

**KNOWLEDGE, ATTITUDE AND PRACTICES OF TRADITIONAL HEALERS
WITH REGARDS TO PRIMARY EYE CARE (PEC) IN KWAZULU NATAL.**

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Declaration

I, Tate Clifford Madlala, declare that:

1. The research reported in this dissertation, except where otherwise indicated, is my original research.
2. This dissertation has not been submitted for any other degree or examination at another university.
3. The dissertation does not contain other persons' data unless explicitly acknowledged as being sourced from other persons.
4. This dissertation does not contain another person's writing unless explicitly acknowledged as being sourced from other researchers.

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Date:

Signed:

MW Hlengwa (Supervisor)

Date:

Dedication

This dissertation is dedicated to the following:

- The almighty God who gives me strength and wisdom
- To my all ancestors who protect and guide me
- My late parents Mr Galofu A. Madlala & Mrs Bongiwe J. Madlala
- All my children and family
- My friends who gave me support throughout this journey

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- My family and friends for the support and encouragement that they gave me during this research study.
- Lastly, to all the traditional healers that agreed to be interviewed and shared their knowledge, perception and practice of their trade.

Abstract

The title of the study: Knowledge, Attitude And Practices Of Traditional Healers With Regards To Primary Eye Care (PEC) In Kwazulu-Natal.

Background: It is estimated that 80% of global blindness is avoidable (i.e. either preventable or treatable) yet the number of people living with vision impairment and blindness continues to rise. Epidemiological data indicate that approximately 2.2 billion people in the world are visually impaired or blind. Furthermore, 90% of those live in developing countries and are mostly in rural areas. A significant number of Black South Africans consult traditional healers for general and eye health as well as for other reasons.

Objectives: To assess the Knowledge, Attitude and Practices (KAP) of traditional healers with regards to primary eyecare in and around Durban City.

Methodology: A quantitative cross-sectional study design, using convenience sampling was employed. A validated semi-structured interview questionnaire was administered to participating traditional healers. The questionnaire contained questions on the knowledge, attitude and practices of traditional healers with regards to PEC. The data collected was analysed with the Statistical Package for Social Sciences (SSPS).

Results: Of the 162 traditional healers interviewed, 34% were below 40 years and 62% were older than 40 years. There were more (55%) male traditional healers than females (45%). The majority (77.8%) reported being able to read and write. Of the total respondents, 43.2% were herbalists, 25.2% divine healers and 13.6% faith healers. Most (77.8%) had more than 5 years of experience as a traditional healer. The mean score for knowledge about the causes of eye illnesses or injuries was 8.3 ± 2.25 and knowledge about conditions that may result in eye illnesses or injuries was 8.45 ± 1.9 . The mean score for attitude towards relationship with doctors and referral of patients to medical doctors was 5.85 ± 1.32 . The mean score for practice regarding mode and approach to treatment of eye illnesses was 9.49 ± 4.06 ; and attitude towards referral of patients by medical doctors to traditional healers was 3.12 ± 0.40 .

Conclusion: Lack of eye disease knowledge, its causes, diagnosis and treatment was shown amongst the traditional healers. A positive attitude was reported by the majority of traditional healers to want primary eye care training and referral of patients by western medical doctors to them. Therefore, the study demonstrated the need for training program for traditional healers regarding modern primary eye care for traditional healers in and around Durban.

Keywords: Tradition Healers, Primary Eye Care (PEC), Knowledge Attitude Practise of traditional healers in Durban

Definition of Terms

AIDS	Acquired Immunodeficiency Syndrome
DoH	Department of Health
DTA	Durban traditional Association
HIV	Human Immunodeficiency Virus
KAP	Knowledge Attitude Practice
PEC	Primary Eye Care
PHC	Primary Health Care
SPSS	Statistical Package for Social Science
TAC	Treatment Action Campaign
TH	Traditional Healer
TM	Tradition Medicine
T&CM	Traditional & Complimentary Medicine
CAM	Complimentary Alternative Medicine
THO	Traditional Healers Organization
TPB	Theory Planned Behaviour
WHO	World Health Organization
EC	Eastern Cape

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Chapter 1

Introduction

1.1 Background of the Study

Epidemiological data from International Agency for the Prevention on Blindness IAPB (2019) indicates that approximately 2.2 billion people in the world are visually impaired or blind and that 90% percent of these live in developing countries and are mostly in rural areas. Lecuona (2007) and Naidoo *et al.* (2013) says Africa with only 10% of the world population bears the brunt of the highest-burden of vision impairment and blindness. Even though the World Health Organisation says that about 80% of global blindness is either preventable or treatable, there is reported increase in the number of people suffering from vision impairment and blindness.

Women, the elderly, people with disabilities, ethnic minorities and indigenous people are the most vulnerable groups in accessing eye care because of unfair primary eyecare distribution (IAPB, 2019). In South Africa, significant causes of blindness and visual impairment are cataracts (66%), glaucoma (14%), refractive error (10%) as well other conditions such as trachoma (Sacharowitz, 2005), whereas diabetic and hypertensive retinopathies also make up 10% (Do, 2002). The WHO paints a glaring estimate that, in South Africa, nearly 100 people become blind because of cataracts daily (WHO, 2013). Current figures, therefore, show that over 375 000 people in South Africa are blind with the prevalence of blindness at 0.75 of these, women have a significantly higher prevalence of blindness than men (DoH, 2002; Bucher & Ijsselmuiden, 1998).

1.2 Problem Statement

Literature suggests that a large number of Black South Africans prefer to consult traditional healers (Nyika, 2007; Dagher & Ross, 2004). This is especially so in the rural and informal settlements as a result of limited access to health care service. The issue of access to health care services is demonstrated well by the Lasker (1981) study in the Ivory Coast where she investigated why people choose different modes of therapy. The results of the study suggested that the major determinant to the utilisation of either modern or traditional medicine was not

cultural beliefs or the level of education, but accessibility to health care services. The author further asserted that accessibility included the distance to the health facility, the cost of service and the degree of communication between health providers and patients. According to Abdullahi (2011), the increased use of traditional eye medicine (TEM) is due to its affordability when compared to allopathic medication. Ntim-Amponsah, Amoaku and & Ofosu-Ammah (2005) found that communities will look for and utilise alternative treatment methods if they live in places where there are no health facilities. Levers (2006) further adds that treatment provided by traditional healers is holistically aimed at healing the body, mind and soul of patients. Megabelagin and Babalola (2015) argue that communities have absolute trust in traditional healers and the treatment that they provide.

Research conducted by TAC and the Aids Law Project (2003) has shown that traditional healers are more accessible to people, especially those living in rural areas. Pertinently, eye care in Africa is not easily accessible to the majority of people (Foster & Johnson, 1994). They affirm that most nurses and doctors have inadequate training in eye diseases and eye care delivery, especially since eye medicines are often not available at public health facilities and are expensive to obtain from private pharmacies and optometrists or ophthalmologists.

Research by Eze, Chuku-Okosa & Uche (2009) found that there was a global increase in the use of traditional medicine for the treatment of eye diseases. Courtright (2000) lists the treatments that traditional healers' "prescribe" for eye diseases ranging from drinking of mixtures, face washing, wearing of amulets, smoking or powder blowing, diet or fasting, licking, incantations, scarification, poulticing / cupping, topical instillation, fume baths and surgery (epilation, eyelid surgery, couching). These traditional eye medicines and practices, according to Iqbal, Orakzai & Ayaz (2012), are used in all stages of disease treatment from diagnosis to intervention and maintenance of patient or community's well-being.

Omalase & Mahmoud (2008) reported that the therapeutic use of traditional eye medicine is both toxic and non-toxic to the eye and cautioned against the reckless use of toxic traditional eye medicine as it can potentially further damage the already damaged eye. Additionally, they argued that traditional eye medicine use is questionable because the treatment might distort the severity of the eye's damage or disease.

Although research indicates that many people use traditional eye medicine for the treatment of eye diseases (WHO, 2013) yet, a larger number of patients present themselves to local clinics and hospitals when the traditional medicine treatment, as primary choice, does not work

(Nyathirombo, Mwesingye & Mwaka, 2012). Omalase & Mahmoud (2008) suggested that this phenomenon supports the fact that many western medical eyecare professionals report to witnessing eye complications due to using traditional medicine. Ocular diseases such as purulent discharge, corneal scarring, vision impairment, amongst others, can be caused by use of traditional eye medicine (Chandrasekhar, Sudha, Preneeth, Mahaboob & Shaik, 2014).

Poudyal, Jimba, Wakai (2005) found that traditional healers training programmes on primary eye care services in Nepal, India, improved their referral practices to modern practitioners and discouraged harmful traditional ocular medication. This was achieved by training traditional healers in modern medicine and practice, with particular emphasis on primary eye care. Research conducted in Zimbabwe and Malawi also found that collaborative efforts between traditional and modern/professional eye care practitioners resulted in a significant reduction of preventable and avoidable blindness that was caused by the use of harmful traditional ocular medicines (Courtright *et al*, 1997; Mselle, 1998).

Therefore, this proposed research study aims to determine the knowledge, attitudes and practices among traditional healers in order to develop collaborative programmes between traditional and modern eye care practitioners that would encourage traditional healers to play a significant role in reducing avoidable blindness (Foster & Johnson, 1994).

Developing a clear referral protocol for urgent eye conditions that are beyond the scope of the traditional healer's capabilities, is crucial. A timely referral is imperative to the success of PEC (Murthy & Raman, 2009). The study can serve to demystify the practices of traditional medicine with regards to primary eye care in South Africa and open up a dialogue to dispel mistrust between western medical practitioners and traditional healers.

1.3 Aim, Objectives and Research questions

1.3.1 Aim of the Study

The study aims is to investigate the knowledge, attitudes and practices of Durban's traditional healers with regards to primary eye care.

1.3.2 Objectives of the Study

The objectives of this study are to:

1. Determine traditional healers' knowledge of most commonly presenting eye conditions in South Africa, their cause, diagnosis and treatment;
2. Determine traditional healer's specific practices with regards to primary eye care;
3. Determine the attitudes of traditional healers towards collaboration with modern medical eye care doctors and training.

1.3.3 Research Questions

This study aimed at answering the following critical questions:

1. What are Traditional healers' knowledge for most common eye condition in South Africa?
2. What are Tradition healers' current practices with regards to primary eye care?
3. What are Traditional healers' attitudes towards working with modern medical eye doctors?

1.4 Summary

This chapter entailed the background of the study and the motivation for conducting this research study. This chapter also highlighted the aims of the study which were to get a better understanding of the knowledge attitude and practice of Durban's traditional healers regarding eye care. This chapter further provided the objectives of the study and the research questions that the researcher sought to answer.

Chapter 2

Literature Review

2.1 Introduction

It is estimated that over 80% of South Africans consult with traditional healers and use traditional medicine (TM) as their primary health care (Kim, 2005). Of this 80%, some use a combination of both traditional and western medicine (Ross, 2010). For example, a study by Ensink and Robertson (1999) in a Cape Town hospital indicated that 66% of psychiatric patients used both western and traditional medicines for their mental sickness. **Moreover, Adams *et al.* (2009) study found that globally there is an increase interest and demand for the use of both traditional and modern health systems. They also report that for years they have observed a growing pattern of using both health systems by patients moving from one healthcare system to another in search of diagnosis, healing or other services or using both systems simultaneously.** This combination is commonly referred to as medical pluralism or medical syncretism (Ross, 2010).

Therefore, a professional collaboration between health systems, where both health systems can compliment each other is desirable (Adams *et al.* 2009). Van Rooyen *et al.* (2015) says the phenomenon of dual usage of medical resources is very significant, espically for this kind of study where the study provides a basis for attempts at collaboration between modern and traditional healing. This is not new to Pretorius (1991) who advocated a new type of national healthcare delivery system. He said traditional medicine can be made relevant through either an inclusive parallel system, whereby traditional medicine other than modern medicine is recognised legally, thus, two or more systems of health co-exist, through integration of both systems. He further adds when a relationship of complimentarity and cooperation exists, traditional and modern medicine co-exists as two independent health systems, each acknowledging and considering the uniqueness of the other.

In Sub-Saharan Africa, the ratio of traditional healers to the population is approximately 1: 500 while professionally trained medical doctors have a ratio of 1:40 000 to the rest of the population (Treatment Action Campaign & Aids Law Project, 2003). The picture is even worse for eye care ophthalmologists in Africa where the ratio is 1: 1 000 000 (Foster & Johnson,

1994). In South Africa, one ophthalmologist for every 50 000 people in the private sector and one ophthalmologist for every 390 000 people in the public sector. Yet modern countries like Belgium has one ophthalmologist for every 6000 people (Meyer, 1998) and these statistics have remained unchanged to date (IAPB, 2019).

Ross (2010), states that a common response when people are asked why they consult with traditional healers, is that they are dissatisfied or have negative experiences with allopathic medical professionals. She adds that other themes to the response were holistic treatment by traditional healers, healers having a close association with their religion, cultural, language and spiritual beliefs. Additionally, there is no language barrier for providing a clear explanation for their diagnosis and treatment to be followed. Gregory (2001) reported that in the South African culture, traditional healers occupy respectable positions as they are consulted on a variety of issues such as physical, social and emotional problems and in many occasions are expected to take on many roles of healer, physical, pastor, psychologist, advisor, teacher, diviner and herbalist. Therefore, their importance in communities can never be ignored (Troskie, 2008). Even though many argue or doubt the efficacy of traditional healing, many pharmacological studies, as pointed out by Rose (2008), have demonstrated the herbal substance efficacy in treating malaria, sore throats, appetite suppressing and memory loss.

Traditional healers, as health care workers, are much more accessible to people and play an important role in peoples' lives (Karin et al., 2002). As a result, in 1977, the WHO formally recognised the importance of collaborating with traditional healers in the delivery of health care services (Steinglass, 2002). African, Muslim, Hindu, Chinese and other forms of traditional healing are practiced worldwide, and two-thirds of the global population continue to rely on traditional or alternate forms of medicine.

The Alma-Ata Declaration on Primary Health Care (1978) encouraged countries and governments to include the practice of traditional medicine within their primary health care approach. Over thirty years later, traditional medicine availability and practice is more widely available, affordable, and commonly used. As previously stated, in some Asian and African countries, 80% of the population depends on TM for primary care (Kim, 2005).

Recent studies conducted in North America and Europe indicate that TM health care approaches tend to be used primarily in groups with higher levels of income and education. In other words, in developed nations, Traditional & Complimentary Medicine (T&CM) is not the economically disenfranchised population's alternative to "western" medical care. Furthermore,

and in many cases, T&CM costs are not covered by medical insurance programs. Thus, the use of these traditional, complementary and alternative medicine (CAM) approaches have become a growing and economically viable industry that is expected to continue its exponential growth. For example, 70% of the population in Canada and 80% in Germany have also used CAM therapies. (WHO, 2010).

Statistics released by the WHO in 2014 indicate that over 100 million Europeans are currently TM and CAM users, with one fifth regularly using TM and CAM and the same number preferring health care which includes TM and CAM (European Information Centre for CAM; 2014). There are many more TM and CAM users in Africa, Asia, Australia and North America (Barnes, 2007).

To better illustrate the extent of use of TM, CAM and T&CM below is the table with estimates of use by practitioners and patients worldwide (WHO, 2014): **Table 1**

Region or Country	Extent of use
Africa	Used by 80% of the population for primary health care
Australia	Used by 49% of adults
China	Accounts for 30-50% of total health care. Fully integrated into health system. 95% of Chinese hospital have TM units
India	Widely used, 2860 hospitals provide TM
Indonesia	Used by 40% of the entire population, used by 70% of the rural population
Japan	72% of physicians practice TM
Thailand	TM integrated into 1120 health centres
Vietnam	Fully intergrated into the health care system. 30% of the population is treated with TM
Western Countries	TM and T&CM not strongly integrated into the health system. France: at least 75% of the population has used T&CM at least one Germany: 77% of pain clinics provide acupuncture

	USA: 29-42% of the population uses T&CM
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Source: WHO 2014

Meanwhile, the need to integrate or “harmonize” traditional and western medicine modalities is strongly promoted in the eastern Pacific Rim countries, including China, Korea and Japan (WHO, 2010). These countries believe that their governments, professional organizations, and health care administrators, as well as the insurance sector, will benefit from effective traditional and western medicine integration. Because of this, the incorporation of TM in health information systems is emphasized and forthcoming. China and Korea already use their own TM classifications in health information systems. Meanwhile, there is a significant need to register information on traditional medicine practice in the USA. (WHO, 2010).

According to WHO (2014), there are various other case studies across the globe that integration of TM has been successful and eventually integrated into the health system. For an example, Women fighting AIDS in Kenya (WOFAK) is a non-profit support organization started in 1994 by ten women affected by HIV/AIDS. WOFAK has incorporated traditional medical practices into its program because of a concern that conventional medicine is too expensive for WOFAK clients. WOFAK works to sustain and promote various forms of traditional medicine and beneficial cultural practices throughout the country, and it supports the exploration of traditional therapies for HIV and associated opportunistic infections. The center has two clinic rooms—one for traditional medicine and one for conventional medicine and the center employs one community nurse, one traditional healer, one part-time doctor, and two herbal nurses. Cross-referrals occur between conventional health practitioners and traditional medicine practitioners. (UNAIDS, 2002).

