to describe the research design and the methods of data collections that were used.

Qualitative research design

This study used the Afro-centric method which is the qualitative research design. The Afro-centric method is derived from the Afro-centric paradigm in which the African people are the subjects rather than the objects of the study. Mkabela (2005) observes that the Afro-centric paradigm deals with the African identity from the perspective of the African people as centred, located, oriented and grounded. de Vos, Strydom, Fouchè and Delpont (2007) citing Babbie (2001) state that a paradigm is the fundamental frame of reference that researchers use to organize their observations and reasoning.

The qualitative descriptive research design that is contextual in nature was deemed appropriate because of its emphasis on the natural setting. It enabled the researcher to immerse herself in the cultural setting and social dimension so as to describe events as accurate as possible as they occurred. The researcher immersed herself in the natural setting of IADS, patients and

health professionals so as to explore and describe their beliefs, attitudes, perceptions and experiences about the collaboration of indigenous African and western European medicine in the provision of health services. A thick and detailed description of lived experiences was provided with selected quotes, anecdotes and comments from participants. This was done to capture the sense of actions as they occurred. Babbie and Mouton (2001:272) describe the contextual research method as understanding the events within the concrete, natural context in which they occur. They further state that the inductive research method begins with the emersion in the natural setting describing events as accurately as they occurred.

The quantitative research design that seeks explanation aimed at generalization was also used.

Population and sampling method

Population

The study used three different populations namely:

- Indigenous African doctors from Ga-Dikgale and Ga-Nchabeleng villages. These villages are in the Capricorn and Sekhukhune Districts respectively in the Limpopo Province.
- Western European oriented health professionals providing health services to patients at clinics/hospitals within the Capricorn and Sekhukhune Districts.

- Patients who have readily available health choices from Ga-Dikgale and Ga-Nchabeleng villages.

Sampling

A non-probability convenient and purposive sampling was used to obtain sample sizes. Denzil and Lincoln in de Vos et al (2007) observe that in purposive sampling the researcher looks for individuals, groups and settings where the specific processes being studied are most likely to occur. Sells (1997) says that purposive sampling is a type of non-probability sampling in which data are collected from a group of participants chosen for specific key characteristics. The sample size for the study was as follows:

Fifteen (15) IADs were drawn. Seven (7) of whom were drawn from the Ga-Dikgale village that is situated within the Capricorn District and the remaining 8 were drawn from the Ga-Nchabeleng village that is situated within the Sekhukhune District.

Fifty (50) western European oriented health professionals were drawn from health facilities. Twenty five (25) of whom were drawn from health facilities within the Capricorn Districts and the remaining 25 were drawn from health facilities within the Sekhukhune Districts.

Eighty four (84) patients were drawn from the Ga-Dikgale clinic and Ga-Nchabaleng health centre. Thirty three (33) patients were drawn from the Ga-Dikgale clinic and the remaining 51 were drawn from the Ga-Nchabeleng health centre.

Sampling was continued until data saturation was reached.

Inclusion criteria

The inclusion criteria in this study were as follows:

- All indigenous African doctors who practice indigenous African medicine using herbs, roots fats and oils in the treatment of illnesses at the Ga-Dikgale and Ga-Nchabeleng villages.
- All western European oriented health professionals with experience of at least five years and above and providing health services to patients within the Capricorn and Sekhukhune Districts.
- All patients utilizing the community clinics at the Ga- Dikgale and Ga-Nchabeleng villages in the Limpopo Province in the Republic of South Africa.
- Willingness to participate in the study.

Both districts (Capricorn and Sekhukhune) were chosen because they are rural with a substantial number of indigenous African doctors with different cultural practices to compare similarities and differences. The common language spoken in both villages is Sepedi with the Ga-Dikgale village situated in the Capricorn District and the Ga-Nchabeleng village situated at the Sekhukhune District. Both districts provide primary health care and are in the Limpopo Province that is mostly rural in the Republic of South Africa.

Data collection

Community entry

Community entry involved obtaining approval from the University of Limpopo Ethics Committee and the Provincial Department of Health and Social Welfare Research Committee, Limpopo Province. Permission to access the institution was also obtained from health facility managers and for the village permission was obtained from local chiefs of Ga-Dikgale and Ga-Nchabeleng communities.

Once approval was obtained from all relevant authorities, the purpose and the benefits of the study were explained to the charge nurses of the Ga-Dikgale and Ga-Nchabeleng clinics.

On going rapport with participants was maintained so as to gain their trust.

Methods in data collection

The researcher began by collecting the biographical data of all participants before collecting the narrative information. Different methods of data collection were used to compliment each other thus, maximizing the quality of data and reducing the chance of bias (Hardon, Boonmongkon, Streefland, Tan, Hongvivatana, van der Geest, Van Staa and Varkevisser 1994). These included in-depth interviews, focus group discussions, participants' observation, field notes and tape recording.

Semi- structured in-depth interviews

Semi- structured in-depth interview schedules with the indigenous African doctors from the Ga-Dikgale and Ga-Nchabeleng villages were conducted with the aim of determining the beliefs, attitudes, perceptions and experiences regarding the collaboration of IAM and western European medicine in the provision of health.

At the Ga-Dikgale village the interviews were conducted at the at the clinic in a private room and at the Ga-Nchabeleng village the interviews were conducted at the health centre in a private room. Each interview lasted for forty five minutes to an hour.

Semi- structured in-depth –interviews with health professionals were also conducted at their respective work places in clinics and hospitals in private rooms within the Capricorn and Sekhukhune Districts in the Limpopo Province.

The semi-structured in-depth interviews with the indigenous African doctors and health professionals enabled the researcher to make meaning and to determine the participants' beliefs, attitudes, perception and experiences regarding the collaboration of indigenous African medicine and the Western European medicine in the provision of health in the Limpopo Province.

During the semi-structured in-depth interviews open-ended questions that enabled participants to speak openly and freely were used. These interviews were also flexible and interactive. Babbie and Mouton (2001) state that

qualitative research interviews should be characterized by being “flexible, interactive and continuous rather than prepared in advance and locked in stones”. de Vos et al (2007) also define semi -structured interviews as those organized around areas of interest, while allowing flexibility in scope and depth.

Focus groups

Focus group discussions were also conducted with patients seeking medical/nursing intervention at the Ga- Dikgale and Ga-Nchabeleng clinics.

Data was collected over a period of three days as follows:

First session

The researcher used the first session to make appointments with nurse managers in charge, health professionals and the patient participants at the respective clinics (Ga-Dikgale and Ga-Nchabeleng clinics). The researcher also established rapport and explained the purpose of the study to all participants.

Second session

A total of ten (10) focus group discussions (4 at Ga-Dikgale and 6 at Ga-Nchabeleng) of 7-10 patient participants from each community clinics were conducted. Thirty three (33) participants were from the Ga-Dikgale clinic and fifty one (51) were from the Ga-Nchabeleng health centre.

These focus group discussions enabled participants to discuss and share information about their beliefs, attitudes, knowledge, perception and experiences regarding the collaboration of IAM and western European medicine in the provision of health in the Limpopo Province.

Each focus group discussion lasted for about 45minutes to an hour and the researcher used these focus groups to enable participants to create meaning among themselves rather than individually (Babbie and Mouton 1998).

A tape recorder was used to capture the discussions and field notes were also taken.

Third session

The third session was conducted for verification of data obtained and also to express a word of appreciation to the participants for their contribution towards the attainment of the objectives of the study (de Vos 1998).

Probing

Throughout the semi- structured in-depth interviews and FGD, probing was used to gain deeper understanding of critical issues and this involved tracking clarification and reflective summary (de Vos et al 1998). The researcher repeated what was written in the field notes to the participants to make sure that she understood the ideas and opinions of the participants correctly. Babbie and Mouton (2001) observe that probes are one useful way to get answers in more depth without biasing the answers.

Data collection was continued until the saturation of themes, categories, sub-themes was reached.

Fields notes

Throughout the interviews field notes of events that occurred were taken. These were recorded in a small note book and they included empirical observation and their interpretations, interactions observed, conversations heard and impressions of field setting and its actors. These field notes were also used to validate the taped comments. Babbie and Mouton (2001) insist that the researcher must take full and accurate notes of the preceding during the interview.

Tape recording interviews

A tape recorder was also used during the interviews. Permission to use the audiotape recorder and note-taking during interviews was obtained from participants.

The findings from the above mentioned methods were used in an attempt to answer the research question set out in chapter 1.

DATA PRESENTATION

The biographical data was analyzed using frequency distribution. The descriptive method of data presentation was also used. The focus of the

biographical data was on the numerical description of the age, educational level, religion and years experience.

The narrative data obtained from the participants was analysed using open coding according to Tech's approach as outlined in de Vos (1998). The analysis was done as follows:

- The researcher translated all transcripts and notes from the in-depth interviews with the IADS and the focus group discussions with patients from Sepedi to English.
- Data from the health professionals was obtained in English.
- All transcripts were read carefully in order to get a sense of the whole, internalized and then transcribed verbatim.
- The researcher also listened to the tapes and wrote down all ideas and thoughts as they came to mind.
- The information was then synthesized and analyzed by clustering together similar topics, form topics in columns as major topics, unique topics and leftovers.
- Descriptive words to identify themes, major and sub-categories were used.

- Relationships among the major and sub-categories were reflected as themes.
- Data presentation continued until the saturation of themes, categories, sub-categories and was reached.

ETHICAL CONSIDERATIONS

The quality of the research

The study was conducted for academic purposes and the researcher demonstrated accountability and the ability of executing the research process by adhering to the highest possible standards of research planning, implementation, evaluation and reporting of the research. The quality of the research was ensured by writing a research proposal and obtaining ethical clearance to conduct the study from the Research Ethics Committee of the University of Limpopo. Permission was also obtained from the Limpopo Department of Health and Social Welfare because participants were indigenous African doctors, patients utilizing primary health clinics (Ga-Dikgale and Ga-Nchabeleng) and health professionals providing health services within the Capricorn and Sekhukhune Districts in the Limpopo Province.

Informed consent

Informed consent was obtained from all participants by explaining to them the purpose of the study. Permission to use a tape recorder and field notes

was also requested and obtained from the participants by explaining the importance of a tape recorder and field notes. They were also informed that participation to the study was voluntary and that those who wanted to withdraw during the course of the study would not be victimized whatsoever.

Confidentiality and anonymity

Participants were assured that their names would not be used in the study. The participants' identity, privacy and dignity were protected by ensuring that no connection between the participants and the data could be made. They were also informed that all information obtained would be destroyed after analysis and synthesis.

CHAPTER 4

RESULTS OF INTERVIEWS WITH INDIGENOUS AFRICAN DOCTORS AND PATIENTS

INTRODUCTION

The focus of this chapter is on the presentation of data from interviews with indigenous African doctors and the focus group discussions with patients attending clinics at the Ga-Dikgale and Ga-Nchabeleng

The total number of participants indigenous African doctors interviewed from the Ga-Dikgale village was seven (7) and was composed of both genders. Six (6) of the participants IADS had primary education and one (1) was illiterate. Four (4) participants IADS were not affiliated to any church and only two belonged to the mainstream churches. Only one (1) participant IAD belonged to the traditional church. Only one participant IAD was affiliated to the National Traditional Healers' Association.

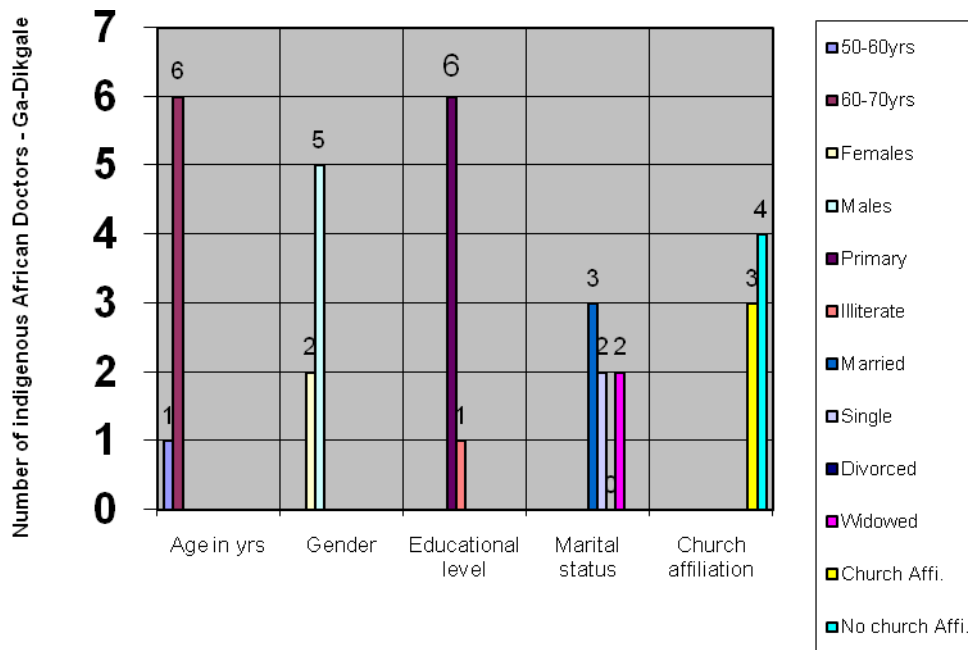


Figure 4.1: Biographical data of Indigenous African Doctors - Ga-Dikgale

The total number of participants IADS interviewed from the Ga-Nchabeleng villages was eight (8) and all were females. Five (5) of the participant IADS were between 50-60 years of age and only three (3) were between 40-50 years of age. With regards their educational level, five (5) were illiterate and only (3) had primary education. With regards to church affiliation (5) were affiliated to the Apostolic churches and (3) were not affiliated to any church. Seven (7) Of the participant IADS were affiliated to the National Traditional Healers’ Association and (1) was awaiting to join the association soon.

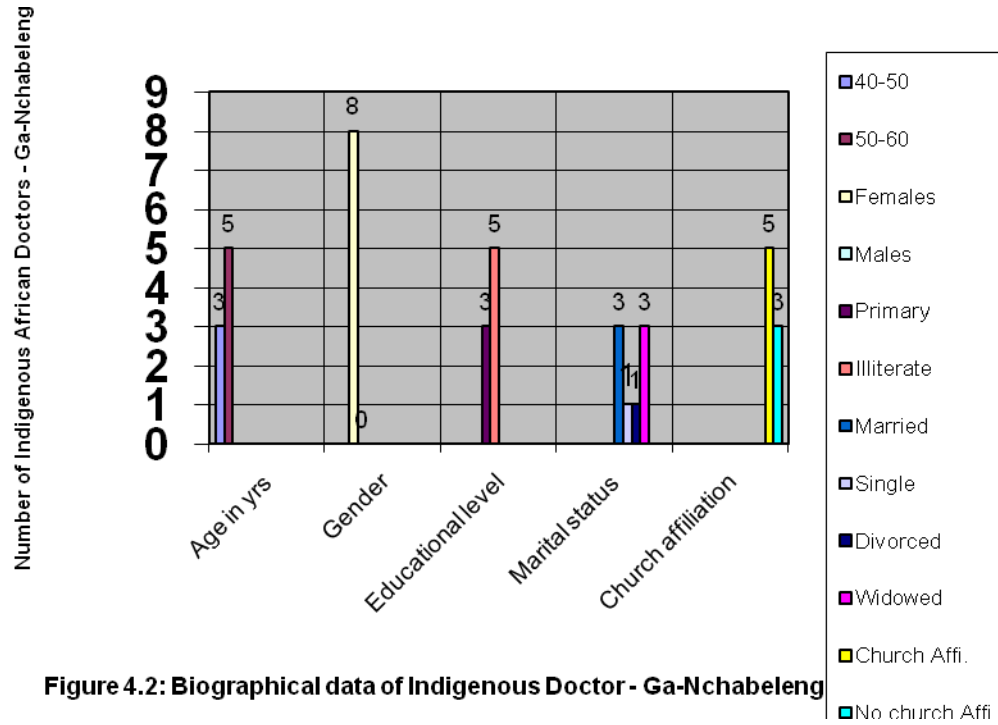


Figure 4.2: Biographical data of Indigenous Doctor - Ga-Nchabeleng

Six (6) focus group discussions were conducted at the Ga-Dikgale clinic over a period of three days. Each focus group consisted of 7-9 patient participants and the total number of participants was 33. Six (6) focus groups discussions were conducted at the Ga-Nchabeleng health centre over a period of three days. There were 7-9 patient participants per focus group and total of (51) patient participants were interviewed.

