

**FACILITATING COLLABORATION BETWEEN TRADITIONAL  
HEALERS AND WESTERN HEALTH CARE  
PRACTITIONERS IN THE MANAGEMENT OF CHRONIC  
ILLNESSES  
IN SWAZILAND.**

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**MARCH, 2001.**

## **DECLARATION**

**I SOLELY DECLARE THAT THIS THESIS IN FULFILLMENT OF THE PHD, IS MY OWN ORIGINAL INVESTIGATION. IT IS NOT BEING SUBMITTED CONCURRENTLY IN ANY OTHER INSTITUTION FOR ANOTHER DEGREE OR EXAMINATION. ALL SOURCES OF LITERATURE HAVE BEEN ACKNOWLEDGED.**

**SIGNED BY**-----



**( CANDIDATE)**

**DATE**-----

*March, 2001*

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## **DEDICATION**

*To my loving father, the late Mr. Joseph Mashampu Dlamini and to my grand Mother, the late Lomkhosi Loncwala Maphalala and my grand mother, the late Monase Makhubu, for their spiritual support and for bringing me up to what I am today.*

And

*To my husband, Philip Galjaard, my son Jonathan Phumelela and my daughter Celiwe Nonjabulo Anka for your loving support. To my friend Jabulile Nkambule for your unfailing support you have afforded me through this tough time.*

**YOU ALL HAVE A SPECIAL PLACE IN MY HEART.**

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Lastly, but not least, to the lecturers and students of the Faculty of Health Sciences, University of Swaziland who had to work hard during my frequent absences.

## **ABSTRACT**

The purpose of the study was to analyze the process of facilitating collaboration between traditional healers and western trained health care workers in the management of chronic illnesses, hypertension and diabetes. This process was facilitated through qualitative participatory action research which utilized the principles of Action Science Enquiry. This was a qualitative research.

Two phases were as followed: phase one was the analysis of the problem of collaboration while phase two was the implementation of strategy one and two. Strategy one was the development of the constitution of traditional healers towards the establishment of the Swaziland traditional Healers' Council and a traditional healers' department within the Ministry of Health and Social Welfare. Strategy two was a small comparative survey into the safety and efficacy of traditional medicine. The survey compared clients who utilized only traditional medicines and those who utilized only western medicines to control their hypertension.

Data was collected through interviews, meetings, observations and clinical measurements.

Audio-taped and field notes were transcribed, carefully studied and analyzed. The editing analysis described by Crabtree and Williams (1992) was utilized in the analysis of data.

The results of phase one was a descriptive profile of traditional healers and the way hypertension and diabetes were managed by the traditional healers and the western trained health care workers, with the aim of finding out how they could collaborate. A number of barriers for collaboration were identified such as the lack of a legal body of traditional healers, negative attitudes of western trained health care workers towards clients and traditional healers, ethical issues, perceptions of illnesses and payments as well as the lack of transparency. Enhancers for collaboration were also identified. Consequences of a successful collaborative process were established by the participants. Strategies to solving the problems of collaboration were identified and two of the strategies were implemented. A traditional collaborative model was identified and compared to an existing modern collaborative model.

Phase two, strategy one, *the legalizing of traditional healers in Swaziland*, was decided upon during one of the meetings held between traditional healers, clients and western trained health care workers. Barriers to successfully organize this strategy were also identified, such as organization and exclusion, leadership style, traditional and cultural structures, lack of resources, poor communication and different traditional healers' categories. Action plans to solve those problems were developed and progress was made. The end result was that a draft of the *traditional healers' constitution content* was developed. Stakeholders who would be part of the development of the constitution were contacted.. The stakeholders included the Ministry of Health and Social Welfare, the Ministry of Natural Resources and Agriculture, the Swaziland World Health Organization, the Ministry of Justice and the University of Swaziland. The traditional healers managed to form an interim committee called the Traditional Healers'

Constitution Development Committee. This committee was still in a process of involving all traditional healers in Swaziland to furnish their views and opinions to the committee concerning the constitution. The target date for the constitution to be completed was set to be around April, 2001. The researcher will still be working with the committee until the legalizing process is completed. This would take another one year to complete.

Phase two : strategy two, establishing the efficacy of traditional healers' medicines to control hypertension was established to enhance trust between the traditional healers and the western trained health care personnel. From the small sample, it would seem that fluctuations of blood pressure levels were similar between the two groups. This showed that traditional healers medicines to control hypertension in Swaziland is effective. Though it was difficult to establish the safety of those clients who utilized only the traditional medicines, there were no abnormalities discovered to be associated with the use of the traditional medicines.



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## **CHAPTER ONE**

### **1. INTRODUCTION**

#### **1. 1 Research Problem Statement**

In 1978 the World Health Organization (WHO) adopted a resolution to launch a worldwide promotion of traditional medicine. The plan formulated at that time attempted to deal with the problem of collaboration between different therapeutic systems. This plan referred to the 'integration into the overall national health care delivery system' of the different kinds of practitioners (Hogle & Prins, 1991).

The traditional healer has been defined as "a person who is recognized in the community in which he or she lives as competent to provide health care by using vegetable, animal and mineral substances and certain methods. These methods are based on the social, cultural and religious background of the community as well as the knowledge, attitudes and beliefs prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability." Traditional medicine is defined "as the sum total of all knowledge and practices used in diagnosis, prevention and elimination of physical, mental and social imbalances. It relies exclusively on practical experiences and observations handed down from generation to generation, whether verbally or in writing." (World Health Organization (WHO). 1978, p.66).

According to Namec (1980) two thirds of the people in the world at that time depended on the healing methods used by their ancestors and in some areas these were the only methods with which people felt comfortable. In Zaire traditional medicine and the position of traditional healers in regard to the law was very ambiguous as their practices appeared to be outside the laws

governing the art of healing ( Ahluwalia & Mechin, 1980). In Senegal the Ministry of Health recently announced that traditional medicines and traditional practices would be legalized as there was a growing interest in that field ( World View, 1998). In South Africa, Simon (1997) reports that more than 80% of the South African population consult traditional healers before, after or in place of a clinic or western medical practitioner. Shai-Mohoko (1996) states that in South Africa traditional healing practices are well established and popular among the blacks. Still at this time even after the 1994 elections, South Africa had not yet produced a clear plan on traditional medicine (Simon, 1997).

In Swaziland more than 85% of the population consult traditional healers, and the ratio of traditional healer to the population being served is 1:1000. The policy on traditional healers was and is still ambiguous, as no proper policy has to date been formulated (Green and Makhubu, 1983).

According to Kalanzi (1990) traditional medicine is an aspect of health in developing countries that has not been readily acknowledged. Traditional medicine has many advantages in the developing countries as it is locally produced and can be obtained cheaply. Developing countries can also save scarce foreign exchange by importing fewer drugs. Traditional medicine fits comfortably into the social surroundings, thereby enhancing any psychological or curative effects.

Chronic illnesses are an international health care problem. In the United Kingdom one third of the population is affected by chronic illnesses at any time. Two thirds of all people over 45 years of age have chronic health problems. The prevalence of chronic illnesses is increasing. Peace (1996) and Newby (1996) state that approximately 110 million people within the United States of

America are afflicted by one or more chronic illnesses. Gort (1987) states that traditional healers in most cases treated more chronic illnesses than they did acute illnesses. Traditional healers considered chronic illnesses mysterious and caused by supernatural powers. Chronic illnesses affect the physical, mental, social and psychological aspects of the patient. Traditional healers are said to manage the patient in a holistic manner, that is taking care of physical, mental, social and psychological aspects (Chavunduka, 1978).

In the wake of the 1978 WHO's resolution on traditional healers, there was an upsurge in research about traditional healers and traditional medicine. Jingfeng (1988) conducted a study on the integration of traditional Chinese medicine with Western medicine. In this study Jingfeng (1988) stated that new investigation into traditional medicine proved that this new field was worthy of further exploration. Chinese traditional medicine and Western medicine should be given equal importance. Hyma & Ramesh (1994) stated that full integration did not seem to be occurring and that the result of integration should be evaluated and examined in some of the developing countries. In Ghana, Brazil, Nigeria and Swaziland certain projects were done as an attempt to integrate traditional healers into the Primary Health Care programmes (Hogle & Prins, 1991).

Ideally these two systems should cooperate with each other and learn from each other. This calls for meaningful collaboration between the traditional healers and the modern health care personnel (Jingfeng, 1988). Hoff (1985) states that traditional healers as a group are seeking more cooperation between themselves as well as with doctors and nurses. They desire some form of training in modern treatment methods. Shai-Mohoko (1996) states that the situation demands that health care workers should cooperate with indigenous healers in providing health care

services. Collaboration among health care workers improves patient outcome, reduces patient cost, and this results in improved quality care of the patient. Kyle (1995) mentions that given the explosion of knowledge and expansion of health care technologies, it is difficult for one person to be an expert in all areas. Collaboration has the potential to involve the client, energise the professional, expand professional practice, and integrate the health care system.

Integration of traditional healers into the modern health care system has been perceived negatively by most authors. Integration implies transforming traditional healers into low status health care workers, accountable to biomedical practitioners. The role of traditional healers is then fundamentally altered while the biomedical system remains unchanged (Hogle & Prins, 1991). Green & Makhubu (1983) advocate cooperation and collaboration between the traditional healers and the biomedical personnel as strategies that imply better working relationships between the two. In these strategies appropriate referrals between the sectors become more routine, certain traditional healers' skills are upgraded, and the cultural sensitivity of modern health care workers is increased.

Langford (1988) states that collaboration as an interaction is characterized by activities directed towards an agreed goal by two or more persons. There should exist a norm of equity and mutual recognition of the complimenting of their knowledge. The characteristics of collaboration adopted from Langford (1988) and Henneman, Lee and Cohen (1995) are as follows:-

- a.) Joint venture or mutual responsibility.
- b.) Sharing a mutual respect for the expertise of collaborators.
- c.) Sharing decision making power.
- d.) Defining a common goal through discussion.

- e.) Communicating in an honest face to face encounter/interaction.
- f.) Having mutual acceptable roles.
- g.) Sustaining non-hierarchical relationship
- h.) Participating willingly
- I.) Sharing knowledge, expertise, values, outcomes and visions for the benefit of collaborators.

The requirements (adopted from Langford's, 1988) for initiating collaboration are a clear understanding of the concept of collaboration, willing collaborators, an opportunity for the collaborators to interact face to face and the provision of necessary resources.

Collaborative efforts have been encouraged between doctors and nurses. Henneman (1995) states that collaboration among physicians and nurses has been espoused as a means to improve patient outcome and increase job satisfaction of health care professionals. It is also clear that barriers to collaboration can be traced to nursing, not medicine, and have been created by the socialization and the educational process of nursing. Edwards (1986) examines relationships between traditional and modern medicine in the treatment of psychiatric patients in South Africa. In the study, patients perceived both traditional and modern practitioners to be helpful. Pretorius (1991) recommends a system of mutual referral between traditional and modern medicine. For any linking programme, Pretorius (1991) suggests that interested groups should cooperate, including the authorities responsible for health care delivery, health care workers trained in western medicine, traditional healers and the users of these services.

Collaboration between traditional healers and western health care personnel has been called for in other illnesses such as HIV/AIDS. Nesbit (1999) reports that Dr. Abdel Kadar Bacha, a medical practitioner, combined the modern treatment and traditional medicine in the treatment of HIV/AIDS patients. He noted an increase in white blood corpuscles, reinforcing the patients' immune system and so allowing the beginnings of a neutralisation of the virus responsible for AIDS. Those patients showed some improvement in their signs and symptoms.

Mamba (1998) reported that King Mswati III at a Southern African Development Community Conference on HIV/AIDS in Swaziland, called for the recognition of traditional healers in Swaziland. The King said that although medical advances and modern preventive measures should be acknowledged, so too should traditional healing methods.

Some projects were conducted in Swaziland as an attempt towards collaboration between traditional healers and western trained health care personnel. Green & Makhubu (1983) conducted a study entitled "Towards cooperation between traditional healers and the modern health care practitioners". This was the first attempt in Swaziland towards collaboration in the management of diarrhoeal diseases. The second project addressed cooperation between traditional healers and modern health personnel in the management of childhood diseases in Swaziland (Hoff, 1985). A third study was conducted by Upvall (1992) concerning the perceptions of nurses towards collaboration with traditional healers in Swaziland.



## **1.2 The purpose of the study**

The purpose of the study is to analyse the process of facilitating collaboration between traditional healers and modern health care personnel in Swaziland in the management of chronic illnesses by using a participatory action research, action science enquiry approach.

## **1.3 Research objectives**

- a) To identify the profile of traditional healers who manage chronic illnesses
- b) To define and analyse the problem of collaboration as exemplified by the management of diabetes and hypertension by traditional healers, western health care workers and clients suffering from diabetes and hypertension. This include an investigation of the nature of current interaction between traditional healers and modern health care personnel, the perceived barriers of collaboration between the two systems of health care delivery and the perceived ways by which collaboration can be promoted
- b.) To develop strategies for collaboration between traditional healers and modern health personnel through a focussed group session
- c.) To conduct a process analysis of the implementation of these mutually developed strategies
- d.) To compare the theoretical essence of these strategies with other established and documented collaborative models and approaches.

#### **1.4 Significance of the study**

Traditional healing and traditional medicine as well as collaboration between the two systems is very significant, not only in Swaziland, but throughout the world. This study is also very significant in that there is an increase in research about traditional healers. According to the World View (1998) Correa, the Minister of Health in Senegal, in a meeting where researchers and healers from Africa and America met to take a new look at traditional healing practices and to see how traditional healing practices might be incorporated into modern medicine, recommended that traditional practices should soon be made legal..

As this study follows some principles of action research, participants will be empowered in the management of chronic illnesses and through the collaboration process, especially the traditional healers. It is anticipated that traditional healers, western trained health care workers and clients, being involved in recognition of the problem of collaboration and assisting in identifying solutions, would be more willing to work towards implementation of the solutions and institutionalizing the selected strategies.

Stott & Browne (1973) stated that the relationship between traditional healers and modern practitioners is that of tolerance rather than of professional respect. This study aims at enhancing professional respect between the two systems of health care delivery in Swaziland so that quality health care should be provided to the clients served. The study would motivate a positive relationship between traditional healers and western health care workers. There would be a move from the western health care workers to stop condemning the traditional healers and vice versa. Stott and Browne (1973) mentioned that the medical practitioner has little in common with the traditional health care workers. Shai-Mohoko (1996) stated that the formal medical practitioners

condemn the services of the indigenous healers. This study, through the process of facilitating collaboration among all parties participating, will encourage professional respect for the benefit of the patients.

The study also contributes to the needed research about traditional healers. Some scientific knowledge about traditional healers, specifically about collaboration between the two systems of health care delivery will be added to the already existing knowledge. Knowledge about the management of chronic illnesses by traditional healers will be made known to western health care workers and vice versa. Strategies for collaboration will be utilized in both practical and educational institutions as part of the collaborative role of western health care workers. Incorporation of such strategies in the health care curriculum in institutions of higher learning will prepare professionals who would be in a position to have knowledge of and appreciation for collaboration among their own professionals and with other health care professional workers.