In Tanzania, The Tanga AIDS Working Group (TAWG) begun in 1990 after a traditional healer successfully used herbal medicines to treat a patient in a government hospital in the Tanga region of Tanzania. The doctors were so impressed that they initiated collaboration with healers to better provide services for their patients with HIV/AIDS. One of the first TAWG activities was to work with local healers to develop three herbal remedies to treat a variety of HIV/AIDS-related conditions. From that activity evolved a home-care service for patients and their families. (UNAIDS, 2002).

In China, Traditional Chinese Medicine (acupuncture and other healing modalities) has been used for thousands of years in treating different types of diseases and symptoms, such as pulmonary, cardiovascular, gynecological, and pediatric, as well as mental illness. During the epidemic of Severe Acute Respiratory Syndrome (SARS) in 2003, the SARS death rate in China (6.5%) was less than the average international death rate (9.5%). Among the 5326 SARS patients treated, 3104 cases involved TCM treatment. This represents 58.3% of the total. Specifically, in Guangzhou, where the integration of TCM started the earliest, the death rate was only 4%. In Beijing, the death rate decreased 80% after integrating TCM treatments. Recently, the State Administration of Traditional Chinese Medicine of the People's Republic of China, the Chinese Ministry of Health, and the Treasury Department are collaborating on a program to provide free TCM treatment for 4500 HIV/AIDS patients in 11 provinces. The preliminary clinical results based on 2300 patients in 2004 are encouraging.” (YANG, 2009).

2.2 Traditional Healing vs Western Medicine in South Africa

There are generally two forms of healing practices, namely the traditional approach and modern or western approach. The traditional healing approach is based on indigenous belief systems. Murove (2009) asserts that the traditional healing's paradigm is based on the fact that traditional medicine, illnesses and diseases disorders arise from natural, social or psychological disturbances that create inequilibrium expressed in the form of physical or mental problems. Graham (2002) adds that the traditional healing paradigm sees the mind, body and spirit as one; it makes no distinction between psychological and physical problems. He further outlines that traditional healers aspires not only to alleviate physical symptoms but also to restore harmony, balance and equilibrium by re-integrating the patient with his or her community, earth and the spiritual world word. Singh (2004) adds that traditional healers strongly believe that their power comes from God and that they regard themselves as a repository of specialised knowledge and sacred practices. Furthermore, Ross (2010) describes African traditional healing as involving a holistic integration of mental and spiritual guidance, herbs, nutrition and physical therapy, and is linked to African cosmology.

According to Zuma *et al.* (2016) in their study in northern KwaZulu Natal in which they sort to describe the role of a traditional healer, the process into becoming and how traditional healers perceived their healing practice in relation to the different categories described in their study. They say traditional healers' roles include, but are not to, being the custodians of traditional African religion and customs, educators about culture,

counselors, mediators and spiritual protectors. The study further found that traditional healers' mode specific roles are influenced by the processes by which they become healers. However, which type of the healer they identified as, the study demonstrated that most traditional healers used similar, generic methods and practices to focus on the physical, spiritual, cultural, psychological, emotional and social elements of illness.

The western biomedical approach is also called allopathic medicine. Rose and Deverell (2010) reported that allopathic medicine's initial approach tended to see illnesses as a manifestation of biological malfunction in the form of chemical, anatomical or physiological changes. Levers (2006) argues that biomedicine has its roots in the Cartesian separation of mind and body. When diagnosing patients' diseases, western medical practitioners base their diagnosis on the patients' medical history, physical examination and sometimes use laboratory test results. Therefore, healing is seen as a scientific, rational and evidence-based process of correcting diseases through right medical, surgical and chemical interventions. The core of western biomedical intervention is the assumption that the efficacy of this treatment approach needs to be determined through science and evidence-informed research says WHO (2013).

2.3 Traditional Healing in South Africa

There are about 150 000 – 200 000 traditional healers affiliated to approximately 100 associations in South Africa, and as yet there is no single governing body (Pretorius, 2000). The Traditional Healers Organisation (THO) is the most prominent umbrella organisation and was established in 1970 (Treatment Action Campaign & Aids Law Project, 2003). It has more than 69 000 traditional healers in Southern Africa as its members with more than 25 000 members residing in South Africa. THO has provincial branches in almost all the provinces of South Africa. Other traditional healer formations are the South African Traditional Healers Health Care group and the Indigenous Traditional Organisation.

During the Apartheid era, traditional healers were forced to operate underground as the government then enacted the 1974 Health Act and its 1982 amendments which prohibited any traditional healers' performance related to medical practices. Despite these oppressive laws, traditional healing remained resilient and operated illegally and unregulated.

According to van Rooyen *et al.* (2015) the formal recognition of traditional healing, and its integration or the incorporation into existing healthcare services, has been controversial for some time with many arguments offered for and against their incorporation. Wiese and Oster (2010) and Abdullahi (2010) argue that part of the misunderstanding regarding African traditional healers emanates from a historical perspective. As Mulaundzi (2010) points out, missionaries were particularly negative towards traditional healers, viewing traditional healers as an impediment to repentance.

However, failure to recognise the traditional health system can result in a dangerous situations including toxic drug herb interaction, failure to administer the most effective treatment (Guan & Chen, 2012) and cases of delayed treatment (Barker *et al.*, 2006) or even abandoned treatment (Amoaha *et al.* 2014).

When the ANC led government took power in 1994, they formulated the White Paper for the Transformation of the Health System as showed in Government Printer 1997. This white paper abolished the traditional healing restrictive laws and but recognised that traditional healers form part of the primary health care team. In 2007, a presidential task team was established to look at the regulatory framework for traditional healers, which resulted in the drafting of traditional healer's bill (South African Traditional Health Practitioners Bill). The bill envisages the establishment of an Interim Traditional Health Practitioners Council of South Africa. The function of the council will be:

1. To provide a regulatory framework to ensure the efficacy, safety and quality of traditional health care services;
2. To manage the registration, training and conduct of practitioners, students and specified categories in the traditional health practitioner profession;
3. To provide for matters connected with the above mentioned.

Although Ross (2010) argues that the Act has been in abeyance owing to lack of consensus among stakeholders, the Eastern Cape (EC) province in 2001 enacted *Health Standards in Traditional Circumcision Act, No. 66 of 2001* which is the only regulated working relationship or profession collaboration between modern health practitioners and traditional surgeons. Otherwise, traditional healers in South Africa have had to fight for recognition by different quarters of society, including the Department of Health, Health Professionals Council of South Africa (HPCSA), medical aid schemes and other

authorities concern with health (Mokgobi, 2012 & Mbatha, 2012). For example, the *Traditional Healer Practitioners Act* (No. 35 of 2004) does not mention religion, initiation, spirits, mediums, possession or trance states, all of which are associated with traditional healing in the popular and academic literature (Mpofu, 2011). Having excluded most of what traditional healers are commonly understood to do, Zuma *et al.* (2016) suggest the Act ignores the importance of their role in spiritual enhancement when treating people, in addition to focusing on the body. Another example is that traditional healers have been under the Health Professions Act of 1974, which is not the case for other health care practitioners in South Africa (Thornton, 2009). The above mentioned reasons key to the view held by (Ross, 2010) that the stakeholders have not agreed on how the *Traditional Healers Act* (No. 35 of 2004) is not worded to be inclusive and cognisant of traditional healers practice in South Africa. Zuma *et al.* (2016) argues that gaps identified in literature around policy and accreditation for traditional healers in the public health system are largely due to lack of systemic evidence about their healing roles, practices and methods.

In South Africa, one can distinguish five broad categories of traditional healers that have different names within the various African language groups and regions. In some cases, tradition healers identify themselves primarily as one type of healer, others combine more than one type says Ross (2010). The five categories as follows:

(1). *Diviners, or isangoma*, are considered the most important healers because they act as intermediaries between humans and the supernatural. Unlike herbalists, one cannot become a diviner by personal choice, you can only become an isangoma when you answer the call of the ancestors as the isangoma (more usually women) regard themselves as servants of the ancestors (Troskie, 1997). Diviners focus on diagnosing the unexplainable, analysing the causes of specific events and interpreting messages from ancestors. They usually diagnose by throwing bones, cards or stones and consulting ancestors. In some cases, they provide medication and/or certain therapies for specific cases that they have diagnosed (Pretorius, 2000; Moskovitz, 1996 and Setswe, 1999).

(2). *Herbalists, or inyanga*, are people who have acquired an extensive knowledge of herbal magical technique and who do not, typically, possess occult powers. They are expected to diagnose and prescribe medicines for everyday ailments and illnesses; to prevent and to

alleviate misfortune or evil; to provide protection against witchcraft and misfortune; and to bring prosperity and happiness (Troskie, 1997; Moskovitz, 1996).

(3). ***Prophets or Faith Healers***, In Zulu faith healers, are commonly referred to as “abathandazi” or “abaprofethi”. They use either prayer, candlelight, water or a combination of all three techniques to diagnose and treat patients (Pretorius, 2000; Setswe, 1999). Sometimes, upon cure, a patient automatically becomes a member of the church to which the faith healer who cured him/her belongs (Pretorius, 2000).

(4). ***Traditional surgeons conduct*** circumcisions of initiates (Troskie, 1997). **In South Africa, tribes like amaXhosa, Vhavenda, Bapedi and Batswana still actively participate in male initiation practices where male initiates undergo traditional male circumcisions performed by traditional surgeons.**

(5). ***Traditional Birth attendants*** assist with the delivery of babies (Troskie, 1997). Traditional birth attendants are also known as traditional midwife providing pregnancy and childbirth care in developing countries. They are usually middle-aged or elderly with no formal training who attend to women during pregnancy, labor and post-natal period by using herbs and traditional practice to facilitate delivery or prevent too much bleeding of the uterus (Owens, 2011).

The research conducted by Jolles and Jolles (2000) and Steinglass (2002) is slightly different from Troskie’s classification of “traditional healers”. They categorise traditional healers into those who serve in the role of diviner-diagnostician / or diviner-medium and those who are healers, usually herbalist. According to them, diviners provide diagnosis, usually through spiritual means, while the herbalists use and apply appropriate herbal remedies. According to Troskie (1997), spiritual healing may involve blowing and throwing of bones and performing rituals such as animal sacrifices. Chana *et al.*, (1994) agree that diviners claim to have contact with the spirit world, which enables them to identify the causes of illness and the measures necessary to take action against it.

Courtright *et al.*, (2000) noted that there are significant gender differences in the activities of male and female traditional healers. Male healers treat children, women and men while female healers tend to treat primarily women and children. Some female healers also serve as traditional birth attendants.

Traditional herbal practice knowledge is passed down from one generation to another orally and through observations (Grierson & Afolayan, 1999) as a form of apprenticeship to an older

healer. Often to become a traditional healer is through a calling, and this calling can be in the form of a dream, a passion or a feeling (Ross, 2010). When this calling is ignored, it can make a “called” person sick or cause them misfortune until they consult with a traditional healer who then diagnoses them as being “called” to become a traditional healer. If the called person accepts the calling, then an initiation process called ukuthwasa begins. According to Hammond-Tooke (1989), ukuthwasa is derived from a Xhosa concept of twasa meaning “the emergence of something new”. Many people believe that the calling to become a traditional healer comes from ancestors and if the calling is not acceded or respected, then the called person will continue to be ill or subjected to misfortune until they accept the calling says (Ross, 2010) even though some traditional healers, especially young ones, wear modern clothes, a majority of traditional healers wear skins of animals, feathers and beads. Many traditional healers carry ishoba, a flywhisk made from the of the wildebeest.

Usually, the patient consulting with the traditional healer does not inform the healer what their sickness is but instead, it is the healer that tells the patient or family he or she believes the sickness or misfortune to be. Traditionally, Africans believe that most illnesses have a specific cause, therefore to heal the sickness, the traditional healer needs to ascertain and remove the cause. Jenkins (2006) makes the two examples (1) HIV and AIDS are seen as some form of retribution for having unfaithfulness to one’s partner by having many sexual partners; (2) bodily and mental sickness is caused by displeasure or conflict between a person and their ancestors, a god, witch or spirit. Jenkins further adds that human relationships breakdown and natural causes also attribute to illness. Therefore, a patient is healed not only by natural products or herbs but also by making mends with ancestors and resolving conflicts with family or community. In her study, Elis (1996) states that some traditional healers believed that spiritual pollution or ritual impurity could bring about illnesses and misfortunes. For example having sexual activities with a woman during her menstruation or a widow while in her mourning clothes or a period; or woman who aborted or terminated a pregnancy or from touching a dead person. Hence, Mzimkulu and Simbay (2006) outline that it is prevalent for traditional healers to treat mental and other diseases by cleansing patients and sometimes together with their family of evil or demonic spirits by steaming, washing, induced vomiting (ukuphalaza) and sometimes animal sacrificing.

2.4 Primary Eye Care

The concept of primary eye care (PEC) was born as a consequence of the Alma Ata declaration in 1978, which highlighted the tenets of primary health care (PHC) (Courtright *et al.*, 2010). In particular, it was suggested that PEC could have an impact on reducing two important causes of blindness in developing countries, (1) vitamin-A deficiency and (2) trachoma, since then PEC has evolved and defined into a broad concept. In the attempt to define PEC as a broad concept (Murthy & Raman, 2009) first argued that there is no common understanding of what primary eye care means and there exists a wide variation both in its content and in the way in which it is delivered. They then later defined primary eye care as a frontline activity, providing care and identifying ocular disease before it becomes a serious medical issue. Furthermore, Murthy and Raman (2009) suggested that PEC can be delivered in many different ways including eye health education, ocular symptoms and signs identification, visual acuity measurement, basic eye examination, diagnosis and timely referral.

On the other hand, the American Academy of Ophthalmology (2009) defines PEC as the provision of appropriate, accessible, and affordable care that meets patients' eye care needs comprehensively and competently while providing the patient with both the first contact with eye care as well as a lifetime of continuing care. According to the American Academy of Ophthalmology (AAO) the following services should be provided in terms of PEC:

1. Educating patients about maintaining and promoting healthy vision;
2. Performing a comprehensive examination of the visual system;
3. Screening for eye diseases and conditions affecting vision that may be asymptomatic;
4. Recognizing ocular manifestations of systemic diseases and the effects of ocular medications;
5. Making a differential diagnosis and definitive diagnosis for any abnormalities that are detected;
6. Performing refractions;
7. Fitting and prescribing optical aids such as glasses and contact lenses;

8. Deciding on a treatment plan and treating patients' eye care needs with appropriate therapies;
9. Counselling and educating patients about their eye disease conditions;
10. Recognizing and managing local and systemic effects of drug therapy;
11. Determining when to triage patients for more specialized care and referring to specialists as needed and appropriate;
12. Coordinating care with other physicians involved in the patient's overall medical management

2.5 Primary Eye Care Overview

According to WHO (2014) more than 314 million people worldwide have a serious visual impairment. Amongst these, about 37 million are blind with 124 million having low vision and a further 153 million being visually impaired because of uncorrected refractive errors (need for glasses). Africa, with only 10% of the world's population, accounts for 19% of the world's blindness (Naidoo *et al.*, 2013). Globally, the major causes of blindness are cataracts, which accounts for 51% of blindness, uncorrected refractive errors (18%), glaucoma (8%), age-related macular degeneration (ARMD) (4%), diabetic retinopathy (4%), pediatric eye conditions (4%), trachoma (3%), and onchocerciasis (0.7%). WHO (2014) further states chronic eye conditions such as glaucoma, cataracts, diabetic retinopathy and ARMD affect an increasing number of people in developing countries. This is partially due to an aging population, but also due to lifestyle changes.

In response to the above-mentioned damning eye health statistics WHO (2008) World Report called for the revitalisation of PHC to enable access to quality eye health for all. A global plan called "the Universal Eye Health: a global action plan (2014-2019) was designed to support the integration of eye care into the health system and more importantly the inclusion of primary eye care into primary health care. This global plan for universal eye health aims to reduce avoidable vision loss (WHO, 2013) thereby curbing the quality of life limitations and economic demands associated with visual disabilities (Langelaan *et al.* 2007 & Laitinen *et al.* 2007).

According to WHO (2007) there is a global focus on health systems strengthening (HSS) as a key strategy to develop services and ultimately improve health outcomes. With

regard to HIV care, for example, integrating HIV services into existing PHC structures, strengthening laboratories and referral linkages, re-training health workers and improving district-level management has been shown to improve HIV care and strengthen wider PHC systems, including improving infrastructure, supervision and patient flow between services (Pfeiffer *et al.* 2010). The Global Action Plan 2014-2019 for universal eye health is similarly based on a HSS approach, encompassing the integration of eye care into all levels of the healthcare system including PHC (WHO, 2013). It is crucial that quality eye care begins at the first point of contact, the primary health care level (de Wet and Ackermans, 2000).

