# TOWARDS AN EXPLANATORY MODEL OF MENTAL HEALTH ETHICS BY NORTHERN SOTHO TRADITIONAL HEALTH PRACTITIONERS OF CAPRICORN DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA

by

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[redacted]

THESIS

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## DEDICATION

This thesis is dedicated to my parents, Mmapitsi Maria Moloantoa and Simon Matsobane Moloantoa for raising me to become the woman I am today.

*“Ke a leboga”*

This dedication extends further to me, as a validation of hard work through all my years of studying.

## DECLARATION

I declare that "**Towards an explanatory model of mental health ethics by Northern Sotho traditional health practitioners of Capricorn District, Limpopo Province, South Africa"** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

……..  21 June 2023

**GEORGINA TUKISO MOLOANTOA**  **DATE**

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## ACRONYMS

THP- Traditional Health Practitioners

MHCP- Mental Health Care Practitioners

HCP- Health Care Practitioners

TM- African Medicine

ATM- African Traditional Medicine

NDOH- National Department of Health

## ABBREVIATIONS

ACA- American Counselling Association

APA- American Psychological Association

WHO- World Health Organization

NHS-National Health System

HPCSA- Health Profession Council of South Africa

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## GLOSSARY

| Concept | Meaning |
|---|---|
| Allopathic health system | A health system in which HCPs such as medical doctors, nurses, therapists treat symptoms and diseases using conventional medicine. The word is used interchangeably with the Western health system |
| *Botho/Ubuntu* | Being human- An African moral principle |
| Caregiver | A person who represents/helps a mental health patient, he. A care-giver can be a family member, relative or a trusted friend. |
| Explanatory model | An explanatory model is an explanation of why a phenomenon is the way it is. An explanatory model in the context of the present study is the developed ethical framework of the ethical framework informing the Traditional Health Practitioners (THPs) in the management of mental health cases. |
| *Indumba* | A sacred hut where THPs consult with the ancestors. The hut is usually built in indigenous rondavel architecture. |
| *Go hlola* | A divination process of consulting with the ancestors. |
| *Go kgopela ditsela* | To request for permission from the ancestors whenever the THP is going somewhere. |
| *Mahunulla-thebele* | The money taken out by a patient to open the divination bones during consultation with a THP. |
| *Mathwasana* | Apprentice THPs who have acknowledged the calling of their ancestors to become a THP. |
| Mental health case | A patient diagnosed with a mental health condition |
| Mental health condition | Health problems which interferes with the normal functioning of a person's mind. The problem usually affects a person's feelings, thinking and behaviour. |
| Mental health care practitioners (MHCPs) | Health care professionals with speciality to treat mental health cases. The professionals such as psychologists, psychiatrists, psychiatrist nurses, counsellors etc. |

| | |
|---|---|
| *Mošate* | A place where the chief and the community authorities stays |
| Moshate wa mangaka Humeleng Dingaka | A traditional healer's association in Polokwane, Limpopo Province led by Dr SF Tau |
| *Nako ya sedimo* | The sacred time (12:00 midday) whereby the THP spiritually connects with the ancestors |
| *Pheko ya badimo* | Medicinal plant used as herbal medicine for healing |
| Traditional health practitioner (THP) | A individual practicing traditional health care, treating all diseases including mental health conditions |

## ABSTRACT

Traditional health practitioners are the first to be contacted for mental illness in many parts of Africa. The literature shows that there are more traditional health practitioners (THPs) than western-trained mental health care practitioners in many African communities. Whilst there are calls for the recognition of traditional health practitioners, little is known about the processes that inform the traditional health practitioners' ethical practices when dealing with patients with mental health issues. The aim of the study was to develop an explanatory ethical framework that informs traditional health practitioners in the management of mental health cases. Specifically, the objectives of the study were to: explore notions of mental health ethics as perceived by THPs; describe what THPs understand to be ethics in the management of mental health conditions; determine THP views regarding what is considered good ethical behaviour in the treatment of mental health conditions; and based on the THPs' representations, develop an explanatory ethical framework informing THP's management of mental health cases.

Using the grounded theory approach, twenty traditional health practitioners were theoretically sampled for the study. The process of data collection and analysis was done simultaneously. Ten well-integrated concepts providing a thorough theoretical explanation of ethics informing the traditional health practitioner's management of mental health cases emerged. The concepts included ethics, *botho,* ancestral guidance, consultations, admissions, referrals, treatment, remuneration, healing progress, and wrath of the ancestors. Five categories accounting for those concepts emerged from the study. An ethical framework informing the traditional health practitioner's management of mental health cases is also presented. The study concludes by recommending that an ethical code of practice for THPs should be documented.



Key words: Traditional health practitioners (THPs), ethics, mental health conditions

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# CHAPTER 1: INTRODUCTION

## 1.1 Introduction

This study aims to develop an ethical framework that informs Traditional Health Practitioners (THPs) in the management of mental health cases. This chapter provides the background of the study as well as the research problem. In addition, it discusses the purpose of the study, whereby the aim is outlined. Moreover, a research question is also stated. Also, this chapter encapsulates the three models of enquiry used in the current study. Furthermore, it outlines the details of the overall structure of the thesis. The significance of the study is also included as part of this chapter.

## 1.2 Background of the study

Ethics is a Greek word derived from *ethos*, or "behaviour", which is an important aspect of health care (WHO, 2015). Although founded on different philosophies (Rendtorff, 2015; Williams, 2011), it is commonly agreed that ethics in health care speaks to issues of morality or conscience (Illingworth & Parmet, 2017; Pera, 2011). Morality, is derived from "morals", and are social rules or inhibitions from the society (Tzafestas, 2016). According to Gert and Gert (2020), morality refers to specific codes of conduct put forward by the society, then accepted and followed by an individual for his or her behaviour. In addition, Gino and Shalvi (2015) defines morality as a community assessment of what is good, right, or just for all. Whereas conscience is defined as committing to morality itself; to acting and choosing morally according to the best of one's ability (Sulmasy, 2008), as opposed to external obligations (Giuibilini, 2021). Morality and ethics are intertwined (Sternberg & Glück, 2019). Tzafesta (2016) states that ethics is the science, and morals refer to one's conduct or character.

Ethics are a system of moral principles and a branch of philosophy that defines what is good for individuals and society (Young, 2016). There are different disciplines of ethics such as professional, deontological, normative, applied ethics etc. The current

study focused mainly on professional ethics, as ethics govern the THPs health care providers. In health care, a code of ethics reminds health care providers (HCPs) of the most ideal conduct 'to protect, promote and maintain public trust (Tarzian, Wocial & ASBH Clinical Ethics, Consultation Affairs Committee, 2015). Ethics in health care also protects the HCPs as professionals.

For instance, in South Africa, the Health Professions Council of South Africa (HPCSA) is a statutory body. Established in terms of the Health Professions Act of 2007 and is committed to protecting the public and guiding the professions. The HPCSA has developed ethical guidelines that govern the conduct of health professionals in promoting good ethical practice (HPCSA, 2016). All health professionals are supposed to adhere to ethical guidelines in their professional practice. The HCPs also have a moral obligation of having good relations with the patients to provide health care, relieve pain, etc. (HPCSA, 2016).

Although THPs provide health care services to the public, they are not featured anywhere in HPCSA. THPs also play a pivotal role in health care (Willcox & Bodeker, 2010; Peltzer, 2009), are expected to practice ethically (McCabe, 2007). The health activities of THPs, are said to be regulated by the Traditional Health Practitioners Act of 2007. The purpose of this Act is:

> "To establish the Interim Traditional Health Practitioners Council of South Africa, to provide for the registration, training and practices of traditional health practitioners in the Republic and to serve and protect the interests of members of the public who use the services of traditional health practitioners" (Traditional Health Practitioners Act, 2007. p.8).

The stipulations of this Act and Health Professions Act of 2007 share a common goal of serving and protecting the public who uses the services of both THPs, and other HCPs recognised by the HPCSA. The main difference between the THPs and other HCPs is that the other HCPs have ethical guidelines governing their practice, whereas

THPs do not have a recognised statutory body that governs their practice. Hence this study was done to develop an ethical framework that informs the THPs in the management of mental health cases.

The existing body of research focuses mainly on the types of THPs, the nature of illnesses they manage and the different forms of interventions they use in dealing with issues of ill health (Semenya & Potgieter, 2014; Afolayan et al., 2014; Mendenhall et al., 2014). “How” or “what” process inform or influence their ethical practice is not yet well documented. One reason for the lack of knowledge around issues of traditional healing and ethics could be the fact that, in the provision of health services in South Africa, THPs have been relegated to the periphery within the mainstream health care system (Campbell-Hall et al., 2010).

### 1.3 Research problem

Several frameworks in South Africa recognises THPs (Department of Health, 2013; The Traditional Health Practitioners Act, 2007; Department of Health, 1997). Traditional Health Practitioners Act Number 22 of 2007 recognised the importance of THPs in primary health care (The Traditional Health Practitioners Act, 2007). Amongst others, this Act seeks to promote and maintain appropriate ethical and professional standards required from THPs. The Act is also intended to serve and protect the interests of members of the public who use the services of traditional health. The 1997 White Paper on the Transformation of the Health System in South Africa (Department of Health, 1997) also recognises THPs as an important component of the broader primary health care team, although they do not yet form part of public health service.

It is also stated in the White Paper of 1997 that the National Health System (NHS) function at a national level should include establishing and maintaining mental health committees and maintaining collaboration with other sectors such as private practitioners, THPs and Non-Governmental Organisations (NGOs). Additionally,

Mental Health Policy Framework and Strategic Plan 2013–2020 also recognised THPs. This policy framework advocated for the decentralisation of mental health care to the district level to ensure that mental care users receive the best possible care at the level closest with them. The Framework also called for collaboration between mental health care practitioners (MHCPs) and THPs in mental health promotion at district levels (Department of Health, 2013). However, the Human Rights Commission Report of 2019 pointed out that the provinces failed to implement the Mental Health Policy Framework and Strategic Plan 2013–2020 (The South African Human Rights Commission, 2019).

The White Paper of 1997 recommended that the regulation and control of THPs should be investigated for their legal empowerment. It further suggested that the criteria outlining standards of practice and an ethical code of conduct for THPs should be developed to facilitate their registration (Department of Health, 1997). Thus, to date, ethical principles guiding the practice of THPs are still not yet documented. Hence, the present study sought to develop an explanatory ethical framework that informs the THPs in the management of mental health cases. The developed framework explains the ethical aspects involved in the practice, specifically how the THPs manage mental health cases. The ethical principles shared by the THPs are mostly unique in application compared to western derived ethics governing the conduct of health professionals, including those registered with the Health Professions Council of South Africa (HPCSA).

Although there were several steps taken towards the regulation of the Traditional Health Practitioners Act of 2007, including calls for closer collaboration between HCPs and THPs (Campbell-Hall et al., 2010; Thornton, 2009; Department of Health. 1997), not much has been documented on the standards of practice and an ethical code of conduct for THPs. As a researcher, I saw the need to explore and understand THPs' views about ethics and how they ensure ethical practice in the management of mental health patients if there is to be any meaningful collaboration between the two health care systems.

## 1.4 Purpose of the study

### 1.4.1 Aim of the study

The aim of this study is to develop an explanatory ethical framework that informs the THPs in the management of mental health cases.

### 1.4.2 Objectives of the study

The following were study objectives:

- To explore notions of mental health ethics as perceived by THPs.
- To describe what THPs understand to be ethics in the management of mental health conditions.
- To determine THP views regarding what is considered good ethical behaviour in the treatment of mental health conditions.
- Based on the THPs' representations, develop an explanatory ethical framework informing THP's management of mental health cases.

## 1.5 Research question

The present study sought to answer this key research question:

- Which ethical framework informs the Northern Sotho THPs management of mental health cases?

## 1.6 Models of enquiry

This study relied upon three models for the design of its research methodology. Models of enquiry are different methods employed in the study. The models are as follows:

### 1.6.1 The Straussian Grounded Theory

The grounded theory methodology has different approaches such as a classic grounded theory by Glaser and Strauss (1967). The Straussian grounded theory by Strauss and Corbin (1998) as well the constructivist grounded theory by Charmaz (1995). Originally, the grounded theory method was developed by Glaser and Strauss (1967). Then later Strauss had his ideas that gave rise to the Straussian Grounded Theory. I adopted the Straussian grounded theory methodology for the current study. A detailed discussion of Straussian grounded theory will follow in chapter 4.

### 1.6.2 Murray and Chamberlain's (1999) sampling procedures

Usually, grounded theorists use what is referred to as "theoretical sampling". However, to reach the concept of theoretical sampling, one should follow the known qualitative sampling procedures. Murray and Chamberlain (1999) gave a detailed procedure of how to sample for a grounded theory study. I used their three sampling procedures, namely, open, variational, as well as discriminate sampling strategies to achieve theoretical sampling.

### 1.6. 3 Charmaz's intensive interviewing

Although I have followed the Straussian Grounded Theory Method, for interviewing study participants, I used what Charmaz (2014) refers to as intensive interviews. It is an approach that includes informational interviewing to gather needed details for the study. In addition, this interviewing approach is subject to change as the study develops. Interviews take place within a culture at a specific historical time and social context. My approach to interviewing, questions, specific word choice, and the interactional style during the interview had to respect the culture, traditions and situations of the participants that took part in the study.

## 1.7 Delimitation of the study

The unit of analysis was restricted to Northern Sotho THPs residing in the Capricorn District, Polokwane. Thus, the study may not apply to THPs of any other tribe in Polokwane or any other area. Furthermore, the study considered THPs with the experience of treating patients with mental health issues, therefore their experiences may not be extendable to THPs who have never dealt with mental health cases. The number of THPs interviewed could also be a delimiting factor, as results could vary with a greater number of participants.

## 1.8 Significance of the study

People utilise both traditional and western treatment for mental health services. However, this study is not a comparative study, it informs and enrich both the MHCPs and THPs about good practice in the management of mental health cases. The study also helps toward the collaboration of traditional health practitioners and mental health practitioners. The ethical principles for HCPs and THPs cannot be the same nor be measured equally, therefore, for the better understanding for both can result in pure collaboration, without another method being undermined or unacknowledged.

The study has the potential to help in the development of official policies and national strategies, as per recommendations to have this kind of study has already been made in some of the official government reports. The study will develop an explanatory ethical framework that informs the Northern Sotho THPs in the management of mental health cases, thus adding literature to the field of ethics as well as adding new knowledge to the branch of psychology. The study will also add new knowledge to Afrocentricity and mental health care.

## 1.9 The structure of the thesis

The thesis is divided into nine chapters that each cover a different area of the topic. A brief summary of each chapter is provided below.

### 1.9.1 Chapter 1: Introduction

Chapter 1 is comprised of the introduction, the background of the study and the problem statement. It also covers the aim, objectives of the study, the research question and the significance of the study.

### 1.9.2 Chapter 2: Literature review

Chapter 2 presents the literature review. This chapter begins with the definition of traditional healing, recognition and regulation of THP and the role of traditional healing. The traditional healing and treatment of mental health conditions as well as ethics in mental health are also outlined in this chapter. The last section of this chapter presents literature on the collaboration between the Western health system and the THPs.

### 1.9.3 Chapter 3: Theoretical Framework

Chapter 3 is the presentation of the theoretical framework underpinning the study. The Afrocentric paradigm is discussed as the adopted theoretical framework for the current study.

### 1.9.4 Chapter 4: Methodology

Chapter 4 comprises the presentation of the methodology followed in conducting the study. The research design, the constructivist paradigm as well as the study setting is

discussed. Sampling decisions, data collection and analysis methods are outlined in this chapter. The last section of this chapter discusses ethical considerations.

### 1.9.5 Chapter 5: Quality and Rigour

Chapter 5 discusses quality criteria, researcher role and bias, theoretical sensitivity, how the data was coded as well as how the three analytical phases were applied in the study are discussed. This chapter also introduces the findings chapter.

### 1.9.6 Chapter 6: The presentation of the findings

This chapter discuss the findings of the study. It is opened with the presentation of the demographic information for the participants. The concepts and categories that emerged from the data are outlined. The core category and the main categories encompassed with examples of the extracts from the transcripts are also discussed.

### 1.9.7 Chapter 7: The presentation of the model

The ethical framework for Northern Sotho THPs in the management of mental health cases is presented in this chapter. The framework is solely grounded in the data collected from the THPs. The process that a mental health patient goes through with a THP is also outlined.

### 1.9.8 Chapter 8: Discussion

This chapter discusses the findings of the study and integrates them with the existing literature. The chapter begins with the discussion on the need for THPs to have an ethical framework informing their practice. *Ubuntu/Botho* as an ethical principle is also discussed. The last section of this chapter discusses the consequences of THP's unethical practice.

### 1.9.9 Chapter 9: Conclusion

Chapter 9 is the last chapter of the study. This chapter covers the summary of the results, the implications of the findings of the study as well as the contributions of this study to various fields. The last section of this chapter discusses the recommendations of the study.

## 1.10 Conclusion

The purpose of this chapter was to give the background of this study and its significance. The chapter has in detail what transpired in the study and provide an idea of what is to be discussed in the next chapters to follow. The aim and objectives of the study were discussed. Most importantly, this study presented answers of the research questions. The delimitation of this study as well as the overview of the whole thesis also formed part of the discussion. The next chapter discusses the reviewed literature.

# CHAPTER 2: LITERATURE REVIEW

## 2.1 Introduction

This chapter reviews the literature on a series of topics related to traditional healing and mental health ethics. Even if the classical Grounded Theory approach has some controversies in terms of the researcher having to review some literature, the literature review was done as the research adopted the Straussian grounded theory. The Straussian grounded theory allows the review of the literature. I have covered a range of topics including the concept of traditional healing, recognition and regulation of THPs in South Africa, the usage of traditional healing in South Africa, traditional healing and treatment of mental health conditions, the concept of ethics and ethical behaviour, ethics and mental health, morality and ethics in traditional healing and the collaboration between the allopathic health system and traditional healing.

## 2.2 The concept of "traditional healing"

According to the WHO (2022) traditional healing is associated with the use of what is referred to as Traditional Medicine (TM). WHO (2022) defines TM as the sum of knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness. In many African countries like Uganda, Ghana and Rwanda the TM practice is referred to as African Traditional Medicine (ATM) (Abbo et al., 2019; Omonzejele, 2008), whereas in South Africa, the practice is usually referred to as "traditional healing". According to Freeman and Motsei (1992), the Africans carry out traditional healing in the community in which the illness is thought to be the result of witchcraft, contact with impure objects or neglect of the ancestors. Mokgobi, (2014), states that the practice of traditional healing is associated with herbs, remedies and advice from a THP with a strong spiritual component.

African traditional healing is intertwined with cultural and religious beliefs and is holistic (Truter, 2007; Gurib-Fakim, 2006). The practice does not only focus on the physical condition but also on the psychological, spiritual and social aspects of individuals, families and communities (WHO, 2022; Zuma et al., 2016; Gureje et al., 2015; White, 2015; Abbo, 2011; Omonzojele, 2008). Most THPs are based in rural communities rather than in urban areas (Peltzer, 2009). Hence, Omonzojele (2008) pointed out that when Western therapies fail among urban residents in most African countries, they go back to their ancestral homes in their villages for divination and treatment.

A THP is a person recognised as a traditional healer by the community where he or she lives. He or she is a competent individual with the ability to provide health care through using plant, animal, mineral substances and other methods based on the social, cultural and religious backgrounds (WHO, 1978). Besides the community recognition where he or she lives, a THP speaks the same language and has extensive knowledge of the strengths, weaknesses and resources available to the community (Abbo et al., 2019). They are highly respected individuals in their communities (Liverpool et al., 2004; Peu et al., 2001; Kale, 1995). The THPs make use of ATMs. Zuma et al.'s (2016) stated that the THP's role includes services that go beyond the uses of herbs for physical illnesses or divination (Zuma et al., 2016).

THPs serve roles that include but are not limited to being custodians of the traditional African religion and customs, educates about culture, serve as counsellors, are mediators and social protectors. THPs could diagnose any form of disorder. They then plan the desired management and prevention strategies to restore physical, psychological and social well-being of the patient (Quick et al., 2002). Thus, they use different techniques to deal with mental health conditions and physical disorders including herbs (phytotherapy), psychotherapy rituals, spirituality and prayer (Abbo, 2003). All the healers put emphasis on their relationship and connection to the ancestral and spiritual worlds, who they are and how they executed healing is reported to be from the guidance of the ancestors (Zuma et al., 2016).

## 2.3 Recognition and regulation of THPs in South Africa

Before South Africa became a democratic country, THPs and their use of TM were criminalised *(Witchdoctor Suppression Act 1957)*. Despite the suppression, people continued to consult THPs over the years (Mankazana, 1979; Edwards, 1986; Freeman & Motsei, 1992; Nemutandani et al., 2016). This contributed to the continuous growth irrespective of its association with witchcraft. Moshabela et al.'s (2016) demonstrated the progress in which traditional healing shifted from a derogatory 'witchcraft paradigm' to a discourse of a 'healing paradigm (Moshabela et al., 2016), and currently protected under the Traditional Health Practitioners Act 2007.

Other than the Traditional Health Practitioners Act 2007, traditional health practitioners are as well recognised through other frameworks and policies. The 1997 White Paper on the Transformation of the Health System in South Africa recognises the importance of traditional health practitioners in primary health care (Department of Health, 1997). It further states that regulation and control of traditional healers should be investigated for their legal empowerment and most importantly, that the criteria outlining standards of practice and an ethical code of conduct for THPs should be developed to facilitate their registration. In addition, ATM has been described in the Draft Policy on African Traditional Medicine for South Africa as a body of knowledge that has been developed and accumulated over quite several years, which is associated with the examination, diagnosis, therapy, treatment, prevention of, or promotion and rehabilitation of the physical, mental, spiritual or social well-being of humans and animals (Department of Health, 2008). Upon evaluating this policy, Gavriilidis and Östergren (2012) concluded that South Africa's ATM legislation need to involve communities in policy design and implementation to capitalise upon the broader benefits of community empowerment.

Mental Health Policy Framework and Strategic Plan 2013-2020 also stands out as one of the major components steps toward the recognition of traditional health practitioners in South Africa. This policy framework has targeted both MHCPs and THPs in working together at district levels (Department of Health, 2013). In addition, the Indigenous

Knowledge Systems (IKS) Policy also seeks to recognise, affirm, develop, promote and protect traditional healing as well as the indigenous knowledge system (Domfeh, 2007).

Summerton (2006) stated that the regulation of the providers and products of TM may be lacking or only partial in developed and developing countries where the health system is inclusive. South Africa is pointed out to be among those countries where, an inclusive system recognises traditional healing, but has not yet integrated it into all aspects of health care (delivery, training, education, and regulation). There is an increasing global awareness of the need to move away from exclusive, intolerant and inclusive systems towards integrated systems characterised by the amalgamation of all health care systems available in a society to optimise health care for all (Summerton, 2006).

Moreover, to strengthen and promote traditional health medicine and practice, the former minister of Health, Dr Aaron Motsoaledi, after consultation with the Council, published the regulations for Traditional Health Practitioners in the Government Gazette No 39358, Notice No 1052 of 3 November 2015 to draw comments from interested persons. The specific focus of the regulations was to set out the process for registration of the different categories of THPs and other pre-requirements, including, but not limited to, the training of students, standards of educational training and codes of good ethical practice associated with ensuring the safety of the public and overall patient satisfaction. Furthermore, the regulations were objectively intended to put the prescripts of the Act into operation and thus promote the process of standardisation of the traditional health practice and its formal recognition (The South African National Department of Health, 2015).

Attempts have been made in South Africa to regulate THPs, with the promulgation of the Traditional Health Practitioners Act of 2007. Ross (2010) points out that this Act has been in abeyance because key role players cannot agree. The Traditional Health

Practitioners Act is seen to provide the long-awaited legal recognition for THPs and the possibility of a central governing body for the sector. Although, traditional health care is described as the 'oldest health-related science in South Africa, it seems like it is yet the last to be formally recognised. According to Weaver et al.'s (2020), both recognition and legitimacy for practitioners are seen to constitute a crucial step towards a stronger TM sector and partnership with the formalised health system (Weaver et al., 2020).

In his article titled "Unpacking the new proposed regulations for South Africa", Street (2016) criticised the published regulations claiming that they lack substantive detail and leave a lot of room for interpretation and speculation by traditional health practitioners. He concluded that traditional medicines must be brought under regulatory measures if they are to be recognised under South African law. This was because South Africa has legislation that regulates almost all its healthcare systems. Le Roux-Kemp (2010) recommended greater recognition and regulation of ATM in South Africa's legal and national health systems, especially when considering the potential positive impact of ATM therapeutic properties.

A recent study by Nzimande et al.'s (2021) on barriers to regulation of THPs found out that THPs were uncertain about why they should be registered and therefore struggled to identify the benefits of being registered. THPs viewed the process of registration as a tax collection instrument, and recognition and legitimacy. Moreover, several THPs viewed registration as a tactic to oppress and squeeze them to contribute towards the countries' taxation system. Recognition and legitimacy were the only benefits identified, as THPs saw registration as a gateway into mainstream health and believed it would separate them from charlatans who ruin this health system (Nzimande et al., 2021).

Tshehla (2015), and Mbatha et al., (2012) argue that although the law allows THPs to issue sick certificates, the current legal and policy landscape is not conducive to this

practice, and there are still inconsistencies and gaps within these legal and policy documents. For example, employers may not be obligated to accept such sick certificates for as long as regulatory structures are not in place. The published THPs' regulations were said to constitute a step in this direction; however, the lack of a conducive policy environment is continuing to threaten efforts to recognise the THPs (Moshabela et al., 2015).

When one goes to consult a biomedical health care practitioner, they carry with them their culture and their religious beliefs (Mokgobi, 2014). One gets assisted by a professional who has his, her health religious and cultural beliefs but have to stick to professional ethics and go by the biomedical book (Mokgobi, 2014). Currently, the published regulations are not available on any governmental website, and little is said about them. It is evident that efforts to regulate THPs in South Africa are underway; however, the lack of a regulatory framework for traditional practices is hampering progress (Street et al., 2018). Sadly, Semenya and Potgieter (2014) found that none of the THPs who participated in their study had any knowledge of provincial or national environmental legislation. To date, THPs remain unregulated.

### 2.4 The role of traditional healing in South Africa

It is estimated that about 200 000 traditional healers' practise in South Africa servicing more than 27 million people (Farlane, 2015; Mahwasane, Middleton & Boaduo, 2013; Truter, 2007; Pretorius, 1999; Setswe, 1999). In their study titled "Are there 200,000 and more traditional healers practising in South Africa?", Louw and Duvenhage (2016) concluded that the number of THPs practising in South Africa could not be confirmed. These authors argued that the number of THPs practising in South Africa was never determined, and the alleged number of 200 000 and more traditional healers was the untested motivator for promulgation of the Traditional Health Practitioners' Act of 2007. However, literature indicates that there are more THPs in South Africa (Mthembu, 2021; Semenya & Potgieter, 2014; Truter, 2007; Meissner, 2004; Peu et al., 2001; Freeman & Motsei, 1992; Kale, 1995).

In South Africa, THPs are said to be the first point of contact for many people in need of health services (Zuma et al., 2016) as they are easily accessible to their fellow community members who utilise their services (Mutola et al., 2021; Abrams et al., 2020; Zuma et al., 2018; Peltzer & Mngqundaniso, 2008). Amongst others, THPs are cost-effective yet highly efficient (Hughes et al., 2022; Nxumalo et al., 2011; Gqaleni et al., 2011; Moshabela, Zuma & Gaede 2016). They also treat and manage many diseases including HIV/AIDS (Audet et al., 2021; Peltzer et al., 2008, Babb et al., 2007; Mills et al., 2005), cancer (Sagbo & Otang-Mbeng, 2021; Ratshikana-Moloko, 2020; Sophy & Mavis, 2018; Moodley et al., 2016), diabetes (Odeyemi & Bradley, 2018; Davids et al., 2016) as well as mental health diseases (Jack, et al., 2014; Campbell-Hall et al 2010; Zabow, 2007).

The country comprises nine provinces. The current study was conducted in Limpopo province, which is dominated by Northern Sotho speaking people or Bapedi. Although there is no exact number of THPs found in Limpopo province, the literature to follow shows that there are THPs in Limpopo. In their study about socio-cultural profile and traditional healing practice, Semenya and Potgieter (2014) found that Bapedi traditional healers could play a leading role in both the preservation of indigenous knowledge and the primary health care sector. A recent study by Lebaka (2021), also demonstrated that a large percentage of Bapedi people consult with THPs for survival and to strengthen their indigenous beliefs and practices, and to adhere to their traditional lifestyle.

A recent study on the status of traditional healing in Limpopo Province pointed out that the work done by traditional healers remains undermined despite their contribution to the country's healthcare system (Maluleka, 2020). The studies recommended that the government should play an active role in ensuring that THPs are formally incorporated into the country's healthcare system that can benefit both the healers and the communities they serve (Maluleka, 2020). Similarly, Chikafu (2022)indicates the need

for long-term strategies to extend the primary health network to moderate spatial limitations to health care utilisation, with the inclusion of THPs . This recommendation is made in almost all study about the role played by the THPs in primary health care.