## **1. 5 Definition of terms**

The following definitions are those adopted in this study:

### ***1. 5. 1 Collaboration***

Phipps, Cassmeyer, Sands & Lehman (1995) define collaboration as a relationship of interdependence, where the ability to work together collaboratively, involves trust and respect not only for each other, but of the work and perspectives each contributes to the care of patients.

According to Kyle (1995) collaboration assumes that interfacing partners are strong enough and secure enough to hear the other's feelings or opinions without being shaken within themselves.

Henneman, Lee and Cohen (1995) stated that collaboration is a complex phenomenon, yet one that is of significance to nursing. The concept of collaboration involves 'working together', 'cooperating with or assisting, usually willingly, an enemy of one's country' and 'cooperating with an agency or instrumentality with which one is not immediately connected often in some political or economic effort'.

Henneman (1995) defined collaboration as joint communication and decision-making process with the expressed goal of satisfying the patient's wellness and illness needs while respecting the unique qualities and abilities of each profession.

#### *1. 5. 2 Chronic illnesses*

Peace (1996) defines chronic illness both in terms of time and quality, that it is long-lasting, constant and bad or incurable. Newby (1996) defines chronic illness as a permanently altered health state, caused by a nonreversible pathological condition, which leaves residual disability which cannot be corrected by simple surgical procedure or cured by a short course of medical therapy. Chronic illness has a profound effect on the individual as well as the family care givers. Phipps et al (1995) give a definition of chronic illness which is similar to Newby's (1996) definition where by it is stated that chronic illness is an impairment or deviation from normal that has one or more of the following characteristics:- the illness or impairment is permanent, leaves residual disability, is caused by nonreversible pathology and it requires a long period of observation, supervision and care.

### **1. 5. 3 Traditional healer**

According to WHO, (1978), cited in Hogle and Prins (1991), a traditional healer is a person who is recognized by the community in which he or she lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on social, cultural and religious background as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability.

According to Stott and Browne (1973) The traditional healer is also referred to 'African medicine man' who honours, placates and exorcize evil. His treatment is often based on information gained from dreams, and his diagnostic is ability attributed to psychic power granted his ancestral spirits.

Edwards (1986) and Gumede (1990) categorized traditional healers according to traditional doctor ( *inyanga*) who is usually a male and specializes in herbal medicine, a diviner ( *isangoma*) who traditionally is a female and operates within the traditional religious supernatural context as an accepted medium with the ancestral shades and the faith healer( *umthandazi or umprofethi*) who functions within a modern supernatural religion.

Some authors like Shai-Mohoko (1996) and Hyma and Ramesh (1994) refer to the traditional healer as an indigenous healer.

### **1. 5. 4 Traditional Medicine**

✓Traditional medicine is the system of medicine based on cultural beliefs and practices handed down from generation to generation. The concept includes mystical and magical rituals, herbal therapy and other treatments which may not be explained by modern medicine (Shiffman Medical

Library, 1998).

WHO (1978) defines traditional medicine as the sum total of all knowledge and practices, whether explicable or not, used for diagnosis, prevention and elimination of physical, social or mental imbalances, relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing. It might also be considered as a solid amalgamation of dynamic medical know-how and ancestral experiences or a total sum of practices, measures, ingredients and procedures of all kinds, whether material or not, which from time immemorial had enabled the patient to guard against disease, to alleviate suffering and provide a cure.

#### ***1. 5. 5 Herbal medicine***

Trevelyan (1993) states that the term herbal medicine refers to the use of whole plant remedies in the promotion of healing and maintenance of health. Herbal medicine uses whole plants since it is claimed to be less aggressive and invasive than modern drugs. Herbal remedies provide the necessary trace elements, vitamins and medicinal substances in a harmonious whole so as to return the patient to full health. They are said to have three effects in the body: detoxification and elimination of waste, strengthening and healing, and building up of the organs. Herbs can be combined or a single herb can be used.

#### ***1. 5. 6 Diabetes mellitus***

According to Smeltzer and Bare (1995) diabetes mellitus is a group of disorders characterized by an elevation in the level of glucose in the blood. In diabetes there may be a decrease in the body's ability to respond to insulin and/or a decrease of insulin produced by the pancreas. Insulin is a

hormone which controls the blood glucose level by regulating the production and storage of glucose. It is produced by the pancreas. Diabetes is classified into four types. Type 1 is insulin-dependent diabetes mellitus (IDDM) and type 11 includes non-insulin dependent diabetes (NIDDM), diabetes mellitus associated with other conditions or syndromes and gestational diabetes mellitus (GDM).

About 5% to 10% of the population in the United States of America have type 1 diabetes and 90% to 95% of the population have type 11 diabetes. Type 1 inadequate amounts of insulin are being produced and in Type 11 the cells are insensitive to insulin and a decreased amount of insulin is being produced (called insulin resistance). All types are serious and can cause complications. In modern medical management various types are treated differently ( Smeltzer and Bare, 1995).

#### ***1. 5. 7 Hypertension***

Hypertension is called the silent killer. It can be arbitrarily defined as persistent levels of blood pressure in which the systolic pressure is above 140 mm Hg and the diastolic pressure is above 90 mm Hg. In the elderly population, hypertension is defined as the systolic pressure above 160 mm Hg and diastolic pressure above 90 mm Hg. Hypertension is a major cause of heart failure, stroke and kidney failure. About 20% of the adult population develop hypertension and 90% of these have essential (primary) hypertension, which has no identifiable medical cause. The remaining 10% may develop hypertension as a secondary disease from renal vascular narrowing or parenchyma-renal disease, reaction to certain drugs, organ dysfunctions, tumors, and pregnancy. Essential hypertension begins as a labile (intermittent) process in a person's late 30's to early 50's and gradually becomes 'fixed.' The disease is strongly familial, though emotional

disturbances, obesity, excessive alcohol intake and overstimulation by coffee, tobacco and drugs play a role. It affects more females than males ( Phipps, et al. 1995).

#### ***1. 5. 8 Western trained health care workers***

In this study the reference is to the doctors and the nurses who were active participants.



## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

The World Health Organization in 1977 resolved to promote traditional medicine by urging member states to give adequate importance to the utilization of their traditional systems of medicine, with appropriate regulations suited to their national health systems (Hogle and Prins, 1991). Following this resolution some countries, organizations and individuals were motivated to carry out research. They also initiated certain projects and programmes concerning the incorporation of traditional healers into the national health care system. These projects were conducted from 1978 to about 1988. After this there was a decline in projects and research being done in the field of traditional healers and traditional medicine. As a result there are not enough current studies in the area of traditional healers in Swaziland. Subsequently, the Organization of African Unit (O. A. U.) has encouraged countries to do surveys to develop a Traditional Medicinal Pharmacopoeia for each African country. It seems most African governments are either working together with the O. A. U. on such projects or they have already compiled their traditional pharmacopoeia. The O. A. U has finished working in 18 countries and Swaziland is the 19th country where such a survey is still ongoing. Other research conducted in Swaziland are about the analysis of maybe one traditional medicinal plant or plants, not necessarily about traditional healers practices.

Hyma and Ramesh (1994) also observe that it was in the 1980's that indigenous health care resources were increasingly brought under the purview of more health services. Hogle and Prins (1991) state that after WHO 's initiatives in 1977 certain terms like "integration", "synthesis",

"cooperation", and "coopted" were used. Collaboration, as it relates to health care, has been described as joint communication and decision-making process with expressed goals of satisfying the patient's wellness and illness needs while respecting the unique qualities and abilities of each profession (Henneman, 1995). This collaboration was related to nursing. Nursing as a profession needed to collaborate with other professions in order to improve patient outcomes and increase job satisfaction. Thus modern health care workers, especially nurses, need to collaborate with traditional healers in the management of illnesses.

Hypertension and diabetes are some of the serious chronic illnesses which tend to occur together. About 50% of diabetes patients have hypertension. When both diseases occur together there is an added risk for the development of arterial diseases. Hypertension is the first killer disease of the vascular system followed by diabetes which is the third killer disease after cancer (van Dellen, 1993).

### **2. 1. 1 Traditional healers and traditional medicines**

In Africa it is estimated that 80% of the population consult traditional healers before they consult the modern health care services ( Shai-Mohoko, 1996). In Senegal, World View (1998) reported that 85% of the population consult traditional healers. In Senegal it was further stated that the ratio of traditional healers to the population at large is 1:1000 to 1200. This figure was quoted in a conference in Dakar where African and American researchers and traditional healers met to discuss traditional healing practices and how they could be incorporated into modern medicine. (World View, 1998).

In South Africa more than 80% of the population consult traditional medical practitioners before, after or in place of going to a clinic or western medical doctor. In the Durban area 84% of clinic patients use traditional medicine more than three times a year, excluding self medication. In Durban there are 1500 healers who create jobs for 3750 assistants and 7500 medicinal gatherers. About 4300 tons of plant material valued at R61-million are traded in Kwa-Zulu Natal annually. Nationally the figure could be as high as 19500 tons, worth R270-million. More than 700 plants are traded and many are on the list of special protected species. About 40 tons of plant material are brought in from Mozambique into South Africa, as well as from Namibia, Botswana, Malaysia and Swaziland (Simon, 1997). This figure has increased since 1997. In the year 2000, they estimated that the traditional medicines are worth R900- million( Macleod, 2000).

In Swaziland in 1983 there were 5000 traditional healers and their ratio to the population was 1:110. Eighty five percent of the population in Swaziland make use of these traditional healers (Green and Makhubu, 1983). It was estimated in 1988 that Swaziland has about 8000 traditional healers who included diviners, healers, herbalist and faith healers who diagnose and treat illnesses ( Ministry of Health, 1988).

### ***2. 1. 2 Chronic Illnesses (diabetes and hypertension)***

According to Newby (1996) approximately 110 million people are afflicted by one or more chronic illness in the United States of America (USA). Only 32.4 million out of the 110 million are limited in their activities of daily living.

Peace (1996) states that one third of the population in the USA is afflicted by chronic illness at any time. Two thirds of all the people over 45 years of age have a chronic illness. The prevalence

of chronic illness is increasing. Diabetes and Hypertension are the most serious and commonly occurring chronic illnesses which also have a lot of complications and a tendency to result in disabilities.

van Dellen (1993) stated that in South Africa 1 million people were affected by diabetes and estimated that by the year 2000 the numbers would have increased to 2 million. About 50% of patients with diabetes would also develop or have hypertension.

In 1987, a total of 2727 deaths were recorded from hypertension in Britain. The primary objective of controlling hypertension is to reduce the morbidity and mortality attributed to cardiovascular and cerebrovascular diseases without increasing the morbidity and mortality from other causes (Manship, 1994).

About 2% of the United Kingdom population had diabetes and its prevalence increased with age as about 5% of people over 65 years were affected. Compared to the rest of the population, patients with diabetes were up to four times more likely to have myocardial infarctions or cerebrovascular accidents (Willis, 1995).

## **2.2 TRADITIONAL HEALERS AND TRADITIONAL MEDICINES**

### **2.2.1 Traditional healers and their categories**

According to Hogle and Prins (1991), WHO's definition of traditional healers reflects an emphasis on herbalists and their practices or activities. Hogle and Prins (1991) also stated that among Africans the supreme importance of ancestral spirits is the source of the very high status of the

type of traditional healer called a diviner, priest/priestess, a medium or a spiritualist. It is this aspect of traditional medicine that is most unsettling to biomedical practitioners. Most traditional healers work as herbalists or ritualists or both.

**The following authors described categories of traditional healers as follows:**

Makhubu (1978) distinguishes three categories of traditional healers, *inyanga*, *sangoma* and *umfembi*. A fourth type of a traditional healers, called *lucedla*, evolves from these three and differs in that his skills are acquired without any spiritual possession, whereas the others undergo training called *kwetfwaswa* (*Siswati grammar*) which is a process whereby ancestors manifest their presence in the subject who will eventually become a traditional healer. *Inyanga* has been described as a medical and a pharmaceutical specialist, who possesses bone throwing skills. The *sangoma* differs in that his or her diagnosis is based upon a process called *kubhula* which involves communication through a trance with supernatural powers who reveal to him or her the source of the patient's problem. The *umfembi* is quite similar to the *sangoma*, but the directing spirits during diagnosis may be evil spirits who use the *umfembi* as a medium to reveal their identity. The *Sangoma* will normally have undergone three years of training. The *umfembi* presumably follows the same path as the *sangoma* but does not undergo so lengthy a period of training. The spirits involved belong to people killed by members of the *umfembi*'s family, perhaps in past wars. Makhubu (1978) did not describe the category of faith healers.

Gort (1987) divides traditional healer into the herbalist (*inyanga*, *lucedla*) and the diviner (*sangoma*), and a third type being the Zionist faith healer (*umprofethi*) a prophet. Traditionally, there was a discrete division of labour between the 'diviner' and the 'herbalist' and to this was added a third category, Zionists 'faith healers,' who appeared in the late 1930s. The diviner's

work was to use bone throwing or other diagnostic techniques to assess the cause of the condition and recommend the herbalist (*inyanga*) best able to treat it medicinally. The herbalists acted as pharmacists and thus dispensed herbal medications but rarely diagnosed or got involved in acts related to and associated with divine intervention. The faith healer aided by the power of the Holy Spirit, relied on prayer and a mixture of water and ashes or minerals (*siwasho*), rather than herbal medicine to cure the sick.

Edwards (1986) like Gort distinguished three basic categories of traditional healers in Zulu society as being the *inyanga*, *isangoma* and *umprofethi* (faith healer). He stated that the advent of the faith healer could be traced back to the rise of the African independent church movement, which broke away from western oriented missionary churches. According to Edwards (1986), the *inyanga* is usually a male and specialises in herbal medicine, the diviner or *isangoma* is usually a female and operates as an accepted medium with the ancestors.

Gumede (1990) stated that the ancestral spirits of the departed ones are called '*amadlozi*, *izinyanya*, *izithutha* or *abaphansi*'. In Shona they are called '*Mhondoro*'. Gumede classifies traditional healers as follows:-

Destructive and evil ones (*abathakathi* or witches).

Diagnosticians or diviners (*izangoma*, *azanusi* (smellers), *abalози* (ventriloquists), *amandiki* and *amandawu*).

Theraputicians, medicine man (*izingedla*) and herbalist (*izinyanga zamakhambi*).

Specialists or sky herds (*izinganga zezulu*), rainmakers, military doctors, disease specialist (heart, kidney, chest).