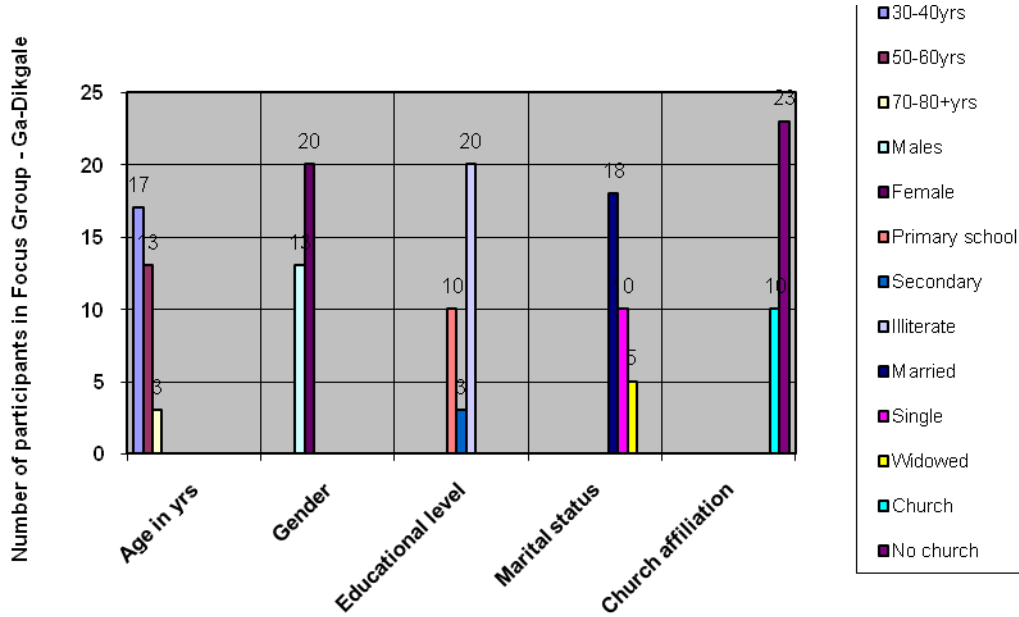


Figure 4.3: Biographical data of Focus Group - Ga-Dikgale

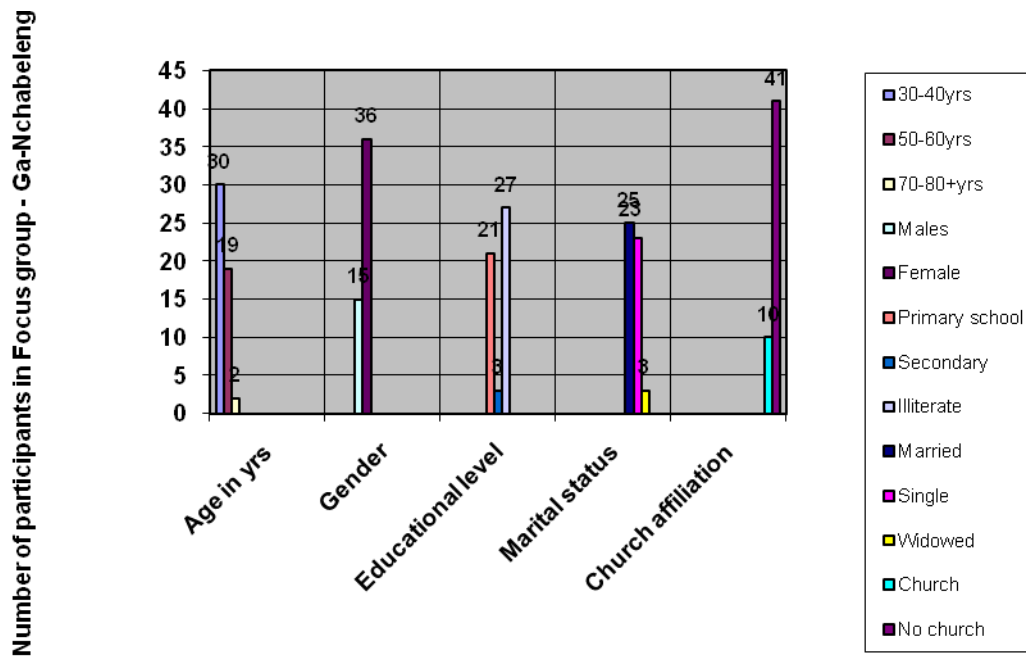


Figure 4.4: Biographical data of Focus Group - Ga-Nchabeleng

What follows are the results of interviews with indigenous African doctors and patients from the Ga-Dikgale and Ga-Nchabeleng villages and the clinics:

The questions that were asked were used as themes namely:

- History of indigenous African healing practices
- The belief system in the indigenous African healing practice
- Influence of apartheid on the indigenous African healing practices
- Health care system used in the prevention of diseases
- Health care system relied on when family member ill
- Who should play a role in the provision of health care?

One theme emerged namely: **INDIGENOUS AFRICAN MEDICINE**

Category A: The origin and nature of indigenous African healing practices

Participants were asked about the origin and the nature of indigenous African healing practices. They provided responses according to their views and their experiences from their communities.

All participants indicated clearly that the indigenous knowledge system on healing practices originates from a family tree and it runs in families. The ancestors pass it from one generation to the next through dreams. Participant indicated that in a family where there are IADS, children are taught how to use indigenous African herbs. Some of the children learn it

while, others do not practice it. Ancestors choose who should be an IAD among the children in a family. They visit him/her in dream. The chosen child may not always know the ancestor that had visited her/him in a dream, but family elders are able to trace the lineage from the family tree.

The majority of the participants further indicated that they dreamt their great-great grand- parents (paternal or maternal) who taught them how to use the divination bones to make a diagnosis. Some of the participants also stated that their ancestors also directed them where to get the divination bones in the family homestead. Some participants also explained that ancestors visit their children and relatives that are still alive in different ways namely, by making the concerned individual to be ill without any apparent cause of the illness. Participants also indicated that sometime the ancestors visit the individual through songs and in vision-like dreams. The following are the participants' responses:

I was very ill and there was no one who could treat me until my ancestors showed me in a dream an IAD who could treat me and teach me about the indigenous African healing practices (IDI female, Ga-Dikgale).

Indigenous African healing practices come from ancestors (IDI male, Ga-Dikgale,).

My parents were IADS and they passed the indigenous African healing practice to me (IDI female, Ga- Dikgale).

Indigenous African healing practices come from my great great grand-parents (IDI female, Ga- Nchabeleng)

All members of my family were IADS at different levels (IDI female, Ga-Dikgale).

I was a staunch member of the Zionist church and I dreamt my maternal great, great grand- mother who wanted me to continue with our tradition (IDI male, Ga-Dikgale).

I was given the indigenous healing practices by my great great grand- parents. It is a gift to me from my ancestors. (IDI male, Ga- Dikgale)

My great great grand- father said I want to give you the heavy load that I am carrying (IDI male, Ga-Dikgale).

I was born a healer. I would see my great great-grand father in a dream and he would teach me how to treat various diseases using indigenous herbs. He would also teach me how to make a diagnosis using divination bones. He would ask me to throw the divination bones down and interpret them in his presence until he was satisfied that I could make a diagnosis and treat diseases. My ancestors also instructed me to go to the river bed where I found the divination bones (IDI female, Ga- Dikgale).

To be an indigenous African doctor is like chieftainship because one is born with it (IDI male and female, Ga- Dikgale).

Indigenous healing practices are inborn (IDI female, Ga-Nnchabeleng).

Indigenous healing practices are a gift from the ancestors that cannot be refused (IDI male, Ga-Dikgale and IDI, female, Ga-Nchabeleng)

One IDI participant from Ga-Dikgale village indicated that his great great-grand father took him and stayed with him under water for 5 years. While under water, he stayed with all his maternal great great grand- parents and his own family members that had died long time ago. He also stated that there was also a big snake that stayed with them as well. His ancestors taught him everything about indigenous healing practices; how to mix

indigenous African herbs and how to treat various diseases. They blessed him with divination spirit that enabled him to make a diagnosis and the divination bones that were made of skin and not bones. He stated it as follows:

I was staying under water with my great great grand- parents and my grand mother's parents. They taught me everything about indigenous African medicine. They also gave me divination bone made of animal skin and the divination power to make an accurate diagnosis (IDI male, Ga-Dikgale).

Some participants also indicated that the ancestors showed them the medicinal bags that they (ancestors) used while they were still in the world hitherto. They (ancestors) also showed them where to dig for the indigenous African medicinal herbs, how to mix the herbs and how to treat various diseases

He showed me his medicinal bag that he used while still in the world hitherto and also showed me the person who would train me to be an IAD (IDI female, Ga-Nchabeleng).

The IAD who trains you is being guided by your ancestors how he/she should train you. (IDI female, Ga-Nchabeleng).

One IDI female participant also stated that her paternal ancestor visited her in a dream and told her that all his (ancestors') children did not want to be IAD and therefore wanted her to take his healer's bag. He showed her how to make a diagnosis using divination bones and also instructed her to pick the main divination bones near a river bank and her homestead. He also showed her how to mix indigenous medicinal herbs and how to treat

diseases. Her ancestor also wanted her to be a rain maker. However, she refused because her father had explained to her that it meant that she would have to be naked whenever she was making rain. She stated it as follows:

The ancestors told me to pick up the divination bones from the river banks and also from the homestead. He (ancestor) showed me how to make a diagnosis using divination bones and how to mix the indigenous medicinal herbs. I did not want to be a rain maker and so I venerated my ancestors requesting them not to make me a rain maker. I told them that they would rather kill me than being a rain maker. Rain making is problematic because you have to be naked whenever you were making rain. (IDI,female, (Ga- Dikgale).

Another IDI female participant from Ga-Dikgale village also stated that her ancestors also informed her whenever a patient was coming for consultation. Another IDI female participant from Ga-Nchabeleng also stated that she was trained by an IAD who interpreted the divination bones in IsiSwati. After completing her training, she could not communicate with her ancestors because they (ancestors) told her in a dream that they did not understand IsiSwati. They (ancestors) then showed her a male mentor who then trained her again to interpret the divination bones in Sepedi.

Participants also explained that it is very difficult to train as an IAD and it take a very long time. One male participant from the Ga-Dikgale village stated that he dreamt his great, great grand-father who said to him:

I want to give you the heavy load that I am carrying (IDI male, Ga-Dikgale).

Category B: Belief system in the indigenous African healing practices

All participants expressed an unquestionable belief in the existence of ancestors. They said that ancestors were real and were people who had passed on to the world hereafter. They also expressed a very strong belief in the IADS and the indigenous African healing practices. They stated that the belief in the indigenous African healing practices come from the ancestors. If the ancestors were IADS then some of the children may become IADS at different levels. They also stated that IADS were able to make an accurate diagnosis using divination bones and they were also able to tell the patient what or who was causing the illness or misfortune. They also indicated that they were able to prescribe treatment regarding the patient's life circumstances. Participants also explained clearly that the art of indigenous healing practice runs in families. This notion was expressed as follows:

The existence of ancestors is real because I see and talk to them daily (IDI male, Ga-Dikgale).

Ancestors visit you in a vision-like dream and tell you that they are giving you the divination bones (IDI, female Ga- Nchabeleng).

Indigenous healing practices are handed from generation to generation by the ancestors either from the maternal or paternal lineage (IDI female, Ga- Nchabeleng).

Indigenous African healing practice is part of our heritage. We are given by our ancestors and it is passed from one generation to the next in a particular family tree (FGD, Ga-Dikgale).

We can not divorce ourselves from it (IAM) because it plays an important role in our lives (FGD Ga-Nchabeleng).

IADs are very effective at making accurate diagnoses and treatment (FGD Ga-Nchabeleng).

With regards to nurses incorporating their beliefs in their care, most of the participants indicated that nurses discourage them from using IAM while still taking treatment from the clinic. Some participants also stated that they discontinue taking treatment from the clinic while on IAM so that they may know the treatment that they are responding to. They indicated that nurses encourage them to use one health care system at a time so that they are able to know the treatment that they are responding to.

Participants also indicated that they did not tell the nurses when they had consulted an IAD because they knew that nurses would discourage them from using IAM. Similarly, nurses too do not ask patients whether or not they (patients) have visited IADS or are taking any IAM. Nurses ask patients only when they notice incisions (*imigcabo*) that the IADS make on patients.

The majority of the participants stated that nurses have a negative attitude towards IADs because they tell patients that IAM is dangerous. Participants elaborated further that these nurses discourage them from consulting IADS yet, when they consult the clinics or hospitals these nurses neglect them. Participants expressed the nurses' negative reaction towards IAM as follows:

Nurses dislike IAM (FGD Ga-Nchabeleng).

We hide it because nurses scold us and say we must stop using IAM because it is not scientifically tested (FGD Ga -Nchabeleng and Ga- Dikgale).

IADs have no measurements for their medicines and we take time to get better (FGD Ga-Nchabeleng).

The majority of the participants were concerned that the belief in the indigenous African healing practice was at a decline particularly among the youth. Few of the participants indicated that they did not believe in the IAM instead they stated that they believed in faith healing.

We are worried because the youth does not visit IADs (FGD Ga-Nchabeleng and Ga-Dikgale).

Category C: The influence of apartheid on indigenous African healing practices

The majority of the participants stated that the apartheid government had a very negative impact on the IADS and the indigenous African healing practices. They indicated that apartheid was a very oppressive system of government that suppressed the development of indigenous African medicine. Participants stated that the apartheid government did not care about the IADs because there were laws that prohibited them to practice and they were called witch-doctors. Participants indicated further that the apartheid government was very myopic in its approach to IAM because it did not realize that both IAM and biomedicine were helping and supporting each other in the treatment of diseases. Some of the participants conceded

that there are some of the IADS that use their ancestral gifts for sinister purposes and are murdering people for medicinal purposes.

Participants further mentioned that the apartheid laws made it very difficult for the IADS to fulfil the wishes of the ancestors who would sometimes require that the IAD should wear an animal skin when attending to patients. White policemen would raid their homes and they would arrest them if they were found wearing an animal skin as required by the ancestors. They were also arrested for killing animals for the skin.

Participants also stated that indigenous African doctors were also threatened with being shot at and sometimes they would be beaten for treating patients. They further mentioned that IADS were also arrested for treating patients if they did not have a certificate as an IAD. Participants also stated that some white people would consult them secretly and if found, the IAD would be arrested because it was a crime to treat a white person.

Most participants also stated that they were also prohibited from digging indigenous herbs and there were rangers that patrolled the fields making it very difficult for IADS to dig these herbs. There were also spies among the black communities that would report IADS to the authorities. The IADS were arrested if they were found digging herbs. Such oppressive treatment from the authorities made IADS to be afraid to go out in the field to look for herbs. If they dared went out into the field, they would hide themselves and took great risks. Participants also stated that the apartheid government led to many IADS abandoning indigenous healing practice much to the anger of the ancestors who retaliated by making them (IADS) ill.

The majority of the participants indicated further that sometimes ancestors would direct them to dangerous and risky places where there were snake to dig for indigenous medicinal herbs. They further indicated that they would communicate with them (ancestors) through the medium of snuff and besiege them (ancestors) to protect them against dangerous animals and snakes. They further stated that there were indigenous African herbs that they used to make the snakes to fall asleep. The importance of communicating with the ancestors was expressed as follows:

When you have to leave home to look for medicinal herbs, you have to ask for guidance and protection from ancestors requesting them to guide you where to find the medicinal herbs. When coming back from the field you also have to notify the ancestors and pay homage to them for their protection and guidance. You have to show them the medicinal herbs that you have obtained from the field (IDI male and female, Ga-Dikgale and IDI female, Ga-Nchabeleng).

Some of the participants from the Ga-Nchabeleng village were appreciative of the government's positive attitude towards IAM. The participants indicated that after the 1994 democratic elections health care professionals in the clinics displayed a positive attitude towards IADS, for example, they are more receptive to patients who consult IADS. Participants also mentioned that they refer patients to the hospital when they noticed that a patient needs an intravenous infusion or blood transfusion. After the patient was discharged from the hospital, health professionals also referred the patient back to the IAD. They indicated that nurses have become very receptive to IAM and they also allow patients to bring along their IAM to the clinic/hospital.

Very few participants said that they were very young and could not remember the effects of apartheid. Some of them could only remember seeing white males on horse back and others mentioned that they only heard about apartheid, but did not experience it directly.

Category D: Health care system most people relied on when ill.

The majority of the participants indicated that they use both health care systems because both systems were very helpful. However, some participants also mentioned that they first consult IADs to establish the cause of the illness and the IAD uses the divination bones (*ditaola*) to establish the cause of the illness. Participants further indicated that they only refer patients to the clinic once the IAD has established that the illness is not caused by the ancestors or witch-craft. Some participants also stated that they refer patients to the clinic only if they did not respond to IAM. Participants also stated that there are well known diseases that respond to IAM and diseases that respond to biomedicine. These sentiments were expressed as follows:

Some ancestors manifest themselves in a song and indicate the ancestor that is causing the illness in the family (IDI, female, Ga-Dikgale).

Ancestors tell me by means of the divination bones what the patient is suffering from and how to treat him/her. Ancestors also direct me where to refer a patient should such a need arise. When members of my family are ill, ancestors will also direct me how to treat the patient or where to refer the patient because I cannot treat myself (motheku ga i thekole) (IDI male, Ga-Dikgale).

As an IAD, I cannot treat myself therefore, I have to refer the patient to another IAD for treatment (IDI female, Ga-Nchabeleng).

If a family member is critically ill we first consult an IAD who makes a diagnosis using his/her divination bones and gives the patient treatment to control the illness. We then take the patient to the hospital for further treatment on the same day (FGD Ga Nchebeleng).

It will depend on the illness because some illnesses are caused by witchcraft and if we consult a biomedical doctor first the patient will die. At the clinic/hospital he/she will be given an intramuscular injection that will make the illness to get worse. There are some illnesses that get worse if a patient is given an injection that is why we go to the IAD first (FGD Ga-Nchabeleng).

If the illness is not caused by witchcraft we take the patient to the clinic/hospital. If the patient is vomiting or has diarrhea we take the patient to the clinic/hospital because nurses will put up a drip, check the blood pressure and do a thorough physical examination (FGD, Ga-Dikgale and Ga-Nchabeleng).

For big illnesses we use IADs and for minor illnesses we use the clinic/hospital. At the clinic/hospital nurses treat symptoms (FGD Ga-Nchabeleng).

If it is TB or cancer the patient needs immediate attention and we take him/her to the clinic / hospital because IADs cannot treat these diseases (FGD Ga-Nchabeleng).

We use the clinic/hospital if it is a fracture because IAD cannot treat a fracture (FGD Ga-Nchabeleng).

Some participants stated that they use both system of health care because biomedicine has emergency treatments such as intravenous drips and blood transfusion. They also indicated that they visit the clinic first because IADS

were no longer known among the members of the community and that IADS did not make themselves known in the communities. Other reasons for consulting the clinic first were that they were attended much more quicker at the clinic and that treatment was cheaper and free. Participants also stated that IADS were expensive because they wanted money for the diagnosis and another amount for the treatment. They also indicated that IADS did not react fast to an emergency. Some IADS participants from Ga-Nchabeleng villages also explained that they refer patients to the clinics especially patients suffering from sexually transmitted infections (STI). The above sentiments were expressed as follows:

I refer patients to the clinic especially patients suffering from sexually transmitted infections (STI) (IDI, female, Ga-Nchabeleng).

Health care professionals react very quickly to an emergency. When a patient is very ill, he/she receives attention quickly (FGD, Ga-Dikgale).

IADs do not react to an emergency. A patient has to wait for his/her turn to be attended (FGD, Ga-Dikgale).

IADs are expensive and deceitful (FGD, Ga-Dikgale).

IADs do not issue a certificate of fitness after treating a patient (FGD Ga-Dikgale).

IADs do not refer a patient to another IAD because they do not work as a team (FGD, GaDikgale)

In the clinic/ hospital we are given a drip or blood. IADs do not have drips or blood (IDI Female Ga-Dikgale and FGD Ga-Nchabeleng and Ga-Dikgale).