The province of Kwa-Zulu Natal is dominated by IsiZulu speaking people, and many people also rely on THPs (Mbongwa et al., 2021; Khanyile & Dlamini, 2021, Ramchundar, & Nlooto, 2017; Zuma et., 2016; Ghuman, 2016; Bujowoye, 2005). Amongst all other diseases that HIV/AIDS is commonly treated by the THPs (Peltzer et al., 2011; Peltzer et al., 2006). A recent study by Chikafu (2022)titled “If I Were to Suffer a Stroke Right Now, the First Place That I Should Be Taken to Is the Traditional Healer" explored the perceptions, beliefs, and health-seeking practices related to diabetes, hypertension, and cardiovascular diseases. The study found that IsiZulu speaking, people consult THPs for treatment of common diseases such as hypertension, diabetes, stroke, and cardiovascular diseases . The study also found that, although both males and females had poor health-seeking practices; it was noted; that males often developed severe illness and that disability and mortality were higher among them because of their delay and, were sometimes reluctance to seek care, hence the title for the study. Males prefer self-care and herbal remedies, probably due to cultural and masculinity expectations (Chikafu, 2022).

Another recent study about cooperative treatment of cancer between traditional health practitioners and radiation oncologists was done by Nkosi and Sibiya (2021). The study found that cooperation between THPs and radiation oncologists is understood as the provision of continuity care, where the parties work independently but share certain information of the patient on treatment, or as already being treated by each of them. The focus was on the type of relationship, enablers and common grounds for cooperation (Nkosi & Sibiya, 2021). More studies about THPs in Kwazulu-Natal were also done on mental health care issues (Van der Zeijst et al., 2021; Labys et al., 2016; Mkize, & Uys, 2004). All these studies found  that THPs also play a vital role in mental health care.

## 2.5 Traditional healing and treatment of mental health conditions

Traditional health practitioners treat various mental illnesses (Ngobe et al., 2021; Jack et al., 2014; Campbell-Hall et al., 2010; Mufumadi & Sodi, 2010; Zabow, 2007). Mufumadi and Sodi (2010), found that THPs follow a logical and culturally congruent system to diagnose and treat patients who present to them with what is mental illness. The study found that VhaVenda THPs use different diagnostic procedures and treatment methods to treat mental illnesses. Complementary to this, a recent study by Ngobe et al.'s (2021) found that Swati THPs treats adjustment disorders, depression, mental illness due to ancestral calling, mental illness due to bewitchment, mental illness due to breaking of taboos, psychotic disturbances and substance-induced mental illness. The study indicates that Swati THPs use different traditional methods to manage various mental complaints (Ngobe et al., 2021).

Green and Colucci (2020) conducted a review study about THPs and MHCP's perceptions of collaborative mental health care in low- and middle-income countries whereby 14 studies were reviewed. Out of the 14, 7 were South African and the rest were from other African countries. All reviewed studies recognised that THPS is widely sought out and play a key role in the provision of mental health care. Their popularity was attributed to two key factors: a shared cultural understanding with patients of the spiritual cause of mental illness and their ability to provide effective psychosocial support or less severe mental disorders (Green & Colucci, 2020). The study found that, despite differing conceptualisations of mental illness causation, both THPs and MHCPs recognised that patients can benefit from a combination of both practices and demonstrated willingness to work together. There are concerns about patients' safety and human rights regarding traditional methods and some healers were sceptical about the effectiveness of the Western psychiatric medication (Asher et al., 2021; Xego et al., 2021; Arias et al., 2016; Ae-Ngibise et al., 2010).

Gutema and Mengstie (2022) listed what was considered to be the main causes of mental illnesses in Ethiopia including, curse/ witchcraft, harsh social conditions,

jealously, hereditary, substance use, and food poisoning. The two authors pointed out that to treat mental illnesses caused by either one of the mentioned causes, THPs use traditional and religious books, herbal medicine, and divination bones. These traditional healing ways of identifying the causes, diagnostic methods and treatment options were culturally specific. The study recommended that traditional healers need to be recognised as mental health providers since they provide culturally appropriate treatments to people in their communities (Gutema & Mengstie, 2022).

A study by Maluleka (2020) on the status of traditional healing in Limpopo, South Africa has shown that many people in Limpopo make use of THPs. The findings suggested that healers hardly advertised their services because people in their areas were aware of what they were capable of. There was some consensus amongst respondents that new clients became aware of their services from the people they had helped before. They mostly worked on referrals and word of mouth. The findings suggested that THPs feel that HCPs undermined their work, whilst some spoke of the bad treatment they had received from the nurses when they took patients to clinics. Healers mentioned that the nurses gave a tough time to patients who were referred to hospitals after consulting them first. These nurses made it clear that they should have consulted the hospital first. However, healers felt strongly that collaboration between Western medicine and traditional medicine was necessary because there were patients who might need help from either side of the camp (Maluleka, 2020).

### 2.6 The concept of ethics and ethical behaviour

Ethics involves judgements about the way we ought to live our lives, including our actions, intentions, and our habitual behaviour (WHO, 2015). The process of ethical analysis involves identifying relevant principles, applying them to a particular situation, and making judgements about how to weigh competing principles when it is not possible to satisfy them all (WHO, 2015). Similarly, Callahan and Jennings (2002) stated that ethical analysis can be usefully divided into several different types, depending on the point of view and needs from where it originates. One or more of them might be appropriate for any specific ethical problem.

According to Callahan and Jennings (2002), numerous ethical perspectives coexist on matters of widespread interest and importance as public health. In their article on ethics and public health Callahan and Jennings (2002) divided their ethical analysis into four, namely professional, applied, advocacy and critical ethics. Professional ethics are ethics that tend to seek out the values and standards that have been developed by the practitioners and leaders of a given profession over a long period and to identify those values that seem most salient and inherent in the profession itself. Applied ethics adopts a point of view from outside the history and values of the profession. Advocacy ethics are less theoretical or academic than either professional ethics or applied ethics, and its perspective has a strong orientation towards equality and social justice. Whereas critical ethics attempts to combine the strengths of the other perspectives mentioned. The perspective of critical ethics has much in common with the egalitarian and human rights-oriented discourse of advocacy ethics in public health (Callahan & Jennings, 2002).

Among several philosophies or formal thought systems that have informed much of western ethical thinking and value systems, the psychology profession included, are consequentialism, utilitarianism, legalistic moralism, and deontologism (Singer, 2013). Consequentialism is more about “assessing the rightness or wrongness of actions in terms of the value of their consequences” (McNaughton & Rawling, 2011). It is against this backdrop that a movement, that is, positive ethics in psychology practice, “attempts to alter the perspective of professional and scientific ethics from an almost exclusive focus on wrongdoing and disciplinary responses to a more balanced and integrative approach that includes encouraging psychologists to aspire to their highest ethical potential (Knapp et al.,2015).

The movement was born out of challenges and weaknesses associated with the western ethical value systems when working with culturally different clientele. This is expressed by Atkinson (2004) in stating that the American Counselling Association

(ACA) and the American Psychological Association (APA) ethical codes have been criticised for the high value they place on autonomy and individuality (Atkinson, 2004). The codes contain the ethical mandate to understand the cultural background of diverse clients; yet by stressing autonomy and individuality; the codes reflect the culture, norms and values of western society (Atkinson, 2004). Therefore, positive ethical philosophical thinking urges mental health practitioners to live up to high ideals (Knapp et al, 2015).

## 2.7 Ethics and mental health

Ethical codes informing practice in various professions, mental health included, are based on principles and/or virtues, all reflecting people's diverse worldviews and cultures (Francis, 2015). According to Young (2016), ethical codes are based on ethical principles, which should have an overarching theory. However, to construct an over-arching ethical theory, the most advanced ethical thought process needs to be used (Young, 2016). For example, ethical codes of the American Psychology Association (APA), are based on five major principles (that is, beneficence/non-maleficence, fidelity/responsibility, integrity, justice, and respect for rights/dignity), which are in line with the western philosophies (Young, 2016).

In practice, these principles foundationally represent the core values that psychologists should uphold (APA, 2010). Felthous (2016) concluded that the ethical principle of beneficence is most apposite and further defined and operationalised by the American Medical Association ethics principles of a primacy of patient welfare and promoting access to medical care in serving mentally ill inmates. This review of ethical choices for psychiatrists facing this ethical predicament concludes that the psychiatrist ought not to abandon the most appropriate and needed hospital care, for inmates in such an extremely severe and needful (Felthous, 2016).

In South Africa, ethical codes informing the practice of psychology are also founded on the same principles (*Health Professions Act 1974)*. The Health Professions Council has developed ethical guidelines which govern the conduct of health professionals for promoting good ethical practice (HPCSA, 2016). All health care practitioners are expected adhere to the HPCSA ethical guidelines. Unfortunately, although it is argued that the conception of psychology ethics is a contextually and culturally relative activity (Nyika, 2009; Peltzer, 2009), such is not yet realised in South Africa.

The shift in emphasis to a universal primary health care in post-apartheid South Africa has been accompanied by a process of decentralisation of mental health services to the district level, as set out in the Mental Health Care Act, no. 17, of 2002 and the 1997 White Paper on the Transformation of the Health System. In their study seeking to assess progress in South Africa concerning deinstitutionalisation and the integration of mental health into primary health care, to understanding the resource implications of these processes at the district level; Petersen et al.'s (2009) suggest that the decentralisation of a mental health services process remains largely limited to emergency management of psychiatric patients and ongoing psychopharmacological care of patients with stabilised chronic conditions.Theysuggest that in a similar vein to other low- to middle-income countries, deinstitutionalisation and comprehensive integrated mental health care in South Africa is hampered by a lack of resources for mental health care within the primary health care resource package, as well as the inefficient use of existing mental health resources (Petersen et al., 2009).

The ethical implications of inequalities in mental health for people and nations are profound and must be addressed in efforts to fulfil a key bioethics principle of medicine and public health: respect for individuals, justice, beneficence, and non-maleficence(Ngui et al., 2010). The ethical concerns associated with international mental health disparities are profound. Human rights and social justice frameworks are arguably central ethical tenets of public health (Beauchamp, 1999). According to the International Covenant of Economic, Social and Cultural Rights, 'everyone has a right to the highest attainable standard of physical and mental health' (Earle, 2006).

As such, addressing global mental health inequalities and the underlying determinants of mental disorders promotes human rights and social justice in any society.

These frameworks call for the ethical care of people living with mental illness and global advocacy of beneficence, autonomy, respect for individuals, non-malfeasance and empowerment of all people, and particularly those who are marginalised, stigmatised and discriminated against (Roberts & Dyer, 2004). Mentally ill individuals who live in rural communities have significant health care needs but experience many obstacles to obtaining adequate health care services (Roberts et al., 1999). Ethical dilemmas in rural mental health care may be recognised in connection with overlapping relationships and altered therapeutic boundaries, patient confidentiality, cultural aspects of health care, generalist care and a multidisciplinary team functioning, limited resources for a consultation about clinical ethics, and heightened stresses on caregivers. These issues in rural mental health ethics have yet to receive systematic study. Nevertheless, they are prominent considerations for rural clinicians, and they may greatly influence rural mental health practices and services now and in the future (Roberts et al., 1999).

Cultural differences between patients and clinicians have become a matter of growing importance in mental health care as western societies have become increasingly diverse. Thus, to be culturally competent, a clinician must be sensitive, knowledgeable, and empathetic about cultural differences and then make therapeutic use of those capacities. Cultural competence is a concrete practical expression of bioethics ideals (Hoop et al., 2017). Mental health providers live out the ethical principles of beneficence, nonmaleficence, justice, and respect for persons in their efforts to understand, appreciate, and empathise with their patient's cultural values and to use those abilities in the service of excellent patient care (Hoop et al., 2017). The effectiveness of public health institutions depends heavily on the trust of the populations they serve. Distrust results in passive and in some cases, active resistance to policies and programs (Kennedy et al., 2007).

In mental health care, ethics and culture are intimately intertwined. To practice ethically requires awareness, sensitivity, and empathy for the patient as an individual, including his or her cultural values and beliefs (Hoop et al., 2017). Ethical principles are an expression of moral ideals and values, which are a product of human culture. Because values are culturally mediated, clinicians' deliberations when faced with ethically challenging clinical situations are thus to some degree a product of their personal cultural development and cultural heritage and may reflect values not shared by their patients. In addition to their cultural heritage, mental health professionals are also immersed in the "health care culture," the traditions and attitudes that pervade contemporary mental health practice (Tseng & Streltzer, 2004). This culture also plays an important role in shaping a clinician's ethical values, and it is to some degree foreign to many patients (Hoop et al., 2017).

### 2.8 Morality and ethics in traditional healing

African morals and ethics are derived from and inextricably interlinked with African spirituality, and there appear to be important principles to be learned from traditional African approaches to healing even for those who do not share the African cosmology or worldview (Manda, 2008). THPs have strong ethical principles and believe that they should develop life in all its forms and alleviate suffering (Ross, 2010). The herbs, wood, minerals and animal bones are used as healing agents because of the belief that humans are part of nature, and natural products are a gift from the Creator (Ross. 2010).

The isiZulu concept of *ubuntu*, or the Sesotho idea of *botho,* is the foundational doctrine of traditional African morals and ethics, and emphasises collective identity (as opposed to the Western emphasis on individual identity), solidarity, caring and sharing, the relatedness between the physical and metaphysical world, the value of interpersonal relationships or humanism, and is encapsulated in the saying 'A person

is a person through other persons' (*umuntu ngumuntu ngabantu*), which is the foundation of *Ubuntu* (Ross, 2010).

According to Downess (1977), the African idea of morality is doing good to others and not evil. African notion and application of moral precepts have a far-reaching implication on how African traditional medicine is practised. Adherence to moral precepts is an important and integral part of traditional health care in Africa and is subsumed in general African ethics. In addition, Omonzejele (2008) indicated that adherence to ethical precepts is an important and integral part of traditional healthcare in Africa and is subsumed in general African ethics. African ethics is that branch of African philosophy, which deals with the critical reflection on the manner, or nature of life, conduct, behaviour and character of the African (Awajuisuk, 2010). It is the conceptualisation, appropriation, contextualisation and analysis of values within the African cultural experience. Ubuntu is the capacity in African culture to express compassion, reciprocity, dignity, harmony and humanity in the interests of the building and maintaining community with justice and mutual caring (Nussbaum, 2003), and that it is a social philosophy, a way of being, a code of ethics and behaviour deeply embedded in African culture.

Sundermeier (1998) stated that in the African culture, good behaviour includes following and practising values and behaviour established by society and culture, participation in religious rituals and practices, and proper respect for family, neighbours and the community. Failure to follow these behavioural guidelines often results in good spirits withdrawing their blessing and protection. Magesa (1997) further argued that moral behaviour maintains and enhances one's life force, but disobedience and disloyal behaviour towards tradition passed on by the ancestors will weaken the life force. This can, therefore, lead to punishment from the ancestors or spirits in the form of disease and misfortune.

According to Tangwa (2007), ethical principles that emanated from atrocities committed by western medical practices should not be used to assess whether some actions of African traditional practitioners are wrong or right because they did not take part in the atrocities. Nyika (2009) argued that continuing to use African traditional medicines for old and new diseases without making efforts to improve their efficacy is unethical since the disease burden affecting Africa may continue to rise due to the non improving usage of traditional medicine. The controversy about the ethical principles followed by African THPs as well as the ethical issues surrounding the use of African traditional medicine is far from being over. Although there are no standards ethical rules that regulate the activities of African traditional medicine practitioners except THP Act of 2007, it is expected that THPs practice within the ethical dictates of their communities (Omonzejele, 2008).

## 2.9 The collaboration between the Western health system and the THPs

In many places of Africa, THPs are the first to be contacted for mental illness and many other disorders.(Mothibe & Sibanda, 2019; Schierenbeck et al., 2018; Burns & Tomita, 2015; Asare & Danquah, 2017; Abiodun, 1995; Ngoma et al., 2003). A systematic review of traditional and religious healers in the pathway to care for people with mental disorders in Africa by Burns and Tomita reported that about half of the people seeking formal health care for mental disorders in Africa opted for traditional and religious healers as their first care provider (Burns & Tomita, 2015). Asare and Danquah (2017) pointed out that amongst many other reasons, seeking health care from the THPs first has been associated with delays in seeking formal health care or the Western Health Care System.

Kohn et al.'s (2004), further explains that THPs have a choice of traditional Modern medicine has often been justified by the fact that they explain the cause of unexplainable medical phenomena better and thereby gives hope to the seekers of these services (Asare & Danquah, 2017). Another systematic review of the effectiveness of THPs in treating mental disorders by Van der Watt et al.'s , established

that some evidence exists for psychosocial interventions by traditional healers for mild to moderate anxiety and depression, but not for severer forms of mental illnesses.

In South Africa, there are far more THPs than MHCPs and HCPs (Meissner, 2004), particularly in rural areas. THPs play a huge role in the health system (Moshabela, 2008). THPs in South Africa represent an important healthcare resource (Street et al., 2018). Peltzer (2009), stated that the National Department of Health (NDOH) supports collaboration between the allopathic health system and THPs on primary health care and HIV/AIDS prevention and education, but the NDOH does not endorse referrals from the allopathic health sector to THPs. Their reasons for refusing to permit or facilitate referrals between allopathic health practitioners and THPs are that THPs, and their medications are not regulated. Despite all that, McFarlane (2015) pointed out that the link between traditional medicine and Western medicine will never coincide but will work together in South African society to ensure that its citizens are receiving the right treatment. In addition, there is no uniform system (or language) of diagnosing, treating and teaching and there is little formal evidence of the efficacy of traditional medicines.

Western-based medical care alone is not designed to cope with the demands of an African environment (le Roux-Kemp, 2010). According to Mothibe and Sibanda (2019), there is evidence for the need to have collaboration between Western-trained HCPs and THPs in managing health care. In acknowledging the dualism that exists in seeking health care, one of the objectives of the strategic health plan of the NDoH is to form links with THPs and complementary healers. Several efforts to collaborate with THPs have been made over the years, many of which were not systematically evaluated and not based on principles of mutual respect. Existing collaborative examples need to be further supported by cost-effective evidence to suit the South African public health budget (Street et al., 2018).

Freeman and Motsei (1992) discussed three possible models: *incorporation*, where THPs are incorporated usually into the primary health care system where they are

“first-line” practitioners; *cooperation/collaboration*, where the traditional and allopathic health care systems essentially remain independent and keep their methods of operation, but they recognise the value and contribution of the other and adopt a system of mutual referral; and *total integration*, which will require the development of a new health care system where traditional and allopathic health systems are intermingled and thus patients would receive treatment from both THPs and western trained health practitioners.

TM plays a role that cannot be completely substituted by conventional medicine; hence, it will remain as a part of the healthcare option available to the population if it is accessible (Mothibe & Sibanda,2019). While there is notable progress and benefit in institutional research and collaboration, there is a great need to provide guidelines and regulations for collaboration in the primary health care and clinical level. Proper education of conventional health providers about African traditional medicine and the role of traditional health practitioners will facilitate understanding and trust between two practices and benefit the health care service (Mothibe & Sibanda, 2019).

In open and democratic South Africa, greater collaboration in the interest of the patient will become increasingly necessary between occupational therapists and THPs, but this is difficult to establish in the current environment where there is no information available about practitioners’ perceptions of each other, or their knowledge of the other’s profession (Van Niekerk et al., 2014).

## 2.10 Conclusion

This chapter covered a range of topics. The discussion was mostly focused on South African literature. Amongst others, the chapter covered the recognition of THPs in South Africa, whereby the challenges about the regulation of THPs were discussed mostly based on government policies. The chapter also discussed the THP’s treatment of mental health conditions, whereby the literature has shown that THPs are capable

of treatment of mental conditions. In addition, the concept of ethics, ethics in mental health were discussed. The collaboration between the allopathic health system and a traditional health system were also discussed. The next chapter will discuss the theoretical framework of the study.

# CHAPTER 3: THEORETICAL FRAMEWORK

## 3.1 Introduction

In many qualitative studies, a theoretical framework is defined as the lens through which the researcher views their study. A theoretical framework serves as a conceptual guide for selecting concepts to be investigated, proposing research questions, and framing the research findings. (Corbin & Strauss, 2008). Although Corbin and Strauss (2008) prefer not to start research with a predefined theoretical framework or set of concepts, they acknowledge that theoretical frameworks are useful in some qualitative studies. In this study, Afrocentricity was adopted as the study lens. The phenomenon of study is therefore investigated from an African ontological and epistemological positionality.

## 3.2 Afrocentricity

Afrocentricity as a philosophy and paradigm is largely attributed to seminal works of Professor Molefi Kete Asante. According to Asante (1998), Afrocentricity places African standards or principles at the centre of any analysis that involves African culture and behaviour. This study sought to establish from an idiographic perspective, THPs conception of ethics as it relates to the practice of mental health in an African setting. It is now that Afrocentricity is a suitable lens to orient the study.

I must point out that I had an opportunity to meet Prof Molefi Kete Asante in person while this study was already in progress. I have listened to his presentation on “The Afrocentric Idea” and engaged with him on the concept of Afrocentricity and how it differs from the concept of Africanity. His explanation stems from his book *“The Afrocentric Idea”* that the substance of one concept is not the same as the other. In simple terms, Afrocentricity seeks agency and action, whereas Africanity broadcast identity and being. However, it is possible to develop a relationship between the two

concepts to generate a more substantive African culture of balance and harmony (Asante, 1998).

The Afrocentric paradigm deals with the question of African identity from the perspective of African people as centred, located, oriented, and grounded (Asante, 2007; Asante, 1998; Mkabela, 2005). Similarly, Mazama (2002) defines Afrocentricity as a perspective on the African experience that posits Africans as subjects and agents, and which therefore demands grounding in African culture and the worldview. THPs are African people who are centred, located, orientated and grounded in the African culture. Masoga and Shokane (2018), introduced the Afro-sensed theory, claiming that Afrocentricity is more American than African. Afro-Sensed Theory encompasses using Indigenous knowledges and cultural approaches to discover uniqueness and Indigenous ways of healing (Masoga & Shokane, 2018). However, looking at what the scholars proposes to be the Afro-Sensed Theory, I maintain that there is not much difference between what the authors' advance in the Afro-Sensed Theory and the basic tenets of Afrocentricity. The practice of traditional healing is also grounded in the African culture. Moreover, the patients and the communities that these THPs offer services to, are also of the same culture. Therefore, for all those reasons I pointed out, Afrocentricity remains the best-suited framework for this study.

Therefore, I will later discuss my involvement and possible bias in this study as I am both a researcher and analyst whose been taught Eurocentric theories and ideologies, this framework helped me to be mindful of my experiences and ideologies during the analysis and interpretation of concepts derived from the data. In her paper on Afrocentricity and the Western paradigm, Monteiro-Ferreira (2009) criticizes the Eurocentric myths of universalism, dismissal of colonisation concepts and racist theories that preside over the triumph of Western paradigm. The author believes that Afrocentricity can open the possibility of a nonhegemonic alternative perspective in the understanding of human expressions in a diverse multicultural society (Monteiro-Ferreira, 2009).

According to Mkabela (2005), Afrocentricity is opposed to theories that "dislocate" Africans in the periphery of human thought and experience. Mazama (2002) argued that Afrocentricity should not be reduced to an epistemological project and that it cannot, and certainly should not, be approached simply as an analytical tool. I agree with Mazama (2002) however, I would like to point out that for a novice researcher, being able to analyse African culture, stories, worldviews using the Afrocentric approach would be the first step to becoming Afrocentric. Getting to the ultimate goal of Afrocentricity being our liberation and freedom from oppression as per Asante's assertion in *"The Afrocentric Idea"* whereby Afrocentricity informs African's approach to everything is a process. Mazama (2002) further questions, if there could be a profound way, where African people reclaim their total selves and reassert their love for Africa, and self-commitment as African people than to only honour African gods and spirits. I still maintain that to attain the levels is a process in progress, and we should appreciate every aspect of Africans being, the Africans are embracing who they are.

Several researchers have shown interest in Afrocentricity as a methodological approach (Pellerin, 2012; Mkabela, 2005; Reviere, 2001). According to Pellerin (2012), Afrocentricity is most appropriate in a methodological approach to producing African realities. Afrocentricity also serves as a governing tool of active agency that informs new approaches in interpreting a social phenomenon and can aid in the redevelopment of social science research (Pellerin, 2012). In addition, Reviere (2001) proposed an Afrocentric methodology suited for the investigation of research questions based on race and culture. The proposed method acknowledges that the researcher should be closely integrated with the inquiry and recognises the importance of race in formulating theories, including African values and experiences as per Asante's ideologies. Mkabela (2005) has also shown how the Afrocentric method can be used to investigate indigenous African culture, IKS and how it can be used as a complement to qualitative research methods. One common feature of these authors suitable to be investigated using the Afrocentric approach is culture. The current study focuses on Northern Sotho THPs; hence I choose Afrocentricity as my theoretical framework.

Afrocentricity demands that African people should think of themselves as African selves and refrain from being satisfied with an individualistic approach. The African selves should understand that they are an organic part of a whole that includes spiritual and physical entities (Asante, 1998; Mazama, 2002). Within the cosmological perspective of the African-centred two elements of the universe-people, animals and inanimate are viewed as interconnected (Graham, 1999). Embracing Afrocentricity entails being fully and consciously in tune with African metaphysics. There is an African way of understanding the visible world around us (the cattle, trees, people, and cities) as well as the unseen world, the supernatural world of spirits, powers, and diseases (Oduro et al., 2008). In the African context, people do not conceive of themselves as separated from the universe, but as being completely integrated into a universe that is much larger than any of them and yet is centred around them (Mazama, 2002).

According to Omonzejele (2008), African concepts of health, ill-health and treatment are best understood within the framework of the African worldview. On contrary, Western biomedical or allopathic medicine initially tended to view disease as a form of biological malfunction, with illness manifesting in chemical, anatomical or physiological changes (Graham, 1999). In support of Omonzele (2008) I am of the view that notions of health and ethics as they relate to health practice may not necessarily be evaluated from any other system of thinking that is the western axiological perspective. For traditional Africans, health is not just about the proper functioning of bodily organs. Good health for the African consists of mental, physical, spiritual, and emotional stability of oneself, family members, and community; this integrated view of health is based on the African unitary view of reality. Mind, body and spirit are seen as one, and no distinction is made between physical and psychosocial problems. (Graham, 1999). In addition, at the neuroscience level, the brain is culturally and socially constructed (Ames & Fiske, 2010). This implies that Modern Medicine practitioners cannot divorce cultural and social issues from disorders and illnesses of the brain and their management. Good health for the African is not a

subjective affair (Omonzejele 2008), therefore it cannot be investigated as a subjective affair. From an African perspective, the concept of disease goes beyond organic and tissue malfunctions. In the traditional African setting, disease and ill health are intricately linked to one's destiny and ancestral spirit. Thus, the current study is best suited in Afrocentricity.

Omonzojele (2008) further explains that good health consists of mental, physical, spiritual, and emotional stability of oneself, family members, and community and this integrated view of health is based on the African unitary view of reality. The current study focuses on mental health. The concept of being a life force, disease, and treatment is similar in most African countries. These concepts are founded on African traditional religion. African traditional religion, though not exactly synonymous with African ethics serves as the bedrock of African morality and this has implications on how African traditional medicine is practised in Africa. African ways of life mode of healing revolve around indigenous religion.

Omonzojele (2008) study sought to highlight the mode of practice and indicate the ethical precepts of African traditional medicine. It is of relevance to indicate that the acceptance and application of African healing methods by other parts of the world would be extremely difficult. Especially where a Western paradigm is employed for that purpose. This is because African healing methods and concepts therein cannot easily be subjected to scientific and epistemic tests as would Western medicine (Omozonjele, 2008). This is the exact reason why the current study is fitting enough to be an Afrocentric study. Other than the controversies about the concepts of good and ill health in the African and Western perspective, this study fits the definition of an Afrocentric study of Pellerin (2012), Mkabela (2005) and Reviere (2001).

### 3.3 Conclusion

This chapter discussed Afrocentricity as the theoretical framework for the current study. There has been a lot of controversies and debates about whether Afrocentricity is suited to be a theoretical framework for African studies. However, Afrocentricity is still used in many studies, and this one was no exception. The above discussions show that, other than being used as a theoretical framework, Afrocentricity can also be used as a qualitative research approach. The next chapter discusses the methodology used in conducting the current study.

# CHAPTER 4: METHODOLOGY

## 4.1 Introduction

This chapter discusses the research design, and the research paradigm followed when conducting the study. The research followed a qualitative design and constructivist paradigm. The epistemological, ontological, methodological, and axiological underpinnings of the constructivists were discussed. The chapter presents how the researcher via Grounded Theory goes about sampling, data collection as well as data analysis. The important concepts in Grounded Theory such as comparative comparison and memo writing were also discussed in this chapter. The chapter further presents the ethics that were involved in conducting this study. To help enumerate the study methodology, it is worth re-stating the study purpose in this chapter. The main intent of the present study was “to develop an explanatory ethical framework that informs the THPs in the management of mental health cases”. To realise this aim the following objectives were put forward:

- To explore notions of mental health ethics as perceived by THPs.
- To describe what THPs understood to be ethics in the management of mental health conditions.
- To determine THP views regarding what is considered good ethical behaviour in the treatment of mental health conditions.
- Based on the THPs’ representations, develop an explanatory ethical framework informing THP’s management of mental health cases.

The most practical epistemological attitude to adopt was a qualitative grounded theory design, and its intricacies are discussed in the following subsections.