However the value of HSS in the context of PEC has been met with a number of challenges such as recommended practices for the integration had little documentation (IAPB, 2019) or evidence existed about models for the effective integration and health system support for the eye health component of PHC (du Toit *et al.*, 2013). Even though in countries like Rwanda and Tanzania demonstrated that PHC centres could successfully provide PEC, the promising effects seem to diminish over time (Courtright *et al.*, 2010; Laviers *et al.*, 2011; Mafwiri, Kisenge & Gilbert, 2014). According to Courtright *et al.*, (2010) many countries' failure of full PEC integration into PHC in general, is that primary health care workers have little or no eye health knowledge and skills for the provision of PEC. Also studies in Kenya, Malawi and Tanzania reported that PHC personnel possessed very low eye health knowledge and practice (Kalua *et al.*, 2014). Even in high income countries general health practitioners reported to have inadequate training in and / or knowledge of PEC (Gibson and Roche, 2014) & (van Zyl, 2011).

According to Department of Health: Primary Healthcare Standards Treatment Guidelines and Essential Medicine List (2014) in South Africa eye care is mostly accessed through private eye care professionals but in the public sector eye care is mainly provided at the primary health care (PHC), also known as Primary Eye Care abbreviated as PEC. When a need arises, a referral to a high level is done. PEC in South Africa has many challenges which include the fact that the country does not have a directorate for eye health or an integrated eye health promotion plan (Sithole, 2017). Just like in many African countries this situation has resulted in lack of eye services in the country (Naidoo, 2007). Scarcity of human resources (Lecuona, 2007; Lecuona & Cook, 2011); expensive and inaccessible eye medication (Cook, 1993) and (de Wet & Ackerman, 2000); lack of Vitamin A supplement coverage, spectacle supply, vision screenings and assessments for eye diseases such as diabetic retinopathy, cataract removal

surgeries (Lecuona, 2007); (Cook, Knight & Crofton, 1993); (Rotchford & Johnson, 2000), (Naidoo, 2003) remain biggest challenges of eye care provision in South Africa.

According to de Wet and Ackermans (2000) study to provide improvement of eye care in the PHC setting in the province Free State the following were found to be problems regarding the provision of quality eye care at PHC level:

Complicated referral systems: At PHC level, there exists a cumbersome referral system where it happens that once the PHC worker has seen the patients and referred them to the medical officer (MO) of health, the patient has to return next day because the medical officer has left for another hospital where s/he also renders services. Should the patient get to see the medical officer, the latter may refer the patient to the specialist services. An appointment at these services has to be made by the medical officer or PHC worker. When the specialist appointment date another referral letter must be obtained from the referring patient for transport authorization. By the time the patient has to travel to see the specialist, the patient would have made about 3 to 4 trips to the PHC facility, often under difficult circumstances such as walking long distance by foot, or taxi/bus which many can't afford.

Problems with transport: Sometimes patients may happen to lose out on the hard-earned opportunity to see the specialist because of problems experienced with patient's transportation. Most often PHC facilities are located far away from referral facilities or tertiary institutions. All patients that have appointments on a specific day are generally picked by the transport services. At times, unfortunately, some patients are left behind due to lack of spaces in the vehicles as a result of poor communication between the transport staff and the primary health care services. Usually when a patient misses the appointment, the whole making appointment process has to be repeated.

Problems related to the supply of medicine: With any condition requiring continued medication, it is important that patient adheres to prescribed medicine in order to obtain optimum outcomes. If patients do not get their medication in rural areas, work done at great expense for example corneal transplant will be useless. According to de Wet and Ackermans (2000) PHC workers experienced two problems with the supply of medicine. In the first place patients cannot afford prescribed medicine by specialist. As a result they do not receive the necessary medication. Secondly, unavailability of suitable ocular medicine at PHC facilities. PHC clinics can only provide level 1 medicine (such as eye ointments). The problem is that the level 1 medicine may not always be the appropriate treatment for certain patients. Particularly, a patient

who has seen a specialist and have been prescribed medication which can't prescribe by PHC worker or medical office.

Insufficient knowledge of PHC workers regarding eye problems: Although during training, professional nurses, PHC worker receive lectures in the physiology and diseases of the eye, PHC workers feel that they do not receive enough in-service training regarding eye care the early detection of eye problems. This has a negative influence on PHC workers, adversely affecting their self confidence as professionals because they realise that knowledge is inadequate (de Wet and Ackerman, 2000). As a result medical officers and specialists are overloaded with patients who could have been treated by the PHC workers if they appropriate knowledge. A more serious consequence of this lack of knowledge is that eye problems that are more serious and / less obvious, go undetected, often with serious consequences for the patient. For example, blindness may be the result of not being diagnosed in time with disease with a disease like glaucoma (Update, 1993).

An overload of specialist services: Newly diagnosed patients with problems such as cataracts stood no chance of being operated on during the year of diagnosis as the surgery quota for the year fills up very quickly (de Wet and Ackermans, 2000). Thus the specialist services become inaccessible to newly diagnosed patients.

Insufficient communication and cooperation between services: there is lack of communication between organisation rendering eye care services and the staff at PHC clinics. Often PHC workers do not know when specialist is visiting the region and if they find out about the visit it is often very late to refer patients to the specialised service. PHC workers often don't get feedback from a specialist regarding a patient's condition for better patient co-management. Often the patient will return from a specialist with only a prescription with no diagnosis communicated to PHC worker nor any accompanying letter provided. Thus PHC worker gains no knowledge from the referral of the patient and does not know how to approach the follow-up treatment of the patient. This situation aggravates the over loading of specialist services which again results in the staff of specialised services not having enough time to give proper feedback to the PHC workers. A vicious cycle develops.

Despite these challenges highlighted by de Wet & Ackerman (study), in 2002 the department of health adopted the World Health Global initiative called Vision 2020 nicknamed "The Right To Sight Campaign" (DOH, 2002). This initiative was aimed at reducing or eradicating the

causes of blindness in the world by 2020 because most ocular diseases can be treated or avoided if diagnosed and treated early.

2.6 Traditional Healers and Allopathic Collaborations

For many years tensions existed between traditional healers and western biomedicine. Biomedical interventions focus on material physical causes to understand and treat illness while traditional healers generally try to establish the spiritual origin of an illness, such as witchcraft or discontent of the ancestors in order to cure an ailment (Jolles & Jolles, 2002). This tension caused the two disease interventions to function separately and non-collaboratively. In South Africa the lack of collaborations between traditional healers and western medicine is exacerbated by the colonial oppression which enacted legislation such as “Witchcraft Suppression Act of 1957”, “Witchcraft Suppression Amendment Act of 1970” and many other laws that explicitly prohibited the practise of traditional healing in South Africa (Jolles & Jolles, 2002) which caused bias towards modern health care system.

Steinglass (2002) argues that traditional healers are undergoing a strange process of mutation as the continent modernises. Collaborations of traditional healers and modern practitioners are a part of this process. **For example, a study conducted by Gqaleni *et al.* (2011) on biomedical and traditional healing collaboration, on HIV and AIDS in KwaZulu-Natal, shows that collaboration between traditional and allopathic healthcare workers can benefit communities significantly. Many other studies such as (Adams *et al.* 2009; Frenkel *et al.* 2008 & Torri 2016) agree with a call for collaborations of both health systems for the benefit of the patient. As both types of health systems are working within the same communities, their respective practices may have had a synergistic or detrimental effect on the others practice to the benefit or disadvantage of the consumers of health services (van Rooyen *et al.*, 2015).**

Several studies such as (Rudolph, Ogunbodede, & Mistry, 2007; Hoff, 1992; Maiello, 2008; Baggaley, Sulwe, Burnett & Ndovi, 1996; Miller, 1980; Barrett, 1996; Schneider P *et al.*, 1989) suggest that if traditional healers are properly trained, they can contribute significantly to the work of primary health care teams. In the Eastern Cape province a study by van Rooyen *et al.* (2015) to explore and describe the collaborative professional between allopathic and traditional health practitioners’s views regarding their collaborative relationship as role players in the healthcare delivery landscape of the Amathole District reported that both allopathic and traditional healers experienced negative attitudes towards each other. They added that

considering realities of staff shortage and the disease burden in South Africa, facilitating collaborations between allopathic and traditional healers is recommended in order to compliment healthcare delivery.

In India, Poudyal, Jimba and Wakai (2005) found that traditional healers training programmes on primary eye care services in Nepal improved their referral practices to modern practitioners and discouraged harmful traditional ocular medication. Furthermore research conducted in Zimbabwe and Malawi also found that collaborative efforts between traditional and modern/professional eye care practitioners resulted in a significant reduction of preventable and avoidable blindness that was caused by the use of harmful traditional ocular medicines (Courtright, 1997; Mselle, 1998).

Freeman and Motsei (1996) investigated whether there is a role for traditional healers in the post-apartheid South African health system. They presented reasons for and against the inclusion of traditional healers in South African healthcare systems and concluded by cautioning health planners not to exclude traditional healers in health care planning. In agreement, the Treatment Action Campaign (TAC) and Aids Law Project (2003) argued that traditional healers have an unmistakable and crucial role to play in building the health system in South Africa and in strengthening and supporting the national response to HIV/AIDS. The Project argues that due to decades of colonialism, cultural imperialism and the power of a multinational pharmaceutical industry, traditional healers and traditional medicine is marginalised and its value to communities underplayed. Furthermore, the TAC project advocated that there is a need for urgent investment and support of traditional healers and traditional medicine, not only by the government but also by civil society and the private sector.

According to Chana (1997), it is inconceivable and impossible to disregard the role of traditional healers in culturally bound rural communities because in Africa, doctors, nurses and traditional healers share the burden of health care services. In the face of economic restructuring, collapsing health care system and the huge burden of people suffering from ocular diseases and visual disability, Chana (1997) added that traditional healers represent an under-utilised resource. Furthermore, there is an agreement that modern practitioners and health care planners cooperate with traditional healers to meet the needs of rural populations (Chana, 1997; Freeman & Motsei, 1996).

The use of some of the traditional eye medication has been associated with corneal disease and complications (Courtright, Lewalen, Kanjaloti, 1996). A study by Bialasiewicz *et al.* (2006)

found that delays in the treatment of purulent stromal keratitis due to the first-line utilisation of traditional medicines increased the risk of adverse effects such as corneal scarring and blindness. Reports from studies done in Zimbabwe (Schwab, & Tizazu, 1985), Nigeria (McMoli *et al.*, 1984) and Haiti (Taylor, Cadet, & Sommer, 1982) have all linked the use of harmful traditional eye medicine with epidemics of acute haemorrhagic conjunctivitis resulting in corneal ulceration and blindness. Even though Chirambo & Ben-Ezra (1976) in a study conducted in Malawi, reported one in four cases of childhood blindness as the result of harmful traditional medicine; a study of ocular trauma in Zambia, reported that more than half the patients with eye injuries would use traditional or home-made eye remedies before accessing modern medical intervention (Wiafe, 1994).

Literature for this study has demonstrated that health systems around the world are experiencing increased levels of chronic illness and escalating health care costs. Patients and health care providers alike are demanding that health care services be revitalized, with a stronger emphasis on individualized, person-centered care (Sarsina *et al.* 2012). With globalization, the pattern of diseases in developing countries is changing (WHO, 2014). Unlike in the past, when communicable diseases dominated, now 50% of the health burden in developing nations is due to non-communicable diseases (WHO, 2014), such as cardiovascular diseases, diabetes, hypertension, depression, and the use of tobacco and other addictive substances. Because lifestyle, diet choices, obesity, lack of exercise, and stress are important contributing factors in the causation of our most prevalent non-communicable diseases. Traditional Medicine and Complementary Medicine approach to these same factors will be increasingly important for the advancement of future health care strategies for the developing world and industrialized nations alike. Therefore, collaborations of traditional healers and allopathic practitioners are more urgent now than ever before.

2.7 Theoretical Framework

This study utilized the Theory of Planned Behaviour (Ajzen, 1991) in investigating the knowledge, attitude and practice of traditional healers. The Theory of Planned behaviour is an extension of the Theory of Reason Action (Ajzen & Fishbein, 1975). Theory of Planned Behaviour (TPB) differs from the Theory of Reason Action in that it includes one additional construct- perceived behavioural control. This construct has to do with peoples' belief that they can control a particular behaviour. TPB explores the relationship between belief and behaviour, intention and attitudes. TPB assume behavioural intention is the most important determinant

of behaviour, behavioural intention is influenced by a person's attitude towards performing behaviour and beliefs about whether individuals who are important to the person approve or disapprove of the behaviour.

Theory of Planned Behaviour, like the Theory of Reason Action, is based on the premise that humans are rational. Both models support a linear process in which changes in an individual's behavioural and normative beliefs will ultimately affect the individual's actual behaviour.

The TPB is a widely used framework that links beliefs and behaviour (Guibo *et al.*, (2015). This theory has been applied to understand the underlying motivation of behaviour among different populations (Downs & Hausenblas, 2005 and Darker, Larkin & French, 2007) especially predicting and explaining healthcare behaviours (Ajzen and Manstead, 2007). For instance, Heath and Gifford demonstrated TPB's ability to understand bus-riding behaviour among Canadian university students (Heath & Gifford, 2002).

Ajzen (2008) states that determinants of health care choice involve (1) awareness of need, (2) its availability and (3) collecting information about the alternatives. While previous studies have applied TPB to patient's choice between private and public providers (Ferreira, 2011), few studies have used TPB to understand the use of traditional healing explicitly.

Access to modern eye care is mostly limited to urban areas, while rural areas suffer desperate shortages of modern eye care providers (Foster & Johnson, 1994). Therefore, when experiencing eye problems, most people living in rural areas consult traditional healers (Nyika, 2007). Traditional healers are respected and important individuals in society and therefore a person consults with traditional because they are trusted individuals in the community. Young people see their parents consulting with traditional healers and therefore believe that their trusted parents will approve of them consulting with traditional healers.

TPB limitations are very individualist and ignore emotions (Ajzen, 1991). Because of the individualist approach, the theory lacks considerations of environment and structural issues. The linearity of the theory components that people may first change their behaviour and then their beliefs/attitudes is questionable. For example, a study in the USA on seatbelt wearing revealed that people often changed their negative attitudes about the use of seatbelts as they grew accustomed to the new behaviour (Kippax and Crawford, 1993).

2.8 Summary

This chapter looked at the literature available regarding traditional healers and primary eye care both locally and abroad. Different types of traditional healers and their roles were discussed as well as the definition of primary eye care explained.

This literature review navigated the current traditional healers' practice in general and also regarding eye care. The understudy literature has shown various collaboration between traditional healers and allopathic practitioners. Successful collaborations with modern eye care professional and traditional healers in areas such as India, Malawi and Zimbabwe was demonstrated in the literature. Considering the positive health & eye care impact from these collaborations with traditional healers elsewhere, the researcher is motivated that such collaboration in Durban can have a similar impact. Yet, the literature review conducted yielded that there is limited, if any, documentation on the knowledge, attitude and practices of traditional healers with regards to primary eye care in Durban, KwaZulu-Natal, South Africa.

The Theory of Planned Behaviour model was discussed as it was to be utilised in the research study.

Chapter 3

Research Methodology

3.1 Introduction

This chapter outlines the research data collection methods that were used during the study. It outlines the research methodology used, research instrumentation, sample, research setting, data collection and data analysis.

Kothari (2004) defines research as an art of scientific investigation and search for knowledge while Clifford Woody (as cited in Kothari, 2004) defines it as comprising defining and redefining problems, formulating a hypothesis or suggesting a solution, collecting, organising and evaluating data, making deductions and research conclusions. In other words, research is a process used to obtain more knowledge about a particular phenomenon of interest. That is why research is used to obtain the necessary knowledge and answers to the research topic of interest through the use of scientific methods and procedures.

The choice in methods and procedures used is based on the research topic and its main objectives. In the case of this study the main purpose was to investigate knowledge, attitude and practice of Durban's traditional healer regarding eye care.

3.2 Research Design

3.2.1 A Quantitative Approach

This was a quantitative, cross-sectional study. According to Bryman (2012) quantitative research method is defined as a research strategy that emphasises quantification in the collection and analysis of data. In other words, quantitative research is about amounting or measuring something. Furthermore, Rasinger (2013) states that this research method attempts to investigate the answers to the questions starting with how many, how much and to what extent. Payne and Payne (2004) further argue that quantitative methods (normally using deductive logic) seek regularities in human life. This is achieved by separating the social world into empirical components called variables that can be represented numerically as frequencies or rare. Therefore, quantitative research focuses on the aspects of social behaviour which can

be quantified and patterned rather than just finding out the social behaviour and interpreting the meaning that people bring to their action argues (Rahman, 2017).

3.2.2 Research Setting

The research study was conducted in Durban namely; Warwick Junction, Dalton, Siphingo (KwaJina) and city centre. Durban city also is known as eThekweni and was founded in 1835 on the site of Port Natal and was named for Sir Benjamin D'Urban, the governor of the Cape Colony. It is located on the east coast of South Africa and is famous for being the busiest port in Africa. According to national census 2011, Durban had a population of 595 061.

Warwick Junction, Dalton, KwaJina are areas within the city but designated as a trade areas for traditional healers. **For economic and market access reasons**, some traditional healers trade in the city centre. The setting of these areas is convenient for the study as all the traditional healers who were interview trade in these areas. The questionnaire interview was conducted at their work station so that the traditional healer did not lose income while being interviewed.