White doctors have machines to see inside (IDI female and FGD Ga-Nchabeleng).

The youth does not utilize the services of IADs (FGD, Ga-Dikgale).

One female IAD participant from the Ga-Dikgale indicated that through the guidance of her ancestors she could treat high blood pressure and diabetes mellitus. However, the majority of the participants, stated that they visited the clinic first because IADS could not treat high blood pressure and diabetes mellitus.

IADs do not know how to diagnose and treat Diabetes mellitus instead, they diagnose it as epilepsy (sefolane) when it is a white man's disease (FGD, Ga-Dikgale).

One male IAD participant from the Ga-Dikgale village indicated clearly that he could not treat mental illness and children's diseases. While another female IAD participant from the same village also stated that she could not state with certainty the diseases that she was able to treat because treatment of diseases was depended on the patient's diagnosis.

The majority of the participants also indicated the diseases that IADS can treat and in some cases they were able to state the treatment:

Children diseases: measles, sunken anterior fontanel (temo or hlogwana) IDI, female, Ga-Dikgale and Ga-Nchabeleng; FGD Ga-Dikgale and Ga-Nchabeleng).

Thlogo (IDI, male, Ga-Dikgale).

Stomach ulcers (FGD Ga-Dikgale and Ga-Nchabelng; IDI, male Ga-Dikgale).

Diarrhea (FGD, Ga-Ncabeleng).

A burning sensation just below the sternum (sibewubewu) (FGD, Ga-Ncabeleng).

Stomach ache (nogana) (IDI, female Ga-Dikgale).

Abdominal pains (go pipitlelana ka dimpeng) IDI female, Ga-Dikgale).

Gonorrhoea (tshofela) (IDI, male, Ga-Dikgale).

Malnutrition (phepo mpe)(IDI, female Ga-Dikgale).

Pellagra (IDI female, Ga-Dikgale).

Kwashiorkor(phepompe) (IDI female, Ga-Dikgale).

Generalized oedema (go roroga) IDI Male, Ga-Dikgale).

Swelling of legs (FGD, Ga-Ncabeleng).

A widow who has not been cleansed ritually and has had sexual relations with a man. This is known as makgoma.(IDI female, Ga-Dikgale and female Ga-Ncabeleng, FGD, Ga-Dikgale and Ga-Ncabeleng).

Male conditions such as when a man has had sexual intercourse with a menstruating woman or a widow who is not cleansed ritually.(FGD Ga-Ncabeleng).

Food poisoning (sejeso) (IDI male, Ga-Dikgale, FGD Ga-Dikgale and FGD, Ga-Ncabeleng).

Segalaka and tosolla (FGD -Ga-Ncabeleng).

Sefolane (FGD Ga-Nchabeleng).

HIV and AIDS (IDI female Ga-Nchabeleng and IDI male, Ga-Dikgale).

African poison that is put on ones path. The poison then gets into one bloodstream causing an illness. This is known as (Magatišwa) (FGD Ga-Dikgale and Ga-Nchabeleng).

Irregular menstruation (go se ye mabakeng gabotse,) (IDI female, Ga-Dikgale).

Diseases of the uterus (malwetši a popelo), dysmenorrhoea, menorrhagia and infertility (go se belege). Infertility is treated by medicinal herbs known as (disehla). The IAD combines different medicinal herbs. He/she ties and boiled them together. The woman is then expected to drink the mixture. Within a short space of time the woman will fall pregnant (IDI, female, Ga-Dikgale, FGD Ga-Nchabeleng) .

Big headache is treated by burning a mixture of different medicinal herbs that are grounded into a fine black powder. The patient then adds this black powder in to her/his breakfast porridge. In biomedicine a big headache could be interpreted to be high blood pressure. In the olden days when a patient had big blood, the IAD would suck out the bad blood by blood letting known as (go lumega) and the patient would get better (FGD Ga-Dikgale).

IADs are able to treat epilepsy provided the patient was not burnt or has not been given an intramuscular injection in the clinic or hospital. When the patient has already been given an injection, IADs are unable to treat him/her (IDI male, and FGD Ga-Dikgale, IDI female and FGD, Ga-Nchabeleng,).

Sesepedi was described as follows: When a patient feels as though something is moving and pinching him/her all over the body (FGD Ga-Dikgale).

IADs can treat mental illnesses and biomedical doctors can only treat the symptoms and the patient is expected to take treatment continuously. Mafufunyane is a mental illness (FGD, Ga-Dikgale).

Only one participant from the FGD at Ga-Nchabeleng indicated that she uses faith healing before referring a patient to the clinic/hospital.

One IDI participant from Ga-Dikgale stated that it was important that a patient should use one health care system at a time and patients should not use IAM and biomedicine simultaneously so that they are able to know the medication they are responding to.

Category E: The health care system used in the prevention of diseases.

The majority of the participants stated that in the African culture there are no preventative measures against diseases, but there are indigenous African medicinal herbs that are used to fortify homesteads and the family members and thereby prevent illnesses. They further stated that there is also a belief that witches are able to place bewitched substances around the area where the targeted person stays and when he/she steps on the bewitched substance, he/she will contract an illness. These are known as (*di-gatišwa*). They also indicated that there are certain activities that are culturally forbidden and people who do not follow these cultural beliefs fall ill. Participants also indicated how fortification of the homestead and family members is done:

Adding indigenous medicinal herbs in the family drinking bucket to prevent any illnesses and if a family member has an acute illness the severity of the illness will become mild(IDI female, Ga-Dikgale).

For the males the indigenous African medicinal herbs are added in the African home brew beer (IDI female Ga-Dikgale).

The homestead is sprinkled with a mixture of indigenous African medicinal herbs and sand. Family members are also sprinkled with the medicinal herbs and steamed. Some IADs also use nails smeared with medicine and are pushed underground at the four corners of the homestead and at the main entrance. Family members are sometimes given some of the medicine to drink. Motse o a thegiwa (IDI female, Ga-Dikgale IDI female Ga-Nchabeleng, FGD Ga-Dikgale and Ga-Nchabeleng).

Prevention is better than cure (thibela malwetši i phala kalafo) (IDI, female, Ga-Dikgale).

Small incisions are made on the joints using a razor blade and a mixture indigenous African medicinal herbs is then applied on the incision. The razor is broken into four quarters and one quarter is used for one patient and burnt to avoid passing one illness to the other (IDI, female, Ga-Nchabeleng and FGD Ga-Dikgale and Ga-Nchabeleng).

Some people wear around their waists or wrists armulets that have been fortified. These armulets are worn for various reasons for example, to protect individuals against evil sprits. Sometimes the medicinal mixture is applied on the body, eyelashes to enhance dignity (IDI, female and FGD Ga- Di-Kgale and Ga-Nchabeleng).

A mixture of indigenous African medicinal herbs is added in the family drinking water for prevention of diseases (IDI, female, Ga-Nchabeleng, FGD Ga-Dikgale).

After six weeks of delivery a new born baby is protected against witches or evil spirits by being tapped slightly on the joints using a specific medicinal tool applied with medicinal herbal preparation and this is known as (go kokotela) (FGD, Ga-Dikgale).

There are also known seeds that are used for the prevention of chicken pox (FGD, Ga-Dikgale).

There are also indigenous African medicinal herbs that are used to treat sore throat and toothache (FGD, Ga-Dikgale).

Talking to and asking the ancestors to protect and prevent the entry of witches that bring illnesses in the family. This is known as (go phasa badimo (FGD, Ga-Chabeleng).

The protection of a new born baby against bad air (mimoya e mibi) by means of a mixture of medicinal herbs (FGD, Ga-Chabeleng).

There are special beads that are used for teething in children and are known as (botabia) (FGD, Ga-Chabeleng).

The first born and the last born whose parents have died are expected to wear special beads that prevent them from falling asleep while walking and also prevent them from being stressed by the death of their parents. These beads are known as (bolokwana). There are also medicinal herbs that are mixed with milk and these children are expected to drink it to prevent them from worrying about the death of their parents (FGD, Ga-Chabeleng).

When a baby is very hot we throw him/her in the air and catch him/her and also pour him/her with cold water while calling him/her by name. This will cool his/her temperature (FGD, Ga-Chabeleng).

Activities that were culturally forbidden (*di ayile*) included the following:

A widow or a woman who has just delivered a baby or has had an abortion, is considered to be in a hot state (o a fišha) The widow is considered to be in a state of darkness (se fefe, senyama). She is considered to have (makgoma). She is expected to abstain from

worldly pleasures including sexual intercourse for at least a year. After which, an IAD must cleanse her ritually from the impurities that have been caused by the death of her husband. The cleansing also restores her to a symbolic state of balance. It is believed that the period of a year of mourning allows her to get rid of her husband's blood from her blood stream. It also allows time for the corpse to decompose. If the widow has not been ritually cleansed and has sexual intercourse with a man, it is believed that her partner will have a distended abdomen and swollen testes. If he does not get treatment immediately, he will die. Similarly a woman who has delivered a baby has to abstain from sexual relation for sometime (IDI both females, Ga-Dikgale and Ga-Nchabeleng, FGD, Ga-Dikgale and Ga-Nchabeleng).

Free abortion is causing many problems because young girls request abortion and do not tell their boyfriends that they have had an abortion. They also do not abstain from sexual relation after the abortion. Their boyfriends eventually die without knowing the cause of their illness (FGD, Ga-Nchabeleng).

A menstruating woman is not supposed to have sexual relation with a man because it is believed she is hot (o a fišha) (FGD, Ga-Nchabeleng and Ga-Dikgale).

A woman who has missed her menstrual period is not supposed to carry a newborn baby because she is also considered to be in a hot state. If she carries the baby it is believed the baby will die (FGD, Ga-Nchabeleng).

Only one FGD indicated that they believe in faith healing and for prevention of illnesses the following was done:

The minister uses salted water and sand to sprinkle around the homestead (FGD, Ga-Nchabeleng).

When a person has high blood pressure we add salt to the boiling water for steam inhalation (FGD Ga-Nchabeleng).

When we have flu and cough, we burn stones until brick red. The stones are then removed from the fire and the patient is steamed by placing the hot stones in water and he/she is then covered with a blanket. This is known as (go a ramela) (FGD, Ga-Nchabeleng).

One IDI female participant from Ga-Dikgale village also mentioned that there are well known indigenous African medicinal herbs that are used as contraceptives even though community members do not use them because they want to have more children. She further explained that the youth does not use these indigenous African contraceptives instead, they prefer to visit the clinic for contraception. One IDI male from Ga-Nchabeleng village indicated that there are indigenous African herbs that are used for the prevention and treatment of seasonal diseases and these include medicinal herbs that are used for cough. This was expressed as follows:

In winter children cough and we use indigenous African herbs for the cough (lewotlwawotweng le a palega bana ba a gohlola) (IDI male, Ga-Chabeleng).

Few participants also stated that in the African culture there were no indigenous medicinal herbs that were used for the prevention of diseases. Another IDI female participant from Ga-Nchabeleng stated that she did not know any indigenous medicinal herbs that are used for the prevention of diseases while, another female participant from the same village also stated that she was not sure of any indigenous herbs that are used for the prevention or treatment of diseases. For colds and flu patients are referred to the clinic/hospital. Only one female participant from the Ga-Nchabeleng community indicated that there is no prevention of diseases because illness enters the body through air inhalation for example, measles.

Category F: Who should play a role in the provision of health care?

The majority of the participants indicated that they use both systems of health care should play a role in the provision of health care because both systems are helpful in the provision of health care. They indicated their willingness to work in partnership with biomedical doctors in the provision of health care. They indicated that it was important that they should work together because there were diseases that respond well to biomedicine and diseases that respond well to IAM. They also indicated that when both systems work together, patients as consumers of health care would benefit because they would have a choice. They indicated that it was essential that both systems of health care should work together so that patients could use both health care systems simultaneously if they wished. This notion was expressed as follows:

Indigenous African doctors cannot treat patients suffering from TB and cancer and these patients should be rushed to the clinic/hospital as soon as possible (FGD, Ga-Nchabeleng).

When they work together they will be able to find a cure soon for this deadly disease, HIV and AIDS (FGD, Ga-Nchabeleng).

They should work together because when a woman who is giving birth is attended by traditional birth attendants she is left to bleed and sometimes may bleed to death after delivery. The clinic/hospital is helpful because they give the woman an injection to minimize the bleeding. The hospital is also helpful when the placenta is retained (FGD, Ga-Nchabeleng).

IAM is slow because some herbs need to be obtained from the field while, biomedicine is fast because it is easily available (FGD Ga-Nchabeleng).

Biomedical doctors can treat fractured bones while, IADs cannot (FGD Ga-Nchabeleng).

Hospitals have drips and blood transfusion (FGD Ga-Nchabeleng).

Participants also stated that co-operation between IADs and biomedical doctors would also enhance the referral system because diseases such as diabetes mellitus, stomach ulcers, high blood pressure, HIV and AIDS are not known in BoPedi. Such co-operation would also enable the IAD to refer patients that need intravenous infusion or an operation to the clinic/hospital.

Participants also stated that both health care systems should work together because both were helpful in the treatment of diseases. They also stated that after all they use both health care systems simultaneously and therefore the co-operation of the two systems would be beneficial to the patients. They should therefore support each other so as to remain strong.

Participants also stated that both health care systems should work together because they belong to the same family. They also indicated that there was no difference between IAM and biomedicine and the only difference between the two health care systems was that biomedical doctors had equipment for intravenous infusion, blood transfusion and X-ray machines that were used for diagnosis purposes while, IADS use divination bones to make a diagnosis. This was summarized as follows:

We are children of the same family. We are supposed to work together because we are one. White medicine treats diseases when a patient needs water or blood. The hospital has machines for examination (IDI female, Ga-Nchabeleng).

They should work together because they are the same (FGD Ga-Nchabelng).

Some participants voiced a concern that IADS referred their patients to the clinic/ hospital for further treatment, but biomedical doctors did not refer patients to them. They further stated that the government should hasten the process of co-operation. They also stated that hospital authorities do not call them to the clinic/hospital to treat patients. They are only called to the clinics or hospitals when they have to attend workshops on HIV and AIDS or any other training. They further elaborated that people are not only dying from high blood pressure but, are also dying from other diseases that are of African origin. The majority of the participants had positive responses towards IAM and these were as follows:

Indigenous African medicine is effective and the patient consults an IAD only once and feels better after taking the treatment because IAM treats the cause of the illness whilst biomedicine treats the symptoms. The patient has to visit the clinic/hospital monthly for supply of medication (FGD, Ga-Dikgale).

IADs should also get a salary from the government just like the biomedical doctors (FGD, Ga-Nchabeleng).

Participants also mentioned that there were also well known members of the community who were not IADS but had vast knowledge of indigenous African herbs and experience in the treatment of diseases. They had obtained

this knowledge by following their elders. They were known as *ngaka e tshupša ga e na ditaola*.

At the same time the majority of the participants also had negative responses about IAM and these were as follows:

IADs have become very expensive in their diagnosis and treatment whilst, treatment at the clinics is free. They want a lot of money for opening the bag containing the divination bones to make a diagnosis and a cow for the treatment. To stop this practice, IADs should be registered just like biomedical doctors. Registration will ensure that their specializations are known (FGD, Ga-Dikgale and Ga-Nchabeleng).

IADs do not want to register because they want to continue to be expensive (FGD, Ga-Nchabeleng).

IADs want to be paid cash with each visit and this is contrary to what prevailed in the olden days when an IAD would only be paid after the patient had been cured or gotten better (FGD, Ga-Dikgale).

Indigenous African doctors have become very unreliable and deceitful especially if they are not sure of the diagnosis. Instead of indicating that they are not sure, they will rather point at a relative, a friend or a neighbour as the cause of the illness and in that way they cause a lot of hatred among members in the community (FGD, Ga-Dikgale).

Some IADs falsify a diagnosis stating that a patient is possessed by his/her ancestors who want the patient to be an IAD and it is very expensive and it involves hard labour become a trainee (FGD, Ga-Dikgale).

Some IADs also lie and state that they can treat diabetes mellitus when in fact diabetes mellitus is a white man's disease. They also misdiagnose diabetes mellitus as epilepsy (FGD, Ga-Dikgale).

IADs use unhygienic methods in their treatment and the environment where they work is not clean. They also use one razor blades for many patients and therefore, transferring infection from one patient to another (FGD, Ga-Dikgale).

IADs are not able to help a patient who needs blood transfusion or an intravenous infusion (FGD Ga-Dikgale).

IADs do not have measurement for their medicines and sometimes they overdose patients (FGD, Ga-Dikgale).

IAM is not scientifically tested (FGD Ga-Nchabeleng).

IADs do not have first aid treatment in cases of an emergency (FGD, Ga-Dikgale).

IAM is slow and only treats symptoms whilst, biomedicine is fast and effective (FGD, Ga-Dikgale).

IAM is slow because the indigenous African herbs must be obtained from the veld while, biomedicine is fast because it is easily available (FGD, Ga-Nchabeleng).

IADs keep patients for a long time treating them even if they are aware that they are unable to help them. They do not refer patient to the hospital or to one another (FGD, Ga-Nchabeleng, FGD ga-Dikgale).

Some of the participants were also very sceptical about the collaboration between IAM and biomedicine. They were concerned about the issue of property rights. They indicated that biomedical doctors would steal the

indigenous knowledge systems on the indigenous African healing practices because biomedical doctors are educated and they will then render the IADs redundant. This was expressed as follows:

The biomedical doctors will steal our indigenous knowledge on African medicine if we work together with them (FGD Ga-Nchabeleng).

The prizing of IAM should be regulated (FGD, Ga-Nchabeleng).

The majority of the participants were also concerned that biomedical doctors do not respect the IADs and this was seen as a hindrance to the collaboration and it was expressed as follows:

When they work together, it means that biomedical doctors must not despise IADs. They must appreciate that the indigenous knowledge that the IADs have comes from the ancestors. They should appreciate each others' contributions (FGD, Ga-Nchabeleng).

The fear of ancestors was expressed as follows:

Ancestors are very selfish and jealous; they may not allow the IADs to work together with the biomedical doctors (FGD, Ga-Nchabeleng).