In Zaire, according to Ahluwalia and Mechin (1980), the traditional healers were divided into four categories which focus on the type of treatment administered. The four categories were pure herbalist, herbalist-rituals, rituals-herbalist and spiritualists. Among all the four types there were those who were diviners and those who were not diviners. There were those who were specialist and general practitioners. These healers were found in Kinshasa, a large city, Middle-sized cities and Rural areas. A large number of traditional healers were found in Kinshasa followed by the rural areas of Zaire. Ahluwalia and Mechin (1980) discovered that a traditional healer might be consulted by one person as a herbalist and by another as a diviner. In their study they discovered that patients sought treatment first from modern medicine and its practitioners before the traditional healers.

Most traditional healers stated the categories of traditional healers without mentioning of witches or evil doers. Gumede is the only one who classified this category as part of traditional healing. There are some overlaps and similarities among the categories which show similarities in traditional healers categories in different countries. Some slight differences occurred whereby some authors did not mention the faith healers and their origins. In this literature review one learns that the faith healers were a new category, being some form of traditional healer modernization and the origin of faith healers can be looked at as a way by which traditional religion was preserved from the religion brought in by missionaries.

### **2. 2. 2 The training of the traditional healers**

Gort (1987) agrees with Makhubu (1978) that diviners (*tangoma* or *izangoma*, plural for *sangoma* or *isangoma*) did not choose their calling or their instructors (*bogobela*), but the ancestors (*emadloti* or *amadlozi*) and the spirits of vanquished enemies (*emandzawe* or

*amandawe*) coerced them into that capacity. Chavunduka (1978) calls the *emandzawe* the spirits of the foreigner or alien spirit. This coercion takes the form of inflicting long-lasting and mysterious illnesses, often manifested as signs of mental disturbance, which could not be cured until the sufferer agreed to be inducted into the profession. The process of training is called '*kwetfwaswa*' or '*ukwethwaswa*'. (Gort, 1987 and Makhubu 1978). The trainer is normally identified in visions and dreams as the one uniquely qualified to heal the patient. The process normally takes a long period of about one to three years.

Griffiths and Cheetham (1982) also state that '*ukwethwaswa*' ( *Zulu grammar*) is the act by which the '*isangoma*' is called to her or his vocation by the ancestors and which heralds a period of initiation for her or him. '*Ukwethwaswa*' is viewed as a spiritual or religious experience, a gift from those ancestors ('*amadlozi*' , *Zulu grammar*)who protect yet judge their descendants.

According to Gort (1987) some of the herbalists (*izinyanga* or *tinyanga*) reported having mystic experiences or mystic illnesses, which called them to the profession and/or to the appropriate instructor. The majority of *tinyanga*, as Makhubu (1978) mentioned, had information transmitted to them from a family member who was a practitioner. There seems to be a wide spread of parent to child training patterns.

Gort (1987) observes that with the changing traditional medicine, most traditional healers have a tendency to undertake both divining and dispensing of medicine. It is no longer as Makhubu (1978) reported that the diviner would send the patient to the '*inyanga*,' although there are some who still practise the traditional way. Gort (1987) in his study finds that such changes were brought about by the need for finance, advances in skills of healers, as well as other influences



such as social, political, economical and cultural changes.

*Zionist* or faith healers also have the beginning of their training through dreams. One condition for their being endowed with the power of healing, according to Gort (1987), was that they should not be tainted by monetary reward seeing that they are doing it for God. With the changes in healing, most Zionists do charge their patients, some in a form of money, others request that the patient give a token of gratitude, and that token tends to be in a monetary form.

In the past it was noticed that there was gender influence in that many more women were diviners than herbalists. Kuper (1986), cited in Gort, (1987), stated that this gender difference was due to the different roles. Women were not expected to roam around the country side looking for herbs, but they could divine at home. Gort (1987) states that this trend is also changing in that now more women are found to be herbalists or both. With faith healers, gender differences were found to be irrelevant.

Chavunduka (1978) mentions that much of the traditional healer's time is spent trying to help people to come to terms with their social problems. There are two main ways of becoming a healer in Shona traditional medical practice. Many believe that they inherit their healing spirit from a *mudzimu* (a deceased healer in the family) or from a *shave* (foreign spirit) or both. There is no apprenticeship at all, but the spirit is the guidance. The second type receives some form of medical instruction from other healers. About 51% of the patients with mental disorders first consulted modern medicine and 39% consulted only traditional medicine. Chavunduka (1978) discovered that herbalists treated the widest range of disorders, especially patients with illnesses of the digestive system. A larger number of patients with psychic disorders and those with diseases of

weakness and weight loss consulted with traditional healers than the western trained health care workers.

### **2. 2. 3 Causes of illnesses in traditional medicine**

Most authors classified the causes of illnesses as natural and unnatural causes. Gort (1987) and Makhubu (1978) referred to unnatural illnesses as those illnesses due to supernaturally causes, while Ahluwalia and Mechin (1980) simply referred to them as unnatural causes. Interestingly, Ahluwalia and Mechin (1980) noted that traditional healers called the cause natural not because they had conducted systematic research, but because the illnesses have previous associations and assumptions. Causes are considered natural because of how they occurred and not why they occurred. The supernatural or unnatural causes are those attributed to sorcery or bewitchment, spirits, magic and fetishes. In the case of supernatural and unnatural causes traditional healers are willing to discover the cause of the illness and the fact that the illness was invoked. According to Ahluwalia and Mechin (1980), Gort (1987), Makhubu(1978) and Chavunduka (1978) supernatural causes can be categorized as follows:

- \*transgression of a social rule by a patient or a family member,
- \*conflicts in interpersonal relationships (jealousy, misunderstanding and strange behaviour),
- \* a special relationship between the patient and a spirit, or
- \*violation of witchcraft-related rites and fetishes.

The last one is based on the degree to which the patient is responsible for his illness and is interpreted as punishment. The traditional healer normally divines more than one unnatural cause for each illness.

Gort (1987) stated that most *Swazis* (The nation of Swaziland) believed that illnesses resulted primarily from natural causes and sorcery, and secondarily from ancestral wrath. Western medicine is thought to be the treatment of choice for conditions that are naturally caused, while sorcery and ancestor-induced illnesses are judged to respond best to the ministrations of traditional healers. The diagnosis of an 'African' illness allows healers to interpret social norms and articulate the prohibitions and injunctions of the society.

Like Chavunduka (1978), Gort (1987) also described how the traditional healers provided explanations and guidelines to the patients until the patients became clear about their diagnosis and how the illness occurred, thus their fears were alleviated enabling them to benefit physiologically and psychologically from the reduction of stress.

Gort (1987) however contradicted Makhubu and Green (1983) when he stated that ancestors were loving and concerned, so they would not cause illnesses, but could send a warning, such as the sight of a dog on the roof of a house.

#### **2. 2. 4 Nosology (Language used by traditional healers)**

The language spoken by traditional healers is very interesting. According to Ahluwalia and Mechin (1980) healers' spoken languages contain many different names for illnesses. A single illness can have several names to suit different circumstances. Sometimes each symptom of one illness might be interpreted by the healer as an illness. The form, odour or colour or other quality of the symptom may be linked with an animal or a plant. At times the illness is named after its cause. With such naming patterns it is clear that terms for illnesses used by healers cannot be formally compared with those of Western medicine, although a majority of names of illnesses

refer, as do those in Western medicine, to an organic symptom.

### **2. 2. 5 Diagnosis made by traditional healers**

It is doubtful that traditional healers possess an organized body of anatomy and physiological knowledge, even though their medicine may be recognized as effective. They might know a number of organs, their names and their locations in the body. Most authors contend that the healers are not interested in how the organs work, or what the major physiologic systems are. Traditional healers tend to attach great importance to symptoms and focus their attention on changes in the various parts of the body affected by the illness (Ahluwalia and Mechin, 1980).

There are three ways of diagnosing identified by most authors in traditional medicine, one being the patient's explanation of the illness, through divination by either spirits, '*kufemba*', or making the patient to drink something so that the patient can engage in self diagnosis whereby the healer becomes the interpreter and bone throwing normally used by the herbalist (*lugedla*) (Gort, 1987).

The most important influence the traditional healers have is that they are alert to any alterations in symptoms as well as in the patient's psychic condition, thus making the patients feel that they are receiving proper follow up. Makhubu (1978) states that, in modern medicine, a description of a sickness is given by the patient to the physician. The physicians deduce the nature of the disease following established methods generally accepted throughout the modern system. The physician is consulted for preventive and treatment purposes. In traditional medicine, especially in Swaziland, the traditional healer is contacted not only for an illness, but even when an evil omen (*umhlolo*) is noticed or when an actual misfortune such as an accident has occurred. In the case of a disease, a history is very rarely given by the patient because it is the traditional healer's

task to first reveal the nature of the problem to the patient through the '*kuphengula*' process, which involves questioning and response until the cause is established. Some of the traditional healers will throw bones and then interpret the message portrayed by these bones.

There is a fourth type of diagnosing called '*umkhaya*' which is rarely used. This type is used when there is suspicion that a witch (*umtsakatsi*) has caused the illness or the evil omen. The traditional healer consulted would then identify the person who had caused the problem by name. The traditional healer is normally very famous far away from the community where such a problem had occurred and is believed to be very strong and reliable ( Makhubu, 1978).

When it comes to diagnoses the concept of witchcraft explains 'why' the illness occurred and 'why' a particular individual should contract the diseases whereas western medicine would explain 'how' the condition developed. Thus western medicine might not explain the total situation for or answer all questions of a black patient regarding the sickness phenomenon, whereas the *sangoma* provides the assurance and explanation essential to the conceptual framework of illnesses prevalent in his culture (Griffiths & Cheetham, 1982).

Gort came up with another form of diagnosis, the mirror. Mirror reading is another technique whereby the spirits are contacted for their diagnostic assistance. The actual naming of evil doers is prohibited by the law, though some families still practice the '*umkhaya*' process of identifying a witch.

Hall (1998) described the diagnosis which most *sangoma* practices nowadays, that of throwing bones. As Makhubu stated, bone throwing was done by a *lucedla* and not a *sangoma*. Hall described bone throwing as a more compact affair, always serious in tone, and more business-like, efficient procedure.

Before the patient consults a traditional healer, he or she usually already holds some suspicions regarding the cause of illness. Such a patient is looking for confirmation of the suspicions. If the traditional healer can arrive at the same diagnosis unaided, it becomes more convincing. The general practice among Shona patients is to draw the doctor's attention to the part of the body that is painful and let him figure out what is wrong. Thus the traditional healers who tell their patient what is wrong without being told are considered to have great reputation among the traditional Shona. Some Shona traditional healers cleverly elicits information from the patients, who in response to the traditional healers' questions, gives some history of their personal relationships with their neighbours, workmates or kinsmen (Chavunduka, 1978).

Chavunduka (1978) also disclosed that some traditional healers gave their patients some medicine to take before they sleep so that the patients can do self diagnosis through dreams. Makhubu (1978) called this type of diagnosis '*luhhe mane*'. A patient is given a herb called '*luhhe mane*' which has a mind-changing effect and makes the patient talk about his sickness and his whole life until the effect of the medicine wears off, although the patient will not remember what he or she has said. During this time, somebody else needs to listen to what the patient is saying. Diagnosis in Shona was observed to be made mostly through spirit possessions and some through bone throwing (Chavunduka, 1978).

## **2. 2. 6 Functions and methos of treatment by traditional healers**

Makhubu (1978) noticed a lack of body of knowledge such as physiology and chemistry in the methods of treatment utilized by the traditional healers which Ahluwalia and Mechin (1980) also pointed out. A large component of treatment aims at satisfying the belief in the mysterious and superhuman world.

Chavunduka (1978) also noticed that traditional medicine is successful because of its tendency to treat the 'whole man', that is to deal with both physical and psychological needs. Sometimes traditional healers may not be aware that they are applying empirically correct methods of treatments such as sucking the poison out when a person is bitten by a snake. In doing this, the venom comes out and that is the objective. Also, the failure of modern medicine to get good results in certain illnesses makes traditional medicine seem very important. This is true in the area of chronic non-incapacitating dysfunctions. Barker (1959,p.104) (cited in Chavundaka (1978), says " Where we failed, in hopeless cancer or in chronic ailments, the spirit-world would again be invoked, but often from only despair which prompted fond relatives to leave no avenue unexplored which might lead to the last-minute restoration of their sufferer's health."

Ahluwalia and Mechin (1980), like Chavunduka (1978), also mention that the comprehensive approach of traditional medicine is evident in treatments given to the body, to social and spiritual relationships and to certain internal psychic states, such as guilt and anxiety. Whatever form, all treatments involve natural or the use of plants or ritual customary performances by the traditional healers and most therapies combines both.

Griffiths and Cheetham (1982) state that the roles of *isangoma* are those of being a healer through divination or provision of *muti*, a centre of social integration and cohesion, diviner or seer, the protector of people, their possessions and their environment, particularly against lightning, being the religious head of the society and mediator between the ancestors and their descendants. Thus it is clear that the functions of the *sangoma* are extensive.

According to Griffiths & Cheetham (1982) the ministrations of these traditional healers appears to have proved significantly effective in alleviating both physical and emotional disturbances and they continue to represent a major therapeutic resource within African society despite the increasing availability of treatment based on the western model of sickness and disease. The *sangoma* is perceived by Blacks as being in possession of powers of greater magnitude than those of western trained health care personnel or of uniquely different powers essential to the achievement of complete remission.

Gort (1987) also identified the comprehensive approach to practice whereby traditional healers incorporated some of the western medicines in their treatments as a change influenced by socioeconomic and other factors. What was noticed was that healers may employ these western medicines differently from what the manufacturer intended them for. This might not be good since unintended effects may be experienced by the clients.

## **2. 2.7 Medicines used and the way they are administered**

Traditional medicine is an ever present reality in both rural and urban societies. Despite the introduction of modern medicine by the colonial powers, inhabitants of Africa have never stopped utilizing traditional medicine. After independence in South Africa, in 1994, economic



circumstances were such that imported techniques and medicines became less accessible to Africans. This forced the authorities to approach the problem by exploring the possible utilization of indigenous sources (Pretorius, 1991).

Preparation of medicines would be in a form of powder, or liquids called '*imbita*'. Some of these could be administered through '*kugata*' which is an analogue to an injection. Small cuts are made on the body surface by means of a razor blade or piece of glass. These cuts should cause some bleeding and then medication in the form of a powder would be instilled in the cuts to be transported through the blood system. This could be used as a preventive measure or as a curing measure. An enema (*kucatseka*) is used by most Swazi traditional healers as a way of administering medicine. Sometimes they would administer large amounts of liquid medicine orally and the client would have to drink this large amounts such that vomiting can be easily induced by inserting a finger or a feather, and this process is called '*kuhlanta*.'