## 4.2 Study design

According to Groenewald (2004), one needs a grasp of a vast range of research methodologies to select the most appropriate design, or combination of designs, most suitable for a particular study. According to Corbin & Strauss (2008), research should dictate the methodological approach that is going to be used to conduct the research. It is for this reason, that amongst the two main research designs, namely qualitative and quantitative design, I thought qualitative research is the most suitable method to conduct the present study. According to Barbour (2014), qualitative research suits best when studying a specific context.

For this study, the context under study is that of THPs, hence the choice to follow the qualitative research method. Babbie (2012) explained the three purposes of qualitative research, mainly being to explore, describe and explain. Exploratory studies are normally done when a researcher examines a new interest or when the subject of the study is new. Exploratory studies are also done to satisfy the researcher's curiosity and the desire for a better understanding of a particular phenomenon, to test the feasibility of undertaking a more extensive study and develop methods that can be used in other studies to follow. The purpose of descriptive qualitative studies is to describe situations and events. Descriptive studies also study processes that involve why certain things are done in a certain manner, whereas explanatory qualitative research aims to  to explain a certain phenomenon (Babbie, 2012).

Amongst all the three purposes mentioned above, this study is more exploratory. The study explored the ethics followed by THPs in the management of mental health cases. This is a phenomenon that little is known about it, hence the choice for the qualitative approach. Strauss and Corbin (1998) also indicated that qualitative research is used to explore the potential antecedents and factors  that little has been known and explored. Qualitative research allows researchers to get the inner experience of participants, to determine how meanings are formed through and in culture, and to discover rather than test variables (Corbin & Strauss, 2008). The study

explored meanings attached to ethical practices involved in THP's management of mental health cases, taking into consideration the culture and the context of the THPs as discussed earlier. The discussion to follow is on the constructivist paradigm that this study is nested into.

### 4.3 The constructivist paradigm

A constructivist paradigm is amongst research paradigms nested in the qualitative approach. A constructivist paradigm suggests that individuals construct their knowledge (Allen, 2004). For the present study, I focused on THP's ethics, aphenomenon known and understood by the THPs themselves, more than any other person or group. Constructivists generate or inductively develop a theory or pattern of meanings, rather than beginning with a theory or hypothesis (Creswell, 2003). The primary aim of this study is to develop an ethical framework that informs THP's management of mental health cases. In line with the aim of the study, I thought that this research is best rooted in this paradigm. A paradigm is composed of multiple belief categories such as axiological, ontological, epistemological, and methodological assumptions. I am going to discuss the epistemological, ontological, and methodological stances of the present study next.

#### 4.3.1 Epistemological stance of the study

Qualitative research is based on constructivist epistemology and explores what it assumes to be a socially constructed dynamic reality through a framework that is flexible, descriptive, holistic, and context-sensitive (Yilmaz, 2013). Honebein (1996) described the constructivism philosophical paradigm as an approach that asserts that people construct their understanding and knowledge of the world through experiencing things and reflecting on those experiences. It is aimed to understand how social experience is created and given meaning. According to the constructivists, knowledge is established through the meanings attached to the phenomena under study (Krauss, 2005). It assumes that all knowledge is built up from scratch by the subject of

knowledge (Heylighen, 1993). This means that reality is socially constructed (Mertens, 2005). The study is deeply rooted in social constructivism where individuals develop subjective meanings of their experiences.

The meanings form through interaction with others and through historical and cultural norms that are adopted in an individual's way of living (Creswell & Poth, 2018). The post positivists focus on research issues in the context of involving the experiences of the majority and announcing the results of what the majority claims is acceptable (Phillips et al., 2000). Unlike the post positivists, the social constructivists inductively develop a theory or a pattern of meaning (Lincoln & Guba, 2000). Generally, the constructivists do not begin a study with a theory rather they, generate or inductively develop theory or pattern of meanings throughout the research process (Creswell, 2003). Although I have not focused much on observation as one of the tools for data collection to develop the framework, I mainly focused on the data provided by the participants. The THPs themselves attached meanings to what they understood to be ethics in the management of mental health cases in their practice. In a constructivist epistemology, the researcher is part of the reality that is being researched, such that the research findings are a creation of the inquiry process itself rather than a collection of external, already existing facts (Linclon & Guba, 1990).

### 4.3.2 Ontological stance of the study

According to Lilcoln and Guba (1990), the ontology of the constructivist paradigm is relativist, meaning that realities are socially constructed, ungoverned by universal laws . These realities are local and specific, dependent on their form and content on the persons who hold them (Lincoln & Guba, 1990). I followed the relativist ontological assumption that maintains that understandings are created through the interaction between the knower and the unknown or subject (Denzin & Lincoln, 1998). Poonamallee (2009) argued that, if reality is thought to be purely subjective, knowledge created about such reality will have to be subjective too and cannot be valid. However, Denzin and Lincoln (1998) stated that the goal of subjective research

is to develop understanding, increase sensitisation to ethical and moral issues, and personal and political emancipation. For the present study, through data collection in the field, I have indeed developed a better understanding and morals involved about THPs as the participants under study.

### 4.3.3 Methodological stance of the study: Grounded Theory

The constructivist researcher is most likely to rely on qualitative data collection methods and analysis (Mackenzie & Knipe, 2006). I adopted Grounded Theory as a qualitative approach for the present study. According to Creswell and Poth (2018), Grounded Theory (GT) is a qualitative research design in which the researcher generates a general explanation of a process, an action, or an interaction shaped by the views of many participants. In addition, the method is designed to create theories derived from real-world settings and situations (Oktay, 2012). Unlike phenomenology where the emphasis is on the participant's lived experiences; Grounded Theory moves beyond description to generate or discover a theory (Corbin & Strauss, 2008). The method was thought to be more appropriate due to the nature of the research question for this study, and the aim for this study was to develop the ethical framework that informs the THPs management of mental health cases.

The Grounded Theory method was developed by Glaser and Strauss (1967). Glaser and Strauss did explicitly declare their ontological or epistemological stance in the *Discovery of Grounded Theory* (Glaser & Strauss, 1967). However, Denzin and Lincoln (2000) argued that Glaser and Strauss, in their original Grounded Theory approach, tried to modify the usual canons of good positivist science to fit their post-positivist conception of rigorous research. Glaser and Strauss explicitly expressed that their perspective was phenomenological, and they presented Grounded Theory as a method that aimed at generating theory. Later, Strauss parted ways with Glaser, and from drawing from their original version of Grounded Theory, the Straussian Grounded Theory was born. Glaser's approach (1978) has come to be known as classic

Grounded Theory research whereas Strauss's approach (Corbin & Strauss, 2008; Glaser, 1978) has taken the name Straussian.

Corbin and Strauss (2008) constructed their Grounded Theory method in both the tradition of Chicago Interactionism and the philosophy of pragmatism inherited from John Dewey and George Mead. This is the reason, why the researcher followed the Straussian Grounded Theory approach. Corbin and Strauss (2008) clearly outlined their methodology. This study is more concerned about the THP as an individual and practicing ethically in the field of primary health care practice. The interaction is in between the self and the social environment that the THP founds himself/ herself without having a choice. The life of THP is a life guided by the ancestors.

According to Charmaz (2008), Grounded Theory not only is a method for understanding research participants' social constructions but also is a method that researchers construct throughout the inquiry. The constructivist worldview manifests in the Grounded Theory perspective, in which the theoretical orientation in the views or perspectives of individuals are grounded (Charmaz, 2014). According to Charmaz (2014), we construct our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices. By grounded, it means that the theory emerges from the data, and not from the hypotheses of formulations that are already determined (Murray & Chamberlain, 1999). According to Charmaz (2014) Grounded Theory can complement other approaches to qualitative data analysis, rather than opposing them. The participants in a Grounded Theory study must have experienced the process or an action in the phenomenon under study, and the development might help explain the practising or provide a framework for further research (Creswell & Poth, 2018).

## 4.4 Study setting

The Capricorn District (Figure 4.1) comprises four municipalities, namely Blouberg, Lepelle-Nkumpi, Molemole and Polokwane. The study only focused on Polokwane Municipality. I collected data in four rural areas under Polokwane Municipality, namely Ga- Makanye, Nchechane, Mamotintane and Ga-Dikgale. Polokwane Municipality is situated in the central part of the Limpopo Province. The population size of this municipality is 628 999, with 178 001 households (Statistics South Africa, 2011). The municipality has 46 health facilities in the form of hospitals and clinics, excluding private hospitals (Statistics South Africa, 2011). Although there are many THPs in the chosen setting, there is not much literature or data about the number of THPs in this municipality. Hence, I thought of exploring the Northern Sotho THPs in this Municipality.

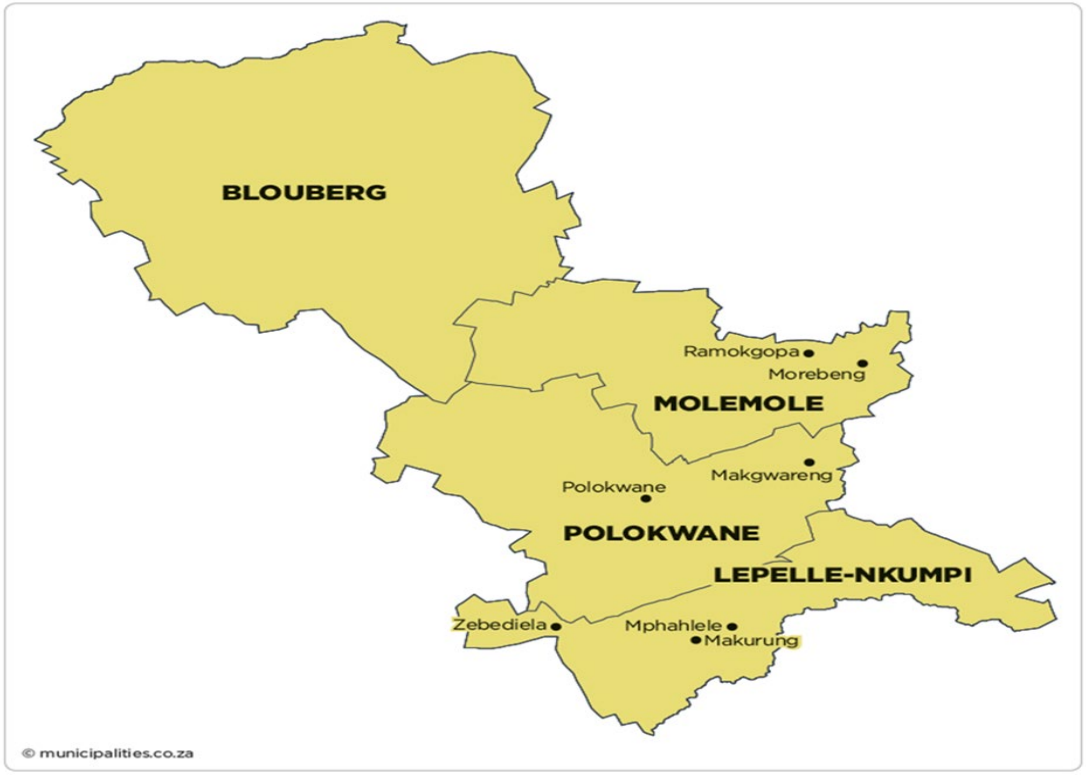


**Figure 1.1** Map of Capricorn District (https://municipalities.co.za/map/126/capricorn-district-municipality)

## 4.5 Sampling

### 4.5.1 Sampling in Grounded Theory

The various aspects of Grounded Theory are interconnected, and it does not lend itself readily to a linear presentation (Murray & Chamberlain, 1999). According to Bitsch (2005), in Grounded Theory, sampling decisions are not fixed or cannot be planned before embarking on the study. This is also supported by Corbin and Strauss (2008); however, they acknowledge that the researcher is supposed to share such information for committees to have an idea of what the study is about. Nonetheless, Creswell and Poth (2018) stated that the researcher typically conducts 20-30 interviews based on several visits to the field during data collection, whereas Starks and Trinidad (2007) reported that sample size for Grounded Theory ranges from 10 to 60 persons. This means sampling decisions evolve as data is collected and analysed. Sampling in Grounded Theory is associated with the explicit sampling of information to develop a theory, rather than containing notions of representativeness (Murray & Chamberlain, 1999). Essentially, sampling decisions are informed by the emerging conceptual categories; the emergent concepts then determine “who” next to the sample to help the researcher clarify understanding and generate the theory of the phenomenon of interest (Bagnasco et al., 2014). It is in this regard that the sampling procedures in Grounded Theory are referred to as theoretical sampling.

### 4.5.2 Theoretical sampling

Theoretical sampling is led by developing ideas. It refines, elaborates and exhausts conceptual categories (Bitsch, 2005; Corbin & Strauss, 2008). Theoretical sampling starts after the first analytic session and continues throughout the research process (Corbin & Strauss, 2008). Theoretical sampling is different from all other sampling techniques in qualitative methods because it does not involve participants, rather involves the concepts. However, I will give a detailed explanation in 4 5.2.1 of how she got the participants, following the grounded theory sampling procedures outlined by Murray and Chamberlain (1999).

Theoretical sampling is a method of data collection based on the concepts derived from the data (Corbin & Strauss, 2008). Theoretical sampling is responsive to the data than rather than established before the research begins. This method makes sampling open and flexible. Concepts are derived from the data during analysis and questions about those concepts drive the next round of data collection. It is about discovering relevant concepts and their properties and dimensions. I followed the lead of the concepts, not certain where they will lead, but always open to what might be discovered.

I collected data from the participants that provided more information about the concepts that were interrogated, and I wanted to learn more about them. It was not much of a challenge to do so, as I was only collecting data from the THPs, and not any other group of participants. In theoretical sampling, the researcher is not sampling people but concepts. The researcher is purposely looking for indicators of those concepts so that she examines the data to discover how concepts vary under different conditions (Corbin & Strauss, 2008). In chapter 6 of the results, I have first presented a table of indicators for each concept before discussing the concept.

As a novice researcher using grounded theory, I was confused when I first encountered theoretical sampling. Unlike conventional methods of sampling, the researcher does not collect the entire set of data before beginning the analysis. Analysis began after the first data collection was done through open sampling. Data collection led to analysis. Analysis led to concepts. Concepts generated questions. Questions leads to more data collection so that the researcher might learn more about those concepts. The process continues until the research reaches a point of saturation, whereby all the concepts are well defined and explained (Corbin & Strauss, 2008).

Theoretical sampling allowed the researcher to go where the analysis indicated would be the most fruitful place to collect more data to answer the questions that arose during the analysis. The researcher began the a study with a general target population and continues to sample from that group (the three-sampling techniques). After the first interview, concepts derived from that interview and questions about the concepts became the basis for gathering more data (Corbin & Strauss, 2008).

The advantage of theoretical sampling is that data collection can never get too far ahead of analysis because of the focus of subsequent data collection; the question to be asked in the next interview are based on what was discovered during the analysis of the previous interview. However, practically, there are times when a researcher might have to continuously collect data. This usually happens when a researcher must travel to get the participants or take advantage of the moment. This catches up with the researcher during the analysis. When questions arise as they usually do during analysis, the researcher might not have the opportunity to collect additional data about a particular concept, it leaves gaps in the research (Corbin & Strauss, 2008). As I was dealing with a group of THP's registered under Mošate wa Mangaka Humeleng, I had an opportunity to sit in one of their meetings, I got about 6 participants and interviewed them on the same day. I was helped by the quick memos I made after each interview.

Theoretical sampling is concept-driven, and it enables the researcher to discover the concepts that are relevant to the problem and population and allows researchers to explore the concepts in depth. Theoretical sampling is relevant when studying new areas because it allows for discovery. It allows researchers to take advantage of casual events. For example, during analysis one of the main concepts I discovered was (admission). So, during my next set of data collection, as I was busy in the sacred hut (*indomba*) with the participant, a patient who was coming for a consultation pitched. The THP whom I was interviewing asked me to pause the interview a bit so that she could attend to the patient. After a few minutes, she came back and told me that the patient was going to sleep-over. I was able to take advantage of that casual event and I asked more questions about the issues of admission. I was able to

discover how admission occurs under different conditions. I found that fascinating. Had I been using more conventional methods of sampling; I was not going to be able to take advantage of the situation.

Theoretical sampling is also cumulative. Each event sampled builds upon previous data collection analysis, and in turn, contributes to the next data collection and analysis. Moreover, sampling become more specific with time because the questions become more specific as the researcher seeks to saturate categories. In the initial data collection, the researcher collects data on a wide range of areas. The researcher always refined and revised the data collection. Once the initial analysis takes place the researcher had a sense of where the study is going because she had concepts to sample for. Not every concept that comes out of the research is sampled (Corbin & Strauss, 2008). The researcher should be practical and stick to developing categories that are most important and relevant in the developing theory.

The sample decision of 20 participants was reached due to the saturation of the categories of the theory being constructed. All participants were residents of Polokwane Municipality, Capricorn District (Figure 4.1). Sampling was guided by the need to develop a theory that is grounded from the data, and the different stages of sampling were intended to facilitate that process. I followed the three sampling phases outlined by Murray and Chamberlain (1999). Each sampling phase is designed to serve a certain goal in the analysis. I chose to follow these sampling procedures because, in Grounded Theory methodology, theoretical sampling and both data collection and analysis are done simultaneously. Murray and Chamberlain's (1999) sampling phases are easier to follow and allowed for integration between data collection and data analysis, but most importantly they are rooted in theoretical sampling.

*4.5.2.1 Open sampling*

Open sampling is the first stage of sampling. The researcher uses any relevant sampling process to obtain the data that is relevant to the research question (Murray & Chamberlain, 1999). The researcher used purposive sampling as the first sampling phase for the present study. According to Mack et.al (2005), purposive sampling is one of the most used sampling strategies, where participants are preselected based on their relevancy to a particular research question. The researcher chooses specific people within the population to use for a particular research project (Choy, 2014). I deliberately chose the THPs to participate in the present study. Taking into consideration that my interest lies more in sampling concepts than sampling in terms of the number of participants. Open sampling was accompanied by the first phase of analysis. From this point I discovered some concepts and refined the interview guide based on those concepts.

*4.5.1.2 Relational/ variational sampling*

More participants were approached as I collected data in the field. This sampling phase is aimed at locating more data that can confirm and elaborate categories, identify relationships between those categories or suggest limits to their applicability (Murray & Chamberlain, 1999). This is associated with axial coding. In axial coding**,** the results in the categories are refined, developed, and related to one another (Corbin & Strauss, 2008). For the present study, as more data was collected and analysed, new categories emerged, requiring the researcher to further do relational sampling. I continued with relational sampling to understand, refine, and scrutinise the categories derived from the data. The core category was discovered in this phase.

*4.5.2.3 Discriminate sampling*

This stage involves a deliberate and directed selection of more data from participants, verifying the core category and ensuring that the theoretical account is saturated.

Discriminate sampling ensures that categories are correctly located in the theory and that the theory is comprehensive and saturated (Murray & Chamberlain, 1999). The analysis process tied up with this stage of sampling is called selective coding. This is where the core category that ties all the other data categories together is identified and related to other categories.

As discussed earlier, all these phases combined accounts for what Corbin and Strauss (1990) referred to as theoretical sampling. It is by theoretical sampling that the representativeness and consistency are achieved. In Grounded Theory, representativeness of concepts, not of persons, is crucial. The aim is ultimately to build a theoretical explanation by specifying phenomena in terms of conditions that give rise to them, how they are expressed through action/ interaction, the consequences that result from them, and variations of these qualifiers (Corbin & Strauss, 1990).

### 4.6 Data collection

As I have already discussed the sampling decisions taken and how they interrelated with both data collection and analysis, here the focus more on data collection. Constructivist researchers rely more on participants' views of the situation or phenomenon under study (Creswell, 2003). Charmaz (2006) stated that data collection and analysis proceed simultaneously in grounded theory. Data collection and analysis are interrelated, and the initial data analysis is used to direct further data collection (Murray & Chamberlain, 1999). By contrast, many qualitative researchers collect much of their data before beginning systematic analysis. This allows the researcher an opportunity to be aware of the recurring categories, as well as follow up on the unexpected findings. What this means that the researcher operates in a zig-zag fashion whereby after each interview the data is immediately analysed.

It is important to note that, unlike in other qualitative approaches in Grounded Theory the data collection is guided by theoretical sampling as discussed earlier, than

population representativeness (Charmaz, 2014). There are few processes involved in collecting data for a Grounded Theory study. Thus, not to miss anything that may be salient, the researcher must analyse the first bits of data for cues. All seemingly relevant issues must be incorporated into the next set of interviews and observations. Although I followed Straussian Grounded Theory, I adopted Charmaz's intensive interviewing. The data was collected by interviewing the participants.

### 4.7 Intensive interviewing

Qualitative research draws on informational, intensive and investigative interviewing strategies (Charmaz, 2014). Informational interviewing entails gaining accurate responses for demographic questions and descriptions of events with clarifications about such details as chronologies, places, and the people who were involved. Investigative interviewing similarly aims for accurate details but also to uncover hidden actions. Corbin and Morse (2003) states that the most data-dense interviews are those that are not dictated by any predetermined set of questions. A researcher requires preparations, skills, and training to do those kinds of interviews.

According to Corbin & Strauss (2008) interviewing and observing are skills that take training and skills to acquire. Interviewing is a skill, more especially because most of the things that happen in the field cannot be predictable. According to Charmaz (2014), grounded theorists use what is referred to as intensive interviews. This approach includes informational interviewing to gather needed details for the study. Charmaz (2014) further highlighted that grounded theorists' interviewing approach may change as the study develops. Interviews take place within a culture at a specific historical time and social context. The researcher's approach to interviewing, questions, specific word choice, and the interactional style during the interview need to respect the traditions and situations for the participants to be interviewed. For example, as I was collecting data, some of the participating THPs requested that I take off my shoes when getting into the sacred hut *(indumba)*. I had to take off her shoes and adhere to the interviewed THPs' traditions.

Grounded Theory and intensive interviewing are an open-ended yet directed, shaped yet emergent, and paced yet unrestricted. Intensive interviewing conducts an open-ended, in-depth exploration of an area in which the interviewee has substantial experience. The focus is on the topic while providing the interactive space and time to enable the research participant's views and insights to emerge. The flexibility of Intensive interviews allows the interviewers to discover discourses and to pursue ideas and issues that emerge during the interview (Charmaz, 2014).

Intensive interviews create and open an interactional space in which the participant can relate his or her experience. The focus is mainly on the research participants' statements, how they portray this experience and what it means to them. Intensive interviewing seeks to understand the research participant's language, meanings and actions, emotions and body language. Intensive interviewing is a useful method for interpretive enquiry (Charmaz, 2014).

For the present study, in-depth intensive interviews were used to collect data. The in-depth nature of intensive interviews prompted the participant's interpretation of mental health ethics involved when patients with mental health issues. The interview tool for the Grounded Theory must be as open as possible because the emerging theory is mainly led by the emerging data. As more data the collected and analysed, the emerging conceptual categories lead to the revision of the interview guide, and how some of the questions should be asked to get more rich data. This contributed towards the saturation of the developing theory as data collection continued.

All twenty (20) interviews were conducted in Sepedi and later translated and transcribed verbatim to English. All interviews were digital-recorded with the permission of the participants. For the first 2 interviews, as I was interviewing the participants; I was also taking notes so that I do not forget the important information. Glaser (1998; Glaser, 2001) argued that taking notes enables a grounded theorist to

record the important information without becoming lost in the details. In contrast, Charmaz (2009) argued that taking notes fails to preserve the participant's tone and tempo, silences and statements, and the form and flow of questions and responses. I stopped taking notes any further during the interviews because I felt like it leads to the loss of the construction of the interview, and it made the whole interviewing process too formal. For the subsequent interviews where I was not taking notes, the participants where a lot freer and more comfortable. I only wrote down important notes after each interview took place.

After the transcription, each interview was coded and analysed before the next one was conducted. This enabled me to incorporate the new interview questions to be explored in subsequent interviews. This also created an opportunity for emerging concepts identified through the coding and analysis of the previous interviews to be explored in follow-up interviews. The development of the theory is an ongoing process. Data collection ceased after the data had reached saturation (Bitsch, 2005), and because both data collection analyses were done simultaneously, the discussion to follow unpacks the procedures involved in data analysis.

### 4.8 Data analysis

As previously stated, that the theoretical sampling process, data collection and data analysis move in a zig-zag manner in grounded theory, the discussion to follow is about all the processes involved in data analysis. Here, analysis is necessary from the start because it is used to direct the next interview and observations. This is not to say that data collection is not standardised. Grounded Theory design involves a constant comparison method of coding and analysing data through three stages. The method enables the researcher to uncover and explain patterns and variations as the theory emerges. The constant comparison method will be discussed later in the chapter. Strauss and Corbin (1990) explained three stages for data analysis, namely open, axial, and selective coding. They contend that concepts are building blocks of a theory. The researcher presents a brief overview of the three stages employed during data

analysis. In the quality and rigour chapter, I have outlined how these stages were applied in the current study from items **5.4.1** to **5.4.4**.

### 4.8.1 Open coding

According to Corbin and Strauss (2008), open coding is breaking the data apart and delineating concepts or categories to each other. Open coding is a process whereby concepts are identified and developed in terms of their properties and dimensions (Strauss & Corbin, 1990). Its purpose is to give the analyst new insights by breaking through standard ways of thinking about or interpreting phenomena reflected in the data (Corbin & Strauss, 1990). Open coding aims to reduce the data (Bistch, 2005). In open coding, events/ actions/ interactions are compared with others for similarities and differences. They are also given conceptual labels. In this way, conceptually similar events/ actions/ interactions are grouped to form categories and subcategories (Corbin & Strauss, 1990). Once identified, categories and their properties become the basis for sampling on theoretical grounds. Here, I identified relevant fragments of data in the transcripts and labelled them with codes while remaining closer to the participants' views. Open coding took place after open sampling. I cross-checked every information from the participants and tried to make sense of the data. Similar concepts were grouped to form categories (Kawulich, 2004).

Open coding stimulates generative and comparative questions to guide the researcher upon return to the field (Corbin & Strauss,1990). Open coding and makes use of questioning and constant comparisons enables investigators to break through subjectivity and bias. I have pointed out my role in the study and how I addressed the issues of bias in the quality and rigour chapter. Breaking down the data forces preconceived notions and ideas to be examined against the data themselves. The second phase to follow open coding is axial coding.

### 4.6.2 Axial coding

Corbin and Strauss (2008) state that axial coding is an act of relating concepts or categories. Axial coding is a set of procedures involved in putting back the data together after open coding by making connections between categories (Strauss & Corbin, 1990). Open coding and axial coding go hand in hand. In axial coding, categories are related to their subcategories, and the relationships are tested against data. Also, further development of categories takes place, and one continues to look for indications of them. The purpose of axial coding is to sort, synthesise, and organise large amounts reassemble them in new ways after open coding (Creswell, 1998). During axial coding, the focus is on the relationship between categories and subcategories, including conditions, cause-and-effect relationships, and interactions (Strauss & Corbin, 1990; Bitsch, 2005).

Axial coding specifies the properties and dimensions of a category. This stage is interrelated to variational sampling, where theoretical sampling strives for increasing variance by including cases that seem to contradict the evolving theory. Here, I linked categories with subcategories and analysed how they are related. I continued to cross-examine cases that contradicts the evolving theory. According to Strauss and Corbin (1998), axial coding answers the when, where, why, who, and how and with what consequences questions. Just like Strauss and Corbin (1998), I grouped participants' statements into components of an organising scheme to answer the above mentioned. The organising scheme includes the conditions, actions/ interactions as well as outcomes. Conditions are circumstances or situations that form the structure of the phenomenon under study. Conditions answers the why, where, how come and when questions. Actions are defined as participants' routine or strategic responses to issues, events, or problems. Actions/ interactions are answered by whom and how questions. Consequences are outcomes of actions. Consequences answer questions on 'what happens because of these actions/ interactions.

The process of axial coding involves relating subcategories to a category, which is developed in terms of causal *conditions* that gives rise to it, its dimensional location in terms of its properties, the context, the *action/ interactional* strategies, used to handle, manage and respond to the phenomenon in the light of that context and the c*onsequences* of such action (Strauss & Cobin, 1990). Through answering those questions, I was better able to link the subcategories to categories as the analysis progressed.

### 4.6.3 Selective coding

Selective coding is the process by which *all* categories are unified around a "core" category, and categories that need further explication are filled-in with descriptive detail (Corbin & Strauss, 1990). Selective coding involves integrating categories and subcategories with a central concept and providing sufficient detail and density for the evolving theory (Strauss & Corbin, 1998, Strauss & Corbin,1990). In the process, one core category is selected and systematically related to other categories, then the relationships between the core category and other categories are validated, lastly, categories that need further refinement and development are filled (Strauss & Corbin, 1990). Sampling during the selective coding phase becomes very directed and deliberate to fill in additional detail, test for further variation, and clarify final questions near the completion of the research project.

In this phase, I tied up all identified categories in the theory together. I was able to present how the categories relate to the core category. During this phase, if certain details are missing, the researcher will go back to participants for filling in those additional details (Bitsch, 2005). For the present study, there was no need to do that because during the analysis I did thorough the cross-checking in the early stages of both sampling and analysis. This enabled me to go to the participants in case there were missing details to be filled. This is the stage where the theory under development has reached saturation.