Only one female IDI participant from the Ga-Dikgale village indicated that though she was in favour of working together with the biomedical doctors, she was not sure how and where she would store her indigenous African medicinal herbs (*dipheko*). She also stated that it would be practically impossible for her to carry all the medicinal herbs to the clinic/ hospital because she kept them as shrubs and only prepared the medicines from the shrubs once she had made the diagnosis. She made an example that it would

be difficult for her to treat a patient with infertility because the patient would be required to take the treatment at night before going to bed and this would not be possible in the clinic/ hospital.

I wan to work together with the doctors but I do not know how I would be able to work with them because I only prepare the medicine after I have made a diagnoses and I store the medicinal preparations as shrubs. It would be difficult to carry all the shrubs (IDI, Ga-Dikgale)

Faith healing

In this study, the use of faith healers as health care providers had no significance. Only one FGD from the Ga-Nchabeleng village mentioned that they consulted faith healers before referring the patient to the clinic.

CHAPTER 5

RESULTS OF INTERVIEWS WITH HEALTH PROFESSIONALS

INTRODUCTION

This chapter focuses on the presentation of data from interviews with health professionals working as employees of the Department of Health within the Capricorn and Sekhukhune Districts of the Limpopo Province. This chapter is essential as it articulates the beliefs, attitudes, perceptions and experiences of health professionals regarding the collaboration of IAM and western European doctors in the provision of health

Fifty (50) health professionals were interviewed. Their distribution according to age and gender are as indicated in Figure 5.1.

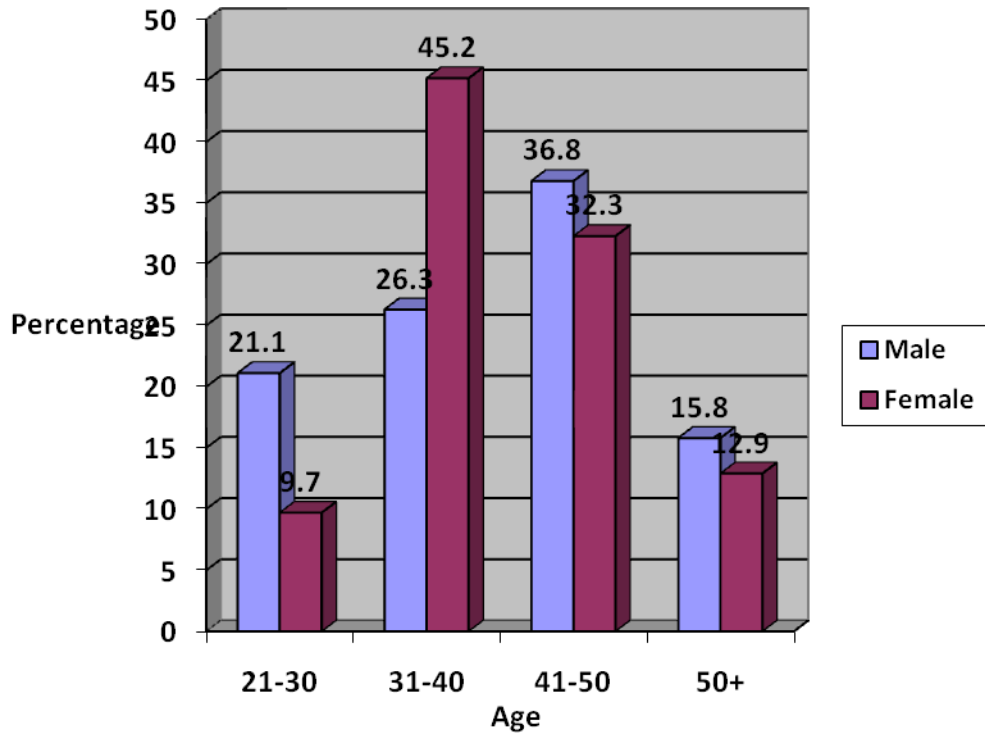


Figure 5.1: Age and gender of participants

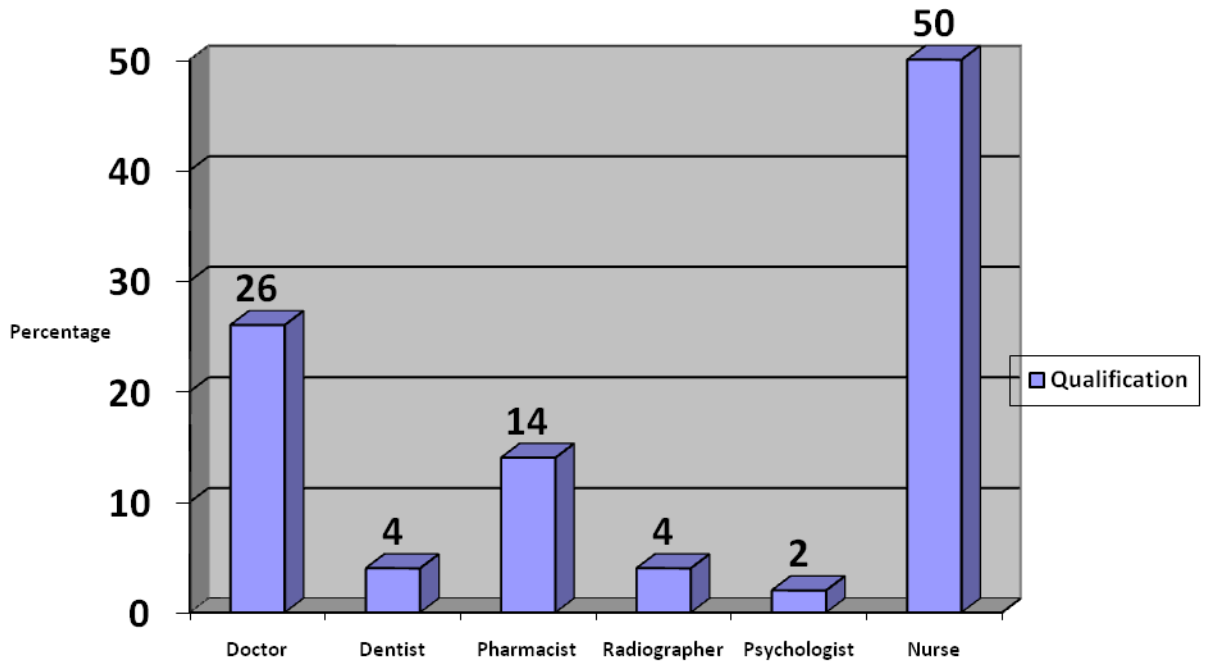


Figure 5.2: Qualifications of participants

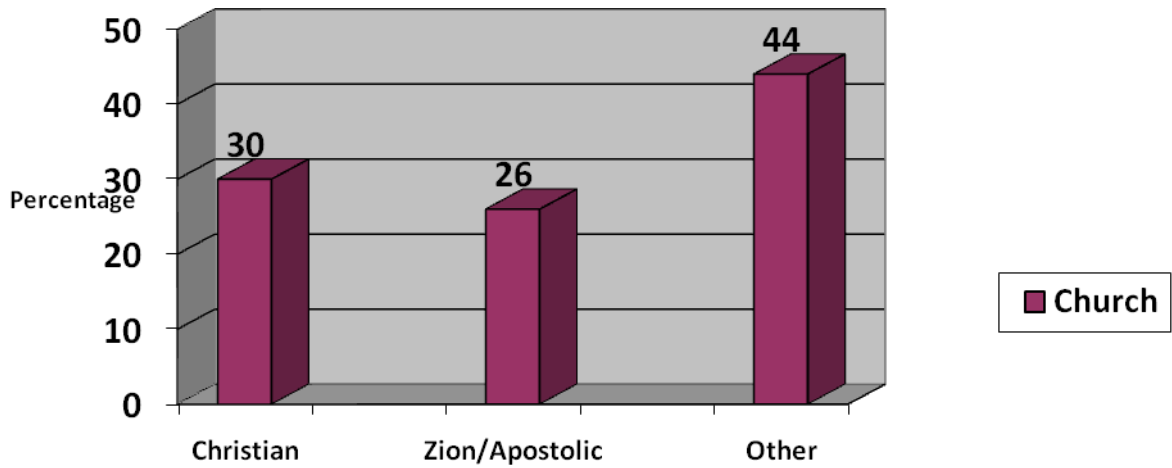
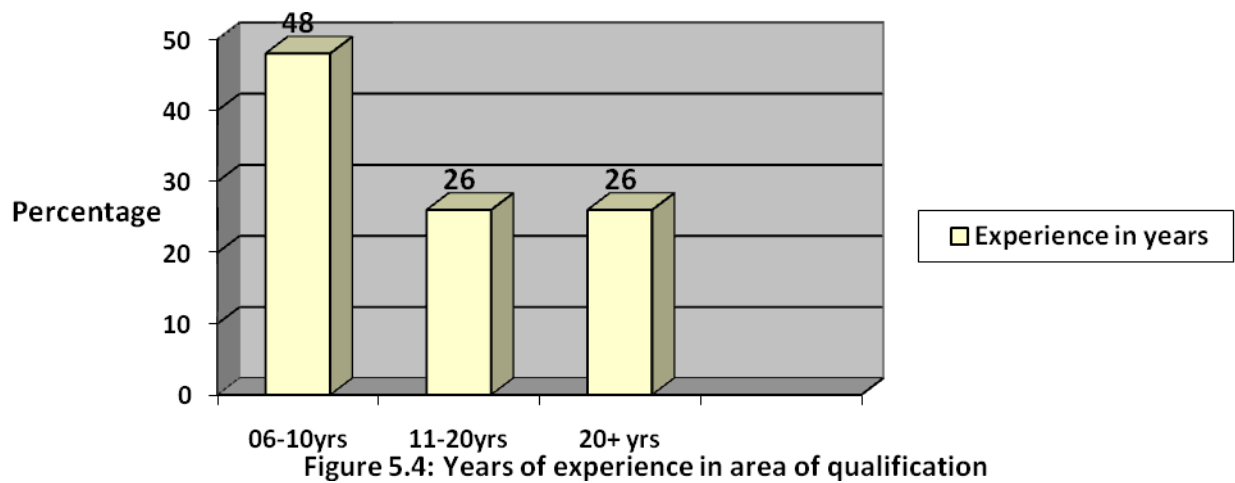


Figure 5.3: Church Affiliation of participants



The questions that were asked were used as categories namely:

- The knowledge of indigenous African medicine in particular the issue of spirituality
- Their perspective of whether the knowledge that IADS have was scientific or not
- Referral of patients to the IAD
- The collaboration of IAM and biomedical doctors in the provision of health care
- The views of professional bodies in the collaboration of IAM and biomedicine in the provision of health care.
- The successes and challenges that could arise in the collaboration of IAM and biomedicine in the provision of health.

In all the categories one theme emerged: **INDIGENOUS AFRICAN MEDICINE**

Category A: The knowledge of the nature of indigenous African healing practices

The majority of the participants interpreted spirituality to mean the belief in the ancestors and that IADS obtained their knowledge of indigenous African healing practices from their ancestors who appear in dreams or vision and tell the IADS how to make a diagnosis, where to obtain medicinal herbs and how to mix the herbs to treat various diseases. To the IADS these dreams are real and they are followed to ensure healing of patients. The following provides the participants' responses:

Spirituality has transcended many generations and was used before the advent of medicine; indigenous African medicine is the backbone of modern medicine (Dr).

Spirituality means that one does not choose to be a healer. He/ she is chosen by his/her ancestor (R/N)

Africans believe in spirituality. They believe in ancestors and they even hold some occasions to honour their ancestors (R/N).

Indigenous African medicine goes hand in hand with spirituality(R/N).

People inherit their healing powers from their ancestors and it is passed from generation to generation (R/N).

Indigenous African doctors get their knowledge of indigenous African medicine from their ancestors. The spirit of the ancestors direct them where to get herbs and roots, how to make a diagnosis and how to prepare the medication for healing purposes (RN, Dr).

A person is given direction by his/her ancestors and he/she performs these duties after being trained by a person who knows IAM (Pharmacist).

I know that indigenous African doctors dream and have visions of their ancestors (R/N).

It is the belief in the ancestral spirits; some indigenous African doctors use bones to detect illnesses and how they can assist people (Social worker).

Participants also indicated the importance of ancestors in the lives of their descendants and the relationship of ancestors to God. This was expressed as follows:

Africans believe strongly that ancestors are a spiritual link between God and the people that are still alive (Dr, R/N).

In African culture when a person dies he/she does not go to heaven but he/she goes to the ancestors who in turn relay messages to God (R/N).

Africans believe that there should be a balance between the body and mind (Dr, R/N).

Spirituality was also viewed as a calling from the ancestors who were also healers themselves while they were still in the world hitherto and that the knowledge of indigenous healing practice ran in families. Participants also indicated that once an individual has been called by the ancestors, he/she cannot refuse. This was expressed as follows:

Spirituality is a calling just like nursing is a calling (R/N).

Spirituality is a calling from the ancestors who were healers themselves and it runs in families(R/N).

Indigenous African healing practice is a calling that cannot be ignored. If ignored the individual will get ill or may sometimes die. The illness may be physical or psychological (R/N).

In indigenous African medicine an individual is called in a dream by his/her ancestors to be an IAD and to perform healing functions on their behalf (R/N).

Participants also expressed that ancestors are honoured and are viewed as protectors of the lives of their descendants and this was expressed as follows:

I also believe that the spirits of my ancestors protect and supervise me on daily basis (R/N).

Ancestors are alive somewhere and have powers to control their descendents by giving them good luck or bad luck (R/N).

Participants also viewed ancestors as mentors of individuals who were being trained to be IADS. The ancestral mentor tells the mentee what to do before the mentee attends training and this was stated as follows:

Before an individual goes for formal training, the ancestral mentor will tell you where to go and will show you herbs and how to use them. The ancestral mentor will also tell you where to get the divination bones(R/N).

Ancestors were also discussed in relation to health and illness as follows:

Any illness or misfortune is regarded as a sign that ancestors are not happy with something (Dr).

Some participants also indicated that they did not believe in the ancestral spirits. One participant acknowledged the existence of ancestors, but indicated that IADS used gods that were not ancestors. The demons and the devil appeared to the IADS under the disguise of being ancestors. These sentiments were expressed as follows:

I do not believe in the ancestors and bone throwing. I see it as magic and dreaming about ancestors as hallucination (Dr, R/N).

The work of the IADS is the work of the devil under the disguise of ancestors (Dr).

*Category B: The scientific nature of the knowledge that IADS
have about indigenous African medicine*

Participants indicated that the knowledge that IADS have about IAM was not scientific because they were guided by the ancestral spirits and that their knowledge was also not scientifically proven. Participants also stated that IADS did not attend any formal education to learn about IAM. They also indicated that quite often the treatment of IADS has led to many complications and sometimes has even led to the death of patients. They also stated that IADS also lacked knowledge of drug interaction, dosage, and the frequency of the administration of the medicines. They also lacked

knowledge about the patho-physiology of diseases and the side effects of their medicines. These sentiments were expressed as follows:

No research is done and therefore, it has no standards to refer to and one is not aware of the extent of the effects and side effects of particular medicines (obstetrician, R/N).

The medicines of IADS are not tested in the laboratory (Pharmacist, R/N).

Indigenous African doctors do not have scientific evidence to prove their effects because they are assisted by the ancestors to make a diagnosis. Their knowledge is based on past experience (Dr, R/N).

Their medicines cause poisoning leading to the failure of many organs such as kidney failure because they overdose patients (Dr, R/N).

They did not go to school to learn about medicine and they do not know anything about drug interaction(R/N).

I do not believe that they can treat disease. Their treatments make patients to get worse (Dr, R/N).

Their medicines are not labelled; patients are given large doses of medicines because they do not measure their medication and this leads to adverse effects like poisoning (R/N).

The practice of IADS is based on demons. IADS could have power to perform miracles, but their power is limited (Dr).

It depends on the disease you are suffering from and also if the witches are not involved(R/N).

The material aspect of its practice opens the way to witchcraft and quackery (Dr).

There is lack of precision of the somatic diagnosis (Dr).

Diagnosis and therapeutic approaches are not guided by the Cartesian rationality (Paediatrician).

Participants stated that most of the IADS were illiterate. One doctor participant indicated that in Africa too many people use IAM and were dying of many diseases and that proved that IAM was not effective in improving the health of the people. She further stated that in the European countries where the majority of people use biomedicine the life expectancy rate was high because there were fewer diseases and that proved that biomedicine was effective in the treatment of diseases. These sentiments were expressed as follows:

As far as I know there is no evidence that IAM is working because Africa has too many ill people (Dr).

Most of the IADS did not go to school to study and the majority of them are illiterate(R/N).

Participants indicated that IAM was scientific. However, its scientific nature was explained in relation to its effectiveness in the treatment of diseases. This was expressed as follows:

IAM is not scientific but IADS are helpful(R/N).

It is not scientific but it is effective in treating other diseases (R/N).

IADS have no measurements for their cocktail, but their treatments sometimes have the same good effects just like biomedicine (R/N).

They are able to treat diseases that biomedicine cannot treat for example hlogwana (pulsating fontanel) (R/N).

Participants indicated that IADS are now trained to be scientific and described their scientific nature in relation to the ingredients found in their medicinal preparations. They said:

These days IADS are trained to be scientific and even refer their patients to the hospital and this is according to the National Health Policy (Obstetrician).

The ingredients found in IAM are also found in biomedicine. The difference is found in the mixing of the ingredients (R/N).

One participant summarized it well when she described her personal experience to emphasise the effectiveness of IAM as follows:

I had my first child at the age of 38 and I had consulted more than twenty times to very famous gynaecologists but I could not fall pregnant. One IAD gave me “umuthi” and told me the position that I should use when drinking the “umuthi”. After three months I was pregnant. I have many scars on my body due to operations (R/N).

Participants also expressed the notion that attending school did not only imply formal education and this was expressed as follows:

They also attend schools which are spiritual (R/N)

They undergo specific training for a specific time and they are taught how to make a diagnosis using bones. Sometimes they also diagnose by taking history (R/N).

IADS follow a certain pattern in their treatment. A patient cannot be given any treatment without being assessed by bone throwing(R/N).