Makhubu (1978) identifies the following ways of administering traditional medicines for either curing or preventing illnesses or removing bad luck:

1. '*Kuhlanta*' is prescribed for problems of cases where they suspect that one has eaten poisonous food (*sidliso*), and they would diagnose it when a person is constantly coughing. The *kuhlanta* is believed to clear the chest. Makhubu (1978) finds this curious since the solution goes into the digestive system instead of the lungs. *Kuhlanta* can also be used to remove excess bile from the abdomen. When there is excess bile the person will experience symptoms like dizziness, nausea, frequent colds, as well as generally bad luck. Then '*kuhlanta*' would be used to cleanse oneself of ill-luck. Ill-luck manifests itself by the frequency of misfortunes at home, at work or in love. An extract of certain herbs is added to cold or warm water and stirred to make a foam. The

patient is given the mixture to drink before *kuhlanta* can take place.

2. Another method is more like a sauna and brings about cleansing called '*kufutsa*'. One would 'have a steam' with a hot herbal solution followed by a bath in the same solution. This process is used to treat a variety of ailments such as skin conditions, colds, painful bruises and also for misfortunes.

3. '*Kubhunyisa*' is another way of administering medicine by inhaling smoke from burned herbs. This is followed by '*kucapha*', which involves adding water and taking the medicine while still hot by means of dipping finger tips into the preparation and placing it on the tongue.

4. '*Kuhlabela*' is a way of treating sprains and fractures by some herbal drink which normally improves circulation and prevents swelling. A certain herbal mixture called '*mahlanganisa*' (the one that connects) is normally used for and '*luhlaka*' (splint) is normally used to keep the broken limb immobilized (similar to a splint). '*Luhlaka*' is a splint made from branches of a tree and the broken part is normally tied on this splint to prevent mobility.

5. '*Kumunya*' (sucking) is a process whereby the traditional healer would make small cuts and then place a horn which is open on both sides over the affected area of the body and then suck. This is believed to remove an illness from the affected system.

Ahluwalia and Mechin (1980) state that remedies in traditional medicine consist of formulas prepared from various substances: animal, mineral and vegetable. The vegetable preparations account for 90%, hence the reference to the practitioner who uses them as a herbalist. These

remedies include extracts of raw materials from a single plant, several related plants, or from animals and mineral substances. The ingredients are combined either at the time of preparation or during administration. Traditional pharmaceutical techniques consist of operations such as selection of the remedy, collection, preservation, preparation and packaging. A healer may use different parts of the same plant to treat two different illnesses; for an example, the vine of *Alchonia cordifolia*, Euphorbiaceae is used for diabetes, while the roots are used for psoriasis. Different methods are used to prepare the remedies such as dividing them into portions, dissolving them, filtering and blending additional ingredients. Powder, solutions, soup and ointments are some of the end products of these remedies. The methods of administration are oral, nasal, anal, vaginal and auricular as well as dermal. The efficacy of a therapy is believed to be the result of the power of the herb and the traditional healer's strong powers.

Treatment is also done through the power of ritual, in which the psychological level is used. Ritual is based on a group of symbols and beliefs. Rituals may be peripheral, integral or universal in the overall therapeutic strategy. Studying the efficacy of a ritual is extremely complex because a person's recovery depends on the remedy administered, the context in which it was administered, the patient's expectations, and the human body's recuperative powers (Ahluwalia and Mechin, 1980).

#### **2. 2. 8 Traditional Healers' Associations**

Traditional healers also have the urge to function as an organized profession. These associations encourage some communication among traditional healers as well as sharing of information. Other health care systems can communicate with the traditional healers in an organized fashion instead of visiting one traditional healer at a time. The associations allow the traditional healers liberation

and they are able to influence legislation and policy makers in their favour and perhaps change some of the laws that prohibit their functions.

Chavunduka (1986) state that traditional healers are working towards professionalisation of traditional medicine and a working relationship with biomedical professions within national health care systems. Traditional healer associations now exist in 23 African countries, and are made up of healers who are interested in learning more about biomedical care, who want to work with biomedical practitioners and ministry of health officials, who want to change the old image of traditional healers as primitive witch-doctors, and who want to be as respected among government officials as they are in their own communities.

In Zimbabwe it was stated that traditional healers want legal status so that their services would be compensated by government and private medical aid programs, and so that traditional healers could have the authority to justify a patient's temporary or permanent leave from work (Cavender, 1988.)

Green and Makhubu (1983) state that in Swaziland King Sobhuza II, before he died in 1982, began to call for the formation of professional association of traditional healers, in part to reestablish social control mechanisms that could operate in a modernized society. Studies done at that time revealed that 80% of traditional healers wanted to have and join a healers' association; 10% were strongly against the formation of an association; 10% felt that jealousy, competition and mistrust among healers would doom the formation of an association and 51% felt that an association would increase cooperation between traditional healers and provide a platform for sharing knowledge and learning from one another.

The association, according to Green and Makhubu (1983), would be responsible for registration, regulation of fee payment, and drawing up a code of conduct acceptable to all healers and consistent with accepted good health care practices. Hence the Ministry of Health established the Commissioner of Traditional Medicine in Swaziland as an attempt to organize traditional healers. The Commissioner of Traditional Medicine established by the Ministry of Health in 1980, whose chairperson was Makhubu, proposed the following structure.

MINISTRY OF HEALTH

MINISTRY OF HOME AFFAIRS

#### NATIONAL COMMITTEE OF THE TRADITIONAL HEALER

Hhohho

Manzini

Lubombo

Shiselweni

Local Community traditional healer under each chief

a) The National Committee should have two traditional healers from each District, HHohho, Lubombo, Manzini and Shiselweni. There should be one principal secretary from the Ministry of Health and one from the Ministry of Home Affairs. A member of the Swazi National Council and the Registrar of births and deaths certificates should be on the committee.

b) The local Committee should have traditional healers selected by their peers who reside under one chief. If the chief so wishes, he/she would be entitled to attend the meeting of the committee.

The formation of a Commissioner of Traditional Medicine was a constructive initiative by the Ministry of Health. This Commissioner did not succeed due to reshuffling and end of terms for the politicians, as well as the passing away of the King. The traditional healers did not view it as their own, since it was initiated and implemented by only the external forces.

It was followed by the formation of the traditional healers' organization by the traditional healers' themselves in 1985. So far Swaziland has two Traditional healers' organizations. One of them, led by Mr Maseko, has been long standing since 1985 and the other one has been formed in 1990 by healers who felt the other organization was becoming too much westernized. The more recent one is led by Mr. Vilane and it tried to make sure traditional healers remain with their traditional practices ( Verbal report from Mr. Langa, 1999).

### **2. 2. 9 Policies Governing Traditional Healers**

According to Ahluwalia and Mechin (1980) in most countries the laws governing traditional healers' practices were very ambiguous and not clear, despite the fact that WHO in 1978 made a resolution that governments worldwide should give adequate importance to the utilization of their traditional systems of medicine, with appropriate regulations suited to their national health care systems.

Green and Makhubu (1983) stated that the Ministry of Health in Swaziland had an ambiguous policy or no policy towards traditional healers. In 1945-6 there was an attempt made by the colonial powers to pass legislation that would provide for the registration of traditional healers and would attempt to control their practice. Prior to that time and dating back to 1894, all 'witch-doctoring' was considered illegal in Swaziland. This led to the introduction of the Witchcraft Act in 1905 forbidding the practice of traditional healers. There was strong opposition to the proposed legislation of 1945-6 by the then director of medical services. Thus, the law was never passed. King Sohbuza II was supportive of traditional healers and their practices. He envisioned the development of a health care system that combined the best aspects of both traditional and modern medicines. He believed that a scientific study of traditional healing should be undertaken

before attempting to restrict or alter practices.

In 1954, the King issued an executive 'Order-in Council' which represented the further development of the earlier proposed legislation. The order dealt with registration, fee payment, referral of patients to clinics by traditional healers, misconduct and malpractice. Taxation and registration of healers began that same year and records were kept by the Swazi National Council, a traditional body under the King. The King in 1979 and 1981 called a meeting of the nation and traditional healers to discuss the formation of a new structure to guide traditional medicine. These meetings were followed by a directive to the Ministry of Health to look into ways of organizing healers. The Ministry of Health appointed a commission which dealt with the issue of traditional healers. This Commission drafted the revised legislation which was modelled on the one that applies to medical practitioners. The draft dealt with registration, code of conduct, fee payment, and the formation of an association of healers. The King unfortunately passed away in 1982 and the work of this commission was disrupted (Green and Makhubu, 1983).

Ministry of Health (1983) states that the modern health care system must develop in such a way that it responds to Swazi culture and tradition. Information must be sought from the *tinyanga* (traditional healers) and other healers in order to make modern health care services more attractive to all members of the population. The National Health Policy never mentioned any collaboration between the two systems except to be concerned about making the modern health care system attractive to the population by seeking information from traditional healers. It does not mention anything about the improvement of the nation's health by collaborating with traditional healers. The health policy acknowledged that if nothing is done to include traditional healers, the modern health care services will not be attractive to the population.

Ahluwalia and Mechin (1980) noticed that in Zaire the traditional healers' position with regard to law was fairly ambiguous and their practices appeared to be outside the laws governing the art of healing. In Zaire, laws limit medical practice to those who hold a recognized diploma. These laws fail to lay down any guidelines whatsoever regarding the practice of traditional medicine. Ahluwalia and Mechin (1980) recommended that the laws needed to be reworked to embody traditional jurisprudence, existing legislation, and informed regulations on the practice of traditional medicine. Because of the ambiguity in present laws, traditional healers become victims of judicial conflict because everyone wants to control them, and no one has the means to do it. The healers are powerless when an accident occurs during treatment or when customers refuse to pay them.

In Swaziland traditional healers and their practice are still legally guided by the Witchcraft Act of 1905 (see the addendum, p)

Good (1988) recommends for collaboration changes in policy making for all countries that would involve traditional healers. The legal status of traditional healers must be clarified and made consistent at the national level. Legislation that blocks the practice of traditional medicine should be replaced by statutes that formally recognize traditional healers. According to WHO (1985), (cited in Good, 1988), such legislation should be flexible, allowing for periodic amendment as situations change, and compatible with policy initiatives such as widespread pilot projects involving traditional healers. The modern system seems to take it upon itself to develop policies for traditional healers instead of acting as a catalyst for the traditional healers themselves to recommend their own policies.



According to Pretorius (1991) numerous legislative approaches to traditional medicine fell into four categories. **a) The Exclusive Monopolistic System:-** In this system only the practice of modern medicine was regarded as legal while all other forms of healing were excluded. There was among this system the strict, total and enforced monopoly and the socialist model. The former was found in the United States of America, France and Belgium and the French and Belgian colonies of Africa and the latter in Russia and the East-European socialist countries.

**b) The Tolerant System:-** Only the system based on allopathic medicine was recognized, while the existence and significance of the traditional sector was ignored. This type of system was to be found in the German Federal Republic, the United Kingdom and the Republic of South Africa. In South Africa the Council of Associated Health Professionals made provisions for the registration of and control of traditional healers. This applies to countries like Swaziland.

**c) The Inclusive Parallel system:-** Traditions other than allopathic medicines are recognized legally, so that the two co-exist. To be legible for such inclusion the traditional system has to be highly formalized. These systems may be found in parts of Southern Asia, such as India. This system would not be found in any part of Africa.

**d) Integrated systems:-** Modern and traditional medicines are united in terms of medical training and jointly practised in unique health care system. This is an official policy. This type of system is to be found in China and Nepal.

## **2. 2. 10 Summary**

It is clear from the above studies that traditional healers seems similar in most African countries, though the systems of legalities are very different when compared to the global world. The categories identified in Africa tend to be similar. The traditional healer's explanations of categories of illnesses and how they diagnose these illnesses are also similar for most African

authors. Such information contributes to form a base or an understanding of who traditional healers are and how they practice. This information would assist in finding out how best the traditional system of health could collaborate with the modern or western system of health in Swaziland.

The nature of traditional healers has been discussed including how they train, diagnose and carry out their treatments using herbs. Understanding the traditional healer and traditional medicine leads us to the discussion of attempts that have been made towards collaboration. Such information about traditional healers, help the researcher to be able to analyse the positive and negative attempts to collaborate. From this knowledge, one can clearly note the differences and similarities between the modern health care system and traditional health care system.

### **2.3 COMPARISON BETWEEN TRADITIONAL HEALERS AND WESTERN TRAINED HEALTH CARE WORKERS**

Edwards (1986) states that the distinction between the modern and traditional is absolutely arbitrary when one considers the personal, interpersonal and community variables affecting the interchange between healers and patients within the total healing context. It is, however, a useful, generally-accepted distinction broadly denoting modern, Western-oriented, biomedical, structurally dominant system in contrast to more local, culturally relativistic, humoral, functionally strong, traditional healing approaches respectively. Traditional medicine is most commonly practised in rural areas lacking modern health care facilities. Western medicine is accepted as a treatment of choice by most, although eclectically chosen combinations of modern and traditional medicine remain common. One of the distinctions between the two is the natural

vs supernatural orientation respectively to modern and traditional.

Gumede (1990) compares traditional healers and modern healers and comes up with the following differences:-

- a) Modern healers are Western in origin while traditional healers are indigenous and African in origin.
- b) Modern healing was fathered by Hippocrates and they date back to the Greek era. Traditional healers were in existence and practising as they do today in Kush/Ethiopia some 4500 years ago.
- c) Modern healers are regarded as rational while traditional healers are considered irrational.
- d) Modern healing is regarded as scientific while traditional healing is regarded as unscientific.
- e) Surgical procedures in modern practice are planned, scientific and based on the study of gross and morbid anatomy while surgical practices in traditional healing are unscientific, unplanned and crude.
- f) The training of the modern practitioner takes about seven years after matriculation and is available to anyone who qualifies while the training for a traditional healer is handed down from father to son, or from master to trainee, apprenticeship, journey-man, or full blown *inyanga*.
- g) Aetiology of disease in modern medicine is based on the germ theory while in the traditional healing world all illnesses are man made in origin.
- h) For modern healers diagnosis entails what germ causes the illness while in traditional healing it is not only what caused the illness but also who caused the

illness.

- i) The modern healer's treatment is specific, individualised and streamlined to meet the presenting problem. The traditional healer's approach is holistic. Healing involves the living and the dead, the natural and the supernatural in addition to the patient. The traditional healer treats the patient within his or her environment-physical, spiritual, emotional, past and present.
- j) The code of conduct for modern healers is laid down by medical and nursing councils while traditional healers' code of conduct is ungoverned, it all depends on their ancestors.
- k) The language of the modern healer is scientific, about aetiology, symptomatology, diagnosis, epidemiology, endemiology, curative and preventive processes, prognosis, rehabilitation, morbidity and mortality while the idiom approach of the traditional healer is social, political, economical, moral, and even recreational and involving a change of environment.

As has been stated, the world of ritual and spirit is very different from the biomedical world. Another difference noted is the way traditional healers are trained, with no concrete body of knowledge about the body, chemistry and physiological functioning. There are also differences noted in the way certain illnesses or symptoms are named. These differences and similarities are some key points to collaboration. Each system would have to know the limits and ways of approach towards the other while still respecting the other's system of health care practices.