## 4.9 Constant comparative method

As already discussed, Grounded Theory involves a constant comparison method of coding and analysing data through three stages: open coding which involves examining, comparing, conceptualising, and categorising data); axial coding which involves reassembling data into groupings based on relationships and patterns within and among the categories identified in the data; and lastly, selective coding which involves identifying and describing the central phenomenon, or "core category," in the data (Dey, 1999; Strauss & Corbin, 1998). Similarly, I followed these steps by ensuring that the open coding is done as reflected in Item **5.4.1** in the quality and rigour chapter. I ensured that axial coding is adhered to as reflected in item **5.4.3** of the quality and rigour chapter. Finally, the selective coding was also done, and this is reflected in item **5.4.4** in the quality and rigour chapter. The constant comparative method is a hallmark of Grounded Theory studies (Murray & Chamberlain, 1999). Merriam (1998) indicated that the constant comparative method assigns codes that reflect the conceptual relationships. According to Glaser and Strauss (1967) whatever unit of data the researcher begins coding, they use constant comparative methods.

Firstly, the researcher compares data with data to find similarities and differences. Also, the researcher compares the interview statements and incidents within the same interview and compare statements in earlier and later interviews. Making sequential comparisons helped in the analysis of data. This technique is for identifying and developing categories. It involves comparing incidents and categories systematically for similarities and differences between them. The constant comparative method is strict enough to be helpful to the researcher in exploring the content and meaning in the data, but not saddled with so many strict rules to be too rigid for a Grounded Theory researcher (Hallberg, 2006).

When an incident is noted, it should be compared against other incidents for similarities and differences. The resulting concepts are labelled as such, and over time, they are compared and grouped as previously described. Making comparisons assists the researcher in guarding against bias, for he or she is then challenging concepts with fresh data. Such comparisons also help to achieve greater precision

(the grouping of like and only like phenomena) and consistency (always grouping like with like). Precision is increased when comparison leads to a sub-division of an original concept, resulting in two different concepts or variations on the first. The use of the constant comparative method does not proceed independently; it is intertwined with other analytical processes such as memo writing.

### 4.10 Memo writing

Writing memos and drawing diagrams are strategies used to assist theory development. Memos are notes of ideas, interpretations, and hypotheses written up throughout the data analysis process. Memo writing obliges the researcher to engage with data and interpret it. It also provides a strategy for the researcher to examine the emerging categories critically for their properties, inter-relationships and for developing the overall theory. Diagrams are used similarly to assist in identifying relationships between categories, and to clarify the core category of the theory and its relation to the other categories (Charmaz, 1995).

Since the analyst cannot readily keep track of all the categories properties, hypotheses, and generative questions that evolve from the analytical process, there must be a system for doing so. The use of memos constitutes such a system. Memos are not simply about "ideas." They are involved in the formulation and revision of theory during the research process. Writing memos begins with the first coding sessions and continues to the end of the research. It incorporates and elaborates on the coding session themselves as well as on the code notes (Strauss, 1987).

Memos vary in form and length according to the stage of the research project and the type of coding one is performing. As a theory becomes better elaborated and integrated, so do the memos. Memo writing should continue until the very end of the project, often including the writing itself. Sorted and resorted during the writing process, theoretical memos provide a firm base for reporting on the research and its implications. If a researcher omits the memo writing and moves directly from coding to writing, a great deal of conceptual detail is lost or left undeveloped. Though

theoretical memos and code note-writing procedures are specific to grounded theory, the recording of field notes, and interview data is not appreciably different from the techniques used by other qualitative researchers (Corbin & Strauss, 1990).

For the present study, I engaged in memo writing as the data analysis progressed. The researcher always jotted notes and reflections after each interview, and this assisted a lot in memo writing. The three played a huge role in data interpretation. Through diagrams, I was able to connect the categories to the core category as the theory developed. The next discussion is about ethical procedures adhered to during the study.

### 4.11 Ethical considerations

It is important that every study conducted should adhere to all ethical standards. The main reasons why a study should adhere to ethical standards is to protect the anonymity and confidentiality of research participants and to protect their health and well-being in biomedical or potentially socially or psychologically disturbing research. This study was no exception. The study has explored ethics for THPs, whereas this section is looking at overall research ethics. The difference between the two is that the only ethics considered in research ethics are addressed from the Western Perspective yet being applied to Africans. The current study looks at ethics from an African perspective. At some point we might have relook at the overall ethical considerations in research.

#### 4.11.1 Permission for the study

It is procedural that the relevant Ethics Committee issues the ethical clearance before any study can be conducted. Most institutional ethics committees are in place to ensure and safeguard that the study adheres to all ethical standards (Corbin & Strauss, 2008). For the present study, an ethical clearance certificate (TREC/216/2018:PG) was obtained from the University of Limpopo's Turfloop

Research Ethics Committee **(See Appendix 4)**. I carried with me the certificate everywhere I went during data collection.

### 4.11. 2 Voluntary participation and informed consent

Before the interviews were conducted, the participants were informed about the nature of the study and the fact that their participation is voluntary. They were also advised that they can withdraw from participating in the study at any time should they wish to do so. Furthermore, I ensured that participants fully understand all the processes involved in the study when recruiting them to take part in the study. I read and explained the content of the consent forms that participants signed as they consented to take part in the study. The consent forms were read in their home language *(Sepedi)* and which allowed them to ask questions if there was something they did not understand or wanted to know more about. This helped the participants to make informed decisions as to whether to participate in the study. Most participants who knew how to read signed their consent letters and those who did not know how to read consented verbally.

### 4.11.3 Anonymity and confidentiality

Ethical considerations are of great importance in qualitative methodology because informants are few and researchers come very close to the participants' personal lives. It may be easy to disclose the identities of the participants, and therefore the researchers are obliged to develop strategies to ensure confidentiality (Dahlgren et al., 2007). The researcher should address confidentiality in a manner desired by the research participants (Hart, 2010). The present study did not require any personal information that could be traced back to any participant. The information provided by the participants and the tape recordings of interviews are only accessed by the researcher and the supervisors. Full confidentiality, privacy and anonymity were maintained throughout the sampling, data collection and data analysis.

### 4.11.4 Respect and dignity

Every participant was treated with respect and dignity, and their rights were protected. For the present study, I was prepared to follow the traditional and cultural way in which THPs do their things. I also used the appropriate language when communicating with the participants. I also had to be patient in terms of THP's adherence to time. Some interviews with THPs had to be shifted because they would have to attend to an emergency, or their spirit did not allow them to speak to me at a particular moment. I had to be patient and respect all that.

### 4.11.5 Safety

According to Hart (2010), respect and safety can be evident when the research participants feel safe and are safe. The study did not impose any physical harm on the participants. All interviews were done at the home of the participants so that they can be as comfortable and safe as possible.

### 4.11.6 Benefits

I informed the participants that there was no direct benefit of the study to them. However, I explained to them that the results of the study are likely to be beneficial to them as well as other traditional healers and the society at large. Most THPs were interested to know if I had funding for research, which I declared. Most THPs wanted the amount they charge for consultation before I could start with the interview. The amounts were between R100.00 - R200.00. Some THPs did not want anything at all. I paid the consultation fee to those who requested it and nothing to those who did not request it.

### 4.11.7 Aftercare of participants

In most psychological studies, the aftercare of participants is important. This is because should the study evoke emotional discomfort of any participant, the researcher must refer them to a registered counsellor or a social worker. For the present study, some THPs started chanting during an interview. I had to give them a few minutes until they were ready to continue or stop with the interview altogether. None of them wanted to stop with the interview. This somehow made me uncomfortable, but I also had to pull myself together. It took quite a few minutes before the mood changed to continue with the interview and get back to normal.

## 4.12 Conclusion

This chapter discussed all processes involved in methodology. Grounded theory was discussed as the methodology that carried out this study. The components of grounded theory such as memo writing and constant comparative method were discussed. The sampling procedures, the intensive interviewing technique, and overall data collection and data analysis processes were thoroughly discussed. The following chapter discusses the quality and rigour of the study.

# CHAPTER 5: QUALITY AND RIGOUR OF THE STUDY

## 5.1 Introduction

This chapter discusses the rigour of the study. In most qualitative research reports, the quality and rigour of the study are presented as part of the methodology chapter. However, due to the nature of Grounded Theory methodology, it is recommended that researchers go at length to demonstrate that the theory to emerge is founded on strong methodological basis (Charmaz & Thornberg, 2021; Corbin & Strauss, 1990). As such, this chapter covers how the discussed procedures covered in the previous chapter of the methodology were applied to the study. The quality criteria, researcher role, and bias, theoretical sensitivity, how the data were coded as well as how the three analytical phases were applied in the study are discussed. Furthermore, this chapter serves as an introduction to the chapter of the results. The indicators and concepts and categories are introduced in this chapter; therefore, it allows for the presentation of the findings to flow. The discussion to follow speaks to the concepts that ensured the quality of the study.

## 5.2 Quality criteria

### 5.2.1 Trustworthiness

In Grounded Theory, the researcher engages with the analysis as a faithful witness to the accounts in the data. As the researcher immerses him/herself in the data, he/she should be honest and vigilant about his/her perspective, pre-existing thoughts and beliefs, and developing hypotheses (Gearing, 2004). Grounded Theory researchers engage in the self-reflective process of “bracketing,” whereby they recognise and set aside (but do not abandon) their prior knowledge and assumptions, with the analytic goal of attending to the participants’ accounts with an open mind (Gearing, 2004). Additional reflexive practices include consulting with colleagues and mentors and writing memos throughout the analysis to help analysts examine how their thoughts

and ideas evolve as they engage more deeply with the data (Cutcliffe, 2003; Finlay, 2002).

Memos also serve the function of establishing an audit trail, whereby the analyst documents his/her thoughts and reactions as a way of keeping track of emerging impressions of what the data mean, how they relate to each other, and how engaging with the data shapes her understanding of the initial hypotheses (Cutcliffe, 2003). For this study, trustworthiness was achieved through the above-explained reflexive practices.

### 5.2.2 Credibility

Credibility refers to the trustworthiness, verisimilitude, and plausibility of the research findings (Tracy, 2010). As it was demonstrated in the previous chapter, to achieve this quality criterion, firstly, the researcher strictly adhered to the grounded theory design while undertaking the study. The elaborateness of the methodology chapter clearly stated study context and that justifies the credibility, and potential of the study transferability. Additionally, credibility is associated with whether there are faithful descriptions or interpretations of human experiences in the study (Guba, 1981). It is evident in the results chapter, that the researcher has offered rich descriptions of the data including illustrative materials directly quoted from participants. Amis and Silk (2008) pointed out that credibility in qualitative studies can also be achieved through aspects such as prolonged engagements while in the field, member or validity checks, and triangulation. In view of prolonged engagements, the researcher invested sufficient time collecting data to have an in-depth understanding of the culture and language of the participants. Prolonged engagements were also essential for building trust with participants and, have helped the researcher to obtain accurate and rich information.

Additionally, the researcher got more familiar with the research community since some of the THPs who participated in the study invited me to be an observer of some of the activities pertaining to their work. Although I was not able to honour all the invitations,

I honoured one of the invitations where I spent the whole just observing and communicating with the THPs. This helped in analysis and filling some of the gaps missing in the theory that was at a developing stage at that particular moment. I was able to understand the culture of THPs as individuals belonging to the respectable community. Credibility was also ensured by the researcher by conducting validity-checks with participants who in their data the researcher was unclear with some of the concepts; this was to avoid misinformation and distortions in the data.

### 5.2.3 Confirmability

The concept of confirmability is the qualitative investigator's comparable concern to objectivity (Shenton, 2004). According to Corbin and Strauss (2008), objectivity in qualitative research does not exist. Researchers bring to the research, their paradigms, perspectives, knowledge, and biases; whereby all these aspects at times become part of the research process (Guba & Lincoln, 1998). Confirmability can be strengthened through a reflexive self-critical account that exposes inherent biases in the work, and triangulation (Amis & Silk, 2008). For the present study, I solely relied on the raw data provided by the participants. To achieve confirmability, I was aware and conscious of how perspectives and ideas could influence data analysis. It is for this reason that the discussion to follow discusses my role and issues of bias. By triangulating some of the methods also helped strengthen study credibility.

### 5.2.4 Dependability

The study dependability speaks to the extent to which the research could be replicated in similar conditions (Sternfors et al., 2020). To allow for a possible replica of a similar study, I have provided sufficient information about the processes and procedures that another researcher can follow to do a similar study.

### 5.3 Researcher role and bias

Bias and assumptions are cultural in nature and at times researchers are unaware of their influence during data analysis and interpretation (Corbin & Strauss, 2008). In every qualitative study, the researcher should be aware of the role they play in the study and avoid biasness at all costs. I acknowledge possible biases in this study. For a Grounded Theory study like this one, the researcher engages more with the data. As the researcher, I engaged with the data from data collection stages, during analysis as well as data interpretation. It is undeniable that I had my perspectives, pre-existing thoughts and beliefs that might have had an influence in the manner which data collection and analysis were carried out. Also, I engaged in self-reflective process of bracketing. Furthermore, I was aware, honest, and vigilant of my perspectives, ideas, and beliefs and that has helped me to set them aside and only attend to the participant's experiences, views and beliefs.

Memo writing during open coding also helped me jot down the most important points, worldviews, and experiences of the participants as I was collecting and analysing the data. During analysis, I reread the memos and noticed that some of my memos were a reflection of my emotional response to the data than a conceptualisation of what my participants told me during the interviews. I then rewrote those memos and ensured that what was written was the conceptualisation of what the participants shared with me.

Classic Grounded Theory methodology encourages omitting literature review as the researcher can have pre-conceived ideas that might channel the way questions are asked during interviews also the way data are interpreted. However, the Straussian Grounded Theory Method supports the review of literature when conducting the study. Straussian Grounded Theory holds that knowledge gained from the literature can help to enhance analysis. Nonetheless, my interest in mental health and traditional healing also had me reading extensively on the topic. However, my reading was more focused on getting a deeper understanding of the area that I could explore and finding the gap

that needs to be filled. To be precise, my reading focused more on the problem statement as a preliminary guideline for the study I was about to embark on, rather than a fixed starting point that would determine the whole research procedure. In addition, the research problem and the research question are generated at the beginning of the study and are based on availability, but limited knowledge. Hence, exploring the two topics could not do much harm to the research processes that followed. That kind of intensive reading was done at the research study proposal level. The literature review chapter was written as the study progressed.

The Grounded Theory approach does not encourage working alone. As a novice in the approach, I did not work alone, especially during data analysis and on the chapter of presentation of the results. I worked with my colleague, Bontle Kgopa and her academic mentor who has used the Grounded Theory approach before. They helped in testing concepts and their relationships during the data analysis. I opened up my analysis to their scrutiny to help guard against bias. Most of the discussions we engaged in the lead to new insights and increased theoretical sensitivity as well. My co-supervisor also played a huge role in scrutinising my concepts and giving immediate guidance after the analysis was finished.

My experience as a psychology student whose research interest lies in Afrocentricity, mental health, and traditional healing might influence on my data analysis. I already had an idea about some of the challenges faced in the health care system. A lot of studies about the collaboration of the western and traditional health systems have been done. However, the movement to reaching the goal has been very slow. I was already positive that this would contribute positively to the field. However, the positive contribution would not solely be based on the results yielded by the study as it is not for comparative purposes. The study is explanatory in nature, and it only serves that purpose.

## 5.4 Theoretical sensitivity

According to Glaser and Strauss (1967), theoretical sensitivity is an important concept in grounded theory and reflects the researcher's ability to use personal and professional experiences as well as methodological knowledge and thereby see data in new ways and think abstractly about data in the process of developing theory. Sensitivity stands in contrast to objectivity. It means being able to present the views of the participants and taking the role of the other through immersion of the data (Corbin & Strauss, 2008). Through alternating processes of theoretical sampling, data collection, and analysis, meanings and significance of the data becomes clearer and the researcher begins to see issues from the perspective of the participants. For the current study, this was enhanced by the time I spent in the field collecting data. I learned the culture and observed how the THPs lead their lives, what ethics are they adhering to, and so forth. All these processes that occurred during data collection and analysis helped me to inform, clarify, and substantiate the theory at the later stage of its development. I used their knowledge in the field, both professional and personal, played a huge in enhancing sensitivity.

According to Glaser (1992), theoretical sensitivity refers to the researcher's knowledge, understanding, and skills, which foster his generation of categories and properties and increase his ability to relate them into hypotheses and to further integrate the hypotheses according to the emergent theoretical codes. Theoretical sensitivity is an ability to generate concepts from data and to relate them according to the normal models of theory in general, and theory development particularly in the field of sociology.

Theoretical sensitivity can also be seen as the researcher's manipulation to explain data in a way that best reflects reality. Therefore, theoretical sensitivity should be complemented by reflexivity, concerning for example, how the researcher-participant interaction and the researcher's perspective affect the analysis and the results (Hall & Callery, 2001). Writing the memos served as the remedial for this.

## 5.5 Coding

Coding is the fundamental analytic process used by the researcher (Corbin & Strauss, 2008). Glaser (1978) and Charmaz (1995) identified a coding process that mainly involves two steps in the data analysis, namely line by line and open coding (substantive). Glaser (1978) conceptualised how the substantive codes may relate to each other as a hypothesis to be integrated into a theory. Through coding, the data are given meaning and interpretation (Charmaz, 2014). Charmaz (1995), has provided a practical discussion and detailed illustrations of coding practices using health psychology examples. The demonstration is about how line-by-line open coding is used to identify initial concepts in the data, then incorporate them into more general categories. I followed Straussian Grounded Theory, whereby the first step taken after data collection is open coding. There is no much difference from Charmaz (1995) practical illustration of line-by-line open coding and Corbin and Strauss (1998; 2008) open coding.

## 5.6 Application of data analysis steps for the present study

As already discussed in chapter four, the researcher has followed Strauss and Corbin (1998) steps for data analysis namely open coding, axial coding, and selective coding.

### 5.6.1 Open coding in the current study

The logical starting point in Grounded Theory data analysis is open coding. The main purpose of open coding is to give the researcher new insights by breaking through standard ways of thinking about or interpreting the phenomena reflected in the data (Wicker, 1985). I read and reread the data to make a clear sense of it. Through that process of reading and rereading the data, the researcher was able to identify relevant events/actions/interactions in the data.

In open coding, events/actions/interactions are compared with others for similarities and differences. They are also given conceptual labels. In this way, conceptually similar events/actions/interactions are grouped to form categories and subcategories. In open coding, little to no selection is made in terms of relevance in data because the researcher cannot yet be able to predict what and what is not valuable. Open coding contributes to a clear organisation of the data. The table below presents a list of initial indicators and concepts derived from the transcripts of all 20 participants. The indicators and concepts accompany the narratives that will follow in the next chapter of the presentation of the results. It is important that the indicators and concepts are clear in this chapter, as the researcher has already explained in the beginning that the chapter shows how some of the procedures were done at a practical level. These indicators were derived from the raw data during open coding.

**Table 5.1: List of initial indicators and concepts from the interviews**

| | |
|---|---|
| Accommodation | Medicine administration |
| Admission procedures | Mental health |
| Admit | Mental health conditions |
| Agreement | Mental health ethics |
| Ancestors | Mental health disorder |
| Ancestral approval | Mentor |
| Ancestral cloth | Moral and values |
| Ancestral disobedience | Mutual agreement |
| Ancestral spirits | Natural causes |
| Animals | No roots digging |
| Assistance from traditional healer | Normal sickness |
| Bad things | Observations |

| | |
|---|---|
| Behavioural changes | Paperwork |
| Care giver | Patient appreciation |
| Causes of the illness | Patient relations |
| Cleanliness | Payment arrangements |
| Comfortability | Focus not on the money |
| Communicate with the ancestors | Patient’s evil deeds |
| Confidential | Payments |
| Conscience | Praises from patient |
| Consent | Protection of the animals |
| Consent forms | Protection of the plants |
| Diagnosis | Punishment |
| Diagnosis | Referral to the clinic |
| Disciplinary hearing | Remedies |
| Discussions | Respect for ancestors |
| Ethical procedures | Respect for authority |
| Ethical standards | Respect for patients |
| Ethics | Retrieve healing gift |
| Evil deeds to another person | Rituals |
| Family relations | Rivers |
| Family member | Rules pertaining treatment |
| First consultation | Sacred places |
| Focus not on the money | Seasonal |
| Follow up consultation | Seek permission |

| | |
|---|---|
| Food | Severity of the illness |
| Guidance from the ancestors | Social problems |
| God | Sleepover |
| Gods | Safety |
| Guidelines | Spirituality |
| Harvesting traditional medicine | Spiritual sense |
| Healing | Steaming |
| Honesty | Stress |
| Humility | Stressors |
| Focus not on the money | Sympathetic |
| Follow up consultation | THP’s responsibilities |
| Food | Throw the bones |
| Forum of THPs | Tie-up |
| Fore front | Time frame |
| Harvesting traditional medicine | Traditional health practitioner |
| Healing | Seek permission |
| Healing practices | Severity of the illness |
| Help | Treatment |
| Lacking blood | Trust |
| Lacking water | Western practice |
| Learning | Whip |
| Love for money | Witchcraft |
| Manmade | Worst case scenario |

| | |
|---|---|
| Medicinal plants | Wrath of the ancestors |

### 5.6.2 From concepts to categories

From the concepts and indicators, the researcher drafted a set of 10 basic concepts to begin the process of analysing and breaking them down into properties. The procedures of Grounded Theory are designed to develop a well-integrated set of concepts that provide a thorough theoretical explanation of social phenomena under study. A Grounded Theory should explain as well as describe. It may also implicitly give some degree of predictability, but only about specific conditions. Herewith are the concepts derived from the initial indicators and concepts. These concepts include ethics, being human, ancestral guidance, consultations, admissions, referrals, treatment, remuneration, healing progress, and the wrath of the ancestors.

Every concept brought into the study or discovered in the research process is at first considered provisional. Each concept earns its way into the theory by repeatedly being present in interviews. Requiring that a concept's relevance to an evolving theory (as a condition, action/interaction, or consequence) be demonstrated is one way that Grounded Theory helps to guard against researcher bias. No matter how enamoured the investigator may be of a particular concept, if its relevance to the phenomenon under question is not proven through continued scrutiny, it must be discarded. Grounding concepts in the reality of data thus gives this method theory-observation compatibility. Once a concept has "earned" its way into a study through demonstrations of its relationship to the phenomenon under investigation, then its indicators should be sought in all subsequent interviews and observations (Corbin & Strauss, 2008).

### 5.6.3 Axial coding in the current study

When researchers employ axial coding, the reasoning moves predominantly from codes to data, unlike in open coding where the reasoning is from data to codes (Landsheer & Boeije, 2010). The difference between these two types of coding are only for explanatory purposes, and to indicate that though the data is broken down in open coding, and concepts identified to stand for the data, the researcher has to put the data back together to relate to those concepts (Corbin & Strauss, 2008). It aims to identify the core concepts in the study. During this process, data that were fragmented during open coding are assembled in a new way to achieve higher levels of conceptual abstraction and develop a paradigm model that is the basis of the new theory (Corbin & Strauss, 1998). The focus is on the relationship between the categories and the sub-categories, including conditions, cause and effect relationships, and interactions. Axial coding answered the when, where, why, who, how and with what questions.

Through the constant comparison method involved in all the three phases of data collection, the memos are written and more reading of the data I was able to establish the relationship between the categories and subcategories, cause and effect relationships and interactions. This was more of a zig-zag untidy exercise of questioning the data, and answering the when, where, why, who, how and with what questions. I regrouped all the categories from the code tree of open coding and looked for more analytical concepts.

After axial coding phase, the relationships and patterns within the categories became clearer. This further helped to reduce and reorganise the data, redundant codes were removed and the best representative codes were selected. As I worked through axial coding, five categories emerged. The categories are also discussed in the next chapter in the findings.

### 5.6.4 Selective coding for the current study

Selective coding is aimed at integrating all the categories and subcategories from both open coding and axial coding with a central code in the study. The central code sometimes referred to as the “core category” is the code that all other codes are related to. During the process of selective coding, the selected core category must be systematically related to other categories, the relationships between the core category and other categories must be validated and the last categories that need further refinement and development must be filled (Strauss & Corbin, 1990). In Grounded Theory studies, researchers usually aim at theory development. According to Landsheer and Boeije (2010), when that is the case, it is in the process of selective coding that certain categories are adopted as theoretical concepts since they will become part of the theoretical model. As already mentioned, the core category for this study is ancestral guidance.

Ancestral guidance was selected as a core category mainly because it fits Corbin and Strauss (1990; 1998) definition of a core category. It is only systematically related to all other categories, but it is also the core aspect of the model that is yet to be presented later in the next chapter. There was no need for the to-do refinements and developments to the existing categories as the core category, other main categories and the model fitted well in their places.

## 5.7 Theory development and saturation

Theory development is aided by the processes of questioning and hypothesising. As more coding progresses, questions are continually asked for the data. As the categories are developed the researcher might change the focus of the questions (Murray & Chamberlain, 1999). For the present study, I have indeed changed the focus of the questions as categories developed. This helped to develop the hypotheses about the properties of the categories and the relationship between them.

The approach argues for initial data collection and preliminary analysis to take place before consulting and incorporating research literature (Murray & Chamberlain, 1999). It was impossible to develop a research question without having some understanding of the field, but Grounded Theory emphasises that the researcher must be alert to the influence of the pre-existing constructs and not allow them to contaminate the theory which is being developed. This is to ensure that the analysis is strongly based on the data, and that pre-existing constructs do not shape the analysis and the development of the theory.

According to Glaser (1978; 1992), a Grounded Theory should be evaluated in terms of its fit, work, relevance, and modifiability. This means that emerging categories must fit and explain the collected data rather than preconceived concepts being forced upon the data. Fit and relevance examine how well the categories relate to the data and derive from constant comparison and conceptualisation of the data. Workability refers to the integration of the categories into the core category that emerges and modifiability refers to ensuring that all the concepts that are important to the theory are incorporated into it by the constant comparison process. A modifiable theory can be altered when new relevant data is compared to existing data.

The generalizability of a grounded theory is partly achieved through a process of abstraction that takes place over the entire course of the research. The more abstract the concepts, especially the core category, the wider the theory's applicability. At the same time, a grounded theory specifies the conditions under which a phenomenon has been discovered in this particular data. A range of the situations to which it applies or has reference is thereby specified. In utilising theory, practitioners or others may encounter somewhat different or not-quite-the-same situations, but still, wish to guide their actions by it. They must discover the extent to which the theory does apply and where it has to be qualified for the new situations (Corbin & Strauss, 1990).

Saturation of the theory is considered to have occurred when no new categories are found which relate to the core issue or process being researched, and the theory can account for all data that have been obtained (Corbin & Strauss, 2008). To ensure this, I examined cases that did not fit the theory and tried to incorporate all variations. Saturation was achieved through theoretical sampling, analysis, and was indeed confirmed as further data were sampled and analysed. Data collection ceased when all gaps in the theory were filled, and also when all categories were linked meaningfully together to provide a comprehensive explanation of the phenomenon under study. The presentation of the framework of the phenomenon under study is yet to follow.

## 5.8 Conclusion

This chapter discussed how I dealt with the threats of bias. It discussed the quality criteria, theoretical sensitivity, and how the data were coded. The chapter also discussed how the three phases of data analysis were applied in the study. The presentation on how the open, axial, and selective coding was applied in the study as an introductory element of the chapter of the findings was also discussed. The chapter also covered the discussion about theory development and saturation. The next chapter presents the results of the study as the continuation of the chapter on quality and rigour.

# CHAPTER 6: PRESENTATION OF THE FINDINGS

## 6.1 Introduction

This chapter discusses the findings of the study. It is opened with the presentation of the demographic information for the participants. The concepts and categories that emerged from the data are discussed. Each concept has a table that shows its indicators as well as the transcript references. After the presentation of each concept, the psychological implications are also discussed. The core category and the main categories encompassed with examples of the extracts from the transcripts are also discussed.

## 6.2 Demographic information of the study

The above table illustrates the demographic information of the participants. All participants were drawn from Capricorn District, specifically Polokwane Municipality. THPs from five areas were interviewed namely, Ga-Makanye (15%), Nchechane (15%), Mamotintane (15%), Ga-Dikgale (15%), and Polokwane (40%). Only 45% of the participants were females and 55% were males. There is no significant difference between a male and a female THP. They are both powerful and are accorded equal respect in their communities.

The participant's ages also varied, with the youngest being 18 years old, and the oldest being 76 years old. Another varying aspect for these participants was their number of years in practice. This was because the calling for traditional healing manifests anytime at one's point of life, and also the fact that many of the THPs do not immediately undergo training or initiation as an individual might not even know that they have a calling to become a THP, until either it is confirmed by another THP, a prophet, or a faith healer etc. The study has shown that age is not a factor in determining when one can become a THP. Hence some people go for traditional

healing initiation at a very young age and some when they are older. Some THPs who were  over 50 years of age, yet have only 2 or 3 years in practice.

Although all the participants were practicing THPs, not all of them were registered. However, 55% of them were registered with a traditional healing organisation, 15% were in the process of registering and only 25% were not registered. Most of the participants were registered under Mošate wa Mangaka Koma Humeleng Dingaka “Healing trust African religion and culture”, a traditional healing organisation in Polokwane, Limpopo Province.

Most participants had gone to school at least up to high school. Most of the THPs who could not finish their high school phase explained that they had to drop out of school to go for traditional healing initiation. Some described that they were very smart, and would have loved to complete matric. There were only three older participants who had never gone to school. These participants were the most experienced and explained that although they have never went to school, there is nothing they do not know. They explained that their wisdom stems from their grandparent’s teaching and how life was led during their time as children and later on as teenagers. There was also one younger participant who was in the process of acquiring an academic degree. The participant was hopeful that he would be able to complete his degree, at the same time practising as a THP.