Category C: Referral of patients to the indigenous African doctors

Participants stated clearly that they have never referred patients to the IADS and they gave various reasons for their actions and these were:

Most patients that visit IADS come back to the hospital with many complications such as toxicity and dehydration. They also get ill and sometimes die because of toxicity and damage to the liver (Dr, R/N).

My training and my ethics do not allow it (Dr).

My profession does not support such referrals (Clinical psychologist).

IADS cannot do transplants (Radiographer).

They think that every illness is caused by witches and that delays the process of healing (R/N)

Many patients that visit the clinic start by consulting the IADS first before consulting us (R/N).

I am working in the paediatric ward and a mother brought her baby who had herbal intoxication and the baby died because the IAD gave the baby too much “umuthi”(R/N).

One participant expressed the notion that IADS promise patients that they have a cure for HIV and AIDS and yet there was no cure and this was expressed as follows:

The treatment of IADS is not safe; they promise patients that they have a cure for HIV and AIDS but they do not come forward when called to prove publicly their cure for HIV and AIDS (R/N).

Some of the participants indicated that they did not believe in IAM and that some of the IADS were themselves psychiatric patients needing treatment. These sentiments were expressed as follows:

I do not believe in IAM and I will not put patients at risk because IAM is dangerous(R/N).

I myself still have doubts about IAM and some of the IADS are psychiatric patients because they believe that they are doctors and have powers to heal diseases(R/N).

Some of the participants indicated that they have not been confronted with a situation where they had to refer patients to the IADS. This was expressed as follows:

I have not been confronted with such a situation, but I would refer a patient to an IAD because there are conditions that respond well to IAM for example, hallucination (R/N).

I have never had a problem that biomedicine could not fix(R/N).

All I know is my knowledge on biomedicine and I'm content with it (Dr).

Participants indicated that there were no policy guidelines that allowed them to refer patients to the IADS:

So far the present hospital policy regarding the referral system does not allow me to refer patients to the traditional healers (Paediatrician).

No referral system or government policy in place to do so; traditional healers are not recognized (Obstetrician).

I am not allowed to refer to the traditional healers even though I know that there are conditions that they treat like childhood diseases(R/N).

There are also no protocols to refer patients to the IADS. We have different referral systems to refer patients except IADS (R/N).

Participants also stated that they did not refer patients to the IADS because their practice was open to abuse and this was expressed as follows:

The IADs possess no written qualifications; the practice is open to a lot of abuse and is difficult to ascertain true IADs from the fake/money making IADs who abuse patients because of their belief in traditional African medicine (Dr).

One participant expressed the need for a dialogue between IAM and biomedicine as follows:

There must be agreement between the IADS and Biomedical doctors. IADS should be able to refer patients to the hospital early before it is too late. Biomedical doctors too should learn more about the patient's cultural beliefs so that they are able to refer patients to the IADS (R/N).

Only two participants indicated that they did not refer patients to the IADS because they believed in God and one summarized the sentiments as follows:

I am a child of God and He knows the truth that the power that IADS use is satanic based (Dr).

Only eight participants stated that they have referred patients to the IADS and various reasons were given:

Indirectly I have particularly patients whom I have seen and have not responded to biomedicine. I say "Did you inform your ancestors that you are not alright and that you are visiting biomedical doctors". That is how I have referred them(R/N).

I got help from an IAD when I had the same condition that the patient was suffering from (Pharmacist).

I have referred patients to the IADS because patients were insisting to visit the IADS (R/N).

I have just encouraged patients to visit IADS for a second opinion as I have seen somebody who has been treated with IAM getting better (R/N).

Some participants referred patients to the IADS because of their own personal experiences and these were stated as follows:

Indigenous African medicine helped me so much and many of the patients that I have referred to the IADS come back to thank me (R/N).

Patients did not respond to biomedicine and some of the signs and symptoms that they had could not be found in any medical text book and could not be explained by science(R/N).

Most patients believe that they have been bewitched and they claim biomedicine does not work (R/N).

Category D: Collaboration of IAM and biomedicine in the provision of health

The majority of participants were in favour of the collaboration of IAM and biomedicine. They gave various reasons to support their arguments. These were related to the knowledge that IADS have about the treatment of diseases and that there were diseases that responded to IAM and did not respond to biomedicine and vice versa. Participants also indicated that collaboration between IAM and biomedicine would also improve communication and improve understanding of each other's point of view and thus improve the delivery of health care. They also stated that both IADS and Western oriented health professionals have a common goal which was the health of patients and that collaboration would also empower the IADs. Participants also stated that patients consult IADS before consulting western trained health professionals and that collaboration would improve research in the African pharmacopoeia and that students could be trained on herbal medicine. These sentiments were expressed as follows:

Many African patients consult the IAD first before consulting biomedical doctors. IADS can therefore play an important role in Primary health care (PHC). Their basic ethics also is to heal patients. If they understand the limitations of their medication they can be

educated about basic medicine, warning signs and symptoms and when they should refer. Good communication without being judgmental will play an important role in establishing rapport which will arise during the process of collaboration (Indian Obstetrician).

Most African people use both IAM and biomedicine (Clinical Psychologist).

Both IADS and biomedical doctors have one goal and that is the health of the patients. Collaboration would also improve understanding of each other and how each work(R/N).

There will be sharing of ideas and expertise through workshops and conferences and this will benefit patients (Dr, Social worker, R/N).

Both parties should be involved in the formulation of policies (R/N).

Indigenous African doctors too have knowledge of how to treat certain diseases. There are diseases that respond to IAM and do not respond to biomedicine such as children's diseases, epilepsy, and psychiatric conditions (Dr, R/N and Social worker).

Collaboration would encourage sharing of knowledge and skills about conditions and treatment that each professional has used in the treatment of diseases. This will benefit patients in a long term(R/N, Dr, Pharmacist and Radiographer).

Through collaboration common facilities that could be used by both IADS and biomedical doctors would be identified(R/N).

They should work in separate consulting (R/N).

Indigenous African doctors should collaborate with western trained doctors who themselves believe in indigenous African medicine and their own value system is not to be compromised as such (Dr).

Co-operation can be possible within research institute for African pharmacopoeia on traditional medicine (Dr, R/N).

IAM must be given a chance because some medicines come from herbs (Dr).

Their gift of knowledge can be used as an advantage (Radiographer)

Collaboration would help in reaching agreements where IADS would be willing to refer patients to the hospital and biomedical doctors too would also be willing to learn and understand the patients' cultural beliefs (R/N).

Collaboration would improve the referrals system between IAM and biomedicine; health workers too will be free to consult IADs during the day and not at night (R/N).

Collaboration would ensure that IADS feel accepted and not undermined (Dr, R/N).

Collaboration will ensure that indigenous African doctors are trained and empowered to provide safe and effective health care (Dr).

Participants also stated that collaboration would be beneficial to the patient because the IADS would focus more on the mental health of patients:

IADs would work on the patients' beliefs because I think that is what they do and the biomedical doctors would then look on the medical needs of patients and this would promote health (R/N).

As long as it deals with the psychology of the patients because I'm worried about the issue of overdose, IADS should rather prescribe medication that the patient might apply on the body and not to drink it (Pharmacist).

Participants indicated that already IADS were on board and this was stated as follows:

In other health set ups IADS are already incorporated and even registration of IADS is in place (R/N).

Some institutions of Higher Learning also employ IADS to work together with health professionals (H.P, R/N).

According to the National Health Plan it is in the pipeline and they are busy training IADS (Obstetrician).

Participants stated that the collaboration would ensure that a data bank was established and this was expressed as follows:

Traditional healers should provide a pharmacological/ herbal data bank on the medicines they use so that clinical trials can be conducted and studied (Dr).

Participants also mentioned that IADS should be controlled and this was stated as follows:

Collaboration should happen provided there is an established controlling body of the IADS where their actions are monitored and they can be held accountable for their actions (Dr).

Some participants were against the collaboration of IADS and biomedical doctors in the provision of health care. They stated that biomedical doctors were scientific and knowledgeable while IADS on the other hand, were illiterate and also lacked knowledge of hygiene and the prevention of infection. Participants also stated that both IAM and biomedicine use different approaches in the treatment of diseases. The interaction of drugs and the time each practitioner spent for training were also stated as reasons against the collaboration and these were expressed as follows:

Biomedical doctors are knowledgeable, their medication have labels, dose and frequency. While IADS are illiterate, their medicines are not labelled and they overdose patients(R/N).

Western trained health professionals maintain hygienic principles and they use sterile procedures to control infection while, IADS spread infection because they use one razor for all patients to make an incision for the application of medicine(R/N).

IADS misdiagnose patients for example they say a patient has "sejeso" (food poisoning) when in fact the patient is suffering from TB (R/N).

Biomedicine is based on scientific principles while IAM is based on culture(R/N).

The interaction of IAM and biomedicine has toxic effects for the patients (RN, Dentist)

They have no dosages and I have seen patients dying because of complications from overdose of medication (Pharmacist).

IADS contradict each other on many issues and they will delay progress (Dentist).

It will be difficult to work together because of the different viewpoints and that biomedicine is scientific and evidence-based and IAM is not (R/N).

The years that health professionals spent at universities were used as reasons against the collaboration of IAM and biomedicine and this was expressed as follows:

I have spent 7 years training to be a doctor and IADS just spend about three months training. They are not hygienic; they do not know personal hygiene (Obstetrician).

Participants also indicated that collaboration would lead to confusion in the delivery of health and this was expressed as follows:

They will bring confusion to both patients and health professionals (R/N)

Category E: The view point of professional bodies towards the collaboration of IAM and biomedicine in the provision of health.

Participants had mixed reactions when asked about the views of their professional bodies towards the collaboration of IAM and biomedicine in the provision of health.

Some participants indicated that their professional bodies were in favour of the collaboration between IAM and biomedicine in the provision of health and this was expressed as follows:

My professional body thinks the collaboration of IAM with biomedicine will be beneficial to the public (Obstetrician, R/N).

My professional body supports the collaboration because both type of medicine are concerned with the patient as long as the patient is safe (R/N).

The South African Health Professionals Council acknowledges IAM but it is not yet taught at medical schools (Dr).

The South African Health Professionals Council is considering such a move because they are persuaded by the government (Dr).

The South African Health Professionals Council encourage collaboration at ward level (Paediatrician).

Other participants also indicated that their professional bodies send mixed messages about the collaboration of IAM and biomedicine in the provision of health. These sentiments were expressed as follows:

It sends confusing information about IAM and it is difficult to get their view (R/N, Pharmacist).

There is no collective agreement as yet (Pharmacist).

Some participants indicated that they did not know the view point of their professional bodies regarding the collaboration of IAM and biomedicine in the provision of health care.

I do not know much about their view but I know that the National Health Ministry supports collaboration (Clinical Psychologist).

I have no idea (Dr, pharmacist, R/N).

Participants also expressed that their professional bodies did not accept the collaboration of IAM and biomedicine in the provision of health care.

The South African Nursing Council permits only those registered with it and IADS are not registered(R/N).

My professional body is against it (obstetrician).

Category F: The successes and challenges that may arise in the collaboration of IAM and biomedicine in the provision of health.

Participants stated clearly that the collaboration of IAM and biomedicine in the provision of health would have many advantages that would benefit patients. These benefits ranged from promotion of research, establishing a data bank on herbal medicine, opening channels of communication between IADS and biomedical doctors, promotion of health, embracing culture, fostering team work, overcoming the complications of IAM to the improvement of the referral system, finding a cure to HIV and AIDS, reduction of stigma attached to IAM and the reduction of mortality rate. These sentiments were expressed as follows:

It will improve access and the provision of health because there are diseases that respond to IAM and do not respond to biomedicines and also diseases that respond to biomedicine and do not respond to IAM (Dr, R/N).

Patients will get the best from both worlds-acknowledging their traditional culture at the same time benefiting from good modern medicine (Dr).

I still believe that if they collaborate they can find a cure to HIV and AIDS (R/N).

Promotion of health will be enhanced because clients' preferences will be taken into consideration. Patients will also be treated holistically(R/N).

Psychotherapy will be enhanced(R/N).

People will have a better understanding of both IAM and biomedicine and they will see each other as equals and they will respect each other (Clinical psychologist).

Collaboration will ensure that the cultivated medicinal plants are conserve to ensure their sustainable use (Dr).

Different ideas coming together will reduce the mortality rate caused by IAM (Dentist).

It will encourage team approach to patient care. The actions of IADS will be valued and this will boost their moral and status. They may divulge their secrets of causing illness(R/N).

The stigma that is attached to IAM will be reduced (Dr).

Where biomedicine has failed then IAM can be used and the referral system will improve (Radiographer, Obstetrician, R/N).

Open referrals will make it possible to embrace culture(R/N).

Most of the complications of IAM will be reduced because patients will no longer visit IADS only (R/N).

If both agree on the management, it will decrease side effects of drugs be it modern medicine or “umuthi” (Dr).

Patients’ sick leave certificates will be approved when they have consulted IADS (R/N).

Patients will be able to talk freely and openly about the type of medicines that helped and also about the type of medicine that endangered their lives from IADS because they will know that it is legal (R/N).

Open communication will lead to the development of a trusting relationship (Dr, R/N).

Africans listen and trust IADS. If they are referred by IADS to the clinic they will definitely come to the clinic (R/N).

Misuse of herbal medication must be avoided as much as possible because of the high mortality rate that is caused by the ingestion of herbal medicines or the misuse thereof (Dr).

Participants also indicated clearly the challenges that may arise from the collaboration of IAM and biomedicine in the provision of health. These included issues of property rights, the different approaches that are use by IAM and biomedicine, refusal of ancestors, lack of respect of the IADS, power struggle, resistance to change, confusion of both health providers, illiteracy level of most IADS and patients from people claiming to be IADS when in fact they are not. These were expressed as follows:

Biomedical doctors are greedy and may steal the knowledge from the IADS concerning the treatment of certain diseases and this may prevent IADS from collaborating with the biomedical doctors in the provision of health (R/N).

Their ancestors may not allow them to collaborate with biomedical doctors and may punish them by repossessing their spiritual healing powers (R/N).

The spiritual aspect of IAM and its implications to patient management is likely to make the collaboration very difficult (Paediatrician).

It will be very difficult to reach an agreement because of the different points of view. Biomedical doctors are educated scientifically on how to make a diagnosis and how to treat patients while, IADS are informed by their ancestors on how to make a diagnosis and treatment (R/N).

Some IADS do not want to share their knowledge (secrets) on IAM because they think that they will lose patients (Dr, R/N).

Traditional healers are usually not open to innovation and progressive modifications of their methods and principles related to the management of patients (Social worker).

Traditional healers lack clinical discipline in medical administration (Dr).

There will be a power struggle between the traditional healer and the western trained doctors (Dr, R/N).

Indigenous African doctors have an inferiority complex (Dr).

Biomedical doctors may want to control IADS because they have more information(R/N).

There will be resistance from both indigenous African and biomedical doctors leading to a poor referral system (R/N).

Biomedical doctors may not want to work with the IADS because most of the IADs are illiterate (R/N).

There will be chance takers who claim to be IADS when they have not been trained (Pharmacist, R/N).

There will be misunderstanding and mistrust and IADS will feel undermined (Dr. Pharmacist, R/N).

The ego of biomedical doctors will be challenged(R/N).

All spiritual beliefs will want to be included and that will cause confusion for both patients and health professionals (Dentist).

The IADS may want the same salary that biomedical doctors receive(R/N).

IADS will not be able to prescribe any medication unless instructed by ancestors(R/N).

The simultaneous use of both types of medicine will lead to drug interaction which may have serious complications such as liver and kidney damage. Patients who are on antiretroviral therapy (ART) may also become resistant to treatment (R/N).

The IADS will not understand the scientific principles that are used in hospitals particularly when patients are in theatre. IADS may want to perform rituals in the theatre rooms and will not be able to maintain sterility (R/N).

There is misdiagnosis of patients in IAM and these delays patients to consult biomedical doctors. One patient suffered from severe depression because an IAD had told him that he was HIV positive and yet he was negative (Dr).

Currently there is no open communication between IADS and biomedical doctors because of racial discrimination. Communication is being hampered by racial undertones and each discussion is viewed on racial basis. Yet medicine is about people regardless of race or colour (white Dr).

Many IADS are illiterate and will take a long time to understand how biomedicine works (R/N).

CHAPTER 6

MAIN FINDINGS, CONCLUSION AND RECOMMENDATIONS

This chapter discusses the extent to which the aim and objectives of the study have been achieved and the limitation of the study. Recommendations and conclusions were drawn based on the in-depth interviews with IADs from the Ga-Dikgale and Ga-Nchabeleng villages in the Capricorn and Sekhukhune Districts, health professionals (HP) employed at clinics/hospitals within the Capricorn and Sekhukhune Districts. Conclusions were also drawn from the focus group discussions with patients consulting health professionals that were employed at Western European oriented clinics/hospitals. In concluding the chapter, the researcher has made recommendations that policy makers will hopefully take into consideration as the momentum for the legalization of IAM is carried forward in South Africa. To place the discussion in perspective, the chapter first briefly restates the research problem addressed and the manner in which it was investigated.

OVERVIEW OF THE RESEARCH PROBLEM AND RESEARCH PROCESS

This section provides a brief summary of the problem and question investigated, the aim and the objectives and the methodology that was used in the study.

PROBLEM AND QUESTION INVESTIGATED

The delivery of health care in South Africa faces many challenges and these include access to health care services that is determined by the individual's ability to pay, inadequate facilities particularly in public hospitals and shortage of skilled health professionals particularly in the rural areas. These challenges have made it imperative for the government to consider collaboration of the indigenous African and European Western doctors in the provision of health care.

During colonization and apartheid European culture dominated African people to the extent that they became marginalized and disempowered. Their indigenous healing practices were also marginalized and any practice of IAM was seen as barbaric, unscientific and tantamount to encouraging ignorance, error and deception. Those who practiced it were all called witchdoctors. Many laws that made the practice of IAM illegal were enacted and these laws disrupted the natural development of the indigenous African healing practices. These laws included the Witchcraft and Suppression Act No.3 of 1957 as amended by the Witchcraft Suppression Amendment Act No.50 of 1970, the Homeopaths, Naturopaths, Osteopaths and Herbalist Act of 1974 and the Medical, Dental and Supplementary Act of 19974.