3.2.3 Measurement Instrument

Brislin (1986) describes a measurement instrument as the methods that the researcher uses to obtain data from participants. Data was collected using of a validated questionnaire adapted from a previous study by Poudyal *et al.*, (2005). The questionnaire comprised of 36 questions designed to capture traditional healer's demographic information and their knowledge, attitude and practice of their eye care services. **The questionnaire contained both close-ended questions and open-ended questions. The open-end questions were designed to allow participants to give a variety of their knowledge, practices and attitude. These varieties were be coded accordingly using a SPSS manual guide.**

3.2.4 Sampling

The study used a convenient sampling technique. This sampling method is a non-randomized technique whereby a researcher is free to use anyone they could find in the research outline. The sample is selected based on preferences and ease of access to respondents (Domyei, 2007). This sampling is easier to conduct and less expensive yet very useful in the early stages of any explorative study (Easton & McColl, 2007). However, it has poor reliability due to its high incidence of bias (Galloway, 1997). Although convenience sampling can cater to a lot of data, Trochim (2007) argues that it is not reliable in terms of whether the sample represents the real population or not.

The study sample was made up of traditional healers from the province of KwaZulu Natal, in particular around Durban Warwick Junction, Dalton, KwaJina. The sample comprised approximately 162 traditional healers and these included 41 izangoma, 70 herbalist (izinyanga) and 22 faith healers (abathandazi / abaprofethi) and 29 who classified themselves as traditional who are a mixed classification. Of the total sample, there were 89 males and 73 females; of these 158 were blacks, 3 Indian and 1 coloured.

3.2.5 Data Collection

Traditional healers in Durban are organised under the Durban Traditional Association (DTA) and the researcher sort permission from DTA secretary to interview traditional healers in their work stations. There was no appointment made with the participants as fieldwork moved from one interviewee to the next after having completed the questionnaire with one. For each interview, the field workers explained the topic and emphasised that participation in the study was purely voluntary. An English or Zulu consent form was given to the participant before the interview commenced which further explained the ethical procedures that were in place. A total of 162 participants were interviewed for this research study.

Before data collection was done, the researcher conducted a training workshop for the field workers to equip them with a better understanding of the study and how to conduct these interviews using the questionnaire. The study questionnaire was translated into Zulu for those traditional who did not understand English and all field workers were fluent in Zulu allowing for a better understanding of the questionnaire.

At the beginning of each interview the aims and purpose of the study were clarified as well as any other queries that the participant may have had. Each participant was informed of the voluntary nature of their participation as well as anonymity, confidentiality and the right to withdraw from the study at any time. Participants were then asked to sign an informed consent form before the commencement of the interview (Appendix A).

Each interview questionnaire was conducted at traditional healers' work station for an approximate time of 45 to 60 minutes. Most interviews were conducted in Isizulu and guided by an interview questionnaire that contained 36 questions.

3.2.6 Data Analysis

The data was captured and analyzed using the Statistical Package for Social Sciences (SPSS) software version 25 (SPSS for Windows, version 24; SPSS, Inc, Chicago, Illinois, the USA). The statistical analysis used in this study includes factor loading analysis, reliability test, descriptive statistics, correlation, t-test, one-way analysis of variance (ANOVA) as well as linear regression. Factor analysis was done to determine the validity of the collected data before further analysis. This was done to check if the various items on the instrument used in data collection quantity specific aspects of stress as well as to determine if the items converge.

Measures of central tendencies depending on the skewness of the data while frequencies and proportions were used to summarise qualitative variables. Graphs such as histograms are also used for a much clear presentation. Inferential statistics are used to make conclusions on the results, whereby associations between quantitative variables will be determined using Chi-square.

3.2.7 Ethical Considerations

Before the commencement of this research, ethical clearance was obtained from the University of KwaZulu Natal Humanities and Social Sciences Ethics Committee (Appendix D). It is vital to highlight that in the progression of this research study there was bound to emerge several ethical issues that were to be addressed. According to De Vos, Strydom, Fouché and Delpoit (2002), the fact that human beings are the objects of study in the social sciences, brings about unique ethical problems. Therefore, it was of utmost significance that the researcher had to attend to all the ethical considerations that may arise when conducting a research study. These involve doing no harm, getting informed consent, anonymity in reporting, gatekeeper consent, confidentiality and consent from participants (Appendix C).

Data obtained will be stored in a safe place for five years to ensure safety. Upon the completion of the five year, the data obtained from the research study will be disposed of.

Part of an ethical issue that needs to be considered is that the research study should not harm the participants. According to De Vos et al. (2002), participants may be harmed physically or emotionally manner. Therefore, it was the researcher's ethical obligation to prevent any form of harm upon the participants during the commencement of the research study. Dane (1990) stated that the researcher must protect participants against any form of discomfort that may arise during the research study. Therefore, it was important for the researcher to inform the

participants about the content of the study and what it entails so that the potential participant may make an informed decision. Furthermore, the researcher informed the participants that should they experience a sense of discomfort during the interview process the necessary support and arrangement would be made.

Before the commencement of the interviews the researcher first pursued to obtain the participants' informed consent (Appendix A). The reason for this was to ensure that the participants had the necessary knowledge and information about the research study before participation. According to De Vos et al. (2002), it is important that accurate and complete information is given to the potential participants so that they can make an informed decision about their possible participation. Therefore, participants were informed about the research study, the purpose and benefit of it before conducting the interviews. The participants were further informed that participation was voluntary; hence, they would not be indebted to participate in the study and had the right to withdraw from the study at any time. The participants were further informed and given assurance of confidentiality of the information that they would be sharing with the researcher.

Confidentiality and anonymity of the participant were some of the ethical requirements that had to be addressed by the researcher. According to De Vos et al. (2002), confidentiality is whereby only the researcher is aware of the identity of participants. Therefore, the researcher informed the participants about the issue of confidentiality and reassured them that their identity would remain anonymous. During the process of reporting the research data, confidentiality and anonymity of the participants were maintained.

3.3 Summary

This chapter entailed the research procedures and methods that were utilised by the researcher to obtain and organise the necessary data. This chapter detailed the steps which the researcher undertook to obtain the information, the instruments used the setting of the study and participation of the traditional healers. Also, the chapter stated the method and detailed the steps that the researcher used to analyse the data collected from the participants. This study mentioned the ethical considerations and the overall limitations of the study.

Chapter 4

The Results

4.1 Introduction

This chapter presents the results obtained in the study. The statistics used in this study include factor loading analysis, reliability test, descriptive statistics, correlation, t-test, one-way analysis of variance (ANOVA) as well as linear regression. Factor analysis was done to determine the validity of the collected data before further analysis. This was done to check if the various items on the instrument used in data collection quantity specific aspects of stress as well as to determine if the items converge. In this study, a factor loading analysis score of ≥ 0.5 was considered. Also, Cronbach's alpha analysis was carried out to measure the reliability of the data. Only Cronbach alpha score ≥ 0.70 was considered.

4.2 Participants' Socio-Demographic Details

This section describes the participants' socio-demographic background such as age, sex, race, years of experience etc.

4.2.1 Age Distribution

Table 4.1

AGE	NO. OF PARTICIPANTS	%
20 – 30 YRS	12	7.4
31 – 40 YRS	44	27.2
41 – 50 YRS	53	32.7
51 – 60 YRS	26	16
61 – 70 YRS	16	9.9
71 – 80 YRS	5	3.1
MISSING	6	3.7

Table 4.1 above represents the table show the age distribution among the participants. The table shows 7.4% was aged between 20 – 30 years, 27.2% (31-40 years), 32.7% (41-50 years), 16% (51-60 years), 9.9% (61-70 years) and 3.1% (71-80 years).

4.2.2 Participant’s Demographics

Table 4.2

	Variables	N (%)
Gender	Female	73 (45.1)
	Male	89 (54.9)
Race	Black	158 (97.5)
	Indian	3 (1.9)
	Coloured	1 (0.6)
Literacy level	Can read and write	126 (77.8)
	Can’t read and write	36 (22.2)
Level of education	Primary	57 (35.2)
	Secondary	92 (56.8)
	Tertiary	12 (7.4)
Type of healer	Devine	41 (25.3)
	Herbalist	70 (43.2)
	Faith	22 (13.6)
	Other	29 (17.9)
How you became a healer	Follow Family Tradition	48 (29.6)
	Calling	81 (50.0)
	Other	33 (20.4)
Received Training	Yes	113 (69.8)
	No	42 (25.9)
	Missing	7 (4.3)
Registered as a Traditional Healer	Yes	101 (62.3)
	No	54 (33.3)
	Missing	7 (4.3)

N = number, % = percentage

The table above presents the socio-demographic characteristics of the respondents in this study. A total of 162 participants were enrolled in this study, 73 (45.1%) of them were females and 89 were males (54.9%). A great percentage of the respondents were blacks (97.5%). Also, a good number of respondents are literate (77.8%). About 50% of the participants said they became traditional healers by calling, and a good number of the respondents have received training as traditional healers (69.8%).

The below figure shows number of years working as a traditional healer.

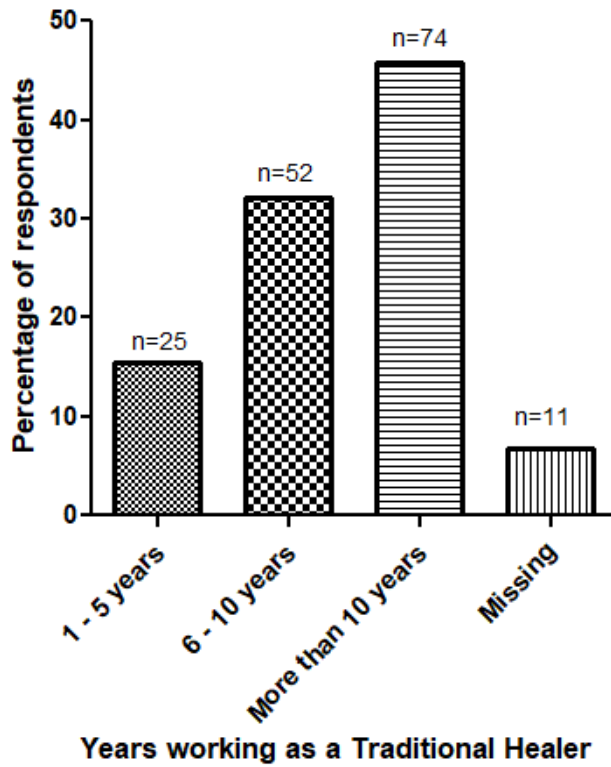


Figure 4.1. Graph showing the years of experience of traditional healers.

The graph above shows that 74 (45.7%) of the traditional healers have more than 10 years of experience, 52 (32.1%) have 6 to 10 years of experience, and 25 (15.4%) have 1 to 5 years of experience.

The below figure shows the number of years traditional healers spent in training.

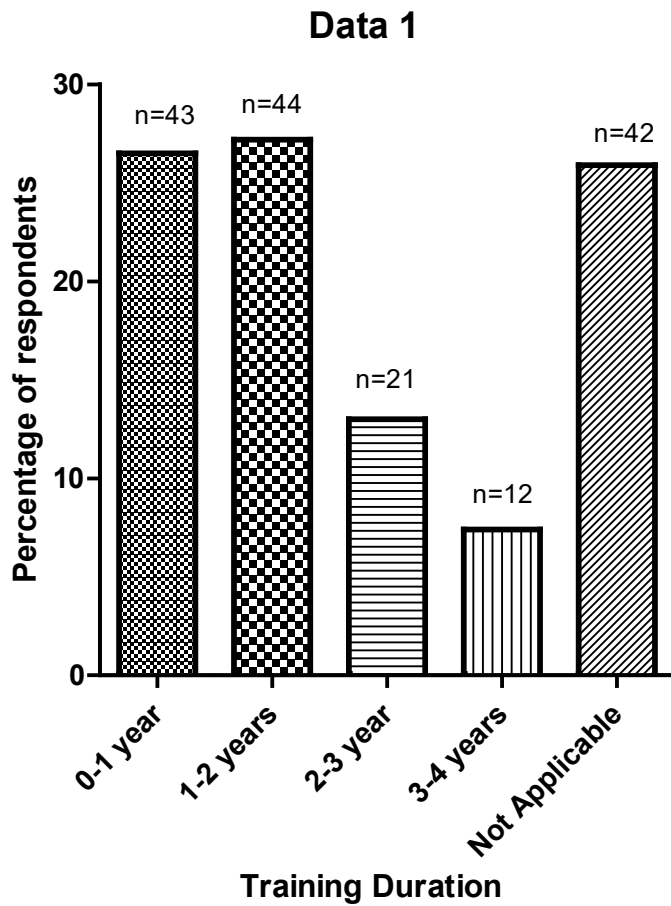


Figure 4.2. Graph showing the training duration of traditional healers.

The graph above shows that 43 (26.5%) of the traditional healers have 0-1 year training, 44 (27,2%) have 1-2 years of training, 21 (13%) have 2-3 years of training, and 12 (7.4%) have 3 -4 years of training.

The below figure shows traditional healers' place of practice in Durban.

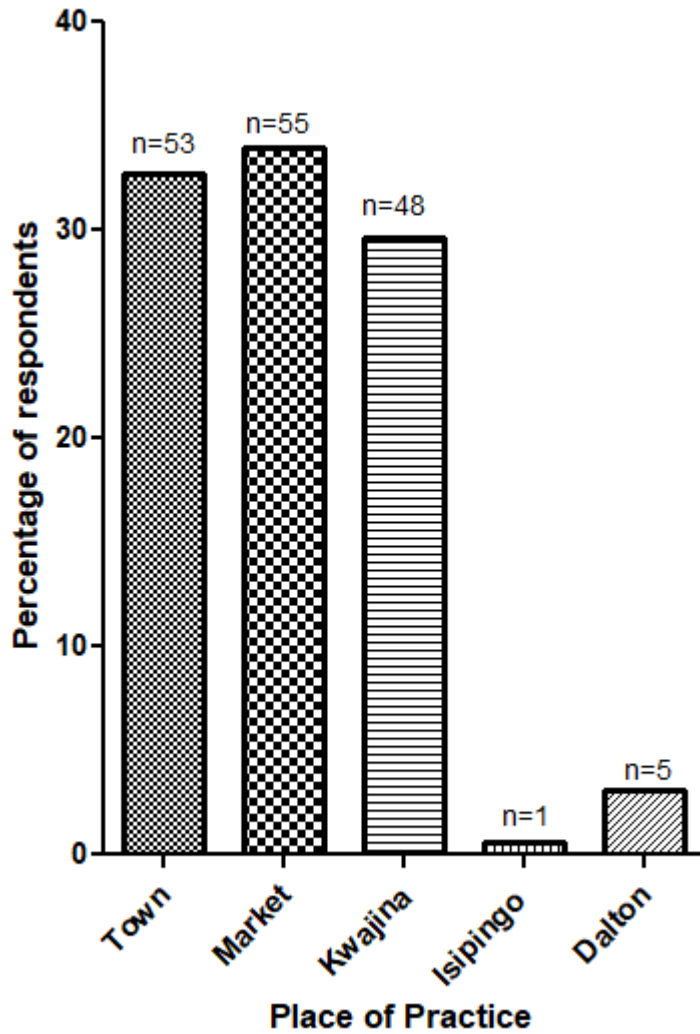


Figure 4.3. Graph showing the place of practice of traditional healers.

The graph above shows that 53 (32.7%) of the traditional healers practice in town, 55 (34%) practice at the market, 48 (29.6%) practice at KwaJina, 1 (0.6%) practice at Isipingo, and 5 (3.1%) practice at Dalton.

4.3 Knowledge of traditional healers with regards to Primary Eye Care.

4.3.1 Factor Loading on Knowledge of Traditional Healers with regards to Primary Eye Care.

Table: 4.3

Categories and items	Factor loading	Alpha
1. Knowledge about the causes of eye illness or damage		
Can eye illness or damage be attributed to being infected with germs?	0.71	0.70
Can eye illness or damage be attributed to HIV infection?	0.74	
Eye infections are caused by evil spirit/ sin or curse in the form of witchcraft?	0.79	
2. Knowledge about conditions that may result in eye illness or damage		
Diabetes can cause eye illness or damage.	0.60	0.83
Hypertension can cause eye illness or damage.	0.61	
Glaucoma can cause eye illness or damage	0.64	
Direct viewing of the sun can cause eye illness or damage	0.52	
3. Knowledge about the use of spectacles to correct eyesight		
Spectacles / glasses help people to see better	0.62	0.98

The results for factor analysis and reliability test for the knowledge of traditional healers with regards to primary eye care are presented in Table 4.3. Based on the factor analysis, the questions on knowledge were divided into three categories: Knowledge about the causes of eye illness or damage, Knowledge about conditions that may result in eye illness or damage and Knowledge about the use of spectacles to correct eyesight.