**Table 6.1 Participants demographic information**

| Participant | Gender | Age | No of years in practice | Registered (R)/Not registered (NR)/Registration in progress (RP) | Highest Educational level | Area of residence |
|---|---|---|---|---|---|---|
| Participant 1 | Female | 62 | 25 | Registered | Typing Cert | Ga- Dikgale |
| Participant 2 | Female | 52 | 2 | Not registered | Grade 3 | Ga- Dikgale |
| Participant 3 | Female | 33 | 5 | Registered | Grade 11 | Nchechane |
| Participant 4 | Male | 36 | 5 | Registered | Grade 11 | Ga-Makanye |
| Participant 5 | Female | 52 | 10 | Not registered | Grade 3 | Ga- Dikgale |
| Participant 6 | Male | 22 | 2 | In progress | Grade 10 | Mamotintane |
| Participant 7 | Male | 27 | 4 | Not registered | Grade 11 | Mamotintane |
| Participant 8 | Female | 72 | 45+ | In progress | None | Ga- Makanye |
| Participant 9 | Female | 45 | 10 | Not registered | Grade 12 | Ga- Makanye |
| Participant 10 | Male | 38 | 6 | Registered | Grade 12 | Polokwane |
| Participant 11 | Female | 70 | 50+ | Registered | None | Polokwane |
| Participant 12 | Female | 53 | 5 | Registered | Grade 12 | Polokwane |
| Participant 13 | Male | 47 | 5 | Registered | Grade 12 | Polokwane |
| Participant 14 | Male | 39 | 15 | Registered | Grade 11 | Polokwane |
| Participant 15 | Male | 50 | 11 | Registered | Grade 09 | Polokwane |
| Participant 16 | Male | 72 | 20+ | Registered | None | Polokwane |
| Participant 17 | Male | 76 | 20 | Registered | 40+ | Polokwane |
| Participant 18 | Female | 58 | 3 | Not registered | Grade 09 | Nchechane |
| Participant 19 | Male | 18 | 1 | In progress | Degree in progress | Mamotintane |
| Participant 20 | Male | 70 | 10 | Registered | None | Nchechane |

## 6.3 Presentation of the results

The results are presented in the form of concepts and categories. Grounded Theory Methodology involves a lot of back and forth, and zig-zagging in terms of its theoretical

sampling, data collection, and data analysis as these procedures subsequently each other, and at times employed simultaneously. After saturation and exhausting all analytical tools, these are the concepts that I arrived at. Before the presentation of the concept, a table for its indicators, and the transcript reference accounting to that concept are also presented. The transcript references are presented on the table whereby; for example, participant no 1 is presented as P1 in the table. The indicators accounting for these concepts on the table are the indicators presented in the previous chapter in table **5.1.** The extracts from the original interviews are also presented to support these findings.

I have explained the three steps that Corbin and Strauss (1998) employed for grounded theory data analysis in both chapter 4 and chapter 5. In chapter 4, the three coding phases are theoretically explained whereas, in chapter 4, there is an element of how they were practically employed when I was conducting the study. I have also pointed out that in practice, open coding and axial coding cannot be separated because in open coding the data is broken apart then in axial coding, the data is put back together to relate the concepts. The concepts presented here, accounts for both open and axial coding presented in **4.8.1, 4.8.2, 5.6.1** and **5.6.2.**

As both a researcher and the analyst for the current study, I have arrived at these concepts, after using the analytic tools of asking questions, as well as the constant comparative method discussed in **4.9** of the methodology chapter. The concepts derived from theoretical sampling earlier discussed in **4.5.2** of the methodology chapter was to being tested under different conditions in order to account for variations. The Grounded Theory Methodology requires transparency on how the concept made it to the higher level. Most of the concepts are also part of the framework/model that is going to be presented in the next chapter. The concepts that I am going to present are as follows:

- Ethics
- Being human *(Go ba le botho)*

- Guidance from the ancestors
- Consultations
- Admissions
- Referrals
- Treatment
- Remuneration
- Healing progress
- Wrath of the ancestors

The presented concepts below provide a theoretical explanation of ethics followed by THPs in the management of mental health cases.

### 6.3.1 The concept of Ethics

| Concept | Indicators | Transcript reference |
|---|---|---|
| Ethics | Ethical Principles<br>THP's responsibility<br>Rules<br>Morals<br>Values<br>Beliefs<br>Ethical Standards<br>Professionalism<br>Good behaviour<br>Doing good<br>Good treatment<br>Ethical procedures<br>Formal instructions<br>Having conscience | P1, P2, P3, P4, P5, P6, P7, P8. P9, P10, P11, P12, P13, P14, P15, P16, P17, P18, P19, P20 |

This research study aimed at developing an explanatory model of mental health ethics by Northern Sotho THPs. The analysis of the concept of ethics was the untidiest as

most THPs understood it is synonyms more than the concept itself. The THPs attached the meaning of the concept “ethics” or associated it with morals, principles, values, and rules. As a grounded theory researcher, I used the analytical tool of asking questions more on this concept. I was interested in knowing if ethics are rules, and who makes these rules? In essence, what are these rules? Who ensures that these rules are practiced accordingly? What happens is a THP is not following these rules? Do these rules apply to all THPs? Answers to all these questions about this concept gave rise to concepts such as guidance from the ancestors and wrath of the ancestors that are yet to follow in the presentation. Other answers came out strongly in other concepts such as consultations, admissions, and treatment.

The concept was not perceived as a stand-alone concept as my focus was mainly on THP’s ethics specifically when they are treating mental health conditions rather than just general ethics of THPs when practicing or treating any other condition. I ensured that the participants understood what I was investigating, which was ethics involved when treating patients with mental health conditions. I noticed that although I specified that ethics should be specifically for when managing mental health cases, one participant explained that ethics cuts across the management of all other diseases. The concept was present in all 20 transcripts. All participants understood ethics as rules that they needed to follow in their practice as THPs. The following extracts from the transcripts show how the THPs understood what ethics in the management of mental health conditions:

***P1*** *“Ethics are rules that guides us as traditional practitioners”* ***(62 years old, female)****.*

***P10*** *“Ethics are rules that governs the practice of traditional healing in our communities”* ***(38 years old, male)****.*

***P11*** *“Although not documented anywhere, we do have rules that guides as we practice. We do not have rules specifically for treatment of mental health conditions, but most of the rules cuts across the treatment of all the diseases”* ***(70 years old, female)****.*

Most of the participants who belonged were registered to a THP organisation mentioned that being ethical is equated to being professional. They explained that working with people requires a certain level of professionalism and they claimed that they possess the highest form of professionalism. Their meaning of ethics attached to being professional also meant doing things right. When further asked what professionalism is, what exactly they are referring to, some mentioned that they should have good communication skills as reflected in the following extracts:

***P9*** *"I am a professional and I do things professionally, from consultations to treatment"* ***(45 years old, female).***

***P4*** *"One of the things that shows that a THP is professional, is how he address his patients. Communication is very important. A healer has to have good communication skills"* ***(36 years old, male)****.*

Although not formally, as I was collecting the data I have also observed how some THPs addressed each other as doctors. They said that they are no different from the Western medical doctors and they deserve the title. They also added that they do similar work, just different in environments. As an analyst, I got to use constant comparison techniques about the meaning of professionalism between the THPs and Western medical doctors. Answers to the question resulted in concepts that I discarded as the theory was building up.. The extract to follow adds to the issue of being ethical as somehow being professional:

***P10*** *"I am a traditional doctor. I practice in my profession traditionally so"* ***(38 years old, male)****.*

***P11*** *"We are not different from the medical doctors. In my view we do more or less the same. The only difference is that they work in the hospitals and clinics, whereas we work in our homes"* ***(70 years old, female).***

***P13*** *"As doctors we deserves the same treatment even from the government. We also need their support. Most of the things are not fair on us, whereas we are the same. We perform the same job, which is to treat and heal the patients"* ***(47 years old, male).***

One of the reasons why I mentioned that the concept of ethics was the untidiest and not easy to analyse is its relation to the other concepts that also have to be individually analysed. The other concepts to be discussed later in the study such as, being human, ancestral guidance, confidentiality, and other ethical principles involved in consultations, admissions, and treatment of patients with mental health conditions has a relationship to this concept. The extracts presented above show how the THPs struggle with the issues of belonging and identity. This resulted in some comparing themselves with the Western medical doctors. The extracts also indicate that the THPs feel that they are not supported and are treated unfairly compared to the HCPs.

### 6.3.2 The concept of ancestral guidance

| Concept | Indicators | Transcript references |
|---|---|---|
| Ancestral guidance | Supreme guidance<br>Ancestral powers<br>Spiritual-guidance<br>Incantations<br>Communicate with the ancestors<br>Spiritual sense | P1, P2, P3, P4, P5, P6, P7, P8. P9, P10, P11, P12, P13, P14, P15, P16<br>P17, P18, P19, P20 |

The concept of guidance from the ancestors was present in all the transcripts. Based on the analysis process, they understood the concept of guidance from the ancestors as a form of advice or direction given to the THPs from their ancestors. From the analysis, guidance from the ancestors came in two forms. The first is the personal form and the other is during practice. All participants pointed out that they are guided by their ancestors in everything they do, irrespective of it is personal or during practice.

The concept fits the description of a core category (**See 5.6.4**) as it relates and ties up to all other concepts and categories in the study. All participants showed that they live, practice, act, and do everything based on how their ancestors require. THPs believe that they are guided by their ancestors to act ethically at all times.

All 20 THPs who participated in the study explained that they are guided by ancestors in everything they do in their daily lives and as well as in their practice. The guidance was said to be communicated through signs, visions, dreams, instincts, and conscience. The relationship between the THPs and ancestors appears to be reciprocal. At times the ancestors are the first to communicate something to the THP. However, in most instances the THPs are the ones who initiate the communication by throwing the bones and then doing incantations. Not only during consultation with the patient, but also if they want to do something personally, like leave the house, going to harvest the medicinal plants, going out to perform rituals, etc.

During the consultation after the THP throws the bones, the ancestral spirits guide him/her in terms of what the problem is with the patient. Participants also explained that they usually know how their day is most likely to go by what their ancestors show them during the night in their sleep. The above extracts support this:

***P2*** *"When I am with the patient, after throwing the bones and speaking to them. After reading the bones, I will be able to see what is the problem of the patient"* ***(52 years old, female).***

***P17*** *"Look, when you are a traditional healer you do not control yourself. Everything you do, you are guided by the ancestors. If you want to do something, they must approve of it first. It's not an easy journey"* ***(76 years old, male)****.*

***P20*** *I "always know how my day is most likely to go, they pay me a visit every night. When I wake up, already I know what I am supposed to do"* ***(70 years old, male)****.*

One participant further added that he gets very worried should the ancestors not communicate with him. This reveals the spiritual and the relationship that exists between this THP and his ancestors.

***P19*** *"My ancestors communicate with me at all times, when they are quiet I become very worried"* ***(18 years old, male)****.*

In addition to the idea of the THPs knowing how their day is most likely to look. Some participants revealed that their ancestors show them the patients that are going to come for a consultation, what the problem of the patient is, and how they are supposed to address it.

***P5*** *"However, in most instances, the ancestors will show you the patient who is coming the next day and also show you the herb you need to use to treat that patient. You are shown on this in your sleep"* ***(52 years old, female)****.*

Sometimes the communication is not clearer. The ancestors communicate in many forms. The meaning and purpose of that particular unclear communication are most likely to appear after certain events. It also takes wisdom to be able to figure out the most unclear communication they sent. However, in most instances, the purpose of the unclear communication turns out to be either protecting the THP, the patient or even saving a life.

***P3*** *"You have to consult with them for whatever you want to do. Even when you go to the shops, you consult. At times they would not want you to go out at all, you have to listen and indeed not go. This usually happens when I am so eager to do something and they do not want that, or there is something more important that they want me to do. There was a time I really wanted to go out, but they refused little did I know. A patient who was just about to die came consult on that day, and I saved a life"* ***(33 years old, female)****.*

***P7*** *".... (Sighs) I've learnt to listen more when the ancestors speak to me. They have saved me in many occasions. My ancestors talk to me through whispering ("sebela") to my ear"* ***(27 years old, male)****.*

Participants also postulated that before embarking on any journey they have to consult *(go kgopela ditsela).* If the ancestors approve it is only then that they would go. They also added that they seek permission from them when going to harvest the medicinal plants, or going to perform some rituals, and it is only when they can approve that the THP can indeed go out to do all that. Also, when you get there they are supposed to communicate, and also when they come back they have to report back.

***P4*** *"Yah, there are rules. You cannot just go find a plant then you start digging. It's not yours, it belongs to the ancestors (ke pheko ya badimo). You ask for it. Even when you come back, you report back to them and tell them that its patients can now come to get it. The ancestors cannot give you a patient that you do not have medicine for"* ***(36 years old, male)****.*

The extract below is of a participant who saw that the patient needs immediate hospital medical attention. This proves that there are certain conditions that need western medical attention, more than traditional medicine. He explained that the patient was very sick and he had to reveal the patient something very sensitive. The participant explained that the ancestors guided him on how he should break the news to the patient. Basically, the ancestors guided the participant to refer the patient to a western medical doctor. The referral is also among the concepts that I arrived at during analysis. Referral will be discussed in **6.3.6**.

***P6*** *"I had a patient who was very sick, and after throwing the bones the ancestors showed me that the patient it's a matter where a person has to go to a medical doctor, I see it and I tell the patient. The ancestors help with how I am supposed to communicate with the patients"* ***(22 years old, male)****.*

Some participants experienced a situation where they were not sure if it is a good idea to help a patient. This was established in consultations where the cause of mental health disorder was due to the patient's evil deeds to another person. Most participants faced this challenge. However, they claimed to immediately cease and advise the

patient to do certain things before can deal with the mental condition issue. However, there is one participant who was sceptical about what should be done in that situation.

***P3*** *"Through the guide of the ancestors, you will know if you are supposed to help that person or not. I don't want to lie, there are times when you take rational decisions as a healer, but also there are times when you really need that kind of guidance"* ***(33 years old, female)****.*

The ancestors do not only provide guidance to the THPs. They also require acknowledgement, respect, and honesty. There are certain do's and don'ts that the THPs need to take into consideration and adhere to. This differs from a THP to another THP as every THP has his/her ancestors. The extracts below show some of the expectations that the ancestors have of the THP.

***P4*** *"In this institution of traditional healing, you do not command yourself. For example, I do not use the bones (ditaola) from 12 mid-day. At 12 mid-day I stop everything. If I was on top of a mountain harvesting the medicinal plants, I climb down and rest then resume at 1. 12 midday ke nako ya sedimo (it's the ancestral time), and it needs to be respected. This is something that I don't compromise"* ***(36 years old, male)****.*

***P19*** *"If you want peace, you just have to follow ancestral instructions. I had to go back to wearing the traditional clothes they want me to wear even when I go to class or even walking around campus. It's not easy, but I do it anyway"* ***(18 years old, male)****.*

All the participants shared a common feeling that it is always good to have your ancestors guiding you always. However, two participants seemed to be unhappy about their lives as THPs. These two participants had to leave school and join the traditional healing initiation. They were struggling with acceptance of the life they were leading at the moment. However, one thing that stood out in their lives was their ancestors' protection and guidance.

***P6*** *"I had dreams, and all of a sudden I had to leave school…and damn I was very good in Mathematics. At times all my dreams come back and reality hits that I am on another path. However, I appreciate the guidance and protection of my ancestors…"* ***(22 years old, male)****.*

***P7*** *"Although I left school. I have big dreams, and I sometimes wish to have a normal life. I hope my ancestors will guide me and help me reach my goals"* ***(27 years old, male)****.*

From all extracts presented, it is evident that most THPs are indeed guided by their ancestors in many aspects of their lives including just their daily lives as well as during practice. The guidance is even more evident during patient consultations, admissions, and treatment of their patients. Although guidance from the ancestors is the most important in traditional health care, not all THPs respect that. Some THPs defy the ancestor's guidance, such THPs usually faces the wrath of the ancestors which will be discussed later.

Communication plays a very important role in ancestral guidance. From the communication initiated by the THPs to their ancestors through throwing the bones; to the communication from the ancestors to the THPs through signs, dreams, visions. Other than communication, respect also plays a huge role in enhancing the relationship between the THPs and ancestors. Some THPs explained how they ask and report everything to their ancestors. Also, the specific rules about the way they lead their lives as both being an individual and a THP. For example, the participant who explained that they do not do anything from 12:00 midday to 13:00 because it is a sacred time for the ancestors "*ke nako ya sedimo"* and that they never compromise on that; shows the level of respect for the ancestors.

I have pointed out earlier that this concept ties up to all other concepts that will follow in the discussion, and that it is also the core category of this study. The participant's psychological implications revealed on this concept, accounts for a variation on different conditions it was presented upon. Although most THPs shared feelings of

contentment and appreciated guidance from their ancestors, some shared different feelings. Some participants explained that being THP is not easy and seemed to be troubled by the route or path they took of being THP. The extracts also showed that some THPs were struggling with acceptance of the route they took of being a THP, although they still appreciated the protection and guidance provided by their ancestors. It was also evident that the THPs had no choice but the path was chosen for them by their ancestors. The participant who also pointed out that he has to be rational in some decisions rather than being guided reflects that some THPs are selective about when to follow their ancestors, or rather they believe that they can make some decisions on their own.

The extracts also revealed both the spiritual and physical relationship that the THPs had with their ancestors. The spiritual relation whereby the THP is spiritually given information about the patient that is yet to come gave the THPs assurance that the ancestors are watching over them. The same applies to the physical relation whereby they were saved on numerous occasions just based on how they were feeling following their gut. However, some THPs showed frustrations, confusion, and anger when the ancestors disapproved of something they eagerly wanted to do and whenever the message from the ancestors was not clear.

### 6.3.3 The concept of being human (*Botho*)

| Concept | Indicators | Transcript references |
|---|---|---|
| Honesty | Truthful<br>Honest to patients<br>Respect for patients<br>Respect for the ancestors<br>Respect for authority<br>Humility<br>Honesty | P1, P2, P3, P4, P5, P6, P7, P8. P9, P10, P11, P12, P13, P14, P15, P16 P17, P18, P19, P20 |

| | | |
|---|---|---|
| | Good heart | |

The concept of being human encompasses some of the concepts that I thought could be stand-alone. Being human encompassed other concepts such as respect, humility, honesty, and having good communication skills. Participants explained that being human means being a human being or being a person. The participants further explained that being human means having everything to do with doing good. During analysis, I tested this concept of being human with a different condition of what would "*not being human"* to understand the concept of being human better. The following extracts support the previous statement:

***P15*** *"You cannot be a traditional healer if you do not have a good heart. Okay, let me put it like this, actually in order to be a traditional healer you must have morals. Meaning that, you must be human and act human in all the times"* ***(50 years old, male)****.*

***P17*** *"They say you can't speak for yourself, but I do. I am a good a person, that's why I am a traditional healer"* ***(76 years old, male)****.*

Another meaning attached to being human had to do with participants emphasising that a THP should have a heart. This kind of statement was said by most of the participants. This is what a participant mentioned:

***P16*** *"A healer should have heart so the he can be able to put himself in the shoes of a patient (O swanetse o be le pelo). He must be able to feel what a patient and that patient's family are going through. A healer has to be pure at heart and be human. You must not have a cold ugly heart (A o a swanela o be le pelo ye mpe, ya makgwakgwa)"* ***(72 years old, male)****.*

During analysis, I further questioned the statement in a condition about what would not having a heart means for a THP. I also questioned if there are THPs who are not human. I had to ask these questions to check for variation in a different condition. Some answers to this question lead to the participants deducing some THP to animals to show what not being human means. That seemed to not be a good trait, and some participants mentioned if a THP does evil, they are most likely to face the ancestral wrath.

Some participants believed that everyone has a human element in them, and lose it by doing evil. Not being human was also at some point associated with not being ethical. Herewith, are some of the answers:

***P5*** *"Being human is spiritually embedded in a human being. The THPs who are not human are usually witches. They are people who would use their gift of healing and do evil. That is unethical"* ***(52 years old, female)****.*

**P7** *"Remember that people are free beings who chooses to behave in a manner they want. Some THPs are just bad people. They have evil hearts and do not treat patients in a good manner. Usually, those kind of THPs deal with the wrath of the ancestors"* ***(27 years old, male)****.*

***P16*** *"The bottom line is that there are morals, rules, taboos…that the THPs need to adhere to. All of those are human. Some THPs behaves like animals. That is why in our organisation we have a disciplinary committee for the THPs who do not practice accordingly"* ***(72 years old, male)****.*

Almost all of the participants emphasised that a THP has to be an honest person. They postulated that a good THP has to be truthful all the time. Participants mentioned that you do not need to only be honest to your patient as a THP, but you should also be honest to yourself. They mentioned that by so doing, the ethic of being human is fulfilled. Herewith the extracts that support the issue of honesty:

***P1*** *"There is a saying that "the truth hurts". The difficult part about this work is that you have to tell the truth at all the times. You need to tell the truth, no matter how much it can hurt the next person"* ***(62 years old, female)****.*

***P8*** *"You need to be true to yourself as a healer, before you can be truthful to your patients"* ***(72 years old, female)****.*

The participants showed that a THP is a mediator between the living and ancestors. The participant mentioned that their ancestors would not allow the THP to help a person who has done evil to the next person. Another participant explained that the ancestors wants purity. The extracts yet to follow also accounts for the concept of ancestral guidance. These extracts show that indeed a THP has to be an honest person:

***P7*** *"I tell it as it is. For example, there is no way I will help a patient who's done evil to the others. My ancestors do not allow such"* ***(27 years old, male)****.*

***P18*** *"My ancestors want purity. I cannot lie to my patients no matter what"* ***(58 years old, female)***

One participant spoke of humbleness and the ability to be able to live with other people in your community as a THP. The participant had just graduated from her initiation.

***P3*** *"I was taught to humble myself at the training. I was also taught to respect everyone, including my patients"* ***(33 years old, female)****.*

Participants belonged to different communities which have different cultures and waysof doing things. However, they understood the role they play in their communities and claimed to be executing them very well. They emphasised that they belong to their communities and respect that. Participants showed that they are part of their communities and are supportive of fellow community members. They also know their

place and follow the culture of their tribal authority (*mošate).* The following extracts support this:

***P5*** *"I am a healer of my community. They are me and I am them. Although I am not an ordinary person like them, but I ensure to attend ceremonies in my village"* ***(52 years old, female)****.*

***P10*** *"No matter how busy I am; I know what is happening in my place. I know this because those people are part of me and they support me"* ***(38 years old, male)****.*

***P11*** *"As a healer, I also follow the rules of mošate. Even the king knows. I respect his mošate. When I have patients who are not from my community I report to mošate"* ***(70 years old, female)****.*

The extracts also show that the participants feel belonging in their communities and have good relations with fellow community members and the tribal authorities. It shows that they play their roles as THPs. They are part of their communities and they participate in community events. The extracts also indicate that a THP has to be empathetic. They have to be willing to help at all times.

### 6.3.4 The concept of Consultations

| Concept | Indicators | Transcript references |
|---|---|---|
| Consultations | Incantations<br>Divination<br>Comfortability<br>Family member<br>First consultation<br>Follow up consultation<br>Management of the disorder<br>Throw the bones<br>Trust | P1, P3, P4, P5, P14, P18, P20 |

| | | |
|---|---|---|
| | Help<br>Diagnosis<br>Traditional health practitioner's role<br>Ancestral cloth<br>Manmade<br>Stress<br>Social problems<br>Witchcraft<br>Normal sicknesses<br>Natural causes<br>Patient's evil deeds | |

Consultation is the process of meeting with someone, especially when they are seeking help or advice. During the analysis, I realised that the concept presented itself in two forms. The first was that consultation occurred when patients consulted with the THPs. The second was when the THPs consulted with their ancestors in order to help the patients. Both forms of consultations are equally important in the discussion.

People consult the THPs for different reasons. However, this study focused specifically on mental health cases. The analysis revealed that a patient with mental health condition does not come for a consultation alone. The patient is supposed to be with a family member or a relative. The consultation happens in the sacred hut (*indomba*) all participants showed that such a patient is most likely not to understand anything, therefore, someone who is going to be his/her representative should be there. All participants made it very clear that they do not help a person with mental health conditions if the person is alone, also even if the person is with a friend. The following transcripts show how THPs felt about the issue of patient consultations.

***P1*** *"In the first consultation, we address quite a few things. When it's the first time one comes for consultation it will depend on whether the patient is alone or with someone and a lot depends on the severity of their illness. If the patient is alone, we get to the hut and get on with consultation. If the patient is accompanied by someone, I ask if he/she is comfortable with being with that person in the hut. Usually people who have mental health conditions come with a friend or relative, I then let the person who has accompanied them stay with us in the hut during consultation*" ***(62 years old, female)***

***P14*** "*A mentally ill person should come for consultation with a close family member, so that we can see where does the problem emanates from"* ***(39 years old, male)****.*

***P18*** *"There is no way a person with mental health disorders can come alone, I will not help him. There are lot of things discussed during consultation, things like payments"* ***(58 years old, female)****.*

One participant stated that during consultations, issues of payments are discussed right away. Therefore, it is important that a family member who is not ill, is present to make the important decisions such as the issues of payments. The concept of remuneration is also present amongst the concepts to be discussed, and it will be discussed in **6.3.8.**

***P20*** *"……if such a person comes and they are alone, or with a friend, I won't help them. I want someone who will take responsible full responsibility of the patient, like a family member* ***(70 years old, male)****.*

One participant who practices through *lefahla,* mentioned that sometimes as a healer she can see that the person who has brought the patient for a consultation has a hand in the patient's illness. The participant explained that those are some of the challenges that THPs face. This participant said this:

***P3*** *"If one is sick and not feeling well, one is most likely not to understand or hear a thing during consultation. Meaning that whoever accompanied the patient will have to come in the hut as well, in order to listen for the patient. Sometimes you might find that the person who is with the patient is actually the cause of the problem. That is when I have to be careful and alert. I have to quickly prepare something for the patient, to*

*make him/her sane for a moment. After that, that is when I have to communicate with the patient and tell the person accompanying him/ her to go get someone else to get to the hut with. By law inside the "indomba" you should be 2 or 3 people"* ***(33 years old, female)****.*

During the interviews, all patients mentioned that although their patients should be with someone in the sacred hut (*indomba*), they ensure that their patients receive the highest form of privacy and confidentiality. They argued that they cannot share anything happening in the "indomba" with anyone, not even another THP. They explained that they are taught that when still at the initiation. They also explained that they encourage their patients not to share their problems with other people. The participants also explained that it is unethical to share the patient's problems with other people. The extracts below support this:

***P4*** *"Whatever is discussed between the patient, the patient's family and the healer is confidential. I am not allowed to share it with anyone. Also, even the patient and her family members are not allowed to share it with anyone. This is because as a healer you will be breaking the rules, and as for patient and his/ her family member they might share the information with the wrong people"* ***(36 years old, male)****.*

***P5*** *"I know people are nosy, but I am not allowed to share whatever I discuss with my patients"* ***(52 years old, female)****.*

***P18*** *"You cannot discuss patient's problems with anyone, not even your spouse. It is just morally unacceptable"* ***(58 years old, female)****.*

The participants knew and understood that the discussions are about the ethics involved when treating a patient with mental health conditions. Most still started with consulting with the ancestors. They explained that sometimes a patient comes to them already knowing the problem, but they still have to consult with the ancestors to check the problem of the patient. This is because they have to make the diagnosis

themselves, and when it comes to their practice, they cannot rely on word of mouth. Different THPs use a different method of consultation with the ancestors, however, all methods serve the same purpose which is, to consult *(go hlola)* The extracts below shows what happens when a THP consults with the ancestors:

***P4*** *"I will consult the bones, or conscience (lefahla), or the bible. It really depends on my spirit on that particular day. The main reason for this is that we want to see and understand what is the problem and where does it originate from"* ***(36 years old, male)****.*

***P15*** *"I throw the bones; the ancestors will reveal to me what is the problem. Indeed, if the problem is a mental health related disorder, the ancestors will reveal it. From there, they will reveal what is the cause of that mental health disorder"* ***(50 years old, male)****.*

Participants declared that diagnosis and cause of the mental health disorder are very important in traditional health practice. They explained possible causes of mental health disorders, and that treatment of the patient depends on the cause of that disorder. The extracts below support that:

***P1*** *"After consultation we know the cause of the mental condition and then we take it from there. If its witchcraft or natural causes. Usually its witchcraft. We will then communicate with issues involved in treatment"* ***(62 years old, female)****.*

***P3*** *"The first thing during consultation, we check what is the cause of the problem the patient is facing. We usually find that the cause of the mental problem that the patient is facing might just be like any other disease, or you find the person has done something bad to the other person then the person retaliated back. At times it could just be stressed that is caused by social issues, either the family or work related"* ***(33 years old, female)****.*

The extracts presented above shows that both forms of consultations are important and involved some ethical aspects within them. Issues of confidentiality, privacy, and respect for the patient plays a huge role in traditional health practice. The extracts also

revealed some of the challenges THPs face in their practice. THPs experience a lot of frustrations, confusion, and not knowing what to do in a case where the ancestors reveal that the person who has accompanied the patient has something to do with the patient's condition. This can cause them stress and make them feel not good. The extracts have also disclosed the importance of family relations. It has shown the relationship between the patient and the family member who brings that patient for consultation, the relationship between the THP and other HCPs as well as the relationship between the THP and another THP. The next concept to be discussed is the concept of admissions.