WHO (1978), Gumede (1990) and Wreford (2005) assert that 80% Of the African people consult IADs before consulting biomedical doctors. This study also confirms these findings that in South Africa, African people consult IADs before consulting biomedical doctors because biomedicine does not provide adequate solutions to certain local therapeutic problems.

WHO (1978) also indicates that throughout Africa, Asia and Latin America populations continue to use IAM to meet their primary health care needs and IAM is part of the African belief system and forms an integral part of everyday life and well-being.

South Africa continues to have a pluralistic health care system in which both IAM and biomedicine operate side by side with the latter being officially recognized while, IAM remains marginalized. The study found that IAM forms an integral part of the African heritage that is passed by the ancestors from one generation to the other through spirituality. The treatment of the sick therefore, involves an intricate relationship between the living and the dead. Treatment without the involvement of ancestors is inconceivable and impossible.

After the democratic elections of 1994 and the vision of the African renaissance that promotes cultural identity, the South African government acknowledged the importance of IAM in the provision of health care and the popularity of IAM became intensified. The introduction of PHC meant that health services could be extended to the rural communities where the majority of the South African live. PHC is also suitable for the provision of IAM because it provides a service that is culturally acceptable, decentralized to the local population, accessible, affordable and effective in dealing with health problems within the community. It also ensures that communities are empowered to take more responsibility for their own health. The WHO Alma Ata Declaration (1978) recognizes the contribution that IAM makes in the provision of health. IADS can therefore, play an important role in this

regard because they are more attuned to prevention, protection and fortification.

In 1970 WHO formally recognized the importance of the collaboration between IAM and western European medicine in the provision of health. Richter (2003) states that IADS are keen to collaborate with biomedicine, but there is no enthusiasm from biomedical doctors. This research study found that health professionals were keen to collaborate with the IADS because they identified the successes that the collaboration of IAM and biomedicine could bring in the provision of health. They also identified challenges that could hamper the collaboration of IAM and biomedicine.

This study also found that health professionals did not refer patients to the IADS. They cited various reasons that prohibited them from referring patients to the IADS namely, that their education and training did not prepare them to refer patients to the IADS, their professional bodies did not support such referrals, lack of protocols in clinics/hospitals that allowed them to refer to the IADS, the unscientific nature of IAM, the toxicity of IAM and that some patients consult the IADS before consulting the clinic/hospital. Very few health professionals referred patients to the IADS and they did so based on their personal experiences. Indigenous African doctors also indicated that they referred patients to the clinics but Western European oriented health professionals did not refer patients to the IADS. They further indicated that they were only called to the clinics/hospitals when they have to attend workshops. Hence Wreford (2005) is of the opinion that IADS are the only ones that have to learn from and adapt their practice to the principles of biomedicine.

These issues led to the following research question: Can South Africa develop a collaborative health care delivery system that includes both indigenous African and Western European oriented doctors on equal basis?

RESTATEMENT OF THE AIM AND OBJECTIVES OF THE STUDY

The aim of the study was to advocate for a collaborated health care delivery system with indigenous African doctors that is administered and controlled by the government. To achieve this aim the following objectives were set:

- To demonstrate how apartheid disrupted the natural development of indigenous African healing practices.
- To remove misconceptions in the use of indigenous African medicine in the treatment of diseases.
- To demonstrate the need to protect both indigenous African and western European medicine.
- To demonstrate that African patients use both indigenous African and western European doctors for various aspects of their treatment in their health care choices
- To demonstrate that patients expect the government to provide an effective health delivery system.

RESTATEMENT OF THE HYPOTHESIS

The following hypothesis was tested:

The collaboration of indigenous African and western European medicine can contribute to the prevention, treatment of diseases and improve the health status of communities in South Africa.

RESTATEMENT OF THE RESEARCH QUESTIONS

The question explored in this dissertation is: How can South Africa develop a collaborative health delivery system using both indigenous African and Western European oriented doctors that is effective and open to everyone on an equal basis?

The following are the principal research questions:

- How did apartheid disrupt the natural development of indigenous African healing practices?
- How can indigenous African medicine contribute to the prevention and treatment of disease and the care of patients in a collaborated health care delivery system?
- Why should the South African Government administer and control a collaborated health delivery system, ensuring equal treatment for all?
- How do patients presently use both indigenous African and biomedical doctors in their health care choices?

- Do patients expect the government to provide an effective health care delivery system for them?
- Do patients want a government-administered and controlled collaborated health care delivery system?

RESTATEMENT OF THE THEORETICAL FRAMEWORK

The theoretical framework of this study was based on the Afro-centric worldview in which events and ideas are perceived from an African perspective with the African people as the main players rather than victims. In the African worldview an individual is seen as an interrelated self with body, mind and the environment. African people view themselves as integrated with the universe which is larger than them and yet centred on them. Good health does not only mean a healthy body, but it also means the harmonious relation with the environment with the self at the centre of events.

In the African worldview there is no difference between life and death. Death is viewed as a rite of passage from the world of the living to the world of the ancestors; there is also no separation between the world of the living and the spirit world because life is one. The ancestors are central in the African worldview making the living and the dead to be interdependent. By virtue of being spiritual in nature ancestors are seen as closer to God. They guide, guard and communicate with their descendants in dreams. Contact, communion and fellowship between the living and the dead are established and maintained by pouring libation, making sacrifices, appropriating and fulfilling requests that the ancestors make to their descendants.

The Afro-centric approach was used because at the centre of this study were the African people, their history, belief system, attitudes, perceptions, experiences, health, disease pattern and healing practices. The aim of Afro-centricity is to bring back to the African people their victory, consciousness and their liberation. Hence, this approach was employed to instil a sense of freedom and empowerment to the IADS as they provide health care to the majority of the African people.

RESTATEMENT OF THE METHODOLOGY EMPLOYED IN THE STUDY

RESEARCH DESIGN AND METHODS OF DATA COLLECTION

The purpose of this chapter is to describe the research design and the methods of data collections that were used.

Qualitative research design

This study used the Afro-centric method which is the qualitative research design. The Afro-centric method is derived from the Afro-centric paradigm in which the African people are the subjects rather than the objects of the study. Mkabela (2005) observes that the Afro-centric paradigm deals with the African identity from the perspective of the African people as centred, located, oriented and grounded. de Vos et al (2007) citing Babbie (2001:42) state that a paradigm is the fundamental frame of reference that researchers use to organize their observations and reasoning.

The qualitative descriptive research design that is contextual in nature was deemed appropriate because of its emphasis on the natural setting. It enabled the researcher to immerse herself in the cultural setting and social dimension of participants so as to describe events as accurate as possible. The researcher immersed herself in the natural setting of IADS, patients and health professionals so as to explore and describe their beliefs, attitudes, perceptions and experiences about the collaboration of indigenous African and western European medicine in the provision of health services. A thick and detailed description of lived experiences was provided with selected quotes, anecdotes and comments from participants. This was done to capture the sense of actions as they occurred. Babbie and Mouton (2001:272) describe the contextual research method as understanding the events within the concrete, natural context in which they occur. They further state that the inductive research method begins with the emersion in the natural setting describing events as accurately as they occurred.

Population and sampling method

Population

The study used three different populations namely:

- Indigenous African doctors from Ga-Dikgale and Ga-Nchabeleng villages.
- Western European oriented health professionals providing health services to patients at clinics/hospitals within the Capricorn and Sekhukhune Districts.

- Patients with readily available health choices from Ga-Dikgale and Ga-Nchabeleng villages.

Sampling

A non-probability convenient and purposive sampling was used to obtain sample sizes. Denzil and Lincoln in de Vos et al (2007) observe that in purposive sampling the researcher looks for individuals, groups and settings where the specific processes being studied are most likely to occur. Sells (1997) says that purposive sampling is a type of non-probability sampling in which data are collected from a group of participants chosen for specific key characteristics. The sample size for the study was as follows:

- Fifteen (15) IADs were drawn, seven (7) of whom were drawn from the Ga-Dikgale village that is situated within the Capricorn District and the remaining 8 were drawn from the Ga-Nchabeleng village that is situated within the Sekhukhune District.
- Fifty (50) western European oriented health professionals were drawn, 25 of whom were drawn from clinics/hospitals within the Capricorn Districts and the remaining 25 were drawn within the Sekhukhune Districts.
- Eighty four (84) patients were drawn, 33 of whom were drawn from the Ga-Dikgale clinic and the remaining 51 patients were drawn from the Ga-Nchabeleng health centre.

- Sampling was continued until theoretical saturation was reached.

Inclusion criteria

The inclusion criteria in this study were as follows:

- All indigenous African doctors who practice indigenous African medicine using herbs, roots fats and oils in the treatment of illnesses at the Ga-Dikgale and Ga-Nchabeleng villages.
- All western European oriented health professionals with experience of at least five years and above and providing health services to patients within the Capricorn and Sekhukhune Districts.
- All patients utilizing the community clinics at the Ga- Dikgale and Ga-Nchabeleng villages in the Limpopo Province in the Republic of South Africa.

Both districts (Capricorn and Sekhukhune) were chosen because they are rural with a substantial number of indigenous African doctors with different cultural practices to compare similarities and differences. The common language spoken in both villages is Sepedi with the Ga-Dikgale village situated in the Capricorn District and the Ga-Nchabeleng village situated at the Sekhukhune District. Both districts have clinics and are in the Limpopo Province that is mostly rural in the Republic of South Africa.

Data collection

Community entry

Community entry involved obtaining approval from the University of Limpopo Ethics Committee and the Provincial Department of Health and Social Welfare Research Committee, Limpopo Province. Permission was also obtained from health facility managers and the local chiefs of Ga-Dikgale and Ga-Nchabeleng communities.

Once approval was obtained from all relevant authorities, the purpose and the benefits of the study were explained to the charge nurses of the Ga-Dikgale and Ga-Nchabeleng clinics. Permission was also obtained from health professionals rendering health services to patients within the Capricorn and Sekhukhune Districts of the Limpopo Province.

Ongoing rapport with participants was maintained so as to gain their trust.

Methods in data collection

The researcher began by collecting the biographical data of all participants before collecting the narrative information. Different methods of data collection were used to compliment each other thus, maximizing the quality of data and reducing the chance of bias (Hardon, Boonmongkon, Streefland, Tan, Hongvivatana, van der Geest, Van Staa and Varkevisser 1994). These included in-depth interviews, focus group discussions, participants' observation, field notes and tape recording.

Semi-structured in-depth interviews

Semi-structured in- depth schedules with indigenous African doctors from the Ga-Dikgale and Ga-Nchabeleng villages were conducted with the aim of determining the beliefs, attitudes, perceptions and experiences regarding the collaboration of IAM and western European medicine in the provision of health in the Limpopo province.

At the Ga-Dikgale village the interviews were conducted at the clinic in a private room and at the Ga-Nchabeleng village the interviews were conducted at the health centre in a private room. Each interview lasted for forty five minutes to an hour.

Semi- structured in-depth –interviews with health professionals were also conducted at their respective work places in clinics and hospitals within the Capricorn and Sekhukhune Districts in the Limpopo Province.

The semi-structured in-depth interviews with the indigenous African doctors and health professionals enabled the researcher to determine the participants' beliefs, attitudes, perception and experiences regarding the collaboration of indigenous African medicine and the Western European medicine in the provision of health in the Limpopo Province. Each interview lasted for forty five minutes to an hour.

During the in-depth interviews open-ended questions that enabled participants to speak openly and freely were used (refer annexure A). These interviews were also flexible and interactive. Babbie and Mouton (2001)

state that qualitative research interviews should be characterized by being “flexible, interactive and continuous rather than prepared in advance and locked in stones”. De Vos et al (2007) also define semi -structured interviews as those organized around areas of interest, while allowing flexibility in scope and depth.

Focus groups

Focus group discussions were also conducted with patients seeking medical/nursing intervention at the Ga- Dikgale and Ga-Nchabeleng clinics.

Data was collected over a period of three days as follows:

First session

The researcher used the first session to make appointments with nurse managers in charge, health professionals and the patient participants at the respective clinics (Ga-Dikgale and Ga-Nchabeleng clinics). The researcher also established rapport and explained the purpose of the study to all participants.

Second session

A total of ten (10) focus group discussions (4 at Ga-Dikgale and 6 at Ga-Nchabeleng) of 7-10 patient participants from each community clinics were conducted. Thirty three (33) participants from the Ga-Dikgale clinic and

fifty one (51) from the Ga-Nchabeleng clinic participated in the focus group discussion.

These focus group discussions enabled participants to discuss and share information about their beliefs, attitudes, knowledge and experiences regarding the collaboration of IAM and western European medicine in the provision of health in the Limpopo Province.

Each focus group discussion lasted for about 45minutes to an hour and the researcher used these focus groups to enable participants to create meaning among themselves rather than individually (Babbie and Mouton 1998).

A tape recorder was used to capture the discussions and field notes were also taken.

Third session

The third session was conducted for verification of data obtained and also to express a word of appreciation to the participants for their contribution towards the attainment of the objectives of the study (de Vos et al 1998).

Probing

Throughout the interviews, probing was used to gain deeper understanding of critical issues and this involved tracking clarification and reflective summary (de Vos et al 1998). The researcher repeated what was written in the field notes to the participants to make sure that she understood the ideas and opinions of the participants correctly. Babbie and Mouton (2001)

observe that probes are one useful way to get answers in more depth without biasing the answers.

Fields notes

Throughout the interviews field notes of events that occurred were taken. These were recorded in a small note book and they included empirical observation and their interpretations, interactions observed, conversations heard and impressions of field setting and its actors. These field notes were also used to validate the taped comments. Babbie and Mouton (2001) insist that the researcher must take full and accurate notes of the preceding during the interview.

Tape recording interviews

A tape recorder was also used during the interviews. Permission to use the audiotape recorder and note-taking during interviews was obtained from participants.

The findings from the above mentioned methods were used in an attempt to answer the research question set out in chapter 1.

DATA PRESENTATION

The biographical data was analyzed using frequency distribution. The descriptive method of data presentation was also used. The focus of the

biographical data was on the description of the age, educational level, religion and experience.

The narrative data obtained from the participants was analysed using open coding according to Tech's approach as outlined in De Vos (1998). The analysis was done as follows:

- The transcripts and notes from the in-depth interviews with the IADs and the focus group discussions were translated from Sepedi to English.
- Data from the health professionals was obtained in English.
- All transcripts were read carefully in order to get a sense of the whole, internalized and then transcribed verbatim.
- The researcher also listened to the tapes and wrote down all ideas and thoughts as they came to mind.
- The information was then synthesized and analyzed by clustering together similar topics, form topics in columns as major topics, unique topics and leftovers.
- Descriptive words to identify themes, major and sub-categories were used.

- Relationships among the major and sub-categories were reflected as themes.
- Data presentation continued until the saturation of themes, categories, sub-categories and was reached.

ETHICAL CONSIDERATIONS

The quality of the research

The study was conducted for academic purposes and the researcher demonstrated accountability and the ability of executing the research process by adhering to the highest possible standards of research planning, implementation, evaluation and reporting of research. The quality of the research was ensured by writing a research proposal and obtaining ethical clearance to conduct the study from the Research Ethics Committee of the University of Limpopo. Permission was also obtained from the Limpopo Department of Health and Social Welfare because the participants were indigenous African doctors, patients utilizing community clinics (Ga-Dikgale and Ga-Nchabeleng) and health professionals providing health services within the Capricorn and Sekhukhune Districts in the Limpopo Province.

Informed consent

Informed consent was obtained from all participants by explaining to them the purpose of the study. They were also informed that participation to the

study was voluntary and that participants who wanted to withdraw during the course of the study would not be victimized whatsoever.

Permission to use a tape recorder and field notes was also requested and obtained from the participants by explaining the purpose and the importance of a tape recorder and field notes.

Confidentiality and anonymity

Participants were assured that their names would not be used in the study. The participants' identity, privacy and dignity were protected by ensuring that no connection between the participants and the data could be made.

FINDINGS

This section summarizes the findings from the in-depth interviews with IADS, health professionals (HP) and FGD with patients consulting HP at the Ga-Dikgale clinic and the Ga-Nchabeleng health centre within the Capricorn and Sekhukhune Districts. It also provides literature to validate the findings of the study

One theme emerged from the study: *Indigenous African Medicine*

Belief System

All participants stated clearly that indigenous African healing practices were part of the African heritage and that they originate from ancestors who

pass it from one generation to the next through spirituality. They also indicated that the indigenous African healing practices were a gift from the ancestors that could not be refused. Generally, ancestors reveal themselves in dreams though sometimes they reveal themselves through illnesses. Participants also mentioned that they talk to their ancestors daily. Through the medium of dreams, ancestors guide and direct the trainees where to collect the main divination bones (*ditaola*), teach the trainees how to use the divination bones to make a diagnosis, where to get the different medicinal herbs and also direct them how to mix these herbs in the treatment of various diseases. Through dreams ancestors were also able to show trainees their mentors. To the IADS these dreams are real and are followed to ensure the healing of patients. Mbiti (1992) confirms the findings of this study when he says that in the African culture death does not change the communion between the living and the dead. What they were in the world hitherto they continue to be in the world hereafter.

Only one male participant from the Ga-Dikgale village indicated that he stayed for five (5) years under water receiving training from his ancestors who were living with a big snake. Gumede (1977) confirms these findings when he states that ancestors manifest themselves in snakes. Bürhmann (1984) also says that ancestors are conceptualized as psychologically complex and can manifest as animals in the thinking of people and in dreams.

Mbiti (1992), Ngubane (1977) and Gumede (1990) also confirm these findings when they state that dreams have been accepted as common channels of communication between the living and the dead. Bürhmann

(1984:49) summarizes it as follows “the active involvement with dreams is one of the most striking aspects of the healing methods of the *amgqira*. It runs like a silver thread through everything they do during treatment and training –the ancestors guide them in their procedures”.

Authors such as Mbiti (1992) and Gumede (1990) further confirm these findings when they state that it is impossible to examine indigenous African medicine without first examining African religion which gets in touch with the spirit world, particularly the spirits of the ancestors. Mbiti (1992) further says that religion is part of the African heritage which cannot be understood without its religious parts. Ngubane (1977:102) also confirms the findings of this study when she says “a person does not choose to become a diviner (isangoma), but it is said to be chosen by her ancestors, who bestow upon her clairvoyant power”.