4.3.2 Descriptive Statistics for Knowledge Categories

Table: 4.4

	Number of items	Mean \pm SD
Knowledge about the causes of eye illness or damage	3	8.3 \pm 2.25
Knowledge about conditions that may result in eye illness or damage	4	8.45 \pm 1.9
Knowledge about the use of spectacles to correct eyesight.	1	5.70 \pm 1.69

SD = standard deviation

Table 4.4 shows the descriptive statistics for the different knowledge groups. The mean score of participants with regards to knowledge about the causes of eye illness or damage, knowledge about conditions that may result in eye illness or damage and knowledge about the use of spectacles to correct eyesight is presented.

4.3.3 Pearson Correlations Coefficient for the Knowledge Categories

Table 4.5

	1	2	3
1. Knowledge about the causes of eye illness or damage	1.00		
2. Knowledge about conditions that may result in eye illness or damage	0.41**	1.00	
3. Knowledge about the use of spectacles to correct eyesight.	0.22**	0.49**	1.00

**Significant at 0.01 level

Table 4.5 above presents the Pierson correlation coefficient to determine the relationship between the Knowledge about the causes of eye illness or damage, Knowledge about conditions that may result in eye illness or damage and Knowledge about the use of spectacles to correct eyesight. This is to determine the level degree of relationship the measured variables. The obtained result shows that there exist a significant positive correlation between all the knowledge variables ($P < 0.01$).

4.3.4 The difference in the Mean Scores of Knowledge Categories with regards to Literacy Level of Traditional Healers.

Table: 4.6

Measure	Literacy level	Mean \pm SD	DF	T-value	p-value
Knowledge about the causes of eye illness or damage	Literate	8.27 \pm 2.18	162	-7.37	0.46
	Non-literate	8.58 \pm 2.49			
Knowledge about conditions that may result in eye illness or damage	Literate	11.22 \pm 3.77	162	-3.25	0.001
	Non-literate	8.97 \pm 3.30			
Knowledge about the use of spectacles to correct eyesight.	Literate	2.16 \pm 1.13	162	-1.50	0.14
	Non-literate	2.47 \pm 1.01			

SD = standard deviation, DF = degree of freedom

The table above (Table 4.6) presents the mean knowledge score of respondents with regards to the literacy level. There was no significant difference in the knowledge score of literate and non-literate traditional healers about the causes of eye illness or damage ($p>0.05$), this was also the case with their knowledge of the use of spectacles to correct eyesight ($p>0.05$). There was a significant difference ($p<0.05$) in the knowledge score of literate (11.22 ± 3.77) and non-literate (8.97 ± 3.30) traditional healers about the conditions that may cause eye illness or damage.

4.3.5 The difference in the mean scores of knowledge categories with regards to training among traditional healers.

Table 4.7

Measure	Received Training	Mean \pm SD	DF	T-value	p-value
Knowledge about the causes of eye illness or damage	Trained	8.28 \pm 2.11	162	-7.64	0.45
	Untrained	8.56 \pm 2.60			
Knowledge about conditions that may result in eye illness or damage	Trained	9.46 \pm 3.71	162	-0.40	0.69
	Untrained	9.73 \pm 4.13			
Knowledge about the use of spectacles to correct eyesight.	Trained	2.37 \pm 1.17	162	2.21	0.01
	Untrained	1.92 \pm 0.95			

SD = standard deviation, DF = degree of freedom

Table 4.7 presents the mean knowledge score of traditional healers with regards to receiving training. There was no significant difference in the knowledge score of trained (8.28 ± 2.11) and untrained (8.56 ± 2.60) traditional healers about the causes of eye illness or damage ($p>0.05$). Also, there was no significant difference in the knowledge score of trained (9.46 ± 3.71) and untrained traditional healers (9.73 ± 4.13) about conditions that may result in eye illness or damage ($p>0.05$). The knowledge score was significantly higher in the trained group (2.37 ± 1.17) compared to the untrained group (1.92 ± 0.95) of traditional healers about the use of spectacles to correct eyesight ($p<0.05$).

4.3.6 The difference in the Mean Scores of Knowledge Categories with regards to Duration of Training among Traditional Healers.

Table 4.8

Measure	Duration of training (years)	Mean \pm SD	F-value	P-value
Knowledge about the causes of eye illness or damage	0-1yr	8.18 \pm 2.29	0.38	0.82
	1yrs-2yrs	8.60 \pm 2.34		
	2yrs-3yrs	8.24 \pm 1.73		
	3yrs-4yrs	7.83 \pm 1.95		
	Not Applicable	8.40 \pm 2.46		
Knowledge about conditions that may result in eye illness or damage	0-1yr	9.32 \pm 3.64	0.50	0.74
	1yrs-2yrs	9.93 \pm 4.13		
	2yrs-3yrs	9.61 \pm 3.63		
	3yrs-4yrs	8.25 \pm 2.05		
	Not Applicable	9.40 \pm 4.05		
Knowledge about the use of spectacles to correct eye sight.	0-1yr	2.16 \pm 0.99	3.70	0.007
	1yrs-2yrs	2.66 \pm 1.25		
	2yrs-3yrs	2.43 \pm 1.43		
	3yrs-4yrs	1.75 \pm 0.45		
	Not Applicable	1.88 \pm 0.89		

SD = standard deviation

Table 4.8 shows the one-way ANOVA results based on the duration of training among traditional healers. There was no statistical difference in the knowledge of traditional healers to causes of eye illness or damage and Knowledge about conditions that may result in eye illness or damage taken into consideration the duration of training ($p > 0.05$). The knowledge of traditional healers to the use of spectacles to correct eyesight varied significantly among the group ($P < 0.05$) and was higher in the group that received 1 -2 years of training ($p > 0.05$).

4.3.7 The difference in the Mean Scores of Knowledge Categories with regards to the Registration Status of Traditional Healers.

Table 4.9

Measure	Registration status	Mean \pm SD	DF	T-value	p-value
Knowledge about the causes of eye illness or damage	Registered	8.91 \pm 2.19	162	-7.64	0.02
	Not registered	8.02 \pm 2.27			
Knowledge about conditions that may result in eye illness or damage	Registered	9.59 \pm 3.90	162	-0.40	0.88
	Not registered	9.50 \pm 3.71			
Knowledge about the use of spectacles to correct eyesight.	Registered	2.29 \pm 1.14	162	2.21	0.59
	Not registered	2.19 \pm 1.10			

Table 4.9 presents the mean knowledge score of traditional healers with regard to their registration status. The knowledge score was significantly higher in the registered group (8.91 \pm 2.19) compared to the unregistered group (8.02 \pm 2.27) of traditional healers with concerning their knowledge about the causes of eye illness or damage ($p < 0.05$). There was no significant difference in the knowledge score of registered (9.59 \pm 3.90) and unregistered (9.50 \pm 3.71) traditional healers about conditions that may result in eye illness or damage ($p > 0.05$). The knowledge score did not differ significantly among the registered (2.29 \pm 1.14) compared to the unregistered group (2.19 \pm 1.10) of traditional healers about the use of spectacles to correct eyesight ($p > 0.05$).

4.3.8 Regression Analysis of Knowledge Categories and Disease Diagnosis

Table 4.10

Variable	β	T	Sig	95% CI	
				LL	UL
Knowledge about the causes of eye illness or damage	0.01	0.18	0.84	-0.09	0.11
Knowledge about conditions that may result in eye illness or damage	-0.07	-2.26	0.03	-0.14	-0.01
Knowledge about the use of spectacles to correct eye sight.	-0.09	-0.86	0.39	-0.30	0.12

***Statistical significance ($p < 0.001$); β = beta; CI = confidence interval; LL = lower limit; UL = upper limit*

Linear regression analysis was performed with Knowledge variables to establish the predictive value of disease diagnosis associated with knowledge regarding eye illness or damage. The result shows that Knowledge about conditions that may result in eye illness or damage ($t = -2.26$, $p < 0.05$) was significant. Thus this knowledge contributes to disease diagnosis. There was no significance in knowledge about the causes of eye illness or damage ($t = 0.18$, $p > 0.05$) and knowledge about the use of spectacles to correct eyesight ($t = -0.86$, $p > 0.05$).

4.4 The attitude of Traditional Healers to Primary Eye Care.

4.4.1 Factor Loading on Attitude of Traditional Healers to Primary Eye Care.

Table 4.11

Categories and items	Factor loading	Alpha
1. Training and exposure as a traditional healer		
Trained well to Treat Eye Illness	0.64	0.79
Training Participation	0.74	
Training Helpful	0.84	
Received Training by Medical Doctor or NGO'S	0.85	
2. Relationship with doctors and referral of clients to medical doctors		
Relationship with Eye Care/ western doctors	0.77	0.80
Refer Patients to Medical Doctors	0.81	
Why do you Refer	0.82	
3. Referral of patients by medical doctors to traditional healers		
Do Medical Doctor's Refer to Traditional Healer	0.91	0.82
Why Medical Doctor's Refer	0.82	

Factor analysis and reliability test for the attitude of traditional healers to primary eye care are presented in Table 4.11. The questions on attitude were grouped into three categories: training and exposure as a traditional healer, relationship with doctors and referral of clients to medical doctors and referral of patients by medical doctors to traditional healers.

4.4.2 Descriptive Statistics for Attitude Categories

Table 4.12

	Number of items	Mean \pm SD
Training and exposure as a traditional healer	4	12.88 \pm 2.20
Relationship with doctors and referral of clients to medical doctors	3	5.85 \pm 1.32
Referral of patients by medical doctors to traditional healers	2	3.12 \pm 0.40

SD = standard deviation

Table 4.12 presents descriptive statistics for the different categories of attitude. The mean attitude score of respondents regarding training and exposure as a traditional healer, relationship with doctors and referral of clients to medical doctors and referral of patients by medical doctors to traditional healers is reported.

4.4.3 Pearson Correlations Coefficient results for the Attitude Categories

Table 4.13

	1	2	3
1. Training and exposure as a traditional healer	1.00		
2. Relationship with doctors and referral of clients to medical doctors	0.28**	1.00	
3. Referral of patients by medical doctors to traditional healers	0.31**	0.32**	1.00

***Significant at 0.01 level*

The above table (Table 4.13) presents the Pierson correlation coefficient to determine the relationship between attitude to training and exposure as a traditional healer, relationship with doctors and referral of clients to medical doctors and referral of patients by medical doctors to traditional healers. The result shows that there exist a significant positive correlation between all the attitude variables ($P < 0.01$).

4.4.4 The difference in the Mean Scores of Attitude Categories with regards to Literacy Level of Traditional Healers.

Table 4.14

Measure	Literacy level	Mean \pm SD	DF	T-value	p-value
Training and exposure as a traditional healer	Literate	12.80 \pm 2.37	162	-0.73	0.47
	Non-literate	13.11 \pm 1.37			
Relationship with doctors and referral of clients to medical doctors	Literate	5.77 \pm 1.34	162	-1.47	0.14
	Non-literate	6.14 \pm 1.25			
Referral of patients by medical doctors to traditional healers	Literate	3.10 \pm 0.38	162	-1.22	0.23
	Non-literate	3.19 \pm 0.47			

SD = standard deviation, DF = degree of freedom

Table 4.14 presents the mean attitude score of traditional healers attitude in concerning to literacy level. There was no significant difference in the attitude score of literate and non-literate traditional healers with respect to the three categories of attitude analysed ($p > 0.05$).

4.4.5 The difference in the Mean Scores of Attitude with regards to Training among Traditional Healers.

Table 4.15

Measure	Received Training	Mean \pm SD	DF	T-value	p-value
Training and exposure as a traditional healer	Trained	12.47 \pm 1.95	162	-1.96	0.052
	Untrained	13.17 \pm 1.92			
Relationship with doctors and referral of clients to medical doctors	Trained	5.71 \pm 1.12	162	-0.36	0.72
	Untrained	5.79 \pm 1.42			
Referral of patients by medical doctors to traditional healers	Trained	3.08 \pm 0.35	162	-0.64	0.53
	Untrained	3.12 \pm 0.33			

SD = standard deviation, DF = degree of freedom

Table 4.15 shows the mean attitude score of traditional healers regarding their literacy training. It was observed that no significant difference in the attitude score of the trained and untrained traditional healers with respect to the three categories of attitude analysed ($p>0.05$).

4.4.6 The difference in the Mean Scores Attitude Categories of traditional healers to Registration Status.

Table 4.16

Measure	Registration status	Mean \pm SD	DF	T-value	p-value
Training and exposure as a traditional healer	Registered	12.49 \pm 2.11	162	-1.56	0.12
	Not registered	13.0 \pm 1.61			
Relationship with doctors and referral of clients to medical doctors	Registered	5.60 \pm 1.11	162	-1.48	0.06
	Not registered	5.91 \pm 1.29			
Referral of patients by medical doctors to traditional healers	Registered	3.08 \pm 0.37	162	-2.48	0.98
	Not registered	3.10 \pm 2.29			

The subgroups of attitude in comparison to the attitude of traditional healers to registration are presented in Table 4.16. It was observed that no significant difference in the attitude score of the registered and unregistered traditional healers concerning to the three categories of attitude analysed ($p>0.05$).

4.4.7 Regression analysis of Attitude Categories and Mode of Treatment

Table 4.17

Variable	β	T	Sig	95% CI	
				LL	UL
Training and exposure as a traditional healer	0.14	2.08	0.04	.007	.272
Relationship with doctors and referral of clients to medical doctors	0.05	0.47	0.64	-.167	.271
Referral of patients by medical doctors to traditional healers	0.81	2.17	0.03	.074	1.554

***Statistical significance ($p<0.001$); β = beta; CI= confidence interval; LL= lower limit; UL= upper limit*

The table above shows the linear regression analysis of attitude variables to establish a predictive value of mode of traditional healers treatment attitude regarding eye illness or damage. The result shows that training and exposure as a traditional healer ($t=2.08$, $p<0.05$) was significant, and also regression analysis shows referral of patients by medical doctors to traditional healers was significant ($t=2.17$, $p<0.05$). This implies that training and exposure as a traditional healer and referral of patients by medical doctors to traditional healers are crucial and contribute to the mode of treatment adopted by traditional healers. There was no significance in relationship with doctors and referral of clients to medical doctors ($t=0.47$, $p>0.05$).

4.5 The practice of Traditional Healers with regards to Primary Eye Care.

4.5.1 Factor Loading on Practice of traditional healers with regards to Primary Eye Care.

Table: 4.18

Categories and items	Factor loading	Alpha
1. Prevalence and common form of eye problems presented		
Patients presenting with eye problems	0.75	0.77
Common form of Eye problems presented	0.82	
2. Mode and approach to treatment of eye illness		
Treatment of patients with eye injury	0.86	0.79
Patients with eye chemical burns	0.85	
Method of Eye Treatment	0.95	
3. Advice and handling visually impaired patients		
Patients who can't see	0.76	0.71
Ability to measure V/A	0.74	
Advice for Future Prevention	0.73	

The results for factor analysis and reliability test for the practice of traditional healers with regards to primary eye care are presented in Table 4.18. Based on the factor analysis, the items on attitude were grouped into three categories namely: prevalence and common form of eye problems presented, mode and approach to treatment eye illness and advice and handling visually impaired patients.

4.5.2 Descriptive Statistics for Practice Categories

Table 4.19

	Number of items	Mean \pm SD
Prevalence and common form of eye problems presented	2	5.72 \pm 2.19
Mode and approach to the treatment of eye illness	3	9.49 \pm 4.06
Advice and handling visually impaired patients.	3	13.28 \pm 3.52

SD = standard deviation

Table 4.19 presents the descriptive statistics for the different practice groups. The mean practice score of participants with regards to the prevalence and common form of eye problems presented, mode and approach to treatment of eye illness and advice and handling visually impaired patients are reported.

4.5.3 Pearson Correlations Coefficient results for the Practice Categories

Table 4.20

	1	2	3
1. Prevalence and common form of eye problems presented	1.00		
2. Mode and approach to the treatment of eye illness	0.45	1.00	
3. Advice and handling visually impaired patients.	0.32**	0.27**	1.00

***Significant at 0.01 level*

Table 4.20 shows the Pierson correlation coefficient to determine the relationship between traditional healers practice and the different practice variables. The result shows that there was a significant correlation between traditional healers advice and handling of a visually impaired patient with the prevalence and common forms of eye problems presented ($t=0.32$, $p<0.05$). it was also observed that advice and handling of a visually impaired patient by traditional healers are significantly correlated to mode and approach to the treatment of eye illness ($t=0.27$, $p<0.05$). there was no correlation between prevalence and common forms of eye problems presented with mode and approach to treatment of eye illness ($t=0.45$, $p>0.05$).

4.5.4 The difference in the Mean Score of Practice Categories with regards to Literacy Level of Traditional Healers.

Table 4.21

Measure	Literacy level	Mean \pm SD	DF	T-value	p-value
Prevalence and common form of eye problems presented	Literate	5.66 \pm 2.26	162	-0.54	0.59
	Non-literate	5.89 \pm 1.94			
Mode and approach to treatment of eye illness	Literate	9.67 \pm 4.23	162	1.05	0.30
	Non-literate	8.86 \pm 3.35			
Advice and handling visually impaired patients.	Literate	13.44 \pm 3.67	162	1.13	0.26
	Non-literate	12.69 \pm 3.0			

SD = standard deviation, DF = degree of freedom

Table 4.21 presents the mean practice score respondents with regard to the literacy level. The obtained results showed that there was no significance between the mean score of the different practice categories and the literacy level of the traditional healers ($p > 0.05$).