### 6.3.5 Concept of Admissions

| Concept | Indicators | Transcript references |
|---|---|---|
| Admissions | Admission procedures<br>Accommodation<br>Mutual Agreement<br>Paperwork<br>Care giver<br>Consent<br>Consent forms<br>Discussions<br>Seek permission<br>Severity of the disease | P1, P3, P4. P9, P12, P14, P15, P19, P20 |

The concept of admission emerged from most of the participants during data analysis. For the purpose of this study, admission is the process of being allowed to become a stay-in patient at the THPs place of practice, which is usually the THPs home. The practice of THPs admitting their patients with mental health disorders is not foreign. The THPs usually have backrooms in their homes, specifically for the accommodation

of their patients. The participants pointed out that not all patients with mental health disorders can be admitted. Some can be treated while staying in their homes. However, through the guidance of the ancestors, some patients with mental health disorders can be admitted. Other patients with mental conditions are admitted due to the severity of the condition, therefore they would need closermonitoring. Additionally, it is easier for the THP to observe and do correct medicine administration if the patient is closer to them at all times. Below are extracts accounts for this concept:

***P5*** *"I have to prepare the medicine myself and give to the patient. To a point where through observation I would be able to tell that the patient is getting better"* ***(52 years old, female)****.*

***P19*** *"…. it's easier for me to monitor the patient when he is closer than having to travel everyday"* ***(58 years old, male)****.*

One participant showed that at times admitting a patient serves as a protective measure from the dark forces or spirits that are in their homes. This shows that the THPs carry the responsibility of having a stay-in patient belong to the THP.

***P20*** *"My ancestors guide me in all the decisions I take. One of the reasons for admitting the patient is protecting him/her from the other dark forces at his/her own home. It's purely for safety purposes and enhancing healing"* ***(70 years old, male)****.*

There are a lot of things that THPs consider when admitting a patient with mental health conditions. The patient cannot be admitted alone, just like during consultation, the patient has to be with a family member who is going to act as a care-giver for the patient. The THP's role is medicine administration and any other form of treatment that the patient will need.

***P3*** *"If the person is too much sick, they should have a care-giver who will bath and generally take care of the patient. As a healer, I will only provide treatment, food and accommodation*" ***(33 years old, female)****.*

***P9*** *"The family member will basically take care of the patient, and my focus will only on treatment. I have to make sure that the patient gets the best treatment ever under my care"* ***(45 years old, female)****.*

All the participants followed different procedures when admitting a patient with mental health disorders. The most important was that some had admission and consent forms, which is an important aspect of the ethical procedure. Most participants who were registered as a THP in an organisation had admissions forms that the patient and the caregiver fills. It does not only protect the THPs and require them to take responsibility and accountability for taking care of the patients, but it also protects the latter and gives them a sense of belonging. The following extracts show that:

***P1*** "*We fill in the forms of consent, and then discuss the issues involved with regards to the food and accommodation. This is very important so that we don't have issues during their stay. We discuss that beforehand"* ***(62 years old, female)****.*

***P4*** *"We have paperwork for admissions, and there should be a witness at the end. Should the patient do something to a member of the community, as a healer I have to take responsibility"* ***(36 years old, male)****.*

***P12*** *"We have admission forms. The forms states that I have received a patient and the patients is going to stay with me. It also states that the patient should have someone to take of him/ her when she/ he is staying with me. The form has all the information about accommodation, food and payments"* ***(53 years old, female)****.*

One participant who had just started practicing mentioned a different route. The participant explained that when he admits a patient, they both go to the police to make an affidavit. The caregiver is also present in all these processes.

***P6*** *"Before admitting a patient with mental health condition, we all make an affidavit with the police explaining everything about how we are going to assist each other in relation to food and electricity. The caregiver must also be present in all the processes"* ***(22 years old, male)****.*

Another participant presented that he does not only rely on forms, he goes the extra mile and does it the traditional way. The participant explained that he goes to report to the village headmen (*ntona*) each time he admits a patient.

***P14*** *"We fill in the forms and then I go to the village headman to register that I am admitting a patient. All this is done by myself as the healer and the person who takes care of the patient. This is to be able to account, should something happen to the patient or the care giver.*

This concept was tested in the same condition of how the admission is done. Answers to the question varied based on each THP's knowledge and experience. The extracts above indicate the huge responsibility taken by the THPs with regard to the process of admission in their practice. THPs lead their lives with the burden of uncertainty that anything can actually happen to the patient during their stay in their homes.

### 6.3.6 Concept of referrals

| Concept | Indicators | Transcript references |
|---|---|---|
| Referral | Refer to the clinic<br>Refer to a THP<br>Medical problems<br>Social problems<br>Trust<br>Working relations | P2, P3, P9, P10, P11, P14, |

The concept of referrals emerged during the data analysis. The referral is the process of recommending that a patient goes to see another professional for assessment or help with a specific issue. At times THPs do referrals to the HCPs like social workers, psychologists, medical doctors etc. Although the referrals are not done formally, most of the participants had a formal manner in which they carried out when doing referrals.

Participants clarified that doing referrals to the clinic or hospital does not mean they are failing to help, but they are acting to speed up the process of treatment. The extracts below also show that some THPs refer their patients to clinic or hospital for something specific, and then after attending to that aspect the patient can come back:

***P3*** *"If I can see that a patient is weak, and I can give him/her a certain herb to strengthen him/ her, I know very well that my herb might take time to strengthen that patient. Therefore, a drip would work faster, so I refer the patient to the clinic or hospital for that. Then they come back stronger, and we continue where we left off"* ***(33 years old, female)****.*

***P14*** *"I refer the patient to the clinic after checking what is wrong. I usually write them a letter to the clinic. There are things that needs traditional medicine and those that needs western medicine". For example, the blood transfusion.*

One participant mentioned that some patients come for consultation having social problems that they feel uncomfortable discussing with the THP. The participant stated that they refer them to a social worker for assistance should they realise that the patient needs such kind of help.

***P9*** *"At times as a healer you can see that the patient has social issues that they feel uncomfortable to discuss with you. It is your duty to advise them to go to a social worker and deal with those issues. I can do counselling through just talking to the patient, but I know there are experts in the field who can assist better"* ***(45 years old, female)****.*

Not only are the referrals done to the western health practitioners, but a THP can refer a patient to another THP. The referral from a THP to a THP is usually from a junior to a senior. The extract below is from a participant who had graduated.

***P2*** *"Actually I have a patient who came for consultation, but I did not have the herbs for that patient. So I referred him to my gobela (a person who train or initiate a THP to become a THP)"* ***(52 years old, female)****.*

Other participants who found themselves in need of help with a particular patient, called for assistance rather than making a referral. These participants pointed out that they call a senior THP to come to them rather than taking the patient to that THP. They justified this by saying if they make a referral if anything happens to the patient they have to take full responsibility. They also established that the THP they contact for help is someone they trust and have a working relationship with, it cannot just be any other THP.

***P10*** *"I will call the traditional healer to come to both of us" I cannot refer my patient to another healer"* ***(38 years old, male)****.*

***P11*** *"I'd rather invite the other traditional healer that I trust, so that we help each other"* ***(70 years old, female)****.*

The extracts above show that it is important for THPs to have good relations with other HCP as well as with other THPs. They also have to practice accordingly as they do not work alone, but with other health professionals. THPs should be trustworthy, reliable, and dependable. Even in the processes of referrals, guidance from the ancestors still plays a huge role. THPs do not take decisions from their heads, but through the guidance of the ancestral spirits.

### 6.3.7 The concept of Treatment in traditional healing

| Concept | Indicators | Transcript references |
|---|---|---|
| Treatment | Healing<br>Consent<br>Traditional medical care<br>Medicinal plants<br>Herbs<br>Sacred places<br>Rituals | P1, P2, P3, P4, P5, P6, P7, P8. P9, P10, P11, P12, P13, P14, P15, P16<br>P17, P18, P19, P20 |

Treatment is medical care given to a patient. THPs provide traditional medical care to patients suffering from different types of disorders, including disorders associated with mental health. Participants pointed out that patients with mental health conditions receive a different kind of treatments depending on the severity and the cause of their condition. Participants described that among others, patients with mental health conditions are given traditional herbs, and some have to perform certain rituals led by the THP. The traditional medicine is made from medicinal plants and some from animals. The traditional medicines differ, some are edible but rather while raw, some need to be cooked and the patient drinks the water, and some are not edible rather put in the water while bathing and some are used for application on the body like a body lotion. Participants had nothing much to say about animals rather than that they are mostly used for sacrifices. Lastly, participants spoke of performing certain rituals such as steaming and going to sacred places to perform rituals for the patients.

Participants mentioned that treatment also involves having to harvest the medicinal plants for traditional medicine and going to those sacred places especially rivers, mountains, and caves. Some participants who have *mathwasana* (THPs trainees) go to all these places with them as part of their training. All participants explained that they are guided by their ancestors in all processes involved:

***P6*** *"I just communicate with the ancestors and ask them to guide me as I take the journey to hunt for medicinal plants"* ***(22 years old, male)****.*

***P13*** "*Before I decide to go for harvesting for herbs, I have to communicate with the ancestors. In fact, I have to ask them to carry out that activity so that they can guide me*" ***(47 years old, male)****.*

***P17*** *"As a healer, you have to ask first. When it comes to sacred places, even if it's a small river, you will never know what is inside it The ancestors does guide me, but I also have to be careful. I usually go with mathwasana (THPs trainees or initiates)"* ***(76 years old, male)****.*

There are ethics involved with regards to harvesting medicinal plants as well as going to sacred places that the THPs need to adhere to. Ethical issues surrounding consent from mošate and nature conservation were pointed out by the participants. Some participants indicated that seeking a company from other THPs also make things easy for them. The extracts indicate that:

***P1*** *"I only dig up the herbs in my village, in my territory. In my mošate. If the herb I want is in the nearby village, I have to go to mošate to seek for permission to have access to their herbs. It usually easier when you team up with the traditional healers of that village when we approach the mošate for permission"* ***(62 years old, female).***

***P3*** *"Sometime back, a healer would just go anywhere to get the herbs without having to seek permission from anyone. Nowadays, everything is controlled by a person, so you have to seek permission from whoever you want to invade their place. You have to show them your certificate, and avoid trespassing****" (33 years old, female).***

***P16*** *"Most importantly, when you harvest a medicinal plant, you do not dig the whole plant and the roots if it's not necessary. You have to ensure that you leave some for others. It's just not allowed and that is what we were taught. There are chances that you will need the very same plant in the future"* ***(72 years old, male)****.*

***P19*** *"When digging the plants, they must not be taken out by roots so that we preserve the environment, plants are part of the ecosystem and they should be protected"* ***(18 years old, male)****.*

***P20*** *"Healers and herbalists who follows the rules, knows very well that they must not dig up everything. It's a known matter"* ***(70 years old, male)****.*

Participants further added that sometimes it is difficult to find certain medicinal plants, therefore they should always store some for the future whenever available.

***P13*** *"The thing is there are certain herbs that we are not supposed to dig at a particular season. So whatever is allowed to be dug at that season we dig and store them in bottles for future use"* ***(47 years old, male)****.*

When it comes to sacred places, a few participants had something to say regarding some rules involved when going there to perform rituals.

***P10****" I communicate with the ancestors before going to any sacred place. I have to be spiritually clean and prepared because some sacred places are dangerous. The patient should also be spiritually clean and at ease"* ***(38 years old, male)****.*

***P11*** *"My ancestors will always guide me. However, I also approach a THP who might have gone to that place before me, I do my own research. I always prefer to be with another THP, rather than being just me and my patient"* ***(70 years old, female)****.*

Although there was no detailed discussion about the use of animals for medicinal plants, some participants highlighted that animals should be protected and not be harmed. The extracts below highlighted this:

***P11*** *"We have to protect the animals; we must just not sacrifice the animals for no reason. That should only be done when there is a need"* ***(70 years old, female)****.*

***P15*** *"...with animals, we only kill if indeed there is a need to do so. Animals should be protected from unnecessary harm"* ***(50 years old, male)****.*

The THP's through the guidance of their ancestors, do a lot more in the process of treatment. From harvesting, the medicinal plants to actually turning them into

traditional medicine cannot be an easy task. It also does not end there because they also do the medicine administration as discussed in the previous concept of admission. The process of treatment also shows the importance of the THP-THP relationship. The idea of a THP accompanying another THP to perform rituals in some sacred places, reveals the well-hidden working relationship between the two THPs.

The ethical issues of consent from mošate involved in treatment also show the importance of culture and practices involved in the African culture. The ethical issues surrounding harvesting the medicinal plants also revealed that THPs play a role in preserving nature and the environment.

### 6.3.8 The concept of Remuneration

| Concept | Indicators | Transcript references |
|---|---|---|
| Remuneration | Free<br>Consultation fees<br>Treatment fees<br>Agreement<br>Discussions<br>Arrangements | P1, P3, P6, P14 |

The concept of remuneration is very important and was present in all 20 transcripts. From the point of consultation throughout the whole process of treatment of patients with mental health conditions. Remuneration is money paid for a service. For THPs, the issue of remuneration is quite complex. Although not standardised, at times THPs do get remunerated for their services. The following extracts from the transcripts support the above statement:

***P1*** "*There is a price for consultation, as well as the price for treatment. However, payment arrangements can be made"* ***(62 years old, female)****.*

***P5*** *"Before I can even communicate with the ancestors seeking permission to use the bones, I need pula thebele (money to open the sack of the bones)"* ***(52 years old, female)****.*

Some participants mentioned that on the forms that are filled by the patients before admission, there is a clause that addresses the issue of fees and payments. The services of the THPs are not for free. The THP charges and then the discussion about how and when the money is going to be paid starts until all parties involved reaches a mutual agreement. Depending on the mutual agreement, payment arrangements can be made and then adhered to. Below, are the extracts:

***P6*** *"The patient can pay at the time they have promised to pay. The forms that they fill binds them"* ***(22 years old, male)****.*

***P20*** *"Some patients pay via instalment, and I appreciate that they honour our agreement"* ***(70 years old, male)****.*

Many participants expressed how the issue of payments is not much of a focus as the main idea is to help rather than focusing on money. Being human disregards focusing on money and material things. The THP's focus is more on the well-being of the patient. When a patient is brought, and they do not have money, negotiations take place and the parties reaches an agreement. Most importantly, the participants mentioned that price for anything is determined by the ancestors.

***P3*** *"As tradition healers our focus in not on cash, sometimes a patient comes and they have nothing. Through the guide of the ancestors, you will know if you are supposed to help that person or not. Most of the time you help, then you feel good and your spirit automatically is eased. Some patients would negotiate, and make a promise to come back and "thank you" once they healed and are back on their fee"* ***(33 years old, female)****.*

***P14*** *"The price doesn't come from my head. I charge based on what the ancestors want. I then tell the family member who is taking care of the patient"* ***(47 years old, male)****.*

As mentioned earlier ,the service is not for free. There are patients who never come back to pay although there was an agreement. Participants shared how they deal with that:

***P2*** *"Those who do not pay, will eventually pay. The money will find its way to me, but they will pay"* ***(52 years old, female)****.*

***P18*** *"…at times you find that the patient and the care-giver are staying far. I cannot go around looking for them to come pay back the money. I leave it to God and my ancestors"* ***(58 years old, female)****.*

The THPs shared feelings of contentment and most of them were not very worried about patients who do not honour the agreement as far as remuneration for the service is concerned. Guidance from the ancestors also seems to be playing a huge in issues pertaining to remuneration. The THPs trust their ancestors beyond human measure.

### 6.3.9 The concept of Healing progress

| Concept | Indicators | Transcript references |
|---|---|---|
| Progress of healing | Admit to being well<br>Mental health management<br>Medicine collection<br>Understanding instructions<br>Healing time frame<br>Healthy mental health | P3, P6, P11, P12, |

The purpose of treatment for a patient with mental health disorders is to help the patient to attain a better healthier mental health condition. During the actual process

of treatment, the THPs prepare and administer the traditional medicine to the patients. This is easier if the patient is admitted to the THPs home. The participants highlighted that although they set a time frame of when the patient and the caregiver are most likely to go back to their homes, everything depends on the patient's healing progress.

Healing progress is a process whereby a patient's healing is monitored through observation and change in behaviour. Some participants also explained that a patient's confession with their mouth forms part of the evaluation in healing progress. The participants explained that there are certain things that they look at to see if a patient with mental health disorders is healed or getting better. This concept could not account for a lot of variation. However, it was equally important just like any other concept higher-level concepts in this chapter.

***P3*** *"So if patient with mental issues have been taking treatment, we give them a time frame. If is a patient I stay with, they go home after a certain time frame. Then we work with observation. We can see that a patient is healed through their mental state or their behaviour. If they are healed, they only have to come consult once a month just to check if everything is still in order"* ***(33 years old, female)****.*

***P6*** *"I give  to him/her a few tasks from time to time. Starting with whether the patient is able to understand instructions. Even through communication. Mostly they are stay-in patients so it's easier to see. When they look and seem better, they can be sent home and only come for medicine collection. It is now just going for management of the illness"* ***(22 years old, male)****.*

***P11*** *"A person must admit himself or herself that they are healed or they feel better"* ***(70 years old, female)****.*

Just like me as both a researcher and an analyst, a THP's duty is not only a heal. The primary goal is of course to ensure that a patient feels better, and continues with the management of the condition should there be a need to do so. Through observation and change in behaviour, the researcher can see be able to make certain decisions about a patient.

### 6.3.10 The concept of the Wrath of the ancestors

| Concept | Indicators | Transcript references |
|---|---|---|
| Wrath of the ancestors | Ancestral disobedience<br>Ancestral spirits<br>Bad things<br>Evil deeds to another person<br>Punishment<br>Retrieve the gift of healing<br>Respect for the ancestors<br>Whip | P1, P2, P3, P4, P5, P6, P7, P8. P9, P10, P11, P12, P13, P14, P15, P16, P17, P18, P19, P20 |

The concept of the wrath of the ancestors kept on surfacing in the discussion of other concepts in the study. The wrath of the ancestors is strong extreme danger from the ancestors. This anger can be seen through the events happening to an individual who has angered or not adhering to the ancestors. Following the discussion that took place about the guidance from the ancestors, participants believed that failure to abide by ethics, rules, and guidance of the ancestors leads to the wrath of the ancestors. Most of the participants were not comfortable discussing what is most likely to happen if a THP is being unethical in their practice generally or the concept of the wrath of the ancestors.

I tested the concept by asking questions about what happens then if a THP practices and lives their life accordingto their ancestor's guidance. Answers to that kind of questions was mostly one word such as you will have life, God will bless you accordingly, or you will live nicely. However, more focus remained on the concept of the wrath of the ancestors. The extracts below show about this concept:

***P3*** *"A lot of things can stop. The ancestors can turn their back on you (Badimo ba gago ba a kgona go o furalela). In fact, you might not be able to deal with the simplest disorders like headache. The ancestors can block you (Badimo ba gago ba kgona go*

*o tswalela gore o se bone selo). At times the ancestors can even make you sick. In fact, the moment you agree that you are practicing (thwasa), it means that you no longer have control over your body"* ***(33 years old, female)****.*

***P6*** *"Should you go against them; they will whip you"* ***(22 years old, male)****.*

***P11*** *"…you wouldn't mess with the ancestors, never"* ***(70 years old, female)****.*

***P13*** *"The wrath of the ancestors is not something that one would ever want to face"* ***(47 years old, male)****.*

***P15*** *"The ancestors can be very harsh. They will close you so that you won't see anything anymore. You will have to undergo cleansing".*

One participant stood out and explained that he will not help a patient who has done evil to another person, and then that person has revenged or retaliated. This stems from the fact that the THPs help a patient with mental health condition after knowing the cause of that condition. Therefore, if the cause is something similar to what is pointed out in the extract below, then the THP would not help such a patient:

***P5*** *"You can even die and leave your children. For example, I will never help someone who has done evil to the other person. I just won't because I shouldn't". I won't test my ancestors with such".* ***(52 years old, female)****.*

The extracts presented above indicate that participants experience or acknowledge the concept of the wrath of the ancestors as THPs as an association with fear, panic and distress. The wrath of the ancestors is explained to be extreme to a point whereby a THP's gift or healing powers can be taken away from him/her. Most participants were not very direct and chose their words when it came to this concept. The concept was associated with consequences such harshness, being whipped, being sick and dying.

The extracts above demonstrate how bad the ancestors can be if they are disrespected. The events that are discussed as most likely to happen if a THP does not abide by the rules. One participant mentioned that "*badimo ba gago ba a kgona go o furalela"* meaning that the ancestors can turn their back on you. This means that the ancestors can leave a THP all alone, and not communicate at all. It means that a

THP will be without protection and guidance of the ancestors. In addition, if something like that happens it means that the THP would not be able to connect with the ancestors, and then they would not be able to help their patient. Hence, the THPs should always follow their ancestor's guidance. The next discussion is about the categories that emerged from the study.

## 6.4. Categories that emerged from axial coding

### 6.4.1 Anything can happen - protection (*the why*)

This category refers to why is there a need for THPs to practice ethically when treating patients with mental health conditions. The answer to this question is that it is for the protection of both the patients and the THPs themselves. The THPs need to practice ethically for the protection of the patients using the services of THPs, for protection of THPs themselves as well as the protection for this particular health system. The category addresses the conditions that underlie the need for THPs to practice ethically when treating patients with mental health conditions.

This category addressed mostly the first and the second objective of the study. The first objective was to explore notions of mental health ethics as perceived by THPs, and the second was to describe what THPs understand to be ethics in the treatment of mental health conditions. All participants understood that they need to practice ethically when treating patients with mental health conditions as well as when treating patients with other disorders. Although not formally, most THPs understood what the ethics are in traditional healing practice and why do they have to practice ethically.

The category emanates from a participant who mentioned that "anything can happen in the *indumba*". The participant was referring to the time during a consultation when the patient with a mental health condition, his relative/care-giver are with him in the consultation room. He explained that anything can happen, even a patient can die on

his watch. Therefore, THPs need to practice ethically so that the patients can be protected. Adhering to ethical standards of traditional healing will not only help or protect the patients who come for consultation, but it will also protect THPs should anything go wrong during the processes of treatment of their patients.

For most participants, the protection of the traditional health system was also of paramount importance. As discussed earlier that THPs addressed each other as doctors like medical doctors in the system of health care practice, they know that doctors practice according to their own ethical guidelines, hence they also identified themselves as doctors. For THPs to be recognised, and be credible, they should have their own ethical guidelines.

### 6.4.2 Ethics in traditional health practice- (*the what*)

The category of ethics is the pillar of THP's in the study. Basically, it is what the study is based on, which is mainly ethics in traditional health practice. During the earlier discussion of the concepts, I discussed tethics as a stand-alone concept, however, the discussion now focuses on ethics in traditional health practice as one of the categories in the study. I have also mentioned in the discussion of the concept of "ethics" that at some point I viewed that concept as a core category, however that changed as the analysis proceeded. Although this category does not serve as a core category, it addresses the main aim of the study.

Participants understood ethics in traditional healing specifically by focusing on the management of mental health cases, as all rules, taboos, adherence to morality throughout the process of practice when treating patients with mental health conditions. The ethical principles or guidelines followed by the THPs will be discussed in detail in the next chapter of presentation of the framework. From consultations to a point where we can attest that a patient is healed there are manyof ethical principles

that a THP has to adhere to. The main being the practice of being human as well as following whatever the ancestors guide the THP to do.

### 6.4.3 "Listen to the ancestors" – How THPs adhere to mental health ethical principles (*the how)*

The category of listening to the ancestors is closest to the concept of ancestral guidance which serves as the core category of the study. The category code emanates from a participant who mentioned that as a THP you need to listen to what your ancestors are communicating to you. This particular participant explained that "*badimo ba a mo sebela*" (the ancestors whisper in his ear) to give him a direction of what to do when treating a patient with a mental health condition. He explained that from the point of diagnosis of the cause of the mental health condition to decide whether the patient should be admitted and be a stay-in patient or not, to the treatment plan, he listens to the ancestors.

All participants supported the notion that their adherence to ethical principles is through the assistance of their ancestors. All participants explained that they are guided by their ancestors in everything they do in their practice as well as the way they lead their lives. Although this study does not give a size fit all of framework that addresses the ethics in traditional healing practice, the concepts derived from the analysis account for variation, therefore the framework can inform most THPs as they manage mental health cases.

When asked if the ancestors are capable of making them act unethically, they explained that to be a good THP you must be a good person, with a good heart and serve the people in your community with honesty. Participants explained that if there are THPs who can be instructed to act in an evil manner, then those are not THPs but witches. The most important to the participant was that a THP has to listen to the ancestors and act according to their instructions. The participants were aware that failure to listen to the ancestors can lead the THP to face the wrath of the ancestors.

Each THP has their own ancestors who guides them in their practice. It is important to know that the role of a THP is to heal and create peace and harmony amongst people. The guidance comes in many forms that is only understood by THPs themselves, however the guidance has everything to do with being human and having good relations with other people. Many ethical guidelines and procedures in traditional healing revolves around being human and having good relations with people. The ethical guidelines that can be drawn from this is that of respect and intergrity.

### 6.4.4 Being human (*interaction)*

The category of being human addressed the third objective of the study which was to determine THPs views regarding what is considered good ethical behaviour in the treatment of mental illness. The category is also discussed in the concepts in axial coding. Being human interlinks with listening to the ancestors. Listening to ancestors is more spiritual whereas being human is more physical. This is because being human is seen through an individual's behaviour towards other people, the animals, plants etc. This means that acting ethically is done humanly so.

### 6.4.5 *Badimo ba tla go furalela*- Wrath of the ancestors and protection (*consequences)*

The code of *"badimo batla go furalela"* is closest to the concept of the wrath of the ancestors. The code comes from several participants who explained that if a THP is not following the guidance of the ancestors and not acting ethically will face the wrath of the ancestors. The wrath of the ancestors was explained to be deadly. One participant explained that if a THP is not practising ethically the consequences can even lead to them losing their gift of traditional healing. Others explained that at times bad luck would follow them if they do not practice ethically. A young participant who had just left school explained that the ancestors can whip one if they are not practising ethically. The participant explained that the whipping feels like a physical whip but one

cannot see who is whipping. He explained that when he sees that happen, he then relooks what he might have done wrong. Some participants were just not comfortable talking about the wrath of their ancestors.

There are also consequences for practicing ethically. Most participants explained that the rewards from their ancestors are mostly not materialistic. Participants clarified that the ancestors usually reward the THPs who listens to them with good health and long life and protection from evil.

## 6.5 Conclusion

This chapter presented the results of the current study. The concepts derived from the theoretical sampling, data collection, as well as analysis session, were presented. These concepts are ethics, being human, and guidance from the ancestors, consultations, admissions, referrals, treatment, remuneration, healing progress, and wrath of the ancestors. Each concept was accounted for in terms of how it was analysed. The concepts also interlinked with the categories that were discussed. Both the concepts and the categories discussed forms part of the framework to be discussed in the next chapter.

# CHAPTER 7: PRESENTATION OF THE MODEL

## 7.1 Introduction

The previous chapter of the results presented the concepts and the categories derived from the study. As I have pointed already pointed out that the concepts and categories presented in chapter six feature in the presentation of the model, this chapter is for the presentation of the model. The model is an “ethical framework for Northern Sotho THPs in the management of mental health cases”. The framework is solely developed from the data collected from the THPs, as per the need grounded theory.

## 7.2 The process that a mental health patient goes through with a THP

Before I could present the suggested framework, I saw it fit to share the process of what a patient with mental health condition goes through with the THP. This is necessary as it will help to explain the framework to be presented. This process explained here is solely based on the data collected from the THPs. The diagram below shows the process, and the narrative to come explains the process.

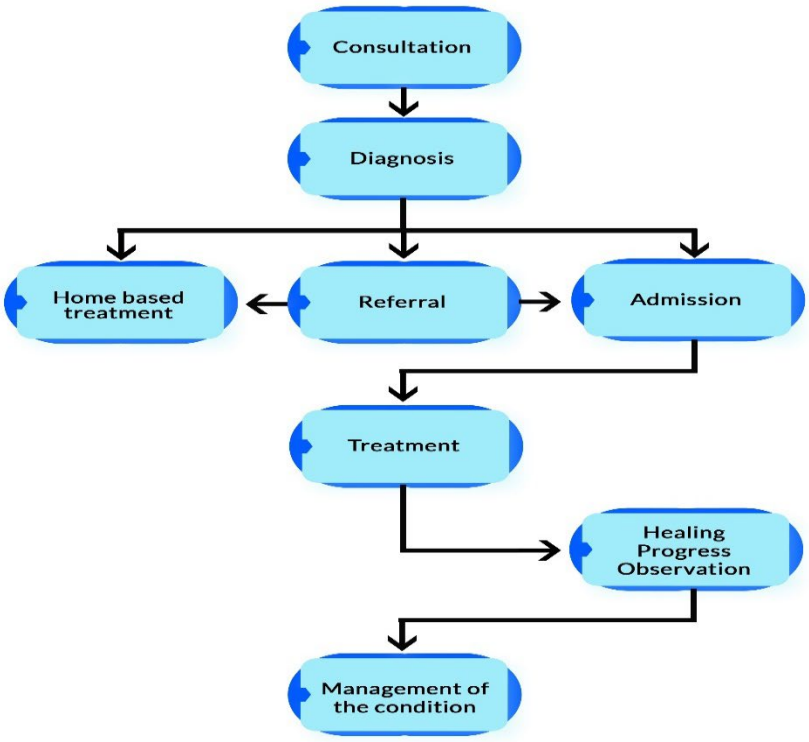


**Diagram 7.2.1:** THP’s process of mental health case management

### 7.2.1 Consultation

The first step to seeking help when a person is unwell is to go for a consultation. The concept of consultation has been discussed in detail in the **6.3.4.** In most instances, a patient is brought in by a family member or a relative to consult with the ancestors. The study has revealed that irrespective of the patient's severity of the condition, a patient presenting with mental health condition does not get into the *"indumba" to* consult with a THP alone.