Gort (1989) ( cited in Hogle and Prins, 1991), states that all support for collaboration should not obscure the fact that biomedical practitioners (specifically doctors, nurses and other technicians) are opposed to the inclusion of traditional healers in the health care delivery system

and are ignorant about traditional medicine in their own countries. They see only healers failed cases in hospitals or clinic settings and tend to think of traditional healers as quacks, charlatans or witch-doctors. Those biomedical practitioners who have the opportunity to work with and get to know traditional healers usually experience a major attitude change. Public health nurses and health educators seem to support a positive working relationship between the two sectors.

Healers have a part to play in the health team and thus should be drawn into the health team and the trust people have in them should never be broken down (Portgieter, 1992).

Traditional healing in Swaziland is a coherent, logically consistent system of beliefs and practices that satisfies many of the physical, mental, and spiritual needs of those who participate in the system. An estimated 85% of the population make use of the traditional system. Swazi healing practices are based on a belief system of magic and religion that parallels Western science and Christianity in attempts to find order, regularity, and simplicity in the apparent chaos and randomness of nature. The traditional belief system provides answers to many questions that perplex the people. Swazi healing has a strong empirical or naturalistic component that relates to cause and effect observations made in the everyday world. The naturalistic or empirical components offer a common ground for understanding between the modern health sector and the traditional health sector, although there are many differences and even incompatibilities between these systems which underlie both theory and practice in general (Green and Makhubu, 1983). Traditional healers are practical and not scholars. Their aim is to cure patients and their knowledge is not academic like that of modern health care professionals.

Wessels (1985) looks into the differences between traditional healers and modern doctors in terms of psychiatric disorders as related to culturally specific syndromes. Culturally, according to Wessels (1985), South Africans viewed illnesses in terms of natural, moral and magical causes.

Moral causation concerns their dead ancestors and usually stems from failure to prevent imbalance between the person, family, environment, ancestors and spirits. The type of treatment depends on the causation. When moral and magical causes are involved, the treatment must include ritual, symbolic procedures. Natural causes and somatic symptoms are treated somatically and empirically. Prevention is achieved by cleansing, purifying and protecting by ritual measures. Blacks divide illnesses according to two distinct groups: the “natural illnesses” and the “African disorders”. The “natural illnesses” include mental retardation, epilepsy, schizophrenia, affective psychoses and hereditary and organic brain disorders. Western trained doctors are generally regarded as qualified to treat these conditions, but not the “African disorders” which are regarded as peculiar to African people and are to be treated by traditional healers. The blacks or cultural-bound syndromes differ widely according to different languages. Descriptive terms in English with the Zulu names were utilized and they are as follows: Ancestral spirit possession (*Ukuthwasa*), Alien spirit possession (*Ufufunyane* and *Izizwe*), spirit possession by chance (*Indiki*), Sorcery (*buthakathi*), poisoning, pollution, environmental hazards, ancestral displeasure and disregard for cultural norms (Wessels, 1985).

Hyma & Ramesh (1994) state that differences in treatment, diagnosis and practice between the traditional healers and western trained health care workers are influenced by culture, religion, levels of social and economic development and other characteristics. According to Hyma & Ramesh (1994) in India, Pakistan, Indonesia and South Korea, for example, traditional medicines

have gained both national and international reputation for the efficacy of herbal remedies. The political stand in these countries is very positive as far as traditional medicine is concerned (Hyma and Ramesh, 1994).

Supporting the differences between the traditional healers and the western health care systems indicated by Hyma and Ramesh (1994), Henneman (1995) also stated differences between the medical and the nursing professions. Henneman states that nursing as a profession has its own history, social and political influences which affected its collaborative relationship with the medical profession.. Two philosophies were identified as having had an impact on nursing knowledge and collaboration being

- i) logical positivism (whereby the science of medicine became a powerful influence in medical education and the structure of health in institutions) This positive move for medicine was not accompanied by a similar move for nursing ) and
- ii) paradigmatic paradigm, and this created frustration in nursing because of the inability to define its paradigm. Hence nursing created barriers by the attempt to find nursing's unique contribution to patient care.

Kuhn (1970)(cited in Henneman, 1995), proposed an approach to science in which one paradigm prevails until a revolution occurs and another is accepted. Florence Nightingale was instrumental in defining nursing as a unique discipline, separate from medicine. Her views included both dependent and independent roles. Unfortunately, it was nursing's independent functions that were lost in the early and mid-nineteenth centuries as the male dominated medical model evolved. This positive move for medicine created a big gap between physicians and nurses and then nursing was relegated to a handmaiden status. The notion that the nurse was in the past viewed as a servant

of the doctor created a low status for nurses such that some traditional healers feel they cannot collaborate with nurses only, but also with the doctors whom they equate themselves to.

The process of education and socialization in nursing has hampered the development of collaboration in the healthcare setting by creating demarcation lines that attempted to create a unique nursing profession. A significant gap exists in nursing curricula with respect to the nurses's role as a member of the 'team'. Walls have been built between nursing and the other health care professionals in an emphasis of the unique role of nursing. This creation of the unique roles of nursing has resulted in not only the physician, but also other healthcare workers to be considered an 'enemy.' This enmity was reinforced by the attitudes of nurses who were negative towards clients who attended traditional healers, and traditional healers who brought their clients to the western health care facilities (Henneman, 1995).

Henneman (1995) relates the concept of power and knowledge as barriers to collaboration since the two are inextricably bound. The development and maintenance of the power relation between nursing and medicine is linked to the control of scientific knowledge by both disciplines. This power/knowledge has a significant impact on both nursing and medicine in terms of their ability to collaborate.

The above discussions show that collaboration is also a problem among the western trained healthcare workers. One wonders how many barriers of collaboration would be found between the traditional healers and western trained health care workers. Already some documented literature showed that the western healthcare workers viewed collaboration with traditional healers not on an equal basis because of certain barriers perceived by the western trained health



care workers.

Stott & Browne (1973) states that collaboration with traditional healers extended only to eliciting their support, not so much on clinical matters and methodology, but rather in matters of public health, by defining those circumstances which warranted referral to the western health services, such as chest X-rays, use of protein foods and diagnosis of cancer. It was stated, in Stott & Browne's (1973) study about clinical patterns of illness, that traditional healers were recognizing Xhosa symptom-sign complexes which they labeled. They realized that this ability to recognize the symptom-signs had some similarity to the western health diagnostic process. This ability suggests that traditional healers have some systematic organization for their training and cross-fertilization of their ideas, or that they are remarkably uniform in their clinical impressions. This showed that the western trained health care workers did not understand the underlying principles of traditional healers' diagnosis of the pattern of illnesses.

Shai-Mohoko (1996) states that most formal medical practitioners condemn the services of the indigenous healers on the grounds that the scientific basis of traditional medicine has not yet been established. Shai-Mohoko observed that whether these two systems, traditional and western health care, oppose or supplement each other, traditional healing practice is well established and popular among the black population. Also, in Shai-Mohoko's study some western trained health care workers showed that they doubted the knowledge of traditional healers.

## **2.4 A REVIEW OF THE WESTERN TRAINED HEALTH CARE WORKERS**

### **(doctors and nurses)**

In the modern health care system the doctor and the nurse form the most important health care personnel. Other professionals include the radiologists, social workers, occupational therapists, physiotherapists, speech and language therapists, laboratory technicians, and assistants. Nurses and doctors are divided into many specialities. They practice through a model called the biomedical model which is different from the traditional healers' model.

Human beings are seen as biological beings made up of cells, which make tissues, then organs and systems. The emphasis in this model is on biological homeostasis, physical manifestations and signs. The physical working parts of the person are of prime importance. Hence this model aims at biological homeostasis, the curing or control of disease, or repair of trauma or malformation (Pearson & Vaughan, 1986).

The biomedical model then consists of preventive medicine, surgery, pharmaceutical services, maternal and child health services compared to the traditional healers' model which consist of traditional midwifery, herbalism, ritual manipulation and taboos: both prescriptive and preventive (Pretorius, 1991).

Nurses and doctors tend to approach illnesses in the same way. They have a process of assessing, diagnosing, managing and evaluating. They tend to possess a similar body of knowledge about the anatomy, physiology and chemical components of the body as well as alterations that take place and are referred to as illnesses. They are involved in the three levels of prevention under

Primary Health Care being primary prevention, secondary prevention and tertiary prevention. They are both guided by codes of conduct. Both undergo formal acquiring of knowledge and skills in their fields, though the doctor takes longer years and acquires more in depth knowledge than the nurses. This places the doctor in a position to diagnose and prescribe what the nurse would have to administer. They both have legally clear status, they belong to an association and have a body of legislation, which is the Council.

“Each registered nurse, enrolled nurse, midwife, nursing assistant or nurse specialist shall act at all times in such a way as to show respect of the clients’ cultural, religious, socioeconomic status and taboos, collaborate with other health care professionals and citizens in promoting community and national efforts which support health, and acknowledge limitations and not carry out procedures they are not skilled in” (Swaziland’s Code of Conduct for Nurses, 1985, p.1).

#### **2. 4. 1 Summary**

From the above literature about traditional healers and briefly about modern health care workers some similarities and differences can be noted. The literature helps in the understanding of who the traditional healers are, how are they trained and how they approach illnesses as well as the treatment of diseases. It is noted that healers also have a process of diagnosis and treatment. It has been noted that they do lack a body of knowledge about the anatomy and physiological functioning of the body, but rely mainly on symptoms. Their ways of diagnosis differ from the modern professionals, since the modern professionals rely on signs and symptoms and the use of certain techniques to come to a conclusion, whereas the traditional healer might use mystic means, like throwing of the bones. While the source of medicines seems to be similar, they differ in that most modern medicines are refined and tested for efficacy and some of them are

synthesized in laboratories, while traditional healers use the raw parts, animals, plants and minerals without any refinement. The world of ritualists and spirits is very different from the biomedical way. The way traditional healers name illnesses is very different from the modern system. These differences and similarities are key points to collaboration. Each system must know the capabilities and limitation of the other, but still show respect for the other's system of practices. The traditional healers are lacking in legal bodies, but they have made attempts to have associations like most of the modern health care professionals. Understanding the traditional healer and traditional medicine leads us to the attempts that have been made towards collaboration between the two systems. The positive and negative attempts towards collaboration can be analysed appropriately.

## **2. 5 THE CONCEPT OF COLLABORATION**

Collaboration according to Henneman, Lee and Cohen (1995) is an important concept for nursing. It is a complex phenomenon whose definition has remained vague or highly variable. Despite its elusiveness, its essence continues to be sought after as a means of improving working relationships and patient outcomes. The term collaboration has been used synonymously with cooperation or compromise which is inappropriate.

According to Henneman et al (1995) the term 'collaborate' is derived from the Latin word which means work together or work jointly. Collaboration is typically described as a process which stresses joint involvement in intellectual activities. In health it has been described as a joint communication and decision-making process with the expressed goal of satisfying the patient 's well and illness needs while respecting the unique qualities and abilities of each professional. It is non hierarchical in nature. It assumes power based on knowledge or expertise as opposed to power based on role or function.

### **2. 5. 1 The attributes of collaboration**

Henneman et al (1995) stated the following attributes:

- a) Two or more individuals are involved in a joint venture.
- b) Willingness is shown to participate in planning and decision-making
- c) Members view themselves as part of a team, and contribute to a common product or goal.
- d) All participants offer their expertise, share in the responsibility for outcomes, and are acknowledged by other members of the group for their contribution to the process.
- e) Power is shared (based on knowledge and expertise versus role and function).

## 2. 5. 2 Modern Collaborative Model (Henneman et al, 1995).

<u>defining attributes</u>	<u>antecedents</u>	<u>consequences</u>	<u>empirical reference</u>
joint venture	individual readiness	supportive, nurturing Environment	Multidisciplinary round, standards
cooperation endeavour	understanding/ acceptance	reinforces confidence, self worth and importance	use of 'We' vs 'I' statements
willing participants	confidence in one's ability	promotes 'win-win attitude	Dialogue between members of the
Shared planning	recognition of Boundaries of disciplines	esprit de corp	team
Team approach	excellent communication	interpersonal cohesiveness	High scores on collaborative practice scales
contribution of expertise	environment of orientation		
Shared responsibility	organizational values	improved productivity	
non-hierarchical relationship	interdependent visionary leaders	improved patient outcome	

Arcand (1992) calls for the urgent collaboration of nurses in the management of cancer. Six principles which she said were central to creating effective partnerships at all levels included commitment, consensus, competence, coordination, communication and courage. All parties involved should have these principles. These principles reflect some attributes in collaboration.

Phipps et al (1995) define collaboration as a relationship of interdependence. The ability to work together collaboratively involves trust and respect not only for each other but for the work and perspectives each contributes to the care of the patient. Collaboration among health care workers improves patient outcome and thus reduces patient cost. This results in improved quality care of

the patient.

Phipps et al (1995) discuss the concept of collaboration as a framework whereby each self-care remedy is determined if it is detrimental and whether it will antagonize a patient's regimen. If the remedy is not harmful, instead of negating a culturally relevant folk treatment and implementing a culturally incompatible regimen, the practice should be incorporated. Patients who have chronic illnesses will stop all treatments that are culturally incompatible immediately after discharge, and this could be interpreted as non-compliance to the regimen by the western trained health care workers. The health care professionals must make an effort to find out from the patient and the family their rationale for using other remedies or practices which might be detrimental or helpful. They can then be in a position to incorporate them easily or explain to the patients why they are detrimental.

Though Phipps et al (1995) did not mention the use of traditional healers and traditional medicine, it is known that in Africa traditional healers form part of the culture and they are also part of alternative remedies that most patient turn to. Their practices are viewed by many Africans as cultural practices. These beliefs and values of Africans cannot be changed overnight. It is very important for the biomedical personnel to find out about these traditional practices in order to have a positive collaborative relationship whereby the good practices can be encouraged for the same goal of improving care of the patient or management of the patient. It is not easy to collaborate with someone if you do not even know the extent of their knowledge as well as their scope of practice. This does not apply only to traditional healers, but also to other alternative treatments such as acupuncture, aroma therapy, homeopathy etc.

Langford (1988) states that collaboration means working together in a joint intellectual effort. The key term is 'joint'. It implies that in collaboration there is no superior or subordinate, order-giving or order-taking, relationship. A common usage implies an equity among the participants in the relationship, both in working and sharing reward. Complementary skills and knowledge are necessary, but is not mandatory for collaboration to exist. Mutual recognition that no one person holds all the knowledge, skills or resources necessary to meet goals, is required in order for true collaboration to exist.

Collaboration is not always necessary since there are situations where one person can offer the care alone effectively, but it can be necessary in situations such as:

- a) those in which a general operating mode of the population organization brings together skills most frequently needed for the population served.
  - b) where the goal to be met requires assembling skills or knowledge not held by one member.
- This is true where chronic illnesses are concerned.