4.5.5 The difference in the Mean Scores of Practice Category with regards to Training among Traditional Healers.

Table 4.22

Measure	Received Training	Mean \pm SD	DF	T-value	p-value
Prevalence and common form of eye problems presented	Trained	5.50 \pm 2.17	162	-0.87	0.39
	Untrained	5.83 \pm 2.09			
Mode and approach to the treatment of eye illness	Trained	8.97 \pm 3.70	162	-1.55	0.12
	Untrained	10.05 \pm 4.15			
Advice and handling visually impaired patients.	Trained	13.04 \pm 3.32	162	0.23	0.51
	Untrained	12.90 \pm 3.33			

SD = standard deviation, DF = degree of freedom

The results presented in Table 4.22 shows the mean practice score of respondents with regards to training among traditional healers. There was no significant difference between the mean practice score of the different categories to training among traditional healers ($p > 0.05$).

4.5.6 The difference in the Mean Practice scores of respondents with regards to Referral of Patients among Traditional Healers.

Table 4.23

Measure	Refer patients	Mean \pm SD	DF	T-value	p-value
Prevalence and common form of eye problems presented	Yes	5.45 \pm 2.19	162	-1.77	0.02
	No	6.26 \pm 1.87			
Mode and approach to treatment of eye illness	Yes	9.05 \pm 3.65	162	-1.14	0.67
	No	9.96 \pm 4.17			
Advice and handling visually impaired patients.	Yes	12.76 \pm 3.24	162	-1.79	0.60
	No	14.00 \pm 3.15			

SD = standard deviation, DF = degree of freedom

Table 4.23 shows the mean practice score of the different practice categories with regards to a referral of patients by traditional healers to other traditional healers. The result obtained showed based on prevalence and the form of eye problems presented by patients, more of the traditional healers (6.26 \pm 1.87) do not refer patients to other traditional healers ($p < 0.05$) compared to the ones who do (5.45 \pm 2.19).

4.6 Summary

This chapter discussed the findings of the research study. The chapter showed the demographic profile of traditional healers who participated in the study and highlighted their practice and level of eye care knowledge and their attitude to a modern eye care professional.

Chapter 5

Discussion

5.1 Introduction

The purpose of the study was to understand knowledge attitude and practices of traditional healers with regards to primary eye care and with defined study objectives to (1) determine traditional healers' knowledge of most commonly presenting eye conditions in South Africa, their cause, diagnosis and treatment; (2) determine traditional healer's specific practice with regards to primary eye care; (3) determine the attitudes of traditional healers towards collaboration with modern medical eye care doctors and training.

This chapter discusses the findings of the research study, and the themes that arose from study results and current results suggest to have answered all the study research questions. This study results differ from previously conducted KAP studies in Africa regarding traditional healers and primary eye care. Firstly, unlike other studies such as Courtright (1997) and Mselle (1998), the current study used an adapted validate questionnaire. Secondly, a scoring system was developed and participants scores were analysed accordingly.

5.2 Participants Socio-Demographic

5.2.1 Participants Age

The participants' age distribution showed that 35% was of between 20 -40 years while from 41 to 80 years accounted for 62%. This age distribution trend suggests an aging cohort of traditional healers when there seem to be very few young people joining the trade. This observation is similar to that of Mathibela *et al.*, (2015) study where there were more than 50% elderly traditional healers in Blouberg. In this study, only 7.4% of the respondents report to being between the ages of 20-30 years suggesting that there may be very few young people becoming traditional healers or training to become one. This may be because more young people are now at tertiary level school and have no time to follow family tradition or accept the calling to become a traditional healer.

If the current age trend continues as observed both in this study and Blouberg study, there will be a declining number of traditional healers, which will eventually result in a loss of indigenous knowledge. Therefore the traditional healer trade is under threat of becoming extinct if young people do not take up the trade.

5.2.2 Gender

The study had more males than females. This is different from other reports by (De Wet *et al.*, 2012) in South Africa; (Betti, 2004) in Cameroon; (Geissler *et al.*, 2002) in Kenya & (Voeks, 2007) in Brazil that there are more female traditional healers than there are male ones, by that, there are more male traditional healers than there are females ones. A recent study by Mathibela *et al.* (2015) conducted in Limpopo province of South Africa in the area of Blouberg Mountain found that traditional female healers dominated the profession. In the Limpopo study, only 32 healers were interviewed and 80% were females. This female dominance trend is not the same in other reported studies such as (Moeng & Potgieter, 2011) and (Semenya, 2012) where they found that there was more male dominance in the traditional healing profession.

5.2.3 Racial Distribution

The majority of the traditional healers were blacks (97.5%) with Indians and Coloured making up the remaining 2.5% of the participants. This racial distribution of participant is in line with the provincial race population that blacks constitute 80.9% of the province population according to 2018 Census estimates (STATS, 2018). Therefore, this study demonstrated that in Durban, traditional healing practice is dominated by blacks and very few of the other races.

5.2.4 Literacy Levels

This study showed that 77.8% of the participants can read and write, while 22.2% of them cannot read and write. The study also shows that a majority of the healers (56.8%) have secondary education, 35.2% of them have primary education and only 7.4% of the healers have tertiary education. This data clearly shows that the traditional healers who participated in this study can read and write, not only that they all have reported having attended some schooling in life. However, Mathibela *et al.* (2015) found that 64% of the traditional healers had no formal education while 32% have primary school level and only 4% have secondary school education in Blouberg Mountain. The Blouberg Mountain study traditional literacy levels were in line with a study by (Semenya & Potgieter, 2014) conducted in the greater Limpompo areas where

they reported 77% of female healers and 95% of traditional male healers had no schooling education. In the early nineties in KwaZulu Natal at the township of Umlazi (Mthembu, 1990) reported that 40% of Zulu speaking traditional healers had no formal school education.

However, Tanzania's findings of the study by (Geisler et al., 1995) showed that only 23% of traditional healers having no formal education and 61% of them with some form of schooling education. This shows that the reported low literacy levels amongst traditional healers are not a global or an African phenomenon. Van der Berg (2008) says that these different levels of literacy can be attributed to poor quality of education in South Africa especially in rural areas.

5.2.5 Becoming a Healer & Practice

50% of the participants said they became traditional through a calling and 29.6% by following a family tradition. The remaining 20.4% reported various reasons on how they became healers, these included being forced by family members, employment opportunities etc. Mathibela *et al.* (2015); Semanya & Potgieter (2014) and Gesissler *et al.* (2002) all report that in their studies a considerable number of participants became healers because of family tradition. Researchers such as (Grierson & Afolayan, 1999) say that traditional healing knowledge and practice is passed down from one generation to another orally and through observations.

The data reaffirms many study findings that the majority of healers become traditional healers because of ancestral calling usually through a dream. Moagi (2009) also adds that in the calling dream the ancestors reveal where the "called" must go for training. Once a person has accepted the calling, they will become an apprentice serving and supervised by an older experienced healer for the training duration.

This study reveals that of the 162 participants, only 69.8% received healers' apprentice training, and about 25.9% did not receive any training. Some healers even though there were called they resisted training because training is long, costly and demanding says (Booi, 2004). Ensink and Robertson (1996) add that sometimes the attitude towards the process of apprentice (ukuthwasa) is ambivalent in the sense that it viewed as both the gift from ancestors and a burden none wish for themselves and their children. Hammond-Tooke (1989) adds that during the training course trainees are not allowed to engage in sexual activity. Therefore, it is not surprising that you would find practicing traditional healers who did not go for healers' training. Some healers have picked up the trade on the street or viewed the practice of traditional healing as purely an income-generating opportunity.

Notwithstanding the fact some healers in the study did not attend training, those that attend training 43 (26.5%) have up to one-year training, 44 (27.3%) have one to two years of training, 21 (13%) have two to three years of training, and 12 (7.4%) have three to four years of training. Peek (1991) says that training is a formal, complicated and meticulous process that can months and years depending on how fast the trainee learns the trade. Therefore it is not surprising that this study showed a range of training periods for the healers.

On the question of how many years the participant been working as traditional healer, study data showed that 74 (45.7%) of the traditional healers have more than 10 years of experience, 52 (32.1%) have 6 to 10 years of experience, and 25 (15.4%) have 1 to 5 years of experience. Therefore, a majority of the healers of the sample study is made up of more experienced healers. The study findings are line with (Mathibela *et al.*, 2015) study which reported almost 71% of healers had experience ranging from 11 years to more than 30 years.

The study data indicated that the participants comprised 43,2% herbalist, 25.3% divine healers, 13.6% faith healers and 17.9% who classified themselves as others. It is evident that in the Durban area, traditional healing practice is dominated by herbalists.

About 62.3% of the study healers reported to being formally registered as a traditional healer and 33.3% not registered with any formal body. A large number of traditional healers are now members with regulatory or association bodies so that they have one collective voice to address challenges face by traditional healers says Traditional Healers Organisation (THO). Registration of traditional healers will also help making healer recognised so that they can endure the respected and dignity they deserve from being ridiculed by media and some sector of the public explains Mr Maseko of THO Maseko adds that member registration will assist in differentiating the real and healers from the fake ones.

5.3 Knowledge of Traditional Healers (TH) with Regards To PEC.

5.3.1 Factor Loading on Knowledge of TH with regards to PEC

To perform factor analysis and reliability test for the knowledge of traditional healers with regards to primary eye care, the questions of knowledge were divided into three categories

namely (1) knowledge about the causes of eye illness or damage, (2) knowledge about conditions that may result in eye illness or damage, and (3) knowledge about the use of spectacle to correct eyesight. In accordance with De Vellis (2012), this study considered a factor loading analysis of ≥ 0.5 and Cronbach alpha score ≥ 0.70 .

It is important that when selecting scales for the study that the scale is reliable and have a good internal consistency says (De Vellis, 2012). One of the widely used measures of internal consistency is Cronbach' Alpha coefficient. The Cronbach's alpha shown in reliability test for (1) knowledge about the causes of eye illness or damage = 0.70, (2) knowledge about conditions that may result in eye illness or damage = 0.83 and (3) knowledge about the use of spectacles to correct eyesight = 0.98. In all categories, the alpha value is greater 0.7 suggesting a very good internal consistency reliability for the scale with the current study.

5.3.2 Descriptive Statistics for Knowledge Categories

The mean score of participants with regards to (1) knowledge about the causes of eye illness or damage = 8.3 ± 2.25 SD, (2) knowledge about conditions that may result in eye illness or damage = 8.45 ± 1.9 SD, and (3) knowledge about the use of spectacles to correct eyesight is presented = 5.70 ± 1.69 SD.

Even though the study showed that means scores of respondents were poor regarding knowledge categories, participants knowledge about causes of eye illness or damage was not consistent amongst the healers; on the other hand participants' knowledge about conditions that may result in eye illness or damage was slightly consistent amongst the healers and lastly, participants were more consistent in the knowledge about the use of spectacles to correct eyesight. It is clear from the findings that even though other healers struggle with the knowledge of some eye diseases and its causes, there were more traditional healers who know that spectacles are used to correct vision. This resulted can be interpreted in two ways, firstly it could be common knowledge that spectacles are used for correcting vision, or secondly that part of their ukuthwasa training teaches them that spectacles are used to correct vision.

5.3.3 Pearson's Correlation Coefficient for the different Knowledge Categories

The Pierson correlation coefficient to determine the relationship between the (1) Knowledge about the causes of eye illness or damage = 0.41, (2) Knowledge about conditions that may result in eye illness or damage = 0.22 and (3) Knowledge about the use of spectacles to correct

eyesight = 0.49. This test was performed to determine the level degree of relationship between the measured variables. The obtained result shows that there exist a significant positive correlation between all the knowledge variables ($P < 0.01$).

This results expected outcome as demonstrated by previous studies such as (Poudyal et al., 2005) in India, and (Courtright, 1997) in Zimbabwe and (Mselle, 1998) in Malawi that showed a positive correction between knowledge eye conditions and their causes. It is such outcomes that prove that there can't be effective eye disease treatments and management without imparting knowledge of causes of eye diseases and the use of spectacles.

5.3.4 Difference in the Mean scores of Knowledge Categories with regards to Literacy the level of Traditional Healers.

The study investigated the mean knowledge score of respondents with regards to the literacy level reported. The findings were that there was no significant difference in the knowledge score of literate and non-literate traditional healers about the causes of eye illness or damage ($p > 0.05$), this was also the case with their knowledge of the use of spectacles to correct eyesight ($p > 0.05$). However, there was a significant difference ($p < 0.05$) in the knowledge score of literate ($11.22 \pm 3.77SD$) and non-literate ($8.97 \pm 3.30SD$) traditional healers about the eye conditions that may cause eye illness or damage.

This result is showing that literate respondents achieved better in the knowledge score for the conditions that may cause eye illness or damage than those healers who were illiterate. Most of these conditions that were surveyed were pretty much a general health knowledge inquiry and would be expected to be known by someone literate. Many studies done in rural areas show that a majority of traditional healers are illiterate; therefore it is important to increase eye care knowledge to this section of traditional healers.

5.3.5 Difference in the Mean scores of Knowledge Categories with regards to Training among Traditional Healers.

Investigation in the mean knowledge score of traditional healers with regards to receiving training before practicing traditional healing. The results showed there was no significant difference in the knowledge score of trained ($8.28 \pm 2.11SD$) and untrained ($8.56 \pm 2.60SD$) traditional healers about the causes of eye illness or damage ($p > 0.05$). Also, there was no

significant difference in the knowledge score of trained ($9.46 \pm 3.71\text{SD}$) and untrained traditional healers ($9.73 \pm 4.13\text{SD}$) about conditions that may result in eye illness or damage ($p>0.05$). However, the knowledge score was significantly higher and participants more consistent in the trained group ($2.37 \pm 1.17\text{SD}$) compared to the untrained group ($1.92 \pm 0.95\text{SD}$) of traditional healers about the use of spectacles to correct eyesight ($p<0.05$).

The trained group of healers demonstrated to know that spectacles are used for correcting vision than those healers who indicated they have never received training by western doctors regarding primary eye care. The training of traditional healers by western doctors regarding primary eye care yields better knowledge about eye care. This results in collaborative with the findings from (Poudyal et al., 2005) study that found after receiving eye care training, the healers were able to treat patients better, improved referral practices to western doctors and discouraged harmful traditional eye medication. According to Poudyal et al. (2005), this was only done through training traditional healers in modern medicine practices with particular emphasis on primary eye care.

5.3.6 Difference in the Mean scores of Knowledge Categories with regards to Duration of Training among Traditional Healers.

Using one-way ANOVA, the study results based on the duration of training among traditional healers. There was no statistical difference in the knowledge of traditional healers to causes of eye illness or damage; and Knowledge about conditions that may result in eye illness or damage taken into consideration the duration of training ($p>0.05$). The knowledge of traditional healers to the use of spectacles to correct eyesight varied significantly among the group ($P<0.05$) and was higher in the group that received 1 -2 years of training ($p>0.05$).

While one-way ANOVA results showed no statistical difference in the first two knowledge categories, it showed that participants who got 1- 2 years of traditional healer training programme scored better than those who got different training duration in knowledge score for the use of spectacles to correct vision. According to the current literature, there is no basis or an explanation for this finding because (Peek,1991) says traditional healer apprentice training is a formal, complicated and meticulous process that can last months and years depending on how fast the trainee learns the trade. According to Peek, the training duration is highly dependent on how fast the trainee learns to grasp the trade. The literature review lacks to show information about the type of training programmed when becoming a traditional healer versus

training duration. One question arises why would a healer trained for between 3-5 years scored less regarding knowledge of the use of spectacles to correction.

5.3.6 Difference in the Mean Scores of Knowledge Categories with regards to the Registration Status of Traditional Healers.

The study investigated the mean knowledge score of traditional healers with regard to their registration status. The knowledge score was significantly higher in the registered group ($8.91 \pm 2.19SD$) compared to the unregistered group ($8.02 \pm 2.27SD$) of traditional healers with regard to their knowledge about the causes of eye illness or damage ($p < 0.05$). There was no significant difference in the knowledge score of registered ($9.59 \pm 3.90SD$) and unregistered (9.50 ± 3.71) traditional healers about conditions that may result in eye illness or damage ($p > 0.05$). The knowledge score did not differ significantly among the registered ($2.29 \pm 1.14SD$) compared to the unregistered group ($2.19 \pm 1.10SD$) of traditional healers about the use of spectacles to correct eyesight ($p > 0.05$).

The study showed that about 62.3% of the respondents reported being formally registered as a traditional healer and 33.3% not registered with any formal body. Registered and organised members are easy to find and often government and non-government agencies form collaborative initiatives with them. Therefore, there is a possibility that the better scores achieved by registered members in knowledge scores about causes of eye illness or damage are attributed to some training received or health promotion pamphlets circulated by these health agencies. For the current study, this result is an indication that just by belonging to an organised structure one get an added edge over those individuals who are not organised.