The patient consults with a family member who brought him/her for consultation, hence the person should be a trusted somebody. The family member represents the patient, because there are a lot of things that should be discussed between the THP and the patient before treatment resumes. For example, whether the patient will be treated staying in their home or not, or whether the patient will be admitted into the THP's home etc. Such discussions need a sober mind as it has lots of implications. Implications include the decisions about who will cover the costs of treatment, and also should the patient be admitted, who will be taking care of them. Also, should the patient be treated while staying at home, who will be bringing them for follow-up consultations etc.

The discussions that take place between the two parties (THP and the patient representative) go beyond treatment. Before "*go hlola"* (consult/check) the patient has to put down *"mahunolla-thebele"* (money that a patient gives to the THP before the THP takes out the bones) in order for the THP to start communication with the ancestors. After consulting with the ancestors, the THP will give the diagnosis, at times the also the cause of the condition, and then recommends how to go about treatment. However, the study revealed that there are certain things that the THP together with the patient representative should agree upon before treatment starts. First, it is whether the patient will be admitted at the THPs home or be treated while staying at their home. Secondly, not always, but at times the THP would refer the patient to the clinic or hospital for certain aspects that need to be attended to before the traditional

treatment resumes. All this is discussed during that first consultation. The discussion to follow is about what happens when a patient is treated while staying at their home.

### 7.2.2 Diagnosis

Although the study specifically focuses on the treatment and management of mental health cases, procedurally, a THP has to diagnose the patient. Not only will the THP diagnose the patient or confirm the diagnosis of a mental health problem but the THP also explains the cause of that particular problem. The THP then explains where the problem emanates from. At times, the THP might also find other comorbidities associated with the mental health condition. The ability to diagnose and explain in detail what the patient is embedded in THP and it is his/her special gift from the ancestors.

### 7.2.3 Home based treatment

Home-based treatment is very common in traditional healing. Home-based treatment means that after consultation, the patient can be given the traditional medicine to use at home. It is similar to consultations in clinic or with any other HCP. In a situation where a THP has advised a patient to the clinic or to the hospital, the patient would come back, and then the traditional treatment part would then resume with the patient staying in their home. Also, all necessary rituals can be performed and the patient goes back home. However, the patient cannot do all these alone. Help from a family member or a care-giver is very crucial to ensure that the patient takes the medicine according to the instruction given by the THP. The THP will manage the patient's condition in that manner. The discussion to follow is about an instance whereby a THP has referred the patient to the clinic or hospital before the traditional treatment begins.

### 7.2.4 Referrals

The concept of referrals was discussed in **6.3.6**. Although not formal, some THPs explained that they refer their patients to the clinic or hospital if they see a need to do so. The usual cases were when they see that a patient needs water and at times blood transfusion due to the severity of the mental health condition. Not that they do not have medicine for such, however, they explained that a drip for water yields quicker results than feeding the patient with the traditional medicine that increases water in the body. There were also cases whereby, the THP sees that there is another underlying disease than the mental health condition that needed to be confirmed at the clinic. THPs explained that those kinds of referrals are very sensitive, and they are very careful of how they recommend them to their patients. Moreover, the THP refers their patients to the social workers to help them deal with their social problems before they start with treatment for traditional medicine.

Based on these cases whereby THPs are comfortable referring their patients to the clinic or hospital, shows the relationship that the two health systems have, although it is not formalised. After the patient has gone to either the clinic or hospital, consulted with the recommended professional, and got all the necessary help, they then return to the THP and continue where they left off. In that manner, either they start with their traditional treatment while staying in their homes or they are then admitted to staying with THP in their home. The discussion to follow, explains what happens during admission.

### 7.2.4 Admissions

In the previous discussion about consultations, I have mentioned that a patient does not consult alone but with a family member or a relative. I have also mentioned that there is a lot that a THP discusses with that person who at that moment serves as the patient representative. Amongst what needs to be discussed, are issues pertaining to if a patient has to be admitted. THPs admit patients for different reasons, but mainly is for them to be able to administer the traditional herbal remedies and observe their

healing progress. Some THPs also explained that they admit patients to protect them from the evil spirits that might be roaming in their homes.

In the results, chapter 7, where I discussed this concept of admissions, I have also pointed out that a patient cannot be admitted alone. A patient is admitted with a care-giver whose responsibility is to take care of the patient. The THP only provides accommodation and administers the traditional medicine/traditional herbal remedies for the patient. Depending on the agreement between the THP and the patient representative during a consultation, decisions about cooking, buying certain necessities, and how the patient and the care-giver will be living would be in place. Moreover, it is not always the case that a patient representative will also be a care-giver during the time of admission. Usually, families decide about such matters based on the availability of the carer. The patient together with the care-giver will stay at the THP's home until the THP sees it fit to discharge the patient based on the healing progress. The THP does not put a time frame as to when the patient will be discharged. However, the patient and the care-giver can leave the THP's home whenever they feel they want to. The next discussion is on treatment.

### 7.2.6 Treatment

The concept of treatment has also been discussed in **6.3.7**. All three discussed procedures about what usually happens after consultation are part of treatment. Regardless of what happens after consultation, treatment is very important. The treatment of patients presenting with mental health conditions comes in many forms such as traditional herbal remedies and rituals. What still stands out about treatment, is that a patient should be with a care-giver throughout. The THP instructs the care-giver of the patient how to cook and administer the traditional herbal remedies for a patient is who is treated while staying at his/her home. Whereas, he/she prepares the edible herbal remedies and administers the traditional medicine to the patient who is admitted at his/her home.

In terms of the rituals that need to be performed in sacred places such as rivers, mountains. or in veld, the THP is usually helped by initiates *(mathwasana)* or another THP. This is very important because it has implications for the patient and care-giver's safety. In fact, a THP who has initiates goes almost everywhere with the initiates as part of their teachings. Also, even with medicine administration, the initiates help the THP. In most cases, if not with initiates, the THP is helped by another THP especially, with rituals performed in dangerous sacred places. This shows the importance of relations between THP and another THP.

In addition, to what happens in the process of treatment, a follow-up/check-up is also very important. The THPs encourage that throughout treatment, their patients come for a follow-up consultation. This happens for patients who stay at their homes while being treated. In addition, the patients at times come for consultation if they need clarity on certain aspects even though they are already in treatment. This helps the THP to see the healing progress. It has been revealed that it is easy for the THP to observe the healing progress of patients who are admitted as the THP would be closer to them.

### 7.2.7 Healing progress

As treatment continues through administering traditional medicine, going to perform injunctions in sacred places and through follow-up consultations, the THP continues to observe the healing progress of the patient. Depending on the healing progress of the patient, the THP would then make a decision to now manage the condition. Most THP were confident that when they get to the stage of managing the condition in most instances the patient would not need a caregiver as they would be able to do most of the things on their own. At times the THP a patient would be so healed that they do not need any medicine anymore nor any follow-up consultation. THPs expressed that they find joy in such cases. Although patients would shower them with praises, they do not accept praises themselves. They redirect the praise to their ancestors as their

guides. Although this process, the THPs always maintain that they are guided by their ancestors in everything they do, meaning in all the process.

THPs explained, that there are only few cases where a patient would not be healed, due to reasons they mostly did not want to share. THPs maintain that although they might not know the reasons why a patient is not getting better in the early stages. At the end of the day their ancestors would show them such reasons. In everything, all different THPs believed that their ancestors are the most powerful and they protect them at all times.

### 7.2.8 Management of a mental health case

The management of mental health cases depends on the type of the condition, the treatment given before and the healing progress. THPs were able to account for cases whereby they were staying with the patients in their home. Many participants explained that when they are satisfied with the patient's progress of healing, they discharge them and let them go to their respective homes. However, the treatment does not usually end there. The patients, together with their caregivers, continue with treatment while at home. THPs explained that their patients continuously come for consultation and treatment for as long as they are not healed.

## 7.3 The ethical framework informing the Northern Sotho THPs in the management of mental health cases

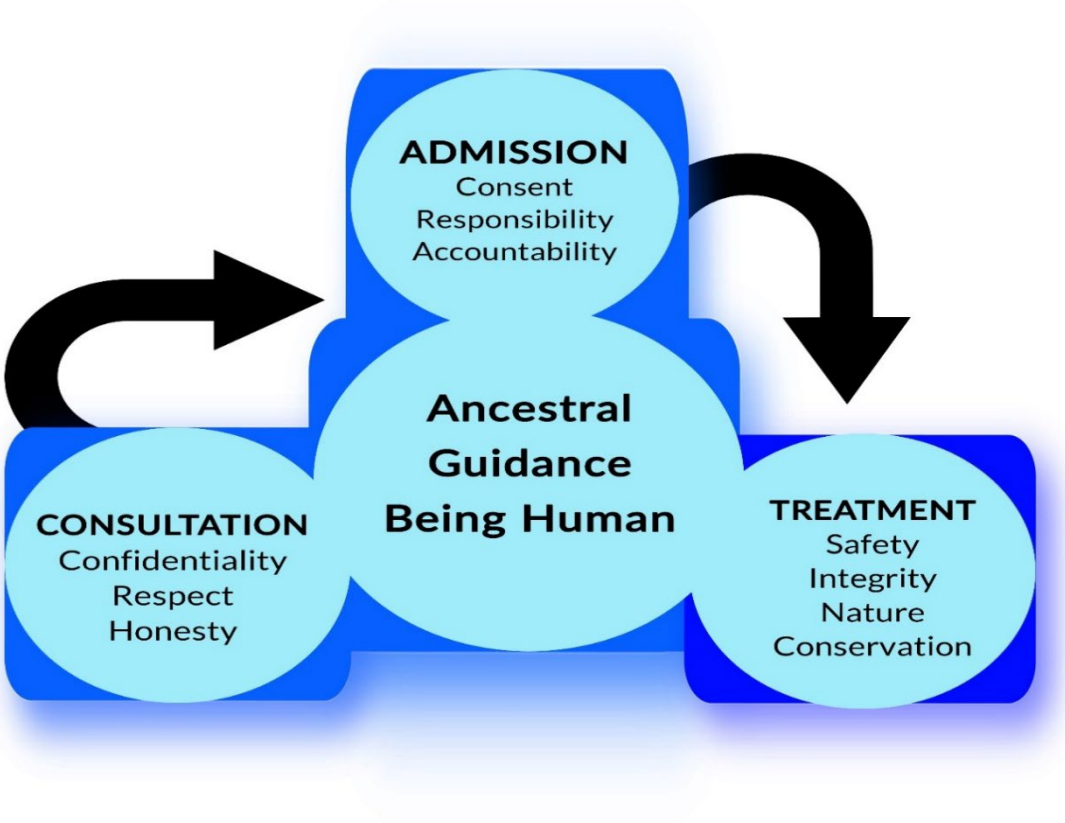


**Diagram 7.3.1: Ethical framework informing the Northern Sotho THPs in the management of mental health cases**

The above diagram of the ethical framework is based on the overall process that the THPs follow when managing mental health cases. There are ethical principles involved in each process. I have mentioned earlier that it is important to understand the steps involved from consultation to the management of the condition. All ethical principles to be discussed derive from some of the concepts discussed in chapter six of the results. The discussion to follow focused on the ethics involved in each process of THPs management of mental health cases.

### 7.3.1 Ethical principles in Consultation

Based on the intensive interviews, I had with the THPs, the following are three ethical principles they adhere to in the management of mental health cases.

#### *7.3.1.1 Confidentiality*

THPs do not share any information about their patient with any other person. Taking into consideration that consultation happens in the sacred hut with the patient and the other person/caregiver, it is the THP's responsibility to explain in detail the importance of confidentiality to both individuals, as they are also not supposed to share whatever happened in the sacred hut with anyone. The THPs explained that it is a taboo to share whatever happening in the sacred hut, as it is sacred and in order for the treatment to work, they have to keep their private affairs to themselves. More especially because, some mental conditions are due to witchcraft.

#### *7.3.1.2 Respect*

The ethical principle of respect is not only applicable during consultation. It is applicable in all processes. The THP has to be respectful to the patient and the care giver. Respect comes in many forms, and it is shown through communication and behaviour. The THP has to communicate with the patient and the caregiver in an acceptable manner and not shout, insult or swear at them. The THP should respect everyone, more especially the community members and *mošate*.

#### *7.3.1.3 Honesty*

The principle of honesty is amongst the discussed concepts in chapter six. A THP has to be honest at all times. Participants explained that no matter the circumstances during consultation, the THP has to be honest. Even in cases where the message from the ancestors is not clear, a THP have to be honest that they do not end up giving wrong diagnosis or treatment.

### 7.3.2 Ethical principles during Admissions

#### *7.3.2.1 Consent*

Consent is very important in traditional health practice. Many participants explained that they have to get consent from their patients before they can admit them. Although, most of the time, consent is given verbally, some THPs explained that they have a written consent form that has all the information and rules and clauses about remuneration. Most THPs explained that they also get consent from their *mošate* before they can admit a patient and the caregiver in their homes. One THP explained that he goes to the police station to do an affidavit with the patient and the caregiver. All that they agree about should be on pen and paper as people can change stories when things do not go well.

#### *7.3.2.2 Responsibility and Accountability*

THPs explained that they take full responsibility and accountability for their admitted patients, hence mošate should give consent for the THP to host the patient. One THP explained that they have to ensure that the patient and the caregiver are safe. Some participants pointed that should the patient harass one of the community members, it would be the problem of the THP. One participant mentioned that should the patient go missing, the THP has to take responsibility.

### 7.3.3 Treatment (medicinal and rituals)

Treatment comes in the form of rituals, medicinal plants and sometimes having to sacrifice some animals. Ethical principles that are followed by THPs in the treatment of mental health conditions are as follows:

*7.3.3.1 Safety*

THPs explained that they have ensure that their patients are safe. They have to ensure that the medicinal plants administered to them are safe. Some THPs explained that amongst others, the reason why they admit some patients is because they want to administer the medicinal plants themselves. They also mentioned that they feel satisfied to be the ones preparing and cooking the medicines. When it comes to treatment in the form of rituals, they also have to ensure that the patient is safe. Some THPs explained that at times they have to perform certain rituals in sacred rivers and caves. They explained that for them to be able to do that, they have to be spiritually pure. Some THPs explained that at times they have to be accompanied by another THP who has knowledge and experience about where the ritual has to take place. THPs explained that their patient's safety comes first.

*7.3.3 2 Integrity*

The principle of integrity is also amongst other ethical principles in treatment of mental health cases. The THPs has to do always do the right thing. The THPs explained that their mandate is to help people. Although they charge fees for consultation and treatment, they have a moral obligation to help patients. THPs explained that for them, a patient comes first, therefore they would always help people even if they do not pay them, and that is because helping people is the right thing to do.

*7.3.3.4 Nature conservation*

Although nature conservation has no direct implications on the mental health patients. THPs explained that it is their responsibility to conserve and protect the nature. THPs explained that humans are connected to the plants, animals, minerals and the soil of their land. They explained that if they fail to preserve the nature, they will not be able to heal the people. THPs explained that they observe the rules that goes with harvesting certain medicinal plants. They explained that some medicinal plants cannot

be harvested during certain seasons, and some medicinal plants cannot be harvested during the day. THPs explained that it is important to follow all the rules pertaining harvesting of medicinal plants, so that they do not make the ancestors angry. One THP explained that if the ancestors can be angry, they can make the plants extinct.

### 7.3. 2 Ancestral guidance

In chapter six of the results, the concept of ancestral guidance was discussed in detail. The concept is the core-category of the study. Ancestral guidance/guidance from the ancestors is the core ethical code that all THPs should adhere to. This code is special because each THP is guided by his/her own ancestor. The only common thing about ancestral spirits and what they require from the THP is to do good. Ancestral guidance is more spiritual, than physical.

### 7.3.3 Being Human (*Botho*)

Being human also cuts across all other ethical principles. This principle advocates that THP has to put the patient first. Being human means being humbleness towards the patients, showing humility and being empathetic to the patients. It means respecting all the people and communicating with them is a good manner. Being human disregard the issues of whether the patient has paid or not. As I mentioned earlier, THPs have a moral obligation to do good. It is not about the money.

## 7.4 Summary of the ethical framework

### 7.4.1 Ancestral guidance and Being Human (*Botho*)

Ancestral guidance and being human are  in the centre of the model because the THPs follow their ancestral guidance in their daily lives as well as in their practice.. Should the THP's disobey their ancestors, they face the ancestral wrath which was explained to be very harsh. It was also highlighted that at times it can get to a point

whereby the ancestors retrieve the traditional healing gift from the THP. Hence, the importance that is placed on the rule of always doing right by the ancestors. The THPs listen to their ancestors and adhere to their instructions at all times.

### 7.4.2 From Consultation to Treatment: THP's process of mental health case management

These three processes were amongst the main categories in axial and selective coding. The discussion about what happens in each role is. The first process is the **consultation** of a patient with mental health disorder to a THP.

Firstly, a patient with mental health disorder comes to consult a THP with a family member, secondly, the THP throws the bones and confirms the diagnosis. Thirdly, the cause of the disease is discovered. Lastly, through the guidance of the ancestors, the THP decides whether to admit the patient or not. In this case, the patient is then admitted.

The second process is an **admission** of a patient with mental health disorders by the THP. Firstly, the patient is admitted together with the family member who will be the caregiver to the patient. They both fill in the admission forms that have all the information with regards to accommodation, food, and payments. Lastly, through the guidance of the ancestors, a THP will have to administer suitable treatment to the patient.

The last process is the actual **treatment** of a patient with a mental health disorder. Through ancestral guidance, a THP has to go harvesting for traditional medicinal plants or take the patient to a sacred place. Then the THP makes the traditional medicine and administers to the patient. Different types of treatment are administered to patient until they are better/ healed as explained in the concept of healing progress.

## 7.5 Conclusion

This chapter presented the explanatory model/framework used by Northern Sotho THPs in the management of mental health cases. Most ethics in traditional healing are ancestral-driven. The ethical principles presented in this chapter are solely from the participant's interviews. The presented model is grounded from the data as per the Grounded theory method. Although the presented ethics followed are not formal, the study conducted shows that THPs have ethical principles that they adhere to.

# CHAPTER 8: DISCUSSION

## 8.1 Introduction

In this chapter, the researcher discusses the findings of the study and integrates them with the existing literature. The findings were presented in the form of concepts and categories as per the grounded theory method. Through the discussion of concepts and categories in the two previous chapters' presentation of the results and presentation of the model), all the four research objectives stated in the first chapter were met. Therefore, the discussions in this chapter will be based on the categories discussed in the results as well as the framework presented.

## 8.2 Categories that emerged from the study

### 8.2.1 The need for THPs to have an ethical framework informing their practice "Anything can happen"

This category explains the need for THPs to practice ethically when treating patients with mental health conditions. As I have discussed in the results chapter in **6.1.1,** the study revealed that there is a need for THPs to practice ethically. This category emanates from a participant who explained that anything can happen in the *indumba,* therefore the THPs have to practice ethically for their own protection as well as the protection of the patients. Through this category, the first and the second objective of this study were met.

The first objective was to explore notions of mental health ethics as perceived by THPs and the second objective was to describe what THPs understand to be ethics in the management of mental health conditions. The first and foremost was to understand what THPs understand what ethics are in the management of mental health cases. The study revealed that THPs associated the concept of ethics with morals, principles, values, and rules that they adhere to in their practice of traditional healing. In support

of these definitions, Illingworth (2017) and Pera (2011) pointed out that ethics in health care speaks to issues of morality or conscience. Sternberg and Glück (2019) also pointed out that morality and ethics are intertwined. Furthermore, Young (2016) defined ethics as a system of moral principles and a branch of philosophy that defines what is good for individuals and society (Young, 2016).

In addition, to the meaning of ethics as moral principles that THPs have to adhere to in the management of mental health cases, THPs explained that being ethical is equated to being professional. In their case, the profession is that of traditional healing. Amongst the four ethical analyses found by Callahan and Jennings (2002), professional ethics is one of them. According to Callahan and Jennings (2002), professional ethics are ethics that tend to seek out the values and standards that have been developed by the practitioners and leaders of a given profession over a long period of time and to identify those values that seem most salient and inherent in the profession itself.

The THPs in the present study claimed that they possess the highest form of professionalism, whereby they also address themselves and each other as doctors. They explained that they are no different from the western medical doctors as they do the same job as them, and they deserve the title. However, Latif (2010) pointed out that the THPs must be prevented from referring to themselves as a ‘doctor’ or ‘professor’. Latif (2010), explained that it misleads people into believing that they are allopathic doctors and recommended that THPs be renamed ‘spiritual practitioners’.

Given controversies surrounding the traditional health practice, and as per this study’s participant’s belief that “anything can happen” in the *indumba,* indeed there is a need for THPs to practice ethically. McCabe (2007) stated that THPs are expected to practice ethically, although they do not have formally approved ethical codes. The establishment of The Traditional Health Practitioners Act of 2007 was also an attempt to ensure that THPs practice ethically; as amongst others, the purpose of the Act is to

serve and protect the interests of members of the public who use the services of the THPs (The Traditional Health Practitioners Act, 2007). It is undeniable that THPs play an important role in health care (Willcox & Bodeker, 2010; Peltzer, 2009); hence there have been many attempts for its regulation. In addition, the recognition of traditional health practice through frameworks and policies such as the White Paper on the Transformation of the Health System, Draft Policy on African Traditional Medicine, The Mental Health Policy Framework, and Strategic Plan 2013-2020 (Department of Health, 1997; Department of Health, 2013) shows the vital role of this health system and the need for its protection and regulation.

### 8.2.2 Ethical principles informing THPs in the management of mental health conditions

This category accounts for the end goal of the study served by the last objective of the study, which was to develop an explanatory ethical framework informing THP's management of mental health cases. In essence, this particular category discusses the ethical principles mentioned in the previous chapter.

#### 8.2.2.1 Ethical principles with the process of consultations

The THPs explained that people consult for different reasons. However, I was very specific with regards to this study and explained that the focus is only on mental health conditions. The trigger for consultation of a traditional healer may be illness, manifesting physically and or psychosocially. Feeling uncertain about life events can also spur consultation with the THP (Mokgobi, 2014; Edwards, 2011). The ethical principles that THPs in the current study adheres to in the process of consultation include confidentiality, respect, and honesty.

*8.2.2.1.1 Confidentiality*

The participants explained that they are not supposed to share any information about their patient info with any other person. The participants explained that although a mental health patient does not consult alone, the importance of confidentiality also includes the person who becomes part of the consultation. THPs regard their medical knowledge as personal property hence it should be kept in confidence (van den Geest, 1997). Some authors argue that more than confidentiality, secrecy is blatant in traditional healing practice (Edwards, 2011). Similar to the findings of Sodi and colleagues, the THPs in the current study explained that they keep their patients' secrets (Sodi et al., 2011). Another study by Matlala et al.'s (2015) confirmed that consultation confidentiality with regard to traditional medicine is important in African traditional healing (Matlala et al., 2015).

It is believed that breaching the ethical principle of confidentiality makes the treatment lose its efficacy (Cohen, 1969), although, with regards to this study, THPs explained that in a case where the patient is bewitched, sharing their affairs with other people might bring more problems to them. When asked about sharing their work through advertising, the THPs in the current study explained that they do not advertise themselves, they get patients through the other patients they have helped before. Mbiti (1990) explained that THPs practices in trust, it is then morally inappropriate for a THP to praise their art of healing, because he/she is used by the ancestors, and his privileged knowledge is endowed on him by the ancestors for the service and benefit of his/her community.

Gqaleni et al (2011), and Maar and Shawande (2010) discussed the ethical principle of confidentiality in terms of records kept by the THPs. However, the study did not investigate the principle of confidentiality with regards to keeping medical records of their patients.

*8.2.2.1.2 Respect*

Literature shows that THPs are respected people in their communities (Liverpool et al., 2004; Peu et al., 2001; Kale, 1995). They are respected by virtue of the good work they do. The participants in the current study pointed out that THP should respect their patients and anyone in their community. They further explained that they also have to respect other people's cultural beliefs, socioeconomic situation, sexual orientation etc. Respect for people's rights and dignity is amongst the APA (American Psychological Association) ethical principles. Similar to the findings of this study, APA (2022) states that psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination (APA, 2022). Respect for the individual remains the key ethical principle in mental health, medicine, and public health (Hoop et al., 2017; Ngui et al., 2010; Roberts & Dyer, 2004). In addition, the current study also found that the THPs should respect their ancestors. Magesa (1997) stated that failure to show proper respect for family, community, often results in good spirits withdrawing their blessing and protection.

*8.2.2.3 Honesty*

Participants explained thatTHPs have to be honest at all times because the patients rely on them. Honesty, humility, and truthfulness are principles that every THP should adhere to. Participants explained that no matter the circumstances during the consultation, the THP has to be honest. The THP sees what the "ordinary eyes" cannot see. Hence, it is morally binding on the THP to pronounce only what is revealed to him/her. The Adherence to moral precepts is an important and integral part of traditional health care (Mbiti, 1990).

According to APA (2022), psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. Citron (2019) pointed out that virtues of character such as honesty, humility, courage, and strength are important. A recent study on the implementation of honesty principles in therapeutic

agreements based on the health law perspective in Indonesia, based on the outbreak of Covid-19 concluded that the absence principle of honesty in therapeutic agreements is included in an agreement with a defect of will, that can be civically cancelled (Anggraeny & Ayu, 2020).

#### 8.2.2.2 Ethical principles within the process of admissions

The study found that in most instances THPs admit patients who come for consultation presenting with mental health conditions. THPs accommodate patients with mental health conditions in their homes for treatment until they recover (Ngobe et al., 2021). However, THPs explained that they are the ones to diagnose a mental health condition and its cause before deciding on admission. According to Quick et al.'s (2002), THPs have the ability to diagnose any form of a disorder, and then plan the desired management and prevention strategies to the restore physical, psychological, and social well-being of the patient. THPs have used several procedures and methods to diagnose persons with mental health conditions and other illnesses (Gutema & Mengstie, 2022). The ethical principles that THPs in the current study adhere to admitting a patient include consent, responsibility as well as accountability.

##### *8.2.2.2.1 Consent*

Consent is very important in health care, including traditional health practices. In case of admissions, the participants get consent to admit their patients from their *mošate.* Most have also participants explained that they have to get consent from their patients before they can admit them. THPs get the consent from the patients together with their caregivers. THPs explained in most instances they get verbal consent, however, there were THPs who explained that they have a consent form that the patient and the caregiver have to sign. They explained that the contents of the form have information about issues of remuneration and mainly about treatment.

Similar to the findings for the current study, a recent study revealed that most patients consulting THPs for treatment are aware of their right to information confidentiality and the need to reach an agreement before involvement in ATM treatment procedures. The study also showed that some key elements of informed consent are currently being applied during ATM practice in South Africa (Akpa-Inyang et al, 2022). Informed consent is a doctrinal prerequisite in accordance with the National Health Act 2003 and professional ethical guidelines (National Health Act, 2003). In addition, current regulations stipulate that HCP should obtain informed consent from patients prior to treatment. Aderibigbe and Chima (2019) concluded that barriers to informed consent included language and excessive workload.

*8.2.2.1.2 Responsibility and Accountability*

THPs explained that they take full responsibility and accountability for their admitted patients. Similarly, the APA (2022) ethical principle of fidelity and responsibility states that psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behaviour, and seek to manage conflicts of interest that could lead to exploitation or harm. The participants in the current study explained that it is also their responsibility that their admitted patients are safe.

### 8.2.2.3 Ethical principles within the process of treatment

After consultation with the ancestors, THPs also assess a patient's condition before resuming with the treatment (Ngobe et al., 2021). In essence, treatment commences after diagnosis and continues to a point whereby the patient is discharged from the THPs home. Treatment comes in the form of medicinal plants, rituals although the THPs have a timeframe and decide when it is right for the patient to go, the condition is managed and the treatment continues even when the patients are staying at their homes. The ethical principles that THPs in the current study adheres to the process of consultation include safety, integrity, and nature conservation.

*8.2.2.3.1 Safety*

Treatment of patients with mental health conditions includes rituals, medicinal plants and sometimes having to sacrifice animals, depending on the kind of a condition a patient is diagnosed with. The THPs explained that they usually admit patients that present with mental health conditions so that they can administer the medicine to them and also monitor their healing progress. It is also the responsibility of the THP that the medicine administered is safe. The Traditional Health Practitioners Act of 2007, mandates the safety of the patients being serviced by THPs (The Traditional Health Practitioners Act, 2007). Green and Colucci (2020) pointed to concerns about patients' safety and human rights regarding traditional methods in the treatment of mental health conditions.

To ensure safety, the participants explained that they are at times accompanied by other THPs when going to perform rituals in unfamiliar sacred rivers or caves. The rivers, herbs, wood, minerals and animal bones are used as healing agents because of the belief that humans are part of nature, and natural products are a gift from God (Ross, 2010). The ancestral spirits also play the role of protection when such rituals are done (Zuma et al., 2016).