## **2.6 PROJECTS DEVELOPED IN FOUR COUNTRIES TO INITIATE COLLABORATION**

The WHO's 1978 objective is to upgrade traditional healer's skills. The WHO has been successful in the training of Traditional Birth Attendants (TBAs) thus adding new skills and knowledge to their traditionally based information. The WHO's 1978 report recommended that baseline data should be collected through surveys on the following topics within any country-specific effort towards including traditional medicine in health care delivery systems:

- \*Traditional medicine personnel categories in practice,
- \*Traditional medicine centres and functioning services,
- \*Utilization of practitioners of traditional medicine in the health services,
- \*Diseases known to have been successfully treated by traditional healers.
- \*Determinants of manpower needs for primary health care services,
- \*Collaboration factors and supportive infrastructures for the promotion of traditional medicine,
- \*Literary resources to gather information and compile bibliographies of traditional medicine.

Akerere (1978), (cited in Hogle and Prins, 1991), states that the WHO recommended that all elements of traditional medicine be evaluated for safety and efficacy. Hogle and Prins (1991) compiled a report about countries that tried collaborative efforts through training of traditional healers in primary health care activities through organized workshops. The countries were Swaziland, Ghana and Nigeria. In 1995 South Africa followed in implementing programmes like these (Troskie, 1995). These collaborative projects were very successful in teaching traditional healers about some principles of Primary Health Care. These will be noted in the following

discussions.

### **2. 6. 1 Nigeria**

In Nigeria one of the earliest collaborative efforts involving medical workers and traditional healers was 'the family and the community based psychiatric programmes' which began in 1954 in Aro, conducted by Dr. T. A. Mlambo. Aro comprises four villages in a rural suburb, the population of which included farmers, fisherman and artisans. According to Mlambo (cited in Good, 1988) the project integrated the best practices of traditional and contemporary psychology. It was based on the premise that utilization of the therapeutic practices that already existed in indigenous culture, including the power of group therapy, could when joined with modern psychiatry create unorthodox but effective hybrid for treating a broad array of mental disorders. This was done through joint consultation by traditional healers and biomedical trained psychotherapists and participation by the patient's family. Day hospital and boarding out village care programmes, in which the ill had daily unrehearsed and voluntary contact with settled tolerant and healthy people were part of the project. This system was particularly effective with emotionally disturbed and psychotic children. The mean length of stay and recovery in Aro was about six months.

In 1981 another small project for community health education was initiated in Arorami, to choose traditional healers to participate in Primary Health Care (PHC) services. The traditional healers in this place were numerous and they included traditional birth attendants (TBAs), herbalist and bonesetters. The goal for the Arorami project was to "sell" the concept of good health to the local people and improve life through non-directive, social means, such as community mobilization and self diagnoses of health problems, identification of felt needs, acceptance of greater responsibility

for health and fostering participation in solving problems. Poor environmental sanitation, personal hygiene, communicable diseases and dental caries were among the identified health problems. A health committee was formulated which included influential people like traditional healers and TBAs. Arorami was chosen for the project because it is a village with about 10,000 people with limited biomedical facilities, only one health centre with limited equipment, a poor dispensary and maternal centre which were rarely used because of the lack of faith among the villagers in Western-type health care services. Thus, traditional healers were influential people in the community. (Laoye, 1981, cited in Good, 1988). This project was successful in that traditional healers and TBAs succeeded in learning and participating in PHC activities with the modern health care workers.

Caldwell and Caldwell (1985) (cited in Good, 1988), used programmes which tested the hypothesis that traditional healers could be effective agents for changing attitudes and behaviour related to fertility, Family Planning (FP) and Maternal and Child Health Care (MCH), including the possible reinforcement of traditional forms of fertility control. They believed that if the cooperation of traditional healers could be enlisted in Family Planning programmes, which were widely believed to violate basic values and traditions, the healers could be an extraordinarily powerful-stimulus for change within the general population. Caldwell and Caldwell realised that in order to do this, traditional healers needed to be trained and be deployed in communities. Traditional healers were trained and deployed in certain communities and there was success in that they were able to be influential in terms of family planning programmes.

### 2. 6. 2 Swaziland

Most countries when implementing these strategies were looking into the cooperation and inter-sectoral training programmes in health care in Africa. In these aspects some pilot projects were conducted in Swaziland by Green and Makhubu (1984) ( cited in Good, 1988). They stated that for the seminars to be effective:

- \* training should be planned well in advance,
- \* Training seminars should focus on a few topics, including some specifically related to traditional healers which are determined with traditional healers before to finalizing training agendas,
- \* Traditional healers must be treated in an appropriate manner by seminar organizers.
- \* The initial emphasis should be on curative rather than preventive care, indicating the desirability of starting with traditional healers "where they are,"
- \* Cooperation must be joint and reciprocal. Planning must include strategies for educating biomedical personnel about traditional healing methods, overcoming the communication gap, and developing approaches to cooperation.

A second phase of intersectoral cooperation began in 1984-1985 when the Swaziland Ministry of Health (MOH) and Traditional Healers Society jointly sponsored a pilot project. This project was a five-day regional workshop demonstrating that specific PHC services to mothers and children could be improved through cooperative efforts between the nurses and the traditional healers. Promotion and evaluation of attitudinal changes of nurses and traditional healers towards one another was also a key interest in PHC activities. The focus of the project was on nutrition, the use of Oral Rehydration Salts (ORS), immunization, personal hygiene and sanitation. It

included teaching traditional healers specific skills to prevent and control diarrhoea, malnutrition, malaria and immunizable diseases such as whooping cough and tuberculosis (TB) (Hoff, Shapiro and Maseko in 1986, cited in Good, 1988).

Following a quasi-experimental design, a preliminary evaluation conducted two months after the final workshop measured the results of a 5-day workshop with an experimental group of 31 traditional healers and six nurses. A group of 23 traditional healers who did not attend the workshop served as a control. The results were that those who participated in the workshop had an increased understanding on the use of ORS, importance of water sanitation, good sanitation, personal nutrition and immunization. They also referred patients to clinics for the treatment of diarrhoea. All traditional healers who attended the workshop were found to have constructed pit latrines. Only 26% of the control group had them. While 48% of the workshop group attenders had wash basins, only 4% of the control group had these wash basins.

Overall, the project demonstrated that traditional healers could, with proper training and support, assist in the development of more effective PHC at the community level. In general, attitudes of nurses and traditional healers towards one another grew more positive, and communication and cooperation increased. Traditional healers sent more referrals to clinics where they knew nurses would be able to cooperate with them.

Hoff and Shapiro (1986) (cited in Good, 1988), state that the interviewed nurses were highly enthusiastic about cooperating more with healers to improve patient care. The traditional healers who attended the workshops went back to their home regions and organized meetings with other local traditional healers to communicate the information gained from the workshop.

This workshop's results reinforced the argument that traditional healers should be part of the focus of health education efforts and health education should build upon traditional beliefs rather than directly confront or disintegrate traditional beliefs.

### **2. 6. 3 Ghana**

In Ghana, Primary Health Training for Indigenous Healers (PRHETIH) programme was introduced in 1979 in Techiman as an intriguing collaborative experiment in health education and skills development for PHC. Prior to designing the program, detailed information was gathered from the local traditional healers concerning their beliefs, techniques, felt needs for training course and their desire to participate in such activities. The programme was organized between a hospital called Holy Family and the traditional healers in Techiman village.

A survey conducted over six months involved 45 traditional healers (69% herbalist and 31% priests/priestesses) representing 12 ethnic groups. By the end of the survey some traditional healers who were not involved were asking to be included in future training programmes. The common assumption that traditional healers were unwilling to cooperate in such ventures was not found to be the case in Techiman.

Information regarding the community utilization of traditional healers and biomedical services was gathered. Some 69% of the population said they used the services of traditional healers and 94% said they visited biomedical services. These proportions underscore the overlap and joint use of the two systems. Follow-up visits to the traditional healers used a standardized questionnaire which revealed that the trainees retained more than 60% of the basic material they were taught.

What was noted from this program was the recommendation made that the success or failure of such projects will depend largely on the efforts by the Western side to understand the traditional healers' ideas about health and disease, and the respect they show towards traditional healers, including demanding supervision over traditional healers and their practices. The traditional healers are highly recognized specialists and should not be degraded to health workers with status at the bottom of the modern health care system ( Good, 1988).

#### **2. 6. 4 Republic of South Africa**

Programmes which involved traditional healers and traditional midwives as health workers in primary health care services were launched in South Africa in the 1980's.. One was launched in 1986 by the Department of Health and Population Development in Transvaal. The Orange Free State followed in 1993 and they had 10 primary health care clinics participating in the project. The projects aim was to involve traditional healers in health promotion at grass-roots level of health care. The programmes were based on the needs identified during discussions with traditional healers, they included aspects such as personal hygiene, signs and symptoms of commonly occurring diseases in the area, mother and child care and sexually transmitted illnesses. Traditional healers were trained in these aspects of health care ( Troskie, 1995).

Troskie (1995) states that during interviews with traditional healers who had attended the programme, it was found that they were very positive and stated that they all benefited from the information gained. Traditional healers started to refer clients to the western facilities at an early stage of their illness. Patients who were referred by traditional healers, were referred back to them to ensure that clients continue with their treatments. Traditional midwives were issued with gloves.

Presidents of two traditional healers' associations gave their views about collaboration, where they stated that an umbrella organization controlling the practice of traditional healers would be of benefit. Hence, these programmes encouraged an openness to acknowledge the practice of traditional healers. The establishment of an umbrella body, could assist in early referrals and a trusting relationship between the two systems of health care workers could be enhanced.

These programs aimed at cooperation and collaboration in the above countries, they showed a positive initiative in ensuring collaboration between the Modern Health care system and the Traditional health care system. The projects and training that were done showed that the biomedical system realised that traditional healers were very important and influential people who could make positive contributions towards any change that any Health Ministry tried to institute in the community.

All these projects were aimed at educating the traditional healers about preventive aspects of health because most traditional healers are curative oriented. Hence Green and Makhubu (1983) mentioned that collaborative effort has to start with curative aspects since that is what traditional healers understand. This perception to equip traditional healers with knowledge about preventing illnesses by maintaining good sanitation, personal hygiene, building pit latrines and water purification was very good.

The other aspect learned from these projects was that traditional healers themselves were willing to organize themselves into societies so they could function as a profession. They showed a willingness to learn and to collaborate with the modern health care system by learning modern health care services as far as PHC was concerned.



From these strategies in Nigeria, Ghana, the Republic of South Africa and Swaziland some general conclusions can be drawn. The researcher feels that, praiseworthy as the attempts were to engage the local traditional healers in certain aspects of PHC, for the greater good of the community, there were shortcomings as might have been expected in these initial stages.

a) The major flaw was the one sidedness of the collaboration.

The traditional healers were expected to learn about modern health care services and there was no mention of what exactly the modern health care professionals learned from the traditional healers. It is clear that referrals were expected from the traditional healers and not from the modern health care services.

b) The organizers of these projects did not find out how traditional healers practise. They did not find out what illnesses they were capable to manage so that proper collaboration could take place.

From these projects recommendations emerged that a census of traditional healers should be done to provide information about types of traditional healers and their ratio to population, spatial distribution, and organizational patterns. This information could be used to determine the extent to which traditional healers should be taught to diagnose and treat simple ailments along with preventive -promotive activities, or should be limited to screening and referral. From this recommendation one can note that modern health care systems are trying to incorporate the traditional healers as part of modern health care system by training them to do certain limited activities of modern medicine. There is no clear answer as to what the traditional healers status would be when they became part of the biomedical professionals. With such an attitude the researcher doubts if there would be proper willingness on the part of the good traditional healers, who are skilled to cooperate on these terms. It might only be the bogus money searchers who might cooperate, (in anticipation of some monetary gain), rather than those who are real

traditional healers.

#### **2. 6. 5 Limitations of traditional healers in Primary Health Care (PHC)**

- a) The supply of indigenous biomedical personnel who are interested in understanding and cooperating with traditional healers appeared to be limited,
- b) The traditional beliefs about health and disease are set within a holistic social and environmental framework and tend to involve supernatural phenomena,
- c) Formal or systematic methods for evaluating the outcome of therapy, i.e. through measurement, verification and validation, are lacking for many traditional practitioners. Little research has been done on the informal methods that are used,
- d) It is not easy to distinguish between credible traditional healers and the charlatans. This tendency to place bonafide traditional healers in the same category as "a con artist" inhibits movement towards intersectoral cooperation (Good, 1988).

#### **2. 6. 6 Summary**

It was a very positive move for countries to follow up on WHO's initiatives about collaboration between different therapeutic systems, but opportunities were missed to look into other alternative medicines instead of only traditional healers. WHO (1977), (cited in Hogle and Prins, 1991) recommended a National Health Care Delivery System which included all other alternative medicines such as homeopathy, acupuncture, aroma therapy, and traditional healing in each country. This was a motion to encourage collaboration among all the systems of health care delivery and to incorporate them into the National Health Care System of each country.

Hall (1998) mentions that the wealth of any *inyanga* is his medicine (*umutsi*). Every *inyanga* has his or her special recipe, a combination of ingredients to produce specific various ailments. The ingredients are infinite. From the projects conducted in these countries it became clear that no single country bothered to investigate these traditional medicines and their uses in the above discussed projects.

Positively, the Organization of African Unity (O. A. U.) has shown interest in finding out about the medicinal heritage of each country in Africa. In Swaziland the survey on medicinal plants began in January, 1998 being led by the late Dr. Mshana the then Assistant Secretary General of the O. A. U. with some Swazi delegates and other delegates from countries like Tanzania Ghana and Nigeria. The University of Swaziland (UNISWA) is responsible for the conduction and completion of this study under the directorship of the Vice Chancellor Professor Lydia Makhubu. The end result in four year time will be a traditional medicines pharmacopoeia with all the medicine being patented. This is forming a base of information on traditional medicines for the proposed establishment of a medicinal plant and ethnobotanical research centre.

A positive suggestion about collaboration between traditional healers and the biomedical practitioners was made when Good (1988) recommended that new doctors, nurses, and other biomedical personnel should have a curriculum that will enable them to learn about medical pluralism. They should be trained in the nature and role of traditional medicine and traditional healers in their own countries and in the value of the ethno-botanical approach. A primary aim for this new, community-relevant medical training is to inculcate a set of values and skills in social, adult educational, and technical aspects that will facilitate accurate individual and community diagnoses and positive productive interactions with traditional healers.

## **2.7 STUDIES CONDUCTED IN THE AREA OF TRADITIONAL HEALTH SYSTEMS VERSUS WESTERN HEALTH CARE SYSTEM**

### **2.7.1 Towards Improved Cooperation between Traditional Healers and the Modern Health Care Sector**

Green and Makhubu (1983) compiled a research report 'towards improved cooperation between the traditional and modern health sectors'. In 1982 the Ministry of Health requested a report on traditional healers in Swaziland with a view to assess areas and extent of cooperation between these two systems. This was instituted because the Ministry of Health recognized an acute shortage of manpower in the modern health sector, and for a need to research and focus on the traditional health sector manpower. The authors needed to investigate the following areas:

- \*areas and extent of cooperation possible between the two health sectors with reference to diarrhoeal diseases,
- \*possibilities for the development of a traditional healers' association, and the role of government in promoting, monitoring and liaising with such an association,
- \*legislation, customary law, government policy regarding traditional healing and healers,
- \*the extent to which alternative systems are being developed for the consumer, with special reference to the influence of traditional healers,
- \*manpower in the traditional health sector,
- \*potential for the para-professional training of traditional healers,
- \*research into the area of traditional healing.