5.3.7 Regression Analysis of Knowledge Categories and Disease Diagnosis

Linear regression analysis was performed with Knowledge variables to establish the predictive value of disease diagnosis associated with knowledge regarding eye illness or damage. The result shows that Knowledge about conditions that may result in eye illness or damage ($t = -2.26$, $p < 0.05$) was significant. Thus this knowledge contributes to disease diagnosis. This results further demonstrate that effective diagnosis of eye diseases cannot be made correct knowledge of eye illness causes and conditions that may lead to eye illness and damage. It is not surprising to have such a predictive relation with knowledge of eye disease and the ability

to diagnose correctly. Simply means, in order to diagnosed eye diseases properly, one needs to possess inept eye care knowledge.

The results also show there was no significance in knowledge about the causes of eye illness or damage ($t=0.18$, $p>0.05$) and knowledge about the use of spectacles to correct eyesight ($t=-0.86$, $p>0.05$). Though there was no statistical significance in this finding, it is a common fact that in order to make a correct eye care diagnosis a healer needs knowledge about causes of eye diseases and vision correct by spectacles.

5.4. The attitude of Traditional Healers to Primary Eye Care (PEC)

5.4.1 Factor Loading on Attitude of Traditional Healers with regards to PEC

To perform factor analysis and reliability test for the attitude of traditional healers to primary eye care were divided into three categories namely (1) training and exposure as a traditional healer, (2) relationship with doctors and referral of clients to medical doctors, and (3) referral of patients by medical doctors to traditional healers.

The Cronbach's alpha shown in table 4.2 reliability test for (1) training and exposure as a traditional healer = 0.79; (2) relationship with doctors and referral of clients to medical doctors = 0.8; and (3) referral of patients by medical doctors to traditional healers = 0.82

In all categories, the alpha value is greater 0.7 suggesting a very good internal consistency reliability for the scale with this study sample.

5.4.2 Descriptive Statistics on Attitude Categories

The mean score of participants with regards to (1) training and exposure as a traditional healer = $12.88 \pm 2.20SD$; (2) relationship with doctors and referral of clients to medical doctors = $5.85 \pm 1.32SD$; and (3) referral of patients by medical doctors to traditional healers = $3.12 \pm 0.40SD$.

The respondents' attitude towards referral of patients by medical doctors to traditional healers was more consistent than the other categories. This study showed that a large number of traditional healers agree that medical doctors do not refer patients to them for patient's disease co-management, yet research findings by (Ross, 2010) showed that traditional healers favoured

working with allopathic caregivers but felt that allopathic medical practitioners seldomly reciprocated referrals to them.

One would wonder why allopathic medical practitioners are not referring patients to traditional healers. Andrade & Ross (2005) sought to clarify this concern by stating that western medical health care professional does not respect and or trust traditional healers' approaches to healing. Therefore, there exists a lack of trust in the relationship between western medical practitioners and traditional healers.

The participants' attitude towards training and exposure as a traditional healer has a higher standard deviation suggesting a much more inconsistent attitude amongst the healers when it comes to training by western medical eye care practitioners. This finding agrees with Eleanor (2010) and Andrade & Ross (2005) findings that some traditional healers were hesitant to share treatment or healing approaches with allopathic practitioners fearing intellectual copyright loss for their herbal medical healing concoctions and indigenous knowledge. Ross (2010) further states due to constant onslaught on African cultural knowledge systems by the western biomedical systems, traditional healing practices have been demonised and othered as an inferior form of healing practice. This point is well demonstrated in reports that patients do not inform western medical practitioners that they consult with traditional healers fearing denigration and rebuke by allopathic doctors for using "muthi" or otherwise. It is such reasons that some traditional healers are not in agreement with the notion of being trained by western eye care doctors.

5.4.3 Pearson's Correlation Coefficient for the Different Attitude Groups

The Pierson correlation coefficient to determine the relationship between the attitude to training and exposure as a traditional healer, relationship with doctors and referral of clients to medical doctors and referral of patients by medical doctors to traditional healers. This test was performed to determine the level degree of relationship of the measured variables and in the current study, the results show there exists a significant positive correction between all the attitude variables ($P < 0.01$).

Despite trust issues between the western medical practitioners and traditional healers, the finding above showed a significant number of participants indicated they would like training with regards to eye care. As it was in Poudyal et al. (2004) study and many other eye care collaborative studies, such training promoted the relationship between traditional healers and

allopathic practitioners. These studies showed an increase in referral patterns between the two healing practices and to some extent, legitimised some of the practices by traditional healers.

5.4.4 The difference in the mean scores of Attitude Categories with regards to Literacy the level of Traditional Healers.

The study investigated the mean attitude score of traditional healers attitude in relation to literacy level. The results showed that there was no significant difference in the attitude score of literate and non-literate traditional healers with respect to the three categories of attitude analysed ($p>0.05$).

The results mean that irrespective of participants' literacy levels, a significant demonstrated similar attitude towards all attitude categories. This finding is an indication that participants want training with regard to eye care, would like to establish a relationship with western medical doctors. At the same time whether responded were literate or not, a similar attitude was observed that they would like to see more western medical doctors to refer patients to them.

5.4.5 The difference in the Mean Scores of Attitude with regards to Training among Traditional Healers.

The mean attitude score of traditional healers regarding their training was investigated and it was observed that all attitude categories yielded ($p>0.05$) meaning that there is no significant difference in the attitude score of the trained and untrained traditional healers with respect to the three categories of attitude analysed.

Likewise, the study showed that whether participants were trained or not trained they demonstrate similar attitude levels to all attitude categories. Traditional healers' attitude has by enlarge demonstrated to favour training and improved reciprocal referral relationship with their counterparts through studies showed. Therefore, is expected to get such results.

5.4.5 The difference in the Mean Scores Attitude of Traditional Healers to Registration Status

An investigation into sub-groups of attitude categories in comparison to the attitude of traditional healers to registration status was done and it was observed that all attitude categories showed a ($p>0.05$) meaning that there was no significant difference in the attitude score of the registered and unregistered healers with respect to the three attitude categories analysed. Again the results show that regardless of participants' registration status, it was observed that traditional healers registration status had no bearing on the healers mean scores for all attitude categories.

5.4.6 Regression Analysis of Attitude Categories and Mode of Treatment

A linear regression analysis of attitude variables to establish predictive value of mode of traditional healers treatment attitude regarding eye illness or damage was performed. The result shows that training and exposure as a traditional healer ($t=2.08$, $p<0.05$) was significant. The results show a predictive positive relationship between training & exposure as a traditional healer and mode of treatment attitude regarding eye illness or damage.

The analysis shows the referral of patients by medical doctors to traditional healers was significant ($t=2.17$, $p<0.05$). This implies that training and exposure as a traditional healer and referral of patients by medical doctors to traditional healers are crucial and contribute to the mode of treatment adopted by traditional healers. This observation is in line with other findings from several studies such as (Rudolph, Ogunbodede, & Mistry, 2007; Hoff, 1992; Maiello, 2008; Baggaley, Sulwe, Burnett & Ndovi, 1996; Miller, 1980; Barrett, 1996; Schneider P *et al.*, 1989) that if traditional healers are properly trained, they can contribute significantly to the work of primary health care teams.

Furthermore, the results showed, there was no significance in relationship with doctors and referral of clients to medical doctors ($t=0.47$, $p>0.05$). This result is expected as currently, it is only most traditional healers who refer patients to western medical doctors and very seldom visa versa.

5.5 The practice of Traditional Healers with regards to Primary Eye Care.

5.5.1 Factor Loading on Practice of Traditional Healers with regards to PEC.

To perform factor analysis and reliability test for the attitude of traditional healers to primary eye care were divided into three categories namely (1) prevalence and common form of eye problems presented, (2) mode and approach to treatment eye illness; and (3) advice and handling visually impaired patients.

The Cronbach's alpha shown in reliability test for (1) prevalence and common form of eye problems presented = 0.77; (2) mode and approach to treatment eye illness = 0.79; and (3) advice and handling visually impaired patients = 0.71.

In all categories, the alpha value is greater 0.7 suggesting a very good internal consistency reliability for the scale with this study sample.

5.5.2 Descriptive Statistics for Practise Categories

The mean score of participants with regards to (1) prevalence and common form of eye problems presented = $5.72 \pm 2.19SD$; (2) mode and approach to treatment eye illness = $9.49 \pm 4.06SD$; and (3) advice and handling visually impaired patients = $13.28 \pm 3.52SD$.

The results show that participants were more consistent in practice for the prevalence and common form of eye problems presented in this study. The observation suggests that participants practice in an almost similar way when it comes to this practice category.

Furthermore, the results showed that other practice categories showed that participants were not very consistent in agreement with mode and approach to eye illness treatment and advice & handling visually impaired patients. The inconsistency in these categories may be due to different types of traditional healers, and as we know them, they use different methods to treat illnesses and would also advise & handle visually impaired patient differently. In some cases, treatment modalities by a different type of traditional healers do not agree with each other; hence this finding is absorbed.

5.5.2 Pearson Correlations Coefficient results for the Practice Categories

The result shows that there was a significant correlation between traditional healers' advice and handling of a visually impaired patient with the prevalence and common forms of eye problems presented ($t=0.32$, $p<0.05$). The finding supports the fact that if a healer knows eye diseases' prevalence & common forms of his eye problems a healer is likely to give good advice on the eye condition and handle a visually impaired patient wisely.

It was also observed that advice and handling of a visually impaired patient by traditional healers are significantly correlated to mode and approach to the treatment of eye illness ($t=0.27$, $p<0.05$). This result is expected as in the practice of modern eye care, the understanding of mode & approach to treatment of eye illness together with advice & handling of visually impaired patients is very important.

Furthermore, the results showed that there was no correlation between prevalence and common forms of eye problems presented with mode and approach to the treatment of eye illness ($t=0.45$, $p>0.05$). Though the finding is showing no statistical correlation between prevalence and common forms of eye problems and the mode & approach to treatment of eye illness, the finding makes no sense why these two categories do not show the correction. In eye care theory, the practice of modern eye care necessitates a full understanding of eye disease prevalence and mode & approach to treatment.

5.5.3 The difference in the Mean Score of Practice Categories with regards to Literacy Level of Traditional Healers.

The study investigated the mean attitude score of participants with regards to the literacy level. The obtained results showed that all practice categories yielded a ($p>0.05$) meaning that there was no significance between the mean score of the different practice categories and the literacy level of the traditional healers.

Participants literacy levels did not seem to influence the mean scores in all practice categories.

5.5.4 The difference in the Mean Practice Scores of Respondents with regards to Training among Traditional Healers.

The mean practice score of participants with regards to training among traditional healers results showed that all practice categories had a ($p>0.05$) and that there was no significant difference between mean practice score of the different categories to training among traditional healers.

Again, whether trained or not trained the mean scores for practice categories were not impacted. According to the results, trained traditional healers practice almost the same as those that were not trained. Even though it is expected that those that trained traditional healers may practice differently or better than an untrained one.

5.5.5 Difference in the Mean Practice Scores of Respondents with regards to Referral of Patients among Traditional Healers.

The mean practice score of the different practice categories with regards to the referral of patients by traditional healers to other traditional healers was performed. The result obtained showed based on prevalence and the form of eye problems presented by patients, more of the traditional healers ($6.26 \pm 1.87SD$) do not refer patients to other traditional healers ($p < 0.05$) compared to the ones who do ($5.45 \pm 2.19SD$). This observation is surprising and puzzling as there seem to be no reason why would traditional healers do not refer to each other. Does this finding imply that traditional healers do not trust each other or are specialist in all forms of illnesses?

It is puzzling in the sense that a majority of study participants indicated that they would like to see western medical doctors refer patients to them yet they do not refer to each other.

5.6 Summary

The study showed that male healers dominated the sample population of the study even though other studies showed female dominance in other areas and the black healers continue to be the largest number when compared to other races. A majority of the traditional healers can read & write having attended at least some form of schooling education. Calling and following family tradition is the main reason for many people becoming a traditional healer. 0 – 2 years of training is the most preferred number of years for traditional healers apprenticeship and that a majority of the healers are registered with some association.

The findings demonstrated that the study had a very good internal consistency reliability for the scales in all knowledge, attitude and practice categories with alpha values greater than 0.7. In most cases, literacy levels, registration status and training level did not positively or negatively affect mean scores in knowledge, attitude and practice categories. The findings also showed positive correlations on all categories investigated while showing the predictive relationship in some cases. The results confirmed there exist distrust between traditional healers and western medical doctors

Chapter 6

Major Conclusions and Recommendations

6.1 Conclusions

Study objectives were to (1) determine traditional healers' knowledge of most commonly presenting eye conditions in South Africa, their cause, diagnosis and treatment; (2) determine traditional healer's specific practice with regards to primary eye care; (3) determine the attitudes of traditional healers towards collaboration with modern medical eye care doctors and training. The conclusion of the study is as follows:

- (1) The study results showed traditional healers operating in and around the Durban area have poor knowledge of eye conditions, its causes, diagnosis and treatment with regards to primary eye care.
- (2) The study results showed that traditional healers' practice with regard to primary eye care was markedly different from the practice of eye care western medical doctors.

- (3) The study attitude findings indicate that the majority of traditional healers have a positive attitude towards collaborative training programs with regards to primary eye care; and that they want western medical doctors to refer patients to them.

In line with the aim of this study to develop a baseline understanding of the knowledge attitude practice of traditional healers, the study results demonstrate the need for training program for traditional healers regarding modern primary eye care for traditional healers in and around Durban. These training programmes must be aimed at improving traditional healers' knowledge of common eye diseases, diagnosis and treatment of these eye diseases. The training must also include the training of western medical doctors about traditional healing practice so that a clear referral protocol for both healing practitioners can be established.

6.2 Recommendations of the Study

As a result of this study, the following recommendations are made to:

6.2.1 Durban Tradition Healers Organisation

- Provide a mechanism for its members to receive regular training targeting the provision of primary eye care.
- Liaise with training institutions and health to provide primary eye care training to its members.
- Perhaps making it mandatory for its members to undergo primary health care (PHC) training which includes primary eye care (PEC).

6.2.2 UKZN Optometry Department

- To develop primary eye care training manual for traditional healers
- To invite traditional healers or leadership of Durban Traditional Healers Organisation to become a valuable stakeholder or board member of the department

6.2.3 Durban Metro Health

- Capacitate traditional healers with a range of training that includes primary eye care

6.2.4 Further Research

- A more complex research study to investigate other traditional healers in other cities across South Africa.
- What other interventions can assist traditional healers with regard to primary eye care
- An investigation into why traditional healer does not refer patients amongst them.
- An investigation into why young people are not taking to be traditional healers.

6.3 Limitation of the study

The are several limitations to this study which include the study design, sample, time and results

6.3.1 Study Design

The study was a cross-sectional design and therefore, does not have control.

6.3.2 Sample

The study used a convenient sampling method of its participants because of their proximity to the university. The sample population of the study may not be representative of all traditional healers in South Africa.

6.3.3 Time

There was not enough time to get more research participants due to tight timelines for study findings submission for assessment.

6.3.4 Results

Correlations results cannot be generalised but only looked at only for associations.

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Appendix A. English Consent Form

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL For research with human participants

Information Sheet and Consent to Participate in Research

Date: 1 June 2019

Dear Sir or Madam:

My name is Mr Tate Clifford Madlala, a Master of Social Science research student from University of KwaZulu-Natal School of Psychology Department of Health Promotion. My contact details are (cell) 0817173232 and (email) tateperfectvision@gmail.com.

You are being invited to consider participating in a study that involves research to investigate knowledge, practice and attitudes of traditional healers with regards to primary eye care in Durban. The aim and purpose of this research is to learn about the roles of the South African traditional healers in eye care services. More importantly, the information obtain from this study may be used to facilitate / enhance collaborative programmes and training between traditional & modern eye practitioners. The study is expected to enroll 150 participants comprised of 50 herbalist (izinyanga), 50 diviners (izangoma) and 50 faith heakers (abaphrofethi) practicing in Durban. It will involve oral questionnaire

interview. The duration of your participation if you choose to enroll and remain in the study is expected to be 20-30min. The study is self funded by the researcher.

There are no risks involved in this study. We hope that the study will help in identifying potential risk factors in the management of various ocular conditions and in the development of proper referral protocols and criteria.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (Approval No. HSS/0177/099M).

In the event of any problems or concerns/questions you may contact the researcher at (provide contact details) or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Your participation in this research is voluntary and that you are under no obligation to participate in the study. You can withdraw your participation at any point even after you have agreed to participate. In the event of your refusal/withdrawal of participation you will not incur penalty or loss of treatment or other benefit to which you are normally entitled.

There are no costs that might be incurred by you as a result of participation in the study.

The information collected in the study will be kept confidential and will not be given to anyone outside the study. Your name will not be used on any reports and do not indicate and you may not indicate your name in the interview. All data collected and reports will be stored in lockable cabinet and will be destroyed after five years.