*8.2.2.3.2 Nature Conservation*

The participants pointed out that it is their responsibility to conserve nature, because they use medicinal plants to heal. In terms of harvesting and using the medicinal plants, THPs are bound by The National Environmental Management Biodiversity Act 10 of 2004. The aim of this Act is to provide for the management and conservation of South Africa's biodiversity within the framework of the National Environmental Management Act, 1998. In South Africa, the harvesting of medicinal plant material used to be an activity restricted to THPs (Van Andel & Havinga, 2008).

Most THPs are people with no formal medical training, but the communities within which they live recognise them as being competent in dealing with their healthcare needs by using plant, animal, and mineral substances (Agbor and Naidoo, 2011). Most elderly THPs in the current study did not have any formal education, but they understood the practice better compared to the younger THPs with formal education. They explained that they inherited their wisdom from their elderly back in the days and they are guided by their ancestors. According to Sternberg and Glück (2019), wisdom involves the ability to see other people's points of view and to use this dialogical perspective in one's own thinking to seek a common good by balancing one's own, others', and higher-order interests over the long and short terms

Semenya and Potgieter (2014) recommended that THPs be educated regarding the significance of various conservation legislations in their traditional healing. THPs have stringent traditional values, which include taboos, superstitions, norms and cultural beliefs the harvesting of medicinal plants, and therefore they contributed towards the conservation of medicinal plant species (Williams et al., 2000; Kambizi and Afolayan, 2006). A study by Mathibela et al.'s (2015) showed that their participants were in favour of conservation actions to prevent over-harvesting. It was concluded that conservation of natural resources such as garden and farm plants should be taken seriously, as the use of some of these indigenous medicinal plants have proven to treat a considerable number of health-related problems or ailments, and have the potential to satisfy the varied health care needs (Lebaka, 2021).

THPs explained that there are certain rules that govern their harvesting of medicinal plants. All participants explained that they are not supposed to harvest a whole plant if there is no need to do so, also certain plants can only be harvested during certain seasons. Semenya and Potgieter (2014), states that it is customary not to re-fill the soil after harvesting underground parts or entire plants. The reasons forwarded were that re-filling the soil influence the effectiveness of harvested plants parts, worsen a patient's illness. This study shows that there are certain beliefs about harvesting certain plants.

*8.2.2.3.3 Integrity*

The principle of integrity is also amongst other ethical principles in the treatment of mental health cases. Integrity is also amongst the five ethical principles of APA (2022), whereby it is stated that psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of ethically justifiable deception to maximize benefits and minimize harm (APA, 2022). Participants in a study by Hartmann and Gone (2012) raised the issue of trustworthiness in traditional healing. Lack of integrity and safety were also mentioned as the reason why some people preferred other alternative medicines as compared to traditional healing. In another study by Schoonover et al.'s (2014), participants felt that THPs are not effective for the treatment of mental illness or are dishonest and should not be contacted. All this study shows is that THPs have to ensure the ethical principle of integrity is adhered to.

### 8.2.3 The role played by the ancestors: ancestral guidance

All participants pointed out that they are guided by their ancestors in everything they do, irrespective of it is personal or practice-related. Similar to the current study, Zuma et al.'s (2016) attest that all the healers put emphasis on their relationship and connection to the ancestral and spiritual worlds; who they are and how they executed healing is reported to be from the guidance of the ancestors. According to Mokgobi (2014) and Edwards (2011), ancestors are compassionate spirits of the departed blood relatives of an individual and may involve a whole lineage spanning generations.

Mbiti (1990) states that the ancestors are guardians of family affairs, traditions, ethics, and activities. The participants in the current study explained that ancestors guide them in everything they do even outside their practice. Participants also pointed out that, although the patient and the caregiver might have a preconceived idea about the type of illness that brought them in for a consultation, THPs have to consult with the ancestors in order to make or confirm a diagnosis. The THPs determine the cause of

illness by using ancestral spirits (Kale, 1995). Ngobe et al.'s (2021), argued that THPs should not only rely on ancestral spirits' guidance for the treatment of mental disorders but also to use more experience-based knowledge to make a decision with respect to their patients' mental health care needs .

Communication with the ancestors is facilitated by a THP who would also guide on how to specifically communicate depending on the purpose of consultation or the ritual that may be required. The consultation occurs at different time periods and differs from group to group (Mokgobi, 2014; Edwards, 2011). The participants explained that the guidance from their ancestors is communicated through signs, visions, dreams, instincts, and conscience. Mbiti (1990) states that as Africans the ancestors communicate through dreams, come before us, or talk to us during divination sessions. This communication with us is made possible by our own immaterial component (Mbiti, 1990).

The participants mentioned that if they do not adhere to their ancestors, they get punished he ancestors are respected and honoured by the living through being included and remembered in family functions and in decision-making processes. They are believed to provide protection and prosperity but can also leash out punishment to people if rituals are not observed or taboos are violated (Holomisa, 2009). The participants also mentioned that the ancestors guide them before they even go for initiation to become THPs, during training and until practice. However, even though ancestors are believed to be the ones who preserve the knowledge of traditional healing, there are healers who document their knowledge using different mediums chosen by them (Maluleka & Ngulube, 2018).

### 8.2.4 *Ubuntu/Botho* as an ethical principle

All the above-mentioned ethical principles fall under the umbrella of being human (*botho*). All participants mentioned *botho* as an ethical principle that every THP is

supposed to have. Sodi et al.'s (2021) defined *botho* as personhood and interconnectedness, and further explained the relatedness between *botho* and African spirituality, as well as communalism . In terms of *botho* as personhood, THPs mentioned characteristics such as being good, respectful, humility etc. Whereas with *botho* being interconnected, THPs explained the connection they have with their ancestors, the medicinal plants, minerals, and water they use for treatment. THPs explained how they are guided by their ancestors in divination (african spirituality), and observe the moral principles in their communities such as seeking permission from mošate before admitting patients (botho and communalism).

According to Omonzejele (2008), as Africans, we cannot be satisfied with an individualistic approach but must understand that we are an organic part of a whole that includes diverse spiritual and physical entities. Participants in the current study pointed out that they are part of the community they serve, and cannot be separated from it. A good THP is rated by the community based on his/her selfless service to members of the community. A THP who is able to foresee through divination and avert impending doom to the community is held in high esteem. This is in conformity to African ethics, where the interest of the community supersedes that of the individual (Mbiti, 1990).

Africans are known for their strong orientation to collective values, particularly a collective sense of responsibility. The collective ethic recognises that survival derives from group harmony and all actions are within a collective context, which seeks to maintain the harmony and balance of an interrelated and essentially egalitarian system. It always stresses humanness *(ubuntu*) which is characterised by generosity, love, maturity, hospitality, politeness, understanding, and humility (Mkabela & Luthuli, 1997). There is also a principle of ontological unity that has at least two immediate and profound implications, that is, the principle of the 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 (Mazama, 2005). THPs in the current study mentioned that their mandate is to heal and create peace and harmony amongst their

communities and families. THPs use what we would refer to as applied ethics (Callahan & Jennings, 2002). The applied ethics perspective differs from the professional ethics perspective principally in that it adopts a point of view from outside the history and values of the profession. From this more general moral and social point of view, applied ethics seeks to devise general principles that can then be applied to real-world examples of professional conduct or decision-making.

African morality is based on human welfare Downess (1977) indicates that the African idea of morality is doing good to others and not evil. The African notion and applications of moral precepts have a far-reaching implication on how ATM is practiced. The THPs in the current study explained that a good THP must be honest, and they further explained that they refer their patients to another THP or to the clinic or hospital, if there is a need to do so. As discussed earlier that a good medicine man must be truthful and be human, know his limits and refer a patient to another medicine man who is better in a particular sphere (Omonzejele, 2008). A THP must at all times be honest with his patients.

The participants in the current study explained the importance of having good working relations amongst them. They explained that they can refer a patient to another THP if they are unable to help. Masoga and Shokane (2020) indicated that THPs refer patients to each other during the performance of their duties. On the other hand it is clear that there is trust and appreciation of each other's gifts, and that is *botho*. On the other hand, Ngobe et al.'s (2021) found that THPs refer patients to the HCPs for medical examination such as, checking the severity of a patient's high blood pressure; then awaiting feedback, and later commencing with treatment. THPs in the current study also did the same and justified that for things like blood pressure, HIV testing, blood transfusion etc., they prefer that their patients go the allopathic route as the allopathic treatment would be more convenient.

Participants in the current study also mentioned that although their role is to help people in their communities, they are also making a living through the fees they charge for treatment. Most THPs explained that they are guided by their ancestors about how much to charge. A THP is not expected to charge a ridiculous fee. In a traditional African setting, one is not expected to profit from other people's ill health. Hence, it would be morally distasteful and condemnable for a medicine man to materially exploit the sick (Omonzejele, 2008). According to Truter (2007), amongst other reasons, people use ATMs include affordability, availability, and accessibility. Chikafu (2022) pointed out distant health facilities and transport costs hinder the use of allopathic health care. Masoga and Shokane (2020) found out that organisations or associations to which THPs are affiliated also determine the pricing for medicines and treatment. Some THPs explained that most of the time they do not even charge members of their communities for consultation because they can give them their messages before they can even consult. However, Omonzejele (2008) pointed out that in extreme cases, the community takes over the healthcare of a member whose family members cannot afford the THPs fees on their own for their love.

### 8.2.5 Consequences for THP's unethical practice: Wrath of the ancestors

Participants explained that they respect their gift of healing and they have to adhere to African moral principles and ethics taught when they were still training. They also have to adhere to all ethical principles discussed as they all embrace the spirit of *Ubuntu,* and most importantly adhere to their ancestral guidance. They mentioned that failure to adhere to their ancestral guidance leads to facing the wrath of the ancestors. Participants explained that the wrath of ancestors can come in the form of losing the gift of divination. Omonzejele (2008) pointed out that in a traditional African setting, it is strongly believed that if anyone insidiously commits a crime, he is punished by the gods. Similar to the present study, it is pointed out no matter how skillful a THP is, without compassion for his patients, the THP's gift of divination would gradually slip away from him. Magesa (1997) further argued that moral behaviour maintains and enhances one's life force, but disobedience and disloyal behaviour towards the

tradition passed on by the ancestors weakens the life force. Most participants explained that they do not wish to face the wrath of their ancestors.

## 8.3 Conclusion

This chapter discussed the study findings in relation to the existing literature on THPs and ethics. In light of the study findings, ethics and ethical behaviour in health care will always be shaped by the THP's communal moral principles, worldviews, and cultural practices. Despite the THPs being guided by the principle of *Ubuntu* and their ancestors, each THP has its own unique experience in the treatment and management of mental health conditions. For Northern Sotho THPs, ethics informing their practice when managing mental health patients were influenced by their African traditional culture and their community's beliefs and taboos. Most ethics mentioned were similar to those applied in allopathic health system.

# CHAPTER 9: CONCLUSION

## 9.1 Introduction

This chapter discusses the summary of the results, the implications of the findings of the study as well as the contributions of this study to various fields. The chapter also covers the discussion on the limitations and recommendations of the study.

## 9.2 Summary of the results based on the aim and objectives of the study

This research study was using in-depth intensive interviews aimed to open an exploration that would generate a substantive theory regarding the ethical principles followed by THPs when treating patients with mental health conditions. The study aimed to answer the following key research question:

Which ethical framework informs the Northern Sotho THPs management of mental health cases?

The study's end goal was to develop an explanatory model of ethical principles followed by the THPs. To reach the end goal, the following objectives guided the investigation:

To explore notions of mental health ethics as perceived by THPs.

1. To describe what THPs understand to be ethics in the treatment of mental health conditions.
2. To determine THPs views regarding what is considered good ethical behaviour in the treatment of mental health disorders.
3. Based on the THPs' representations, develop an explanatory model of mental health ethics in traditional healing.

All four objectives were achieved through the questions asked during the interviews with the participants. Initially, I had an interview guide **(See Appendix 1)** comprising of open-ended questions. I interviewed the first three participants and started with data analysis as per grounded theory methodology. Based on the concepts and categories that emerged from those interviews, I had the opportunity to re-adjust the interview guide (some questions, choice of words, and the approach to interviewing) in order to be able to explore some concepts and categories. Grounded Theory method supports the refining of the questions asked during interviews based on the emergence of concepts and categories. Therefore, I saw it fit to do that hence all objectives were achieved.

**Objective 1: To explore notions of mental health ethics as perceived by THPs**

The first objective was to explore notions of mental health ethics as perceived by THPs. This objective was supplemented by questions asking how THPs understood, perceive and conceptualise ethics that they need to follow when treating patients presenting with mental health conditions. What was discernable from the data set is that all healers appraised ethics as some basic rules or guidelines that inform their healing enterprise. In spite of this view, the healers preferred to conceive ethics rather as moral principles rather than some codified rules governing their practice**.**

The most important aspect that the healers embodied was a reference to the ancestors who were appraised as their guiding moral campus. Participating THPs explained further that although there are a set of rules that they are taught during their initiation into healing; that does not rule out the fact that they are always expected to do right by their ancestors and for humanity. THPs conceived themselves as doctors who practice at the most professional level.

Most THPs who were registered under a certain traditional healing organisation seemed to be more confident outlining the ethics involved in the whole process of traditional healing practice when dealing with mental health conditions, than those who

were not registered. Based on what I got from the interviews, it was clear that THPs who were registered under an organisation followed that organisation's rules. THPs have shown to be more accountable and responsible in their line of work.

**Objective 2: To describe what THPs understand to be ethics in the treatment of mental health conditions.**

The second objective of describing what THPs understand to be ethics in the treatment of mental health conditions was also achieved through getting deeper in the ethical principles involved during treatment. All participants shared the experiences of what they do in the process of mental health conditions treatment. Ethical issues involved when harvesting traditional medicines, sacrificing animals and performing rituals in sacred places were discussed. Although, the experiences and how the treatment was carried out varied from participant to participant, the patterns and processes of the ethical procedures followed involved were similar. THPs outlined that in their line of practice, their patients consult, then they are admitted and then treated while accommodated in the home of the THP until the treatment is over. The ethical principles that THPs adheres to in the process of consultation included confidentiality, respect and honesty, whereas in the process of admissions included consent, responsibility as well as accountability. Safety, integrity and nature conservation were ethical guidelines in treatment, after the process of admission.

**Objective 3: To determine THPs views regarding what is considered good ethical behaviour in the treatment of mental health disorder.**

The third objective of the study was to determine THPs views regarding what is considered good ethical behaviour in the treatment of mental health disorders. Participants outlined how a good THP is supposed to treat patients with a mental health disorders. Participants explained that a good THP has to be humble and honest. Ethical issues involved from consultation to a point where a THP can confidently attest that a mental patient is better/healed were discussed. Starting with how a THP is

supposed to treat patients, charge them and at times even refer them to clinics or hospitals also emerged. This objective was covered by the principle of Ubuntu and ancestral guidance. The participants were also asked what happens if a THP does not follow those ethical guidelines when treating patients with a mental health disorders. The participants explained that the consequences that comes with that are the kind that no one would want to face. Only a few participants tried to explain the consequences in detail, but ia lot was described as deadly and very bad. Those who gave details mostly spoke of the wrath of the ancestors. They described that the ancestors can actually revoke a THP's gift of divination.

### Objective 4: Develop an explanatory model of mental health ethics in traditional healing

The last objective was to develop an explanatory model of THPs mental health ethics in traditional healing. This objective was achieved through the discussion of the previous three objectives. The overall processes of sampling, data collection and data analysis discussed played a huge role in development of the model. I had to do more probing to attain more understanding of the participants' definitions, conception, perceptions, beliefs, ideas about the phenomenon under study. The model tells a story about the role played by THPs in mental health care and the ethical principles involved thereof. The model (**Diagram 7.3.1: Ethical framework)** was presented in the previous chapter. Major concepts in the model includes ethics, ancestral guidance and being human (*botho/Ubuntu*).

## 9.3 Implications for the findings of the study

This study has several implications. The implications of the theory, implications for traditional health practice as well as implications for clinical practice.

### 9.3.1 Implications for the theory: Afrocentricity

This study adopted Afrocentricity as its theoretical lens. According to Asante (1998), Afrocentricity places African standards or principles at the centre of any analysis that involves African culture and behaviour. This study found that THPs conceived ethics rather as African moral principles rather than some codified rules governing their practice**.** THPs are African centred, located, oriented, and grounded within the African way of doing things, hence to them, ethics were equated to morals. The study also found that THPs still hold a respect for the authority of the people governing them in their communities, because before admitting a patient and the caregiver, they went to mošate to inform the authorities governing them. This remains the core respect in African culture in communities managed by chiefs.

The study also found that even in this changing modern era, THPs adhere to their ancestors. They still observe cultural rules of African spirituality such as respect for 12:00 midday "*nako ya sedimo".* The study also revealed that THPs follow their ancestral guidance even as individuals, outside their practice as THPs by always communicating with them even when just going out. This shows that indeed the THPs are African-oriented. The study also revealed that THPs apply the principle of Ubuntu in their practice. This was through the fact that even when a patient does not have money, payment arrangements were made and at the end, the patient would still be assisted.

### 9.3.2 Implications for traditional health practice

Before one embarks on the journey of training to become a THP, one should have consulted a THP, or a prophet or a religious healer. This study found that just like in any other health care profession, ethics are also important in traditional health practice. It is, therefore, suggested that ethics becomes an important aspect in traditional health practice. The training THPs should be taught how to practice ethically. Those ethics should also be both patient-centred and THP-centred.

### 9.3.3 Implications for clinical practice

The study developed an ethical framework which informs Northern Sotho THPs management of mental health cases. It is undeniable that like MHCPs, THPs also manage mental health conditions. The study found that at times THPs refer patients to the allopathic health care facilities, therefore, MHCPs should be aware of such and find ways of accommodating traditional health in their practice.

## 9.4 Contributions of the study

This study is certainly going to contribute to the field of psychology of traditional health care sector and the field of ethics. The contributions of the study are discussed below:

### 9.4.1 Contributions to the field of psychology

This study focused on ethics informing Northern Sotho THPs management of mental health cases. Besides contributing to the literature in the field of psychology, the study also found that THPs become psychologically affected due to what is expected of them as healers. They also experience the frustrations of having to lead their lives in a certain manner and to please their ancestors always because of the fear of facing the wrath of the ancestors.

### 9.4.2 Contributions to the field of traditional health care sector

The study found that although not documented, THPs are governed by certain rules in their practice. The presented ethics found in the study will add to the existing literature about ethics followed by THPs in their professional the traditional health care practice. The study might also help with the regulation of THPs, and collaborative issues amongst the THPs and HCPs in health care.

### 9.4 3 Contributions to the field of ethics

The field of ethics is very broad (bioethics, professional ethics, applied ethics, mental health ethics etc.). This study will make a contribution to the field of mental health ethics, more especially the incorporation of African moral principles into mental health ethics.

### 9.5 Limitations of the study

The following are the limitations of the current study:

- Firstly, this study was conducted with THPs that were drawn from the Northern Sotho-speaking cultural group only. Therefore, the findings cannot be generalised to other cultural groups in South Africa. However, the findings could be relevant other cultural groups.It is likely that the presented concepts might be relevant in other cultural groups.

- Secondly, the data were collected using mainly using Sepedi, which is the indigenous language of the Northern Sotho cultural group. The data were translated from Sepedi to English, therefore, this might have led to omissions or inappropriate substitutions of the original meanings provided by the participants. However, I have presented some of the concepts and phrases in this indigenous language, so that meaning is not lost.

- Thirdly, as per the grounded theory method, I wrote memos as I was collecting data and I admit that I might have missed some of the original meanings of the data, however the results were presented together with the extracts from the original transcripts.

- Lastly, the study focused only on ethics informing Northern Sotho THPs management of mental health cases. Therefore, the findings cannot be generalised to all diseases managed by THPs. However, some observed

ethical principles presented, might be applicable in the management of other diseases.

## 9.6 Recommendations

The following recommendations are made in line with the study findings and implications elaborated in the previous sections.

- The practice of traditional healing is blanketed in privacy and secrecy; it is therefore recommended that THPs become open about some of their practices for the benefit of this health system growth. It is important that THPs formally document some of what happens in their practices.

- It is evident that THPs treat the majority of common diseases, including mental health conditions. Therefore, there is a need for the government to regulate traditional health practices.

- The study also recommends the collaboration between THPs, HCPs, and MCHPs as all professionals provide services to the people. More especially because THPs do refer patients to HCPs and MCHPs.

- The findings of the study also recommend that more studies about THPs ethics be conducted, especially on other cultural groups. The studies should also not only focus on mental health conditions but other diseases as well.

## 9.7 Conclusion

This chapter discussed the summary of the results, implications of the study, and contributions of the study, limitations, and recommendations from the findings of the study. Traditional healing remains the most important health care system and it should be protected and respected as such. Although there is no standard way of traditional

health practice, it forms part of the indigenous knowledge, hence it should be protected and its processes documented. It is important that an ethical code of practice is developed, this study is in a way leading to that.

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## APPENDICES

### Appendix 1(a): Interview guide (English version)

| Objective | Interview questions |
|---|---|
| 1. To explore notions of mental health ethics as perceived by THPs. | a) According to you, what are ethics in mental health care? |
| 2. To understand and describe what traditional health practitioners understand to be ethics in the treatment of mental health conditions. | b) What do you understand to be ethics in the treatment of mental health conditions? |
| | c) I would like you to share with me your perception of ethics in the treatment of mental health conditions. |
| | d) As a traditional health practitioner, kindly share with me your experiences pertaining to ethics in the treatment of mental health in your years of practice. |
| 3. To determine traditional health practitioners' views regarding what is considered good ethical behaviour in the treatment of mental illness. | e) What do you regard as good ethical behaviour in the treatment of mental health conditions? |
| | f) What are some of the acts that distinguishes a good traditional health care practitioner from unethical practitioners? |
| | g) What are some of the consequences or what would happen to a traditional health practitioner who does not practice ethically? |

| | |
|---|---|
| | h) What are some of the benefits of practicing ethically as a traditional health practitioner? |

**Appendix 1(b): Potšišo Tlhahli (Sepedi Version)**

| **Maikemišetšo** | **Dipotšišo** |
|---|---|
| 1. Go kwešiša ka tsenelelo melawana ya dingaka tša setšo | a) Go ya le ka wena, ke eng melawana yeo e swanetšwego kalofong ya malwetsi a hlaologanyo? |
| 2. Go kwešiša le go hlaloša seo dingaka tša setšo di se kwešišago goba melawana yeo e swanetšego go latelwa ge ba alafa malwetši a tlhaologanyo. | b) Ekaba o kwešiša gore ke eng melawana yeo e swanetšego ge o alafa malwetši a tlhaologanyo? |
| | c) Nka thaba ge o ka nnyetlela, maikutlo a gago ka melawana yeo e swanetšego go latelwa ge o alafa malwetši a tlhaologanyo? |
| | d) Bjale ka nyaka ya setšo, abelana le nna ka ga maitemogelo a gago ka ga ka melawana yeo e swanetšego go latelwa ge o kalafing ya malwetši a tlhaologanyo? |
| 3. Go hwetša seo re ka rego maitshwaro a ma botse ge šetše ngaka ya setšo e alafa malwetši a tlhaloganyo. | e) Ke eng seo le se bitšago maitshwaro a ma botse kalofong ya malwetši a tlhaologanyo? |
| | g) Ke efe melawana ye mengwe ye e farologantšhang nyaka ya setšo yeo e alafago go ya ka melao/ tshwanelo le yeo e sa alafego go ya le ka tshwanelo. |
| | h) Ekaba go diragala eng ge ngaka ya setšo e sa latele melawana ya kalofo/ bontšhe maitshwaro a mabotse kalofong ya malwetši a tlhaologanyo? |

| | |
|---|---|
| | g) Ekaba ke dife tše dingwe dikholego tša ge nyaka ya setšo e alafa go ya le ka tshwanelo? |

**Appendix 2 (a) Consent letter for the participant**

Department of Psychology
University of Limpopo
Private Bag X1106
Sovenga
0727
Date: ……..

Dear Participant

Thank you for showing interest in this study about developing an explanatory model of mental health ethics by Northern Sotho traditional health practitioners. This study is for academic purposes and will not be used for anything other than that.

The research will not disclose your name as a participant in this study, or identify you with the responses you give during the interview. Please note that your participation in this study is voluntary and you have the right to withdraw from participating at any time should you wish to do so.

Kindly answer all the questions as honestly as possible. Your participation in this study is very important. Thank you for your time and cooperation.

Kind regards,

| | |
|---|---|
| …… | ……. |
| Moloantoa GT<br>PhD Student<br>Contact no (073 9989960) | Date |
| …… | ……. |
| Prof T Sodi<br>Supervisor | Date |
| …… | ……. |
| Dr M Makgahlela<br>Co-Supervisor | Date |

**Appendix 2 (b) Lengwalo la motšeakarolo**

Depatemente ya Psychology
Unibesithi ya Limpopo
Private Bag X1106
Sovenga
0727
Letšatšikgwedi: …….

Thobela motšeakarolo

Ke leboga go ba le kgahlego ga gago mo go tšeeng karolo lesolong la go nyakolla ka seo dingaka tsa setšo sa Basotho di kwešišago gore ke melawana yeo e swanetšego go latelwa ge ba alafa malwetši a tlhaologanyo. Nyakišišo ye ke ya thuto, gomme e tla šomišwa fela mabakeng a dithuto.

Monyakišiši a ka se tšweletse leina la gago felo, le ge e le go o nyallantšha le seo o tlabego o ka se bolelago mo nyakišišong ye. Tseba gore go tšea karolo ga gago ke boithaopo nyakišišong ye, ka fao o tlogela nako efe goba efe ge o kwa o nyaka go dira seo.

Ka boikokobetšo, araba dipotšišo tšeo o tlo botšišwago ka bonnete bjo bo feleletšego.Go tšea karolo ga gago go bohlokwa kudu nyakišišong ye. Re leboga nako le tšhomišano ya gago.

Wa lena,

| | |
|---|---|
| …… | ……. |
| Moloantoa GT<br>Morutwana<br>Contact no (073 9989960) | Letšatšikgwedi |
| …… | ……. |
| Prof T Sodi<br>Mothlahli | Letšatšikgwedi |
| …… | ……. |
| Dr M Makgahlela | Letšatšikgwedi |

**Appendix 3 (a) Consent form to be signed by the participant**

I _____ hereby agree to participate in a Doctoral Research project that is about developing an explanatory model of mental health ethics by Northern Sotho traditional health practitioners.

The purpose of the study has been fully explained to me. Participation in this study is voluntary and I can withdraw my participation at any stage. I understand that this is an academic research project, whose purpose is not necessarily to benefit me personally.

I understand that access to the records that pertain to my information in the study will be restricted to persons directly involved in the study, and that the information I give is of importance. The study is strictly confidential.

Signature: ……

Date: ……

**Appendix 3(b) Letlakala la tumelelano leo le swanetšego go saenwa ke motšeakarolo nyakišišong**

Nna _____ ke dumela go tšea karolo Porojekeng ya nyakišišo ya lengwalo la Bongaka ka ga go nyakolla seo dingaka tša setšo di kwešišago gore ke melawana yeo e swanetšego go latelwa ge ba alafa malwetši a tlhaologanyo.

Ke hlalotholletšwe go tlala seatla ka ga maikemišetšo magolo a nyakišišo ye.Go tšea karolo ga ka ke boithaopo nyakišišong ye, ka fao nka tlogela nako efe kapa efe. Ke kwešiša gore se ke nyakišišo dithutong,ebile gago seo ke se humanago go tšea karolo nyakišišong ye.

Ke kwešiša gape gore seo ke bolelago mo,se tla šomišwa fela ke bao ba dirago nyakišišo ye fela,ebile tsebo yaka e bohlokwa. Nyakišišo ye e tloga e bolokegile.

Mosaeno: …….

Letšatšikgwedi : ……..

## Appendix 4: Ethical clearance letter


University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za


**TURFLOOP RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE**

| | |
|---|---|
| **MEETING:** | **27 November 2018** |
| **PROJECT NUMBER:** | **TREC/216/2018: PG** |
| **PROJECT:** | |
| **Title:** | Towards an explanatory model of mental health ethics by Northern Sotho traditional health practitioners of Capricorn District, Limpopo. |
| **Researcher:** | GT Moloantoa |
| **Supervisor:** | Prof T Sodi |
| **Co-Supervisor/s:** | Dr MW Makgahlela |
| **School:** | Social Sciences |
| **Degree:** | PhD Psychology |

**PROF TAB MASHEGO**

**CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE**

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

**Note:**

i) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.**

ii) **The budget for the research will be considered separately from the protocol.**

**PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**

*Finding solutions for Africa*

## Appendix 5: Certificate for editing


Georgina Tukiso Moloantoa
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3 March 2022

TO WHOM IT MAY CONCERN

This editing certificate verifies that this Academic research was professionally edited for Georgina Tukiso Moloantoa. Thus, it is meant to acknowledge that I, Mrs. K.L Malatji and Dr. E.J Malatji professional Editors under a registered company RightMove Multimedia, have meticulously edited this thesis from the University of Limpopo.
Title of the THESIS: “TOWARDS AN EXPLANATORY MODEL OF MENTAL HEALTH ETHICS BY NORTHERN SOTHO TRADITIONAL HEALTH PRACTITIONERS OF CAPRICORN DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA".

Sincerely,

Mrs. K. L Malatji