*The findings and recommendations made by Green and Makhubu (1983) were as follows:*

They discovered more than 5,000 traditional healers and that gave a ratio of 1:110 ( traditional healer to population served). Traditional healers met important needs in their communities and they earned a relatively high fee for their services. Traditional healers were interested in both increased cooperation and in certain types of training in modern health care. Green and Makhubu recommended that Government should help stimulate and support the formation of a traditional healers' association. A proposed legislation of traditional healers should be discussed with them to assess acceptability and enforceability of the legislation. Traditional healers should be trained in the use of oral rehydration salts on a pilot basis, to be followed by an evaluation of training effectiveness. The Health Education Centre should have primary responsibility for coordinating the implementation of all training and information gathering activities related to traditional healers. The Public Health Unit should be the main cooperative unit. Further information should be obtained on the effects of healing and diagnostic practices, on referral patterns, and on the effectiveness of healing training programs.

Traditional healers are often influential opinion leaders on health, family planning and many other concerns related to the development and well-being of the population in the rural and/or urban communities they serve. They not only provide health services, but also play a teaching role (Bennet and Manno, 1986, cited in Good, 1988).

Though other studies were done on traditional healers in Swaziland, this study is the first to contribute efforts towards cooperation between the two systems. This study was initiated by the Government and as such it introduced developments such as the training of traditional healers in certain primary health care projects and the formulation of the traditional healers' association.

Other studies done before this one were individually initiated by those who felt traditional medicine was important and they have formed a base for the literature review for this report and other studies to follow.

### **2. 7. 2 Perceptions of nurses towards collaboration with traditional healers**

Upvall (1992) examined the possibilities that existed for the articulation of indigenous (traditional healers) and cosmopolitan (western) health care systems in Swaziland. Both indigenous and cosmopolitan health care systems aim to meet the basic challenging health care needs of the population, yet they rarely collaborate to make significant changes in health care delivery. Collaboration implies a process of negotiation between nurses and indigenous healers. Both health care givers should agree on diagnosis and treatment modalities for individual patients who consult both nurse and healer. Upvall (1992) targets nurses since they are the ones affected by indigenous healing systems. Nurses may provide the link in promoting collaboration between indigenous and cosmopolitan health care systems. In this study it states that some nurses perceived collaboration positively, but attached specific conditions for collaboration to be possible. Others vehemently opposed collaboration in any way, since they saw few positive results of the traditional healers' work.

The overall results were that nurses could be a source of referral for the traditional healers, but not the reverse. Also that nurses perceived themselves as teachers to traditional healers, but not learning from traditional healers. The Rural Health Motivators( RHMs) were perceived serving as a bridge or link between the traditional healers and the western trained health care workers. They were viewed in this study as cultural brokers, who could strengthen communication between the two systems, traditional and western. Other nurses remained ambivalent about their

perceptions of the possibility of collaboration between the traditional healers and the western trained health care workers and even in the future.

### **2.7.3 Indigenous Healers in the North West Province**

Shai-Mahoko (1996) conducted a study on indigenous healers in the North West Province in South Africa. Shai-Mohoko (1996) stated that cooperation could not be expected when no one knew what the indigenous healers could or could not do. The study's objectives were to identify the conditions that healers treat, determine whether there was any follow-up care, find out the categories of people who sought their services as well as to find out any existing liaison and coordination between the healers and formal health workers.

The findings in Shai-Mahoko's (1996) study were that more than 60% of the indigenous healers were bone throwers and more than 34% practised as both bone throwers and '*sangomas*'. Those who were taught by their ancestors through a dream were about 54%. There were 31% of the healers who underwent formal traditional training. Only 14% were trained by apprenticeship to another traditional healer. The period of training ranged between two and five years. The conditions which the traditional healers were faced with were infertility, septic sores, impotence, sexually transmitted diseases, deliveries, asthma, high blood pressure, palpitations, tuberculosis, alcoholism, diabetes and cancer.

The study by Shai-Mahoko (1996) contributed into the insight into what traditional healers can do so that researchers and health care practitioners have a base for further studies and ways of collaborating with healers knowing what they are capable of doing. As far as liaison or collaboration between the two systems of health care are concerned, Shai-Mohoko could only

make a recommendation that it should be pursued. As the previous project by Green and Makhubu (1983) showed, most moves towards the cooperation of traditional healers were initiated by problems of a Primary Health Care nature. For an example, the most frequent problems of these being "diarrhoeal diseases", and as such most studies were done about cooperation of traditional healers with modern health workers in an attempt to combat diarrhoea in their country.

#### **2. 7. 4 Cooperation between traditional healers and modern health care in the control of childhood diseases**

Hoff (1985) conducted a first phase evaluation of a pilot study about the cooperation between traditional healers and modern health personnel in the control of childhood diseases in Swaziland. This study was conducted through exploratory workshops, regional workshops and interviews for traditional healers and nurses. A five-day, exploratory workshop was held in June 1984 with selected healers and health care personnel representing all the four regions (Hhohho, Manzini, Lubombo and Shiselweni) of the country. The traditional healers were selected according to their willingness to participate, responsibility and experience in teaching others, and to provide representation of traditional healers in general. The health personnel comprised a nutritionist, a health educator, a nurse supervisor, a sister from the mental hospital and four clinic nurses.

The objectives of this workshop were to develop mutual respect, discuss and understand each other's treatment methods, provide experience for the Ministry of Health and traditional healers to plan future workshops, develop opportunities for the traditional healers to be trainers or leaders so they would be able to organize and lead future workshops, and to obtain recommendations from participants on how to promote cooperation between the two groups.



*The results of the workshop were as follows:*

- a) Participants from both traditional and modern health sectors were highly interested and enthusiastic about the workshop and a good rapport was established between the two.
- b) Both groups agreed that cooperation between the two systems was worthwhile and that such cooperation could improve the health of the mother and child.
- c) Traditional healers voiced a strong interest in carrying out and supporting activities in personal cleanliness, safe water and home sanitation and suggested they would teach these preventive health behaviours to their patients.

The second workshop was a regional one conducted at Hhohho Region. As well as the above objectives, two objectives for the regional workshop were added. There were to establish a system of referrals and mutual assistance to improve patient care, and to promote the use of effective traditional remedies and discontinue those remedies that might be harmful or ineffective.

The results were to be determined by interviewing the traditional and the modern healers who participated in a follow up workshop conducted about three months later.

An interview questionnaire for traditional healers was designed to obtain information about what the traditional healers had learned and the extent to which the knowledge gained was used in their practice. The focus was on the treatment of diarrhoea in children. There were two groups of healers who were selected for the interview, in which the the same criteria were used. These two groups were the pre-workshop group (pre-wg) and the post workshop group (post-wg)

*i) Similarities in the characteristics of participants were as follows:*

- a) Interest in and acceptance of the purpose and objectives of the workshop,
- b) Representative of the major part of the traditional healers(herbalist, traditional birth attendants, spiritualist and faith healers),
- c) Members of the Swaziland Traditional Healers Society,
- d) Active member of the community or in leadership role and well known in the community.

*ii) Differences in the characteristic of participants were as follows:*

- a) Rural-urban location: The 23 traditional healers in the pre-wg all lived and practised in a very rural area in the Lowveld of Swaziland. About 26 out of 32 of the post-wg lived and practised in the Middle and Highvelds of Swaziland, closer to urban areas. There were 6 of the 32 who lived in the rural areas.
- b) About 91% of the healers were males in the pre-wg and 41% were females in the post-wg.
- c) the post-wg traditional healers were twice as wealthy as the pre-wg based on ownership of sewing machines, a maize milling machine, a vehicle or a cooking stove owned.

*iii) The results of the interview were as follows:*

- a) The most frequent reported specialty was the treatment of diarrhoea. The treatment of children's diseases and various body pains were also frequent diseases that traditional healers handled.
- b) Patients waited much longer to seek help in the pre-wg and they came sooner to

seek help according to the post-wg.

- c) In the pre-wg about 74% reported giving traditional mixture (*imbita*) to drink and only 55% reported giving the traditional mixture in the post-wg.
- d) The post-wg gave a higher percentage of recommendation to the patient and the family going to the clinic, giving oral rehydration salt (ORS), breastfeeding, eating vegetables and bathing regularly than the pre-wg.
- e) Only 38% of the patients with diarrhoea were referred to the clinic in the pre-wg and 60% were referred by the post-wg.
- f) There were 52% pre-wg and 93% post-wg who reported that they received good cooperation from the nurses in the clinics. The majority of healers in both groups reported that they did not get any feedback about the patients from the clinics.

What was noted in this study was that they did not come up clearly with principles of cooperation. They only showed how traditional healers were capable of learning and applying the principles of primary health care. This does not say anything about collaboration between the two health care delivery systems, traditional and western.

Nurses were also interviewed. The purpose was to obtain information about their attitudes and viewpoints about cooperation between themselves and traditional healers and if referral practices had changed as a result of the workshop. Eight nurses were interviewed.

*iv) The nurses' results were as follows:*

Seven out of eight of the nurses reported that there was cooperation between them and

the traditional healers in that traditional healers referred patients to nurses in the clinics, especially those with diarrhoeal diseases. They stated that the referrals increased in number after the workshops.

Upvall's (1992) study had similar results, where nurses viewed collaboration as a way by which traditional healers should refer to them and not the other way round. There was the lack of a two way system. This is not what cooperation nor collaboration is all about..

#### **2. 7. 5 Changing Traditional Medicine in Swaziland**

Gort (1987) did a study on 'changing traditional medicine in rural Swaziland, a World System Analysis'. The study involved an investigation of the impact of the Global System on the indigenous medical system of rural Swaziland. The primary goal of this study was to delineate the nature of the relationships between local, national, regional, and international interest as applied to the advocacy of traditional medicine. The "global institutions" here refer to the supranational and transnational levels where actors direct policy across national boundaries. Great emphasis is placed upon traditional healing and its practitioners by various international agencies at the global level because of a number of factors: some medical, pseudo-scientific, psycho-cultural and other frankly political and economic.

The global level, according to Gort (1987), is represented by the World health Organization which has an international and multi-cultural constituency. WHO (1978) advocated the reversing of the notion that traditional practitioners were dangerous quacks who should be stamped out and held that traditional healers could provide a high level of available, accessible and affordable health care. The WHO encouraged governments to move from repression of and ignorance about

healers and healing practices, towards efforts to recognize, cooperate and recruit them into primary health care (PHC) programs. Primary health care encourages local traditional practitioners to assume responsibility for giving first aid and treating minor ailments, diagnosing and referring illness upwards for treatment, dissemination of information regarding preventive medicine and environmental health. All these policies are embedded within a political context. A central component of PHC is a commitment to the incorporation of traditional healers into the general system of health care and the facilitation of the employment of traditional healers (seen in WHO's Seventh General Program of work covering the period 1984-1989). The suggestions of the Alma Ata conference have been criticized as arising more from the need of the powerful than the requirements of the powerless.

The attitudes of WHO to traditional medicine as well as the WHO's influence in the developing countries, makes clear that traditional healers and their practices were looked at as inferior to the modern system of care. Traditional health practices were not treated as one of the alternative medicines like other health practices, such as homeopathy. The initiatives by WHO use traditional healers in the PHC without recognizing their practices, needs and desires as far as their own traditional methods of healing are concerned, while a step in the right direction, is far from collaboration.

Gort (1987) recognizes two positions as far as the integration of traditional healers into the Modern Health Care System is concerned. The argument in favour of integration was based on the fact that traditional healers are available, affordable, and accessible; they have skills; they share a common language and beliefs with their clientele and they can be taught to engage in front line activities. Gort (1987) notices that there were many studies which supported the notion of

integration. On the other hand there were those who believed that the integration of systems was not desirable. Some believed that traditional healers were incompetent, fraudulent, dangerous and that their practices should be actively discouraged. Others felt that integration would subsume and undercut traditional medicine, which should be encouraged and supported to flourish on its own.

Gort (1987) spent nine months in Swaziland in 1982 staying with a traditional healer examining all aspects of patient care while observing the management of a successful professional practice at an area called '*Likhaya*' in the Southern part of the country. He collected his data mainly through participant observation and semi- informal interviews. Thirty-seven homesteads out of seven hundred and forty were interviewed on four occasions per homestead. The Family Health and Attitude Questionnaire was utilized as a tool for interviewing. Information was collected about biographical data of the homestead, income and homestead appearance, recording of illnesses from the past three years and how those illnesses were resolved, their own interpretation of illnesses, attitudes towards traditional healers and other health care providers, and their opinions concerning relationship between disease etiology and nosology. Three months of the nine months was spent interviewing western trained doctors, nurse and government health workers as well as officials in hospitals and clinics throughout the country. One month was spent in Johannesburg investigating a pilot PHC and a TRM project sponsored by the Anglo-American Chairman's Fund. Geneva was visited in 1983 for research on the policy of WHO regarding the role foreseen for indigenous healers in meeting the challenge of "*HEALTH FOR ALL BY THE YEAR 2000*".

*Some of the results of the study by Gort were as follows:*

- a) Most homesteads interviewed believed that the number of healers had increased

considerably (Green and Makhubu, 1983, cited in Gort, 1987). In this study 42% thought their illness was of unknown origin, 20% believed in natural causes, and 37% suspected witchcraft.

- b) There was no relationship established between age and type of service being sought.
- c) There was a positive correlation of  $r=.24$  of children seen at modern clinics.
- d) Gender was also not a meaningful category in search of certain type of service.
- e) Education in Swaziland was also found not to be relevant to type of service according to ( Deutsh 1982 , cited in Gort, 1987). In this study there was a negative correlation of  $r=-.18$ ) which showed that the highly educated did not tend to use the traditional sector.
- f) Increased socioeconomic status leads to increased use of all systems. Religion of a family was not found to be a determinant of the service type.
- g) There was no relationship found between high income with the use of traditional system, though traditional medical care is known to be generally costly.
- h) There was a support of the contention that perceived distance is a major factor in selecting the clinic or type of system.
- i) Religion was found to be not a factor in this study, though in other studies it was found that certain Christian groups deter individuals from frequenting traditional healers (Deutsh, cited in Gort, 1987).
- j) The western system was preferred on the basis of fees. It was found that people who paid high fees most likely visited the traditional sector.
- k) Other investigations made were concerning types of illnesses such as chronic and

acute. It was found that there was a positive correlation between chronic illnesses and use of the traditional system ( $r=.10$ ) and a negative correlation between chronic illnesses and use of the western system ( $r=-.12$ ). About 41% seen by traditional healers were perceived as acute and 59% were perceived to be chronic illnesses(long lasting and mysterious). Conversely 53% seen at western centres were acute illnesses and 47% chronic illnesses. The local modern clinic was more likely to be chosen for acute illnesses.