CONSENT TO PARTICIPATE IN RESEARCH

I,, have been informed about the study entitled KNOWLEDGE, PRACTICE AND ATTITUDE OF TRADITIONAL HEALERS WITH REGARDS TO PRIMARY EYE CARE IN DURBAN) by MR TATE CLIFFORD MADLALA.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study, I understand that I may contact the researcher at (cell) 0817173232 or (email) tateperfectvision@gmail.com.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Signature of Participant

Date

**Signature of Witness
(Where applicable)**

Date

**Signature of Translator
(Where applicable)**

Date

Appendix A1. Zulu Consent Form

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL For research with human participants

Information Sheet and Consent to Participate in Research

Date: 1 June 2019

Sawubona Mnumzane / Nkosazana:

Igama lami uMnz Tate Clifford Madlala, umfundi ocwaningweni lweSayensi yezehlalakahle yase Nyuvesi yaKwaZulu-Natal, ohleni lwe Psychology emnyangweni wezempilo. Ngitholakala kuleminingwane (inombolo yeseli) 0817173232 futhi imeyili tateperfectvision@gmail.com Bengicela ukukumema ukuthi ubambe iqhaza kucwaningo lokucwaninga uphenyo, lolwazi, imikhuba kanye nendlela yokubuka izinto kwalabo abelapha ngesintu uma kuziwa ekunakeleleni amehlo endaweni yaseThekwini. Inhloso yalolucwaningo ukufunda ngeqhaza elibanjwe abalapha ngesintu ekulapheni kwamehlo la eMzansi Africa. Okubaluleke kakhulu ukuthi ulwazi oluzotholakala kulolu cwaningo lungasetshenziswa ekuqguquzeleni izinhlelo zokubambisana nokufundisana Phakathi kwabalapha ngisintu nalabo abalapho ngezindlela zanamuhla kwezamehlo. Lolucwaningo lulindeleke ukuthi ludidiyele abantu abayikhulu namashumi amahlanu, abahleleke kanje; Izinyanga ezingamashumi amahlanu, Izangoma ezingamashumi amahlanu kanye nabaprofethi abangamashumi amahlanu abasebenzela endaweni yaseThekwini. Locwacingo luzokwenziwa ngohla lwemibuzo ezobuzwa ngomlomo, lemibuzo ingathatha imizuzu engeqile emashumini amathathu. Umcwaningi uyena ozikhokhela izindleko.

Abukho ubungozi obukhona kulolucwaningo. Siyathemba lolucwaningo luzosiza ekutholeni ubungozi obungase bube khona ekuphathweni nokumakekela izigulo zonkana zamehlo kanye nokuthuthukiswa kwezindlela ezifanelekile zokudluliselwa kwalabo abadinga usizo lwamehlo.

Lolucwaningo luphakanyiswe labuye lavunyelwa ikomiti yohla lwezocwaningo Lwesintu kanye nolweSayensi yezehlalakahle eNyuvesi yaKwaZulu-Natal ngaphansi kwenombolo

Uma uhlangabezisa nokungaqondi noma unemibuzo ungathintana nomcwaningi emniningwaneni enikeziwe okanye ikomiti yohla lwezocwaningo Lwesintu kanye nolweSayensi yezehlalakahle yaKwaZulu-Natal kuleminingwane:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Ukuba yingxenywe yalolucwaningo akube ukuzithandela kwakho, awuphoqelekile nese ukuzibandakanya nalo. Ungahoxa ohleni lokuzibandakanya noma ubusuvumile uma usushitntshe umqondo. Uma unqaba ukuzibandakanya awekho amalungelo ozophucwa wona.

Ayikho imali ozoyikhokha ngokuzibandakanya nalolucwaningo.

Ulwazi oluqoqiwe ngalocwaningo luzogcinwa luyimfihlo futhi ngeke lunikezwe umuntu ongesiyona ingxenywe yalolucwaningo. Igama lapho ngeke lisetshenziswe okanye lishicilelwe emibikweni layolucwaningo kanjalo asikho isidingo sokudalula igama lakho ngesikhathi semibuzo nezingxoxo. Yonke imininingwane iyovalwelwa ikhiyelwe kwikhabhinethi iyoze ikhishwe ibhubhiswe emva kweminyaka emihlanu.



CONSENT TO PARTICIPATE IN RESEARCH

Mina,, ngazisiwe ngalolucwaningo lolwazi, imikhuba kanye nendlela yokubuka izinto kwalabo abelapha ngesintu uma kuziwa ekunakeleleni amehlo endaweni yaseThekwini olwenziwa u Mnz TATE CLIFFORD MADLALA.

Ngiyayoqonda injongo kanye nenqubo yalolucwaningo.

Ngilini kiwe ithuba lokubuza imibuzo ngochwano ngaphenduleka ngokwaneliseka.

Ngiyakubalula ukuthi ukuzibandakanya kwami nalolucwaningo okokuzithandela futhi ngingahoxisa noma inini ngaphandle ngokuphucwa amalungelo ama ajwayelekile.

Ngazisiwe ngesinxephezelo esikhona okanye usizo lwezempilo uma ngilimala ngenxa yemigomo empandakanya ucwaningo.

Uma uhlangabezisa nokungaqondi noma unemibuzo mayelana nomchwano, ngiyaqonda ukuthi ngingathintana nomchwano kuleminingwane: (inombolo yeseli) 0817173232 futhi (imeyili) tateperfectvision@gmail.com.

Uma unemibuzo noma ukukhathazeka ngamalungelo akho kulolucwaningo, noma ukhathazeka ngenxenye yalolucwaningo noma abacwaningi ungathinta:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

isignisha yomhlanganyei

Usuku

**Isignisha yafakazi
(uma sikhona isidingo)**

Usuku

**Isignisha katolika
(uma sikhona isidingo)**

Usuku

Appendix B. Interview Questionnaire

KNOWLEDGE, ATTITUDE AND PRACTICES OF TRADITIONAL HEALERS WITH REGARDS TO PRIMARY EYE CARE IN DURBAN, KZN.

RESEARCH STUDY QUESTIONNAIRE

INSTRUCTIONS TO DATA CAPTURER

- a) Introduce yourself and show credentials.
- b) Read question clearly and loudly.
- c) If respondent doesn't understand English, use Zulu questionnaire.
- d) Do not assist the respondent in answering the questions.
- e) Where appropriate tick or cross the correct answer.
- f) Remind the respondent to be as honest as possible when answering the question.

SECTION A

DEMOGRAPHIC INFORMATION

Interviewer Code : _____

Date / **Usuku** : _____ / _____ / _____

1. Gender / **Yini ubulili bakho?**

Male	Female
Umlisa	Owesifazane

2. Age / **Uneminyaka emingaphi?**

3. Race / **Uwoluphi uhlanga?**

African	Indian	Coloured	White
----------------	---------------	-----------------	--------------

4. Literacy / **Uyakwazi ukufunda nokubhala?**

Can Read & Write Ngiyakwazi ukufunda nokubhala	Can't read and Write Angikwazi ukufunda nokubhala
---	--

5. Highest Education level / **Izinga lemfundo?**

Primary Education	Secondary Education	Tertiary Education
--------------------------	----------------------------	---------------------------

SECTION B

BACKGROUND INFORMATION

6. What kind of traditional healer do you call yourself? / **Uwuhlobo luni lomelaphi wendabuko?**

Devine healer Isangoma	Herbalist Inyanga	Faith Healer Umthandazi	Other (specify) _____
---	------------------------------------	--	---------------------------------

7. How did you become a traditional healer? / **Waqala kanjani ukuba umelaphi wendabuko?**

Following Family Tradition Ngilandela usiko lasekhaya	Calling Ubizo	Other (specify) _____
--	--------------------------------	---------------------------------

8. Did you receive any training as traditional healer? / **Kungabe ukwelapha wakuqeqeshela njengomelaphi wendabuko?**

YES / YEBO	NO / CHA
-------------------	-----------------

9. How long was this training? / **Uqeqesho lwathatha isikhathi esingakanani?**

0 – 1yr	1-2yrs	2 – 3yrs	3 – 4yrs	> 4yrs	Other
----------------	---------------	-----------------	-----------------	------------------	--------------

10. How long have you been working as a traditional healer?

Ususebenze isikhathi esingakanani njengomelaphi wendabuko?

11. Where do you practice as a traditional healer? / **Isigodlo sakho noma indawo yakho yokusebenzela njengomelaphi wendabuko itholakala kuphi?**

12. Are you a registered traditional healer / **Ubhalisiwe njengomelaphi wendabuko osemthethweni?**

YES / YEBO	NO / CHA
-------------------	-----------------

13. Do you refer patients to other traditional healers? / **Kungabe uyazidlulisela iziguli zakho kwezinye izinyanga?**

YES / YEBO	NO / CHA
-------------------	-----------------

14. What are the common health problems that you treat? / **Yiziphi izifo ezijwayelekile ozelaphayo?**

15. How do you diagnose diseases? / **Umuntu umbona ngani ukuthi uphethwe yesiphi isifo?**

16. How do you treat diseases? / **Uzelapha kanjani izifo?**

17. On average how many patients do you consult in a month? / **Ngekwesilinganiso ngabe ubona iziguli ezingaki ngenyanga?**

SECTION C

EYECARE PRACTISE

18. How many of these patients have eye problems? / **Bangaki kubona abanenkinga yamehlo?**

If answer to question 18 is NONE, skip question 19 & 20

19. What are the common eye problems they present? / **Iziphi izifo zamehlo eziwayelekile abafika nazo?**

(For each eye problem stated above, answer question below)

Ezifweni ezibhalwe ngenhla, phendula lombuzo

20. How do you treat it? / **Uzelapha kanjani?**

21. What do you do with patients who say they can't see? / Wezenjani ngeziguli ezifika kuwena zithi aziboni?

22. Do you think you are able to measure V/A (visual acuity)? / Uma ucabanga uyakwazi ukubona ukuthi inkinga yesigulu ingakanani yokubona nokungaboni?

1	2	3	4	5
STRONGLY AGREE NGIKWAZI KAKHULU	AGREE NGIYAKWAZI	IM NOT SURE ANGAZI KAHLE	DISAGRE ANGIKWAZI	STRONGLY DISAGRE ANGAZI NHLOBO

23. What do you do with patients who have injured their eye? / Wenzenjani ngezigulu ezilimele emehlweni?

24. What do you do with patients with chemical burns in their eyes? / **Wenzenjani ngezigulu ezishiswe uketshezi olusabuthi?**

25. What advise do you give about future prevention of eye injuries and diseases? / **Yiziphi iziluleko ozinikeza ngokuvikela izifo zamehlo nokulimala kwamehlo?**

SECTION D	EYECARE KNOWLEDGE
------------------	--------------------------

26. Can the following cause eye illness or damage to eyesight?

Kungabe lokhu okulandelayo kungadala ukungaboni noma kulimaze amehlo?

26.1 Evil spirit / sin or curse in the form of witchcraft? / **Imimoya emibi / isono noma ukuthakathwa?**

1	2	3	4	5
STRONGLY AGREE NGIVUMAKAKHULU	AGREE NGIYAVUMA	DISAGREE ANGIVUMI	STRONGLY DISAGRE ANGIVUMI KAKHULU	DON'T KNOW ANGAZI

26.2 Gems? / **Amagciwane?**

1	2	3	4	5
STRONGLY AGREE NGIVUMAKAKHULU	AGREE NGIYAVUMA	DISAGREE ANGIVUMI	STRONGLY DISAGRE ANGIVUMI KAKHULU	DON'T KNOW ANGAZI

26.3 Diabetes? / **Isifo sashukela?**

1	2	3	4	5
STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGRE	DON'T KNOW

NGIVUMAKAKHULU	NGIYAVUMA	ANGIVUMI	ANGIVUMI KAKHULU	ANGAZI
----------------	-----------	----------	------------------	--------

26.4 Hypertension? / Umfutho wegazi?

1	2	3	4	5
STRONGLY AGREE NGIVUMAKAKHULU	AGREE NGIYAVUMA	DISAGREE ANGIVUMI	STRONGLY DISAGRE ANGIVUMI KAKHULU	DON'T KNOW ANGAZI

26.5 Cataract ? / Ungwengwezi?

1	2	3	4	5
STRONGLY AGREE NGIVUMAKAKHULU	AGREE NGIYAVUMA	DISAGREE ANGIVUMI	STRONGLY DISAGRE ANGIVUMI KAKHULU	DON'T KNOW ANGAZI

26.6 Direct viewing of the sun? / Ukubheka ngqo ilanga?

1	2	3	4	5
STRONGLY AGREE NGIVUMAKAKHULU	AGREE NGIYAVUMA	DISAGREE ANGIVUMI	STRONGLY DISAGRE ANGIVUMI KAKHULU	DON'T KNOW ANGAZI

26.7 HIV / AIDS? / Ingculazi?

1	2	3	4	5
STRONGLY AGREE NGIVUMAKAKHULU	AGREE NGIYAVUMA	DISAGREE ANGIVUMI	STRONGLY DISAGRE ANGIVUMI KAKHULU	DON'T KNOW ANGAZI

27. Spectacles / glasses help people to see better? / Izibuko zamehlo ziyabasiza abantu ukubona kahle?

1	2	3	4	5
STRONGLY AGREE NGIVUMAKAKHULU	AGREE NGIYAVUMA	DISAGREE ANGIVUMI	STRONGLY DISAGRE ANGIVUMI KAKHULU	DON'T KNOW ANGAZI

SECTION E

TRADITIONAL HEALERS ATTITUDE

28. Do you think you are trained well enough to treat eye illness? / **Uma ucabanga ukufundela kahle ukwelapha izifo zamehlo?**

1	2	3	4	5
STRONGLY AGREE NGIVUMAKAKHULU	AGREE NGIYAVUMA	DISAGREE ANGIVUMI	STRONGLY DISAGRE ANGIVUMI KAKHULU	DON'T KNOW ANGAZI

29. Do you refer your eye patient to western eye care doctors? / **Iziguli zakho uyazithumela ko dokotela besilungu?**

YES / YEBO	NO / CHA
-------------------	-----------------

30. If yes above, why do you refer? / **Uma abathumele usuke ukwenzelani lokho?**

31. Do you have any working relationship with an eye care / western doctors in your work place? / **Bakhona odokotela besilungu onobudlelwane noma naba oxhumana lapho usebenzela khona?**

YES / YEBO	NO / CHA
-------------------	-----------------

32. Do western medical practitioners refer patients to you? / **Ngabe odokotela besilungu bayazithumela iziguli zabo kuwena?**

YES / YEBO	NO / CHA
-------------------	-----------------

33. If yes above, why they refer patients to you? / **Uma uthi yebo, bazithumelani izigulu zabo kuwena?**

34. Have you had training by western eye doctors or eye care NGO's? / **Uke waqeqeshwa odokotela bamehlo besilungu noma ama NGO asebenza ngezifo zamehlo?**

YES / YEBO	NO / CHA
-------------------	-----------------

35. if yes above, in your opinion was the training helpful? / **Uma uthi yebo ngaphezula, ngokombono wakho ngabe uqeqesho lwaba usizo?**

1	2	3	4	5
STRONGLY AGREE NGIVUMA KAKHULU	AGREE NGIYAVUMA	DISAGREE ANGIVUMI	STRONGLY DISAGRE ANGIVUMI KAKHULU	DON'T KNOW ANGAZI

36. If answer is no in question 34. Would you participate in training of traditional healers about eyecare by western / modern healthcare worker? / **Uma uthe cha kumbuzo 34. Ungalibamba iqhaza kuqeqesho kubalaphi bomdabu ngokuphatelene nokunakekela amehlo ngokwesilungu?**

1.

1	2	3	4	5
STRONGLY AGREE NGIVUMA KAKHULU	AGREE NGIYAVUMA	DISAGREE ANGIVUMI	STRONGLY DISAGRE ANGIVUMI KAKHULU	DON'T KNOW ANGAZI

Appendix C – Gatekeeper’s Consent Letter



Durban Metro City Health
Traditional Healers Coordinator
Durban
4000

Dear Sir/Madam

REQUEST TO CONDUCT A STUDY AMONG TRADITIONAL HEALERS IN DURBAN

My name is Tate C Madlala, a Master of Health Promotion student registered at the University of KwaZulu-Natal. The title of the study is: Knowledge Attitude and Perception of Traditional Healers with regards to primary eye care in Durban. The results of this study will help establish the knowledge, attitude and practices of traditional healers with regards to primary eye care in KwaZulu-Natal. The study is supervised by Mr Mthokozisi Wellington Hlengwa from the Department of Health Promotion, University of KwaZulu-Natal, South Africa. My supervisors’ contact details are as follows: email hlengwam1@ukzn.ac.za and Tel no. 031-260 7982.

I humbly request permission to approach Traditional Healers to complete this survey study. All the necessary legal and ethical considerations will be adhered to.

Yours faithfully,

Tate C Madlala (Research Student)

Appendix D – Ethical Clearance Certificate



01 August 2019

Mr Tate Clifford Madlala (9801948)
School of Social Sciences
Howard College Campus

Dear Mr Madlala,

Protocol reference number: HSS/0177/019M

Project title: Knowledge, attitude and practices and traditional healers with regards to primary eye care in Durban, KZN

Approval Notification – Expedited Application


In response to your application received on 01 March 2019, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 1 year from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully



Dr Rosemary Sibanda (Chair)

/ms

Cc Supervisor: Mr Mthokozisi W Hlengwa
cc Academic Leader Research: Professor Maheshvari Naidu
cc School Administrator: Ms Nonhlanhla Radebe

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