This research study also revealed an unshakeable belief in the existence of ancestors who are believed to bestow healing powers to the IADs. Participants indicated clearly that the African healing practices are part of the African heritage that ancestors pass from one generation to the next. The participants also viewed the indigenous African healing practices as a calling that cannot be ignored and if ignored the individual will get ill or may sometimes die. Ancestors were also seen as protectors of their living descendants and having power to control the lives of their descendants.

Authors such as Mbiti (1992), Ngubane (1977), Gumede (1990), Bürhmann (1984) and Wreford (2005) support these findings on the African belief in the existence of ancestors. Mbiti (1992) further states that beliefs are an

important part of any religion because they indicate how people think about the universe, their attitudes towards life itself. Ngubane (1977) further says that there are differences in culture and language between different societies, but there are no differences between the different indigenous cultures regarding the African worldview. Bürhmann (1984) says the closeness of the ancestors is unquestionable and that to the African people life without the ancestors is unthinkable. The closeness of the ancestors indicates good life and hence the respect that they are given is an acknowledgement of their wisdom.

Rankoana (2000:25) also found that there was a distinct interrelationship between African religion, magical practices and indigenous African healing practices at the Ga-Dikgale village. She states that the religion of the people at the Ga-Dikgale village was based on the relations with supernatural being that manifests itself in the veneration of the ancestors. She further states that the strong belief in the ancestors (African religion) is used to find out the mystical cause of disease, prescribe the right cure and the prevention of diseases which is done through rituals to neutralize disease. The strong belief in the ancestors make the diagnosis and treatment of many diseases an essentially a religious practice. Thus, treatment of patients without the involvement of ancestors is inconceivable and impossible.

The attitude of health professional towards indigenous African medicine

The study revealed that health professionals did not incorporate the patients' belief system in their health care because they stated that the knowledge IADS have about IAM was guided by ancestral spirits and thus, not

scientific. Health professionals also stated that experience has taught them that the use of IAM leads to many fatal complications. They further indicated that there was not documented proof on the healing practices of IADS. However, there were participants in the study who explained the scientific nature of IAM in terms of its effectiveness in the treatment of diseases.

The study found that such negative attitudes from health professionals has led to many patients not informing health professionals at clinics/hospitals when they have consulted IADS, unless the nurses noticed incisions (*imigcabo*) made by the IADS. Participants further indicated that nurses scold and discourage them from using IAM. Health professionals say that IADS are dangerous; their medicine is not tested scientifically and that IADS do not have measurements for their medicines. Nurses also encourage patients to use one health system at a time so that they (patients) are able to know which treatment has been helpful.

The influence of apartheid on the development of indigenous African medicine

Participants from the Ga- Dikgale and Ga- Nchabeleng villages indicated that the apartheid government was oppressive because they were beaten, threatened with being shot at for wearing amulets made of animal skin. Participants also stated that there were laws that prohibited the practice of indigenous African medicine. There were also rangers who patrolled the fields and spies in the African community that spied on IADS and those without certificate would be arrested. Participants also stated that some

white people would consult IADS secretly and if found, the concerned IAD would be arrested because it was a crime to treat a white person. They also stated that apartheid had negative impact in the development of indigenous African healing practices because it led to the indigenous healing practices becoming secretive and an underground activity. The participants also stated that the apartheid government was very myopic in that it did not realize that both forms of health care were complimentary to each other.

Health system relied on for the treatment of diseases

All participants indicated that when a family member was critically ill they first consult an IAD who uses divination bones to establish the cause of illness and also stabilizes the patient before he/she is taken to the clinic/hospital for further treatment. They also stated that they only visit the clinic if the illness was not caused by the ancestors or if the patient did not respond to IAM. Participants further indicated that there are well known diseases that responded to IAM and did not respond to biomedicine and those that did not respond to western European medicine and those that respond to western European medicine and did not respond to IAM. Participants from the Ga-Nchabeleng health centre indicated that they consult the clinic first because it has X-rays machines, intravenous infusion and blood transfusion which IADS do not have in their treatment. They also stated that they consult the clinic first because IADS are unable to diagnose and treat Diabetes mellitus instead, they misdiagnose it as epilepsy. They also indicated that there are diseases such as epilepsy and diseases caused by witchcraft which respond to IAM as long as the patient has not been given an injection at the clinic/hospital because an injection makes the patient to

get worse. They also stated that for big illnesses, they consult the IAD first and for minor illnesses they consult the clinic because clinics treat symptoms and not the cause of the illness.

Participants from the Ga-Dikgale village also stated that they consult the clinic first and then consult the IAD only if biomedicine is not effective. They also indicated that treatment at the clinic was free and that they are attended to much quicker than IADS. They also indicated that IADS have become very expensive because they want a separate fee for diagnosis and treatment. Participants also indicated that IADS have become deceitful, do not react to emergencies and they do not administer intravenous infusion or blood transfusion. They also indicated that the youth is not interested in using the services of IADS.

Participants also stated that the clinic was very helpful with difficult labour and delivery and diseases of the skeletal system such as fractures. They further mentioned that when the traditional birth attendant was an elderly person both mother and her unborn baby would die due to difficult labour and delivery. The community would just say that “*motho o jelwe ke ntlo*” (*the house has eaten a person*).

Mabunda (1999) also found divergent views regarding the choice of health care system used for the treatment of diseases. He states that these divergent responses suggest that there are fundamental differences between IAM and western European medicine and each health care system has both advantages and disadvantages.

Ngubane (1977) also confirms these findings and states that there are African diseases which western European doctors did not understand and were unable to treat. She further confirms that blood cupping (*go lomega—Sepedi, ukulumeka-IsiZulu*) is done to relieve a severe case of a headache. Ngubane (1977) and Gumede (1999) also state that IADS are able to treat mental illnesses because they are well attuned to the psychological state of the patient and they are part of the society in which the patient stays. Ngubane (1977) further states that *ufufunyane* is spirit possession and is a worst form of mental illness in which the person behaves as if mentally deranged. The IAD does not superimpose a new frame of reference; instead he/she knows the people, their culture religion, fears and joys. Mabunda (1999) also found that 76 % of students at the then University of the North believed that western European medicine could not treat diseases associated with supernatural causes.

Wreford (2005) also confirms these findings and states 80% of African people consult IADS before consulting biomedical doctors. She further states that African people continue to utilize IAM because biomedicine does not provide explanation to the cause of illness, “the why me” which is important in the African understanding of health and healing.

Rankoana (20002) also found that in the Ga-Dikgale community there are diseases that are treated by IADS. She also states that the unquestionable belief in the ever present and the role of the ancestors act as a powerful therapeutic agent. The findings of this study confirms Rankoana’s findings that western European medicine is used to treat symptoms while IAM is used to treat the root cause of physical and/or mental illnesses. Rankoana

(2002) further states that education, western medicine and Christianity have not succeeded in replacing traditional psycho-therapy

The findings of this study indicate that participants use both systems of health care interchangeably depending on the seriousness of the illness, the knowledge and experiences of people that the illness can be effectively treated using IAM or biomedicine. Ngubane (1977) states that there is no definite pattern that is followed among the isiZulu speaking people because it depends on the seriousness of the disease, the availability of particular health agencies, financial position and the person who makes the decision where that patient should be taken for treatment.

Referral system

The study also revealed that health professionals did not refer patients to the IADS because many patients consult the IADS first before consulting health professionals at clinics/hospitals. However, some health professionals indicated that they have referred patients to the IADS because experience has taught them that there are diseases that the IADS can treat. Indigenous African doctors also indicated their dissatisfaction that health professionals did not refer patients to them (IADS) even though they refer patients to the clinic/hospital. They also indicated they were only required to attend workshops at clinics/hospitals.

Health system used for prevention of diseases

There were varied responses regarding the system used for the prevention of illnesses. Some participants stated that they use both systems of health care in the prevention of illnesses. They stated that they use western European medicine for the immunization of babies against diseases such as measles and smallpox.

All participants in the study indicated clearly that in the African culture there are no preventative measures against natural illnesses, but there are preventative measures used against witchcraft/sorcery from entering a homestead and causing illness among members of a family. These preventative measures are carried out by IADS and include among others, the fortification of the homestead by means of special fortification pegs that have been doctored with special indigenous medicinal fats and sprinkling of indigenous medicinal herbs around the courtyard (*go thea motse-Sepedi*). Family members are also strengthened and fortified against diseases caused by witchcraft by steam inhalation in which indigenous herbs have been added, making an incision on the joints and applying medicinal powder directly on the incision. Joints are considered to be weak points in the body and hence these incisions are made on the joints. There are also indigenous medicinal preparations that are applied on the eyelids and the wearing of armulets that are made from sacrificial animal skin to enhance dignity.

Some of these preventative measures are done against diseases that occur when the victim has stepped over magical charms that are placed on the path where the victim will pass and thereby contracting the disease. These are

known as (*di gatišwa-SePedi, umeqo-IsiZulu*). Preventative measures are also done against diseases associated with pollution to protect vulnerable groups such as newborn babies, a woman who has had a miscarriage, a woman who has recently delivered a baby and a woman whose husband has recently died.

Ngubane (1977:131) confirms these findings and states that certain life experiences make people to be in a state of pollution. She further defines pollution as a “mystical concept that cannot be demonstrated according to the law of cause and effect. The correction of the condition involves mystical means expressed in symbolic medicines”. Diseases that are caused by pollution are also referred to as a state of darkness or lack of balance.

Ngubane (1977) further states that there is a dimension of morality in the causation of diseases that are associated with social situations. Sorcerers make the environment polluted and dangerous by placing noxious substances on a particular pathway to harm a specific passer-by. To survive these environmental dangers it is essential that prophylactic measures are done frequently to strengthen and maintain resistance. She further states that the measures taken to thwart the sorcerer’s behaviour make the dangerous substance “to bounce off and become ineffective” (Ngubane1977:131). She further asserts that each individual has a responsibility towards himself/herself and his/her dependants to establish and maintain a proper balance with his/her environment by taking necessary precautions so as to counterbalance sorcery and also environmental dangers. She further states that morality also refers to the maintenance of good relationships with the ancestors so that they are able to maintain their protection. If no relationship

is maintained by pouring of libation, the ancestors would withdraw their protection. Illnesses arising from lack of balance related to a morality principle manifest themselves either by misfortunes with no somatic symptoms or by misfortunes with somatic symptoms (Ngubane 1977).

Gumede (1990) also states that every home is protected against lightning and witches by means of *izikhonkwane (isiZulu)*. Both Ngubane (1977) and Gumede (1990) assert that protection, prevention and fortification play a major role in the psycho-therapy of IADs. Mabunda (1999) also found that the services of IADS that were highly sought after is that of supplying preventative magical potions and amulets to protect people and their property against witchcraft. He also found that respondents were in favour of IADs because there are certain services which are only performed by IADs and these include the magical protection of the homestead against witchcraft (*go thea motse*).

The use of amulets

The study found that African people use amulets (*iziphandla-isiZulu*) made from an animal skin of the sacrificial beast to the ancestors. These amulets are used as preventative measures against diseases caused by witchcraft as well as to enhance dignity and/or personality. Gumede (1999) confirms these findings and indicates that these amulets and goatskin bangles are made from sacrificial beasts and are used as lucky charms and also as reminders of the existence of the continuing living bond between ancestors and their descendants. They also indicate an assurance of victory from an illness or a misfortune.

Diseases caused by pollution

Participants in the study classified diseases caused by pollution as activities that are culturally forbidden (*diayile-Sepedi*). These include a woman who has just delivered a baby, a menstruating woman, a woman who has had an abortion. A woman whose husband has recently died is considered to be in a state of ritual defilement or in a state of ritual darkness (*sefifi-Sepedi*). There are certain behaviours/activities that she is culturally forbidden to perform. For example, she is expected to abstain from sexual intercourse for a period of a year after which an IAD must ritually cleanse and fortify her back to a state of balance with the environment. Only then can she have sexual intercourse with a man. If she breaks the taboo it is believed that her partner will get ill and eventually may die if not treated by an IAD. Participants also stated that newborn babies are also fortified and protected against environmental hazards after 6 weeks of birth by an IAD who taps lightly on the infant's joints with a special medicinal tool. This procedure is known as (*go kokotelaSepedi*).

Participants also voiced out their disapproval of the Choice on Termination of Pregnancy Act No.92 of 1996 which gives South African women the choice to terminate a pregnancy. They indicated that it gives young girls the choice to abortions without telling their parents and boyfriends. They indicated that girls who have had abortions without parental consent may not be ritually cleansed and may have sexual intercourse with their boyfriends who may eventually die from a disease known as *makgoma-Sepedi*.

Ngubane (1977) supports these findings and states that a menstruating woman, a recently widowed woman, a newly delivered mother and her baby are considered vulnerable to misfortunes and environmental diseases. The infant is considered a stranger to the environment. It is considered to have a fragile bone structure that has wide joints such as the anterior fontanelle which is considered a weak point to environmental hazards.

Ngubane (1977) asserts that a recently widowed woman is considered to be in a state of pollution (*umnyama*) which is conceptualized as a mystical force that diminishes her resistance to diseases and makes her susceptible to bad luck, misfortune, disagreeableness and repulsiveness. She is therefore, expected to avoid risky and dangerous undertakings. She is also expected to observe certain behaviours that will minimize contact with noxious substances (*imikhondo*). She further states that these taboos are psychological oriented because they prevent the onset of neurosis so that the individual's attention is directed away from the unpleasant experience to a complexity of ritual behaviours. She also asserts that both birth and death are mysteries that are associated with the other world from which people return in spirit form. She further indicates that there is an area of overlap between the two worlds which is dangerous and marginal.

Mönnig (1967) also confirms these findings and states that ritual impurity is associated with conditions of ritual heat (*go fiša*) and ritual darkness due to the death of a relative. Ritual defilement is considered a very serious condition because the affected person is considered being impure and also the people that she comes into contact. It is not regarded as a disease, but as a period of reduced resistance against diseases, misfortune and the influence

of witchcraft. Breaking a taboo is considered as a sin and sanctioned by ancestors. Rankoana (2002) on the other hand states that, ritual defilement (*makgoma*) is treated by the IADs who perform the cleansing ritual that involves the use of *molora* (the powder of the burnt root of *Euclea natalensis*).

The collaboration of indigenous African and Western European doctors in the provision of health.

All participants stated clearly that both the IADS and western European oriented doctors should play a role in the provision of health care. Advantages of the collaboration that were mentioned were that both the IADS and the western European oriented doctors have a common goal which is the health of patients. Some advantages of the collaboration that were mentioned included improving the channels of communication among all health professionals, fostering of trust and team work among health professionals and an understanding of each others' point of view and thus improving the delivery of health. They also stated that collaboration among all health providers will bring about sharing of ideas and expertise through workshops and conferences and thus benefiting patients. Good non-judgemental communication was essential in establishing rapport and fostering mutual respect.

Participants also stated that IADS have vast knowledge on IAM and the treatment of diseases such as childhood illnesses, epilepsy and psychiatric conditions. As such both health care systems are helpful because there are diseases that respond to western medicine and diseases that respond to IAM

and do not respond to western medicine. Participants also stated that the collaboration between IADS and biomedical doctors could ensure that a cure to diseases such as cancer, HIV and AIDS could be found. They also indicated that collaboration would also bring about the reduction of the mortality rate caused by the wrong use of IAM and the stigma attached to IAM.

Participants also mentioned that many African people consult IADs before consulting western European doctors. As such, IADs can play an important role in Primary Health Care (PHC) because they are well known respected members of their communities. They also indicated that collaboration between IADS and western European doctors would enhance the referral system that is presently one sided. Western European doctors may also begin to learn more about the patients' cultural beliefs so that they are able to refer patients to the IADS. This will ensure that patients get the best of both worlds namely, acknowledgments of their cultural beliefs and at the same time benefiting from modern medicine. Collaboration may also offer patients better choices of the available health services and foster mutual respect.

CHALLENGES IDENTIFIED

Challenges that were identified were as follows:

- *Intellectual property rights*

Participants expressed fear that collaboration between the indigenous African and biomedical doctors would enable biomedical doctors to usurp the knowledge that IADS have on indigenous healing practices and thereafter render them redundant and useless. Such fears may make IADS to remain secretive about their knowledge of indigenous African medicine. They may also become reluctant to work together with western European doctors within the National Health Care system. The WHO Strategy (2002) points out that the issue of intellectual property rights and patients' rights remain a challenge. Strategies must be developed that will ensure that the economic benefits are shared between the IADS and biomedical doctors.

- *Selfish ancestors*

Participants indicated that ancestors are selfish and may not allow the IADS to collaborate with western European doctors and may punish the IADS by withdrawing their healing powers and sometimes kill the IADS or members of his/her family. They also stated that IADS may be unable to treat patients unless instructed by ancestors.

Authors such as Ngubane (1977) and Bürhmann (1984) support these findings and state that ancestors are believed to be primarily concerned with

the welfare of their descendants and when misfortune occur people believe that ancestors are angry with them and have withdrawn their protection exposing family members to witches who cause misfortune and illness. Gumede (1990: 109) states that there are also specialists among the IADs and he refers to one indigenous African cardiac specialist who refused to share his expertise with a western European doctor who was willing to pay with a bag of gold coin. The IAD said: “*Umuthi ngawukhonjiswa abaphansi. Bangangibulala nokungibulala uma ngitshela omunye umuntu!*” (*The medicine was shown to me by my ancestral spirits in a dream. They could even kill me if I let the secret out of the bag and divulged it*).

- *Power struggle and the lack of mutual trust*

Participants also indicated that western European doctors do not want to work with IADS because they look down upon them and they may also want to subjugate the IADs into working under their (biomedical doctors) supervision. This could lead to misunderstanding and mistrust and IADS may also feel undermined. Lack of trust may also develop because many IADs are illiterate and may take a long time to understand how biomedicine works. Western European doctors may also feel challenged and undermined when the IADs challenge their knowledge of medicine. The different points of view may also manifest themselves in power struggle and thus leading to conflict and mistrust.

- *Unsafe environment*

The study also revealed that participants were concerned about the unsafe environment under which IAM is practiced. They stated that IADS work in unhygienic environments, use unhygienic methods in their treatment such as the use of one razor blade for making incisions (*ukugcaba*) on many patients. They also indicated that IADS do not label their medicines, have no dosages and quite often they give patients overdose leading sometimes to fatal complications. WHO (2002) suggests that reliable standard indicators to measure levels of access should be developed and that safest and most reliable and effective therapies must be identified and their use be increased. WHO (2002) also states that all health care providers must be well trained and educated. They must be qualified and licensed to practice. Curricular for all health care providers should have a component of IAM. Such training will enable both IADS and western European trained health professionals to understand and appreciate each others' contributions in the provision of health for all.

- *Fees paid, deceitfulness and the untrustworthiness of IADS*

Participants in this study indicated that IADS have become very expensive, deceitful and unreliable. These findings disputed Gumede (1990) who states that biomedicine was expensive and out of reach of many people in the Third World while on the other hand, IAM is affordable and accessible to the majority of the population in Africa. Ngubane (1977) and Gumede (1990) assert that in the African philosophy of healing full payment in a form of a cow or an ox or an equivalent sum of money is never paid until the

patient has recovered. Ngubane (1977) further indicates that the fees that IADs charge are standardized depending on the nature of the treatment that is expected. In cases of infertility full payment was made when the woman had conceived. If the patient got worse, taken to another IAD, or died, the IAD forfeited his/her final payment even if the patient later recovered. Authors such as Ngubane (1977) and Bürhmann (1984) further state that a small fee (*ugxa*) is paid before any treatment is started and the patient and his/her family can take it back if there are not satisfied with the treatment. WHO (2002) points out that all health providers must be well trained and licensed to practice. Participants also stated that IADS may also want the same salary as that paid to the western European oriented health professionals.

- *Different approaches*

Participants stated that it would be difficult to reach an agreement because of the different approaches. Western European health professionals are educated scientifically to make a diagnoses and how to treat patients while, IADS are informed by their ancestors on how to make a diagnosis and treatment

Faith healing

In this study, the use of faith healers as health care providers had no significance. Only one FGD from the Ga-Nchabeleng village mentioned that they consulted faith healers before referring the patient to the clinic.

RECOMMENDATIONS

Based on the findings and conclusions drawn from the in-depth interviews with the IADs, health professionals and the focus group discussions with patients consulting health professionals at clinics, the researcher wishes to make the following recommendations that should be considered in drawing policy guidelines on the collaboration of indigenous African and European Western medicine in the provision of health:

- *The intellectual property rights.*

Government has to ensure that there is legislation that protect the indigenous knowledge on African medicine and that the African people benefit from the commercialization of IAM.

- *The selfish nature of ancestors*

Common ground has to be found with regards to the selfish nature of the ancestors. More research is needed in this regard.

- *Indigenous knowledge is passed from one generation to the next through the African religion or spirituality*

This is a challenge because indigenous knowledge is not documented nor stored in archives except in the minds and behaviour of a people. That as it may IAM is well established in the cultures and traditions and has become a way of life for many African people.

- *Lack of mutual trust*

Lack of mutual trust that exist between the indigenous African and biomedical doctors has led to a one-sided referral system and making the role of the IADs insignificant. Building of a trusting relationship requires opening of a two way communication system where both are able to understand each other's strength and limitations and to learn from each other. An honest two-way communication will reduce the power relations that are at play in the present one-sided communication system.

- *Indigenous African medicine is expensive and IADS are deceitful and untrustworthy*

IADS have become expensive, deceitful and untrustworthy. This means that there is abuse of the indigenous knowledge on African medicine and communities are misinformed and misled. It is the responsibility of the government to ensure that the indigenous African heritage on indigenous medicine and its citizens are protect from any form of exploitation by means of regulation. The government has to ensure that IADS charge standardized and regulated fees. The present lack of formal regulation makes it possible for anyone to claim to be an IAD even charlatans and thus, the abuse of IAM.

- *Indigenous African medicine is unscientific*

The unscientific nature of indigenous African medicine becomes a challenge because the complex nature of the process of healing cannot be

studied scientifically though the indigenous African herbs can be subjected to scientific scrutiny. There should be regulations that control the recognition of qualification so as to protect the public against unscrupulous IADS.

- *Curricular*

The inclusion of indigenous African medicine in the curricula of all health care practitioners has become long overdue in South Africa because for centuries African people have been using indigenous African medicine in the treatment of various diseases.

- *Political will from government.*

The South African government accepts that the majority of South African consult IADS and that IAM is another form of health care. The South African government has to speed up the legalization of IAM so that it can be legally accepted as an official form of delivery health care service.

- *Institutionalization of indigenous African medicine*

Time has come that IADS operate among other health professionals in the provision of health. Such a move will ensure that patients are able to choose the preferred health service and also improve the referral system.

CONCLUSION

The debate on the collaboration of indigenous African and western European doctors is not new. It dates back in 1947 when the Dingaka's Association made an application for registration to the South African Medical and Dental Council to work together with other health professionals in rendering health care services to all South African citizens (Gumede 1990). The registration of IADs still remains one of the major challenges in the collaboration of indigenous African and western European medicine.

The shortage of health personnel and the escalating prevalence of HIV and AIDS in Sub-Saharan Africa pose major challenges to health systems that are already inadequately resourced. This has negative impact to the provision of health care to the millions of people who are at risk or who are already HIV positive. This also means that IADS also carry the load of treating HIV and AIDS patients. This therefore, means that they are also an appropriate group that has to be included into the formal provision of health.

The aim of this study was to advocate for a completely collaborated health care system that includes indigenous African medicine that is administered and controlled by the government. For many centuries indigenous African doctors have provided health care services to communities. Indigenous African medicine has survived the most brutal forms of government namely, colonization and apartheid.

Both health systems are complementary than contradictory. The western European health professionals need to understand their strengths and

limitations and that they cannot claim that they are the only health providers with superior knowledge of medicine. The IADS too have to recognize their strengths and limitations particularly with regards to technological and medical advancement without which a patient might die. Time has come that both the indigenous African and western European trained health professionals have to understand that they share a common goal of helping those that are sick to get well and that they need each other to attain this goal.

The belief of African people in the existence of ancestors and spirituality remains unshakeable despite western technological and industrial development. It is this belief that has sustained African people and has given them hope where there was hopelessness, particularly in situations of illnesses and misfortunes. Indigenous African medicine is seen as a gift from ancestors and anything that comes from ancestors cannot be refused because ancestors are benevolent towards their off-spring if they obey their commands.

The belief in the ancestors and that IAM is a gift from them creates a challenge for the collaboration of the indigenous African doctors and western European doctors in the provision of health because the spiritual aetiology of IAM is more symbolic and cannot be proven in terms of cause and effect. Gumede (1990:217) refers to this issue and quoting Julius Mpisane, Secretary of the Natal/KwaZulu Inyanga's Association as follows: *"We inyangas don't want a hospital but a big centre for teaching and research- so that if someone dies he does not die with his knowledge but will be able to pass it on first."*

Indigenous African medicine still remains the major form of health care delivery service for the majority of people in Sub-Saharan Africa. The study revealed that people use both systems of health care, but they continue to consult IADS before they consult biomedicine. The study also found that communities believe that there are diseases that respond well to biomedicine and did not respond to IAM and diseases that respond well to IAM and did not respond well to biomedicine. These findings indicate that IAM is successful in the treatment of diseases though quite often these successes are overlooked, but its failures are emphasized.

The introduction of PHC in the provision of health in South Africa has improved the provision of health services particularly in the rural areas where the majority of South Africans live. The WHO Alma Ata Declaration (1978) recognizes the contribution of IAM in the provision of health care. PHC is also suitable for IADS because they provide services that are culturally acceptable to the indigenous people and they are effective in dealing with health problems within the community. Richter (2003) also states that IADS play a crucial role in Africa and in South Africa particularly in Primary Health Care.

Indigenous African doctors have been trained as HIV and AIDS, TB and home based care workers and they provide effective community health. Yeboah (undated) says that such training of IADS is an acknowledgement that a knowledge base has been formed from which IAM and biomedicine can extract information and use it for practice, research and development. Thus, collaboration between indigenous African and western European

doctors can become the only alternative of providing health care services particularly in the rural areas.

Indigenous African doctors play a major role in the treatment of mental illnesses because they are more attuned to psychological and psychopathological state of the patient. The relationship of IADs to the patients is personalized and holistic and this is in direct contrast to the western European oriented health professionals whose relationship with their patients is depersonalized, formal and authoritarian (Gumede 1990).

Chapter 2 of the Constitution of the Republic of South Africa Act 108 of 1996 states that everyone has a right to have access health care services. This therefore, means that all misconceptions and stereotypes should be removed through massive health education programmes to change the mind set of people, that solutions for the identified challenges are also found and that legislation to speed up the process of collaboration is established for the benefit of all South Africans. A collaborated health delivery system will allow people choices and thereby respecting their individuality as human beings and the right to health care.

At the Third Session of the African Union (AU) Conference of Ministers of Health that was held in South Africa in 2007 to review the status and the implementation of traditional medicine in the African continent, it was noted that South Africa has made major progress relating to policies and the regulation of IAM that is geared towards the institutionalization and operationalization of IAM and has joined countries such as Ethiopia, Kenya, Ghana, Malawi, Mali, Burkina Faso, Cameroon, Nigeria, Zambia,

Zimbabwe, Uganda, Senegal, Tanzania and Mozambique to mention a few. It was also noted that she has put in place legislative machinery to officially recognize and empower IAM as part of the public health care delivery system. The AU Conference was also held to review what African Regions have achieved in implementing some of the priority areas of the Plan of Action on the AU Decade of Traditional Medicine (2001-2010) (African Union 2007).

The South African government has drafted the Traditional Health Practitioners Bill of 2003 and in 2004 the Traditional Health Practitioners Act 34 of 2004 was enacted. Its objects are to establish the Interim Traditional Health Practitioners Council of South Africa; to provide for a regulatory framework to ensure that efficacy, safety and quality of traditional health care service and to provide for the management and control over the registration, training and conduct of practitioners, students and specified categories in the traditional health practitioners profession. The Act was established to serve and to protect the interest of the public who use the services of IADs (Government Gazette No. 27275 (11 February 2005).

The Minister of Health Manto Tshabala (2007) indicated that a Presidential Task Team has been established and it has to make recommendations with regards to a National Policy and legal framework for the institutionalization of IAM in the South African health care system. The task team has also to make proposals for possible models to protect IAM. She also stated that there is also a Ministerial Task Team that is working on the South African Medicine Control Council including facilitating the registration and regulation of indigenous African Medicine. There is also a fully staffed

directorate in the Department of Health that manages the work related to indigenous African medicine.

The research study found that participants utilize both health care systems, simultaneously or interchangeably, but for serious illnesses they consult the IAD first to establish the cause of the illness before consulting the biomedical doctors. Participants also mentioned that biomedicine did not provide solutions to some of the local health problems. They strongly believed that there are diseases that respond to IAM and do not respond to biomedicine and diseases that respond to biomedicine and do not respond to IAM. Health professionals pointed out that the simultaneous use of both IAM and biomedicine lead to drug interaction with fatal complications. Patients on anti-retroviral therapy (ART) also develop drug resistance to the ART. The study also found that the youth did not utilize the services of IADS and this is a critical finding because today's youth is tomorrow's adult population.

The study also found that both IADS and western European trained health professionals were also keen to collaborate in the provision of health in South Africa. A two- way communication system that is characterised by mutual respect has to be established so as to resolve the power relations that are evident and to ensure the success of the collaboration between the indigenous African and western European medicine.

In South Africa time has come to fulfil the wish of Mr Solomon Mazibuko who was the life president of the Natal Inyanga's Association who died in 1986. He felt that indigenous African doctors had a lot to offer to the sick people. His last wish was to see indigenous African doctors working closely with doctors and nurses. Gumede (1990: 217) capsulates Mazibuko's last wish as follows: "*he would have liked to see the medicine men working in hospitals*"

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APPENDIX D

INFORMED CONSENT FORM FROM INDIGENOUS AFRICAN DOCTORS

My name is Martha Nozizwe Jali from the Nursing Department, University of Limpopo. I am a doctoral student at the University of Limpopo and I am conducting interviews as part of a research project entitled: **Collaboration of indigenous African and western European medicine: Policy guidelines.**

The purpose of the study is to talk to people like you concerning your experiences regarding the collaboration of indigenous African and western European medicine in the provision of health so as to formulate guidelines that will assist in the formulation of policy on the collaboration of these two health services.

As far as I can tell there should be no risks or discomfort to you in sharing your experiences. Your participation will include taking part in an individual/group interview that will last not more than 45 minutes. During the discussion I will take notes to keep track of what has been covered. I will also use an audio-tape to record the discussion so as not to lose any information that we discuss. As soon as the tape has been transcribed, what has been discussed will be erased so that no one knows who said what. Please also note that your name or any information that identifies you will not appear on the tape or on the transcripts. Your identity will not be revealed when the study is reported or published.

If you have any question about the study or about your participation in the study, please free to contact me (Martha Jali at (015) 267-5843(H) or (105) 268-2385(W)).

This study has been approved by committees that are concerned with rights of people involved in research. Your participation in this study is totally voluntary. You are therefore, under no obligation to participate. You have the right to withdraw at any time if you want to, without any repercussion or penalty.

I _____ have discussed the above points with the participant. It is my opinion that the participant understands the risks, benefits and obligations involved in participating in this study.

SIGNATURE OF THE INTERVIEW

DATE

I _____ understand that my participation is voluntary and that I may refuse to participate or withdraw my consent and stop taking part at any time without penalty.

I hereby freely consent to take part in this research study.

SIGNATURE OF PARTICIPANT

DATE

APPENDIX E

IN-DEPTH SCHEDULE: INDIGENOUS AFRICAN DOCTORS

COLLABORATION OF INDIGENOUS AFRICAN AND WESTERN EUROPEAN MEDICINE: POLICY GUIDELINES

INTERVIEW QUESTIONS

RESEARCHER: MN JALI

SECTION A: Demographic details

1. HOW OLD ARE YOU?

1	2	3	4	5
<16	16-20	21-30	31-40	>40

2. WHAT IS YOUR MARITAL STATUS?

1	2	3	4	5
SINGLE	MARRIED	DIVORCED	SEPARATED	WIDOWED

3. WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?

1	2	3	4	5	6	7
None	<STD3	<STD5	<STD8	<STD10	MATRIC	TERTIARY

WHAT IS YOUR RELIGION?

1	2	3	4	5
Roman Catholic	Protestant	Zion	Apostolic	Other

SECTION B

1. Tell me about the origin the nature of indigenous African healing practices.
2. Tell me about your belief in the indigenous African healing practices.
3. Tell me about the influence of apartheid on the indigenous African healing practices.
4. Tell me about the health care system that you rely on when ill.
5. Tell me more about the healthcare system you use for the prevention of diseases?
6. Who should play a role in the provision of health care?

APPENDIX F

IN-DEPTH SCHEDULE: HEALTH PROFESSIONALS

COLLABORATION OF INDIGENOUS AFRICAN AND WESTERN EUROPEAN MEDICINE: POLICY GUIDELINES INTERVIEW SCHEDULE

MAJOR ISSUES AND THEMES IN THE INTERVIEW SCHEDULE WITH HEALTH PROFESSIONALS.

SECTION A: DEMOGRAPHIC DETAILS

1. HOW OLD ARE YOU?

1	2	3	4
21-30	31-40	41-50	>50

2. RACIAL /CULTURAL GROUPING

1	2	3	4
BLACK	WHITE	COLOURED	INDIAN

3. WHAT IS YOUR RELIGION

1	2	3	4	5	6	7	8
Roman	Anglican	Methodist	U.R.C.S. A	A.M. E	ZION N	Apostolic	other

4. YEARS OF EXPERIENCE

1.	2.	3.	4.	
6-10	11-15`	16-20	.>20	

5. WHERE DID YOU RECEIVE YOUR EDUCATION

1	2	3	4	5	6	7
S.A	AFRICA	ENGLAND	U.S.A	INDIA	CHINA	OTHER

6 AREA OF SPECIALIZATION

1	2	3`	4	5	6	7	8
GP	Surgeon	Obstetrician	Peads	Physician	Pharmacist	Optometrist	Dietician
R/N							

SECTION B

1. Tell me about what you know about indigenous African medicine (Traditional medicine)?
 - The issue of spirituality/ ancestors
2. From your own perspective do you think the knowledge that indigenous African doctors (Traditional doctors) have is scientific?
 - IF YES HOW?
 - IF NO WHY?
3. Have you ever referred patients to an indigenous African doctor (traditional doctors)?
 - IF YES WHY?

- IF NO WHY?
4. In your opinion do you think is it possible for traditional doctors and Western trained health practitioners to collaborate in the provision of health in South Africa?
 - If YES how do you think they should collaborate?
 - IF NO WHY?
 5. What is the view of your professional body towards the collaboration of traditional medicine and Western medicine in the provision of health in SA?
 6. What successes do you think can arise in the collaboration of traditional and Western medicine?
 7. What challenges do you think can arise in the collaboration of traditional and Western medicine?

APPENDIX G

FOCUS GROUP DISCUSSION SCHEDULE: PATIENTS

COLLABORATION OF INDIGENOUS AFRICAN AND WESTERN EUROPEAN MEDICINE: POLICY GUIDELINES

INTERVIEW QUESTIONS

RESEARCHER: MN JALI

SECTION A: Demographic details

1. HOW OLD ARE YOU?

1	2	3	4	5
<16	16-20	21-30	31-40	>40

2. WHAT IS YOUR MARITAL STATUS?

1	2	3	4	5
SINGLE	MARRIED	DIVORCED	SEPARATED	WIDOWED

3. WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?

1	2	3	4	5	6	7
None	<STD3	<STD5	<STD8	<STD10	MATRIC	TERTIARY

4. WHAT IS YOUR RELIGION?

1	2	3	4	5
Roman Catholic	Protestant	Zion	Apostolic	Other

SECTION B

- 1 Tell me about your attitude towards the utilization of the clinic
2. Tell me about your attitude towards the utilization of indigenous doctors
3. Do health care workers incorporate your belief system into their treatment?
4. Tell me about the influence of apartheid on the African healing practices
5. Tell me about your beliefs with regard to indigenous healing
6. Tell me more about the health care system that you RELY ON when ill
7. Tell me more about the health care system you use for the prevention of diseases?

8. Who should play a role in the provision of health care?