- l) Perceived cause of illness determined the use of service type. If the cause was perceived to be supernatural then practitioners would be selected ( $r=.43$ ), while if perceived to be natural, then western practitioners would be selected ( $r=.40$ ).
- m) There was a positive correlation ( $r=.19$ ) that traditional healers' competency is increasing and the use of the traditional system is positive and significant.

Gort (1987) conducted an in-depth study which investigated the external forces, globally, regionally and nationally which affected the local health care selection in Swaziland. This study provides a lot of information about the local people's feelings and attitudes concerning traditional healing. The study does not address cooperation or collaboration and integration between the two sectors. It only looks into influences or factors that make individuals choose between the two systems, as well as factors that lead to the changing ways of traditional healers' practices or traditional medicine. The study does not investigate traditional healers and the western healers' opinions concerning the utilization of the two sectors, their opinions about collaboration and integration. It addresses some of the practices of traditional healers such as diagnostic procedures, and how traditional healers become traditional healers. One of the diagnostic measures which the author identified was called '*Kufemba*'(ceremony held to reveal the source of the illness or



problem and the course of treatment) and '*kushaya ematsambo*' (throw bones for diagnosis).

This is a useful and a very reliable study conducted into traditional healers and it provides an insight for further research. It emphasizes the significance of carrying out research on traditional healers' roles and attitudes towards collaboration particularly concerning chronic illnesses.

#### **2.7.6 Ancient and Modern Ways in the Management of Mental Illnesses and Midwifery**

Jones (cited in Cassidy, 1995), stated that helping to train traditional birth attendants (TBAs) who assist women in labour in rural areas showed collaboration between ancient and modern practitioners. The TBAs learned from the nurses about danger signals during pregnancy, how emergency deliveries could be controlled and to resuscitate babies. The nurses learned from the TBAs about how they turned an unborn baby in the womb thus correcting an abnormal lie and about comfortable delivery positions.

Flo Mdladla (cited in Cassidy, 1995), reported how traditional spiritual healers prayed for the mentally ill patients in an attempt to heal them. It was noted that when a person had a mental illness a traditional healer or spiritualist was always consulted rather than a doctor or nurse. At Kwamashu in Durban the community mental nurse works in collaboration with the traditional healers so that there is a two-way referral system. She recommended that traditional healers should be equipped with counselling skills as they are always confronted with the post- violence stricken patients. This nurse also noted as a positive move that the health reconstruction and development plan for South Africa included a whole chapter devoted to promoting links between traditional and complementary healers and mainstream health professionals. This chapter recognized that healers have an important role to play in the nations' spiritual and psychological

well-being (Cassidy, 1995).

This report by Mdladla was one of the contributions on collaboration between nurses and traditional healers towards collaboration in the areas of mental illness and midwifery.

#### **2. 7. 7 Traditional and Modern medicine in Asia**

Hyma & Ramesh (1994) discussed about the extent and potential for incorporation of traditional medicine into modern national health systems especially in Asian countries. They stated that in Asian countries several forms of empirical indigenous medicines are found, thus giving multiple choices to individuals. The nature of indigenous medical health care systems as they evolved over time is highly differentiated with regard to principles of treatment, diagnosis and practices.

In South Asia traditional systems of medicine are often formally institutionalized, with extensive facilities for education, training, research and health care delivery, including hospitals, clinics and pharmacies exclusively designed for traditional medicine. In Japan, South Korea, Fiji, the Philippines, Solomon Islands and Papua/New Guinea traditional medical practices are independent of government health services. WHO (1978) observes that in China traditional medicine is formal and structured. In China the two systems of medicines are combined. Modern technology and science are applied with the traditional system. Several Asian and African countries now consider the concept of integration a reality that could be fully achieved in the near future (Hyma and Ramesh, 1994).

Hyma & Ramesh (1994) state that the interaction between traditional medicine and modern medicine has been rather poorly researched and understood. It was noted that Good (1987), cited in Hyma and Ramesh (1994), presents a model for the integration of traditional medicines and

modern medicine. Integration may be thought of as a continuum between minimal and total integration, since totally successful and complete integration of the different systems exist nowhere. According to Hyma and Ramesh (1994), the term “integration” can take different meanings such as ‘institutional integration through national health services’; ‘consumers use of more than one medical system’, and health workers providing a combination of traditional and modern care.

#### **2. 7. 8 Summary**

Most authors had been engaged in some form of research about traditional healers and traditional medicine. Some authors like Gort and Shai-Mohoko highlighted how traditional healers trained and practice. They also stated categories and perception of traditional healers about collaboration with the western trained personnel. The views of traditional healers about illnesses were also discussed by most authors. Perceptions of the health care workers towards collaborating with traditional healers have been discussed. It seems that western trained health care workers viewed collaboration as a process whereby traditional healers refer clients to them and not the other way round, especially in the study by Hoff. From these studies collaboration between the two systems were mainly focussed of PHC. There was not much information stated concerning collaboration in the management of illnesses at the secondary levels of primary health care. According to Clark (1984), there are four levels of health care being promotion, prevention, diagnosis and treatment, and rehabilitation. Most of these authors have covered traditional healers mainly from African countries, a few from Asia and none from European countries.

These studies gave an understanding on how traditional healers' practice, the ratio of traditional healers to clients being served, traditional healers' status in terms of politics and socio-economics. It was also learned through these research studies that efforts towards collaboration were successful to a certain extent and that there is still a need to carry out further studies on certain aspects of traditional healers and collaboration. All these authors, one way or another stated that they were stimulated by the WHO's initiatives.

## 2. 8 CHRONIC ILLNESSES

In 1949 a Commission on Chronic Illness (cited in Phipps, Cassmayer, Sands and Lehman, 1995), defined chronic illnesses as an impairment or deviation from normal that has one or more of the following characteristics:

- a) the illness or impairment that is permanent,
- b) the illness or impairment leaves residual disability,
- c) the illness or impairment that is caused by nonreversible pathological alterations and the illness or impairment that requires a long period of observation,
- d) supervision and care.

Wellard (1997) mentions that interest in chronic illnesses as an area of research is increasing across a diverse range of disciplines. The physical, psychological and social effects of chronic illnesses feature as a major emphasis for distinguishing individual variations from the 'norm'. Chronic illnesses have become increasingly prominent in developed countries as mortality rates from acute illnesses decrease in response to improved sanitation. One cannot say the same for developing countries, which are hard hit by all sorts of illnesses including the surge of chronic illnesses brought by the immune-compromised illnesses such as HIV/AIDS related conditions and debilitating diabetic, cancer and hypertensive illnesses.

Biomedical approaches to chronic illnesses remain directed towards the investigation of pathophysiology of specific diseases and mechanisms for clinical treatment. The primary aim of treatment is to reverse, if possible, the course of illness and restore the patient to a normal state of health , thereby effecting a cure. Where a cure is not attainable, treatment becomes focused

on minimizing the impact of the disease on the body. This is primarily achieved through symptom control where treatment seeks to maintain a state that mimics normal health as much as possible (Wellard, 1997).

Wellard (1997) also notes four major themes within the psychosocial area of enquiry by the biomedical approach concerning chronic illnesses, the manifestations of chronic illnesses, mapping of trajectories, assessing quality of life and compliance.

Chronic illnesses create a demand for a treatment regimen. After evaluating the efficacy and value of regimens, ill people often seek to supplement their regimens with alternative treatments. A major endeavour for a chronic ill person is symptom control. People with chronic illnesses were identified as ordering time: juggling the management of both their illness and their lives. A key strategy in living with chronic illness is normalization. Hence the desire for a combination of regimes or turning to another type of medicine. This search shows that the clients themselves believe in a cure rather than maintenance of the illness. Lubkin (1986) (cited in Wellard, 1997) states that the psychosocial impact of chronic illnesses on individuals includes lowered self esteem, anxiety and isolation. Traditional healers offer good services in terms of dealing with isolation.

In the western world the concept of compliance with the regimen is very important, especially when it comes to the management of chronic illnesses. This element of compliance is not as emphasized in the way traditional healers managed illnesses as it is in the western way of managing illnesses. Compliance means the extent to which a person's behaviour ( taking medication, following diets, or executing life style changes) coincides with medical advice.

Wellard (1997) conducted research on compliance and found that 50% of chronic ill patients would comply. Those who fail to comply needed emergency treatments and hospitalization. Compliance goes together with the element of maintenance of illnesses ( Wellard, 1997).

Temmink, Francke, Hutten, van der Zee and Abu-Saad (2000) share similar views when they mention that health care systems are increasingly being confronted by chronic patients who need complex interventions tailored to their needs. Today's health care professionals, organizations and budgets are not sufficiently prepared to take care of such patients. As a result, health care policy, in many countries targets innovations which will reduce health care costs and, at the same time, improve the quality of care. Frequently, these innovations are related directly to the substitution of care phenomenon, in which care is provided by the most appropriate professional at the lowest cost level, and encompass advanced nursing practice, hospital-at-home care and integrated care. Whether these innovations positively influence the quality of care, cost of care or patient's use of health care facilities remains rather unclear ( Temmink, et al, 2000).

Temmink, et al (2000) mention that in addition to the population and the increase in chronic illnesses, the demand for health care is influenced by other socio-demographic or cultural changes. People also insist on quality health care and impose a greater burden on health care professionals. Nursing plays a pivotal role in the health care of chronic ill patients.

Chronic illnesses can be controlled and that period during the time when symptoms are not so obvious is called remission. The illness may become active again and that is called exacerbation. A survey by the National Health of America in (1990), (cited in Phipps et al, 1995), found that chronic illnesses can be classified as selected skin and musculoskeletal conditions, impairments

(visual, hearing, speech, paralysis, deformities, or orthopaedic impairment), selected digestive conditions, selected conditions of the genitourinary, nervous systems, endocrine, metabolic and blood-forming systems, and selected respiratory and circulatory conditions.

The rewards of treating chronic illness cannot be measured by a cure but by the prevention of complications and by helping persons function at their optimal level. Age, race, ethnicity, cultural values and cost of disability play a major role in chronic illnesses. For an example, beliefs and values of the individual may differ from those of the health care personnel, depending on the cultural values. Some persons may view chronic diseases as a form of punishment from God and thus a sense of guilt may be experienced. Understanding between the individual and the health care practitioner can be enhanced by appreciating the person's beliefs and behaviours in the context of their cultural heritage rather than denial of the cultural influences.

The family and the individual suffering from a chronic illness normally are subjected to great personal and emotional losses that must be dealt with, such as loss of self esteem, loss of status within the family, loss of independence, feelings of rejection, and a feeling of helplessness. Apart from these losses the cost to the patient and the family is considerable.

Another problem in chronic illnesses is the identification of causality. The problem is that causalities may be multifactorial in the nature of etiology, absence of a known agent, long latent period, indefinite onset, differential effects of factors on incidence and course of disease, and disease specific mortality rates, since the death may result from factors other than the disease itself.



*The natural history of chronic illnesses is as follows:*

- a) Susceptibility stage: - the presence of risk factors may be laying the groundwork for the illness,
- b) Pre-symptoms stage:- At the stage of pre-symptomatic disease there is no manifestation, but pathologic changes have begun,
- c) A clinical manifestation stage: - at the stage of clinical disease anatomical or functional changes have occurred so that recognizable signs of the disease exist,
- d) A disability stage: - at the stage of disability the extent of occurrence of the disability resulting from chronic disease is very significant to the person and the society because of the person's reduced income, the impact on psycho-social rules, and the burden on community resources.

Because chronic illnesses are long-standing diseases, and considering the problems surrounding them as well as the natural history, it is clear that a multidisciplinary team is needed. The practitioners' team has to involve more personnel than those in hospital team. Community resources in terms of personnel such as traditional healers can play a major role. Traditional healers cannot accomplish management of chronic illnesses alone. Hence modern health care personnel need to collaborate with others, at the same time they cannot cope alone without the community resources where the patient will eventually spend his or her life.

Since chronic illnesses are seen as mysterious by some communities and Gort's (1987) study confirms that in these communities most people with chronic illnesses show a preference for a traditional sector intervention, it is clear that collaboration between the two systems must exist in order to manage chronic illnesses effectively. Phipps et al (1995) mentioned that Western

culture tends to be cure-oriented; therefore, health care for acute conditions is often valued more highly than is health care for chronic conditions.

The most important aspect highlighted in chronic illnesses is prevention. The goal is to detect risk factors as early as possible. As most of the countries discussed in this study have tried to incorporate traditional healers into primary health care activities, the countries could also work towards collaborating with traditional healers in the prevention of chronic illnesses. Phipps et al (1995) mention that the prevention can take the form, recommended by WHO in 1978, that of three levels of prevention. Collaboration could take place in all these levels. The primary level encompasses the stage of susceptibility, and activities done at this stage are aimed at promoting health and specific protection against diseases can be provided by both sectors in a collaborative manner. The secondary level includes pre-symptomatic and clinical disease, and involves early detection and prompt intervention to halt the progress of the disease. The third level uses rehabilitative activities to prevent further complications and restore optimal functioning as much as possible. It should be noted that the stages tend to overlap, for instance rehabilitative activities have to be introduced during the secondary level so that disabilities can be minimized. Secondary level of early detection has to be done at the primary level through education of the community on how illnesses can be identified. The success of each level of prevention leads to the effectiveness of the next stage. If a disease is not identified early, there will be no effective secondary intervention and thus rehabilitation and successful reintegration into the community will be hampered, leaving the patient helpless.

Living in the shadow of a chronic condition has huge emotional and psychological impact. The repercussion spreads from the patient to partner, family, friends and the local community.

Professional health carers may distance themselves in the face of an incurable illness. They may attend only to physical and practical matters. A recurring criticism of most chronic ill patients is that of professional carers for lacking concern for the psychological aspects of the illness (Peace, 1996), in contrast with traditional healers who on the other hand are known to deal with the psychological and curative aspects in the management of chronic illnesses (Kalanzi, 1990).

Peace (1996) further relates that chronic illnesses can have far-reaching effects for patients and those caring for them. Many patients become isolated in their pain, whether through stigma or a sense of being disconnected from those around them. Some even lose their sense of self and become defined by the illness or the disablement.

What is more important in chronic illness is that the patient's and the care giver's concerns about the physical, psychological and spiritual aspects should be identified without making assumptions. The provision of emotional support involves referring the patient and the care givers to the appropriate specialist for certain aspects of the conditions that are beyond the professional's scope of practice. Chavunduka (1978) states that traditional healers are very good in psychological management of illnesses. Peace (1996), like Gort (1987), notices that chronic illnesses present with vague symptoms. In Gort's (1987) study, the people interviewed looked at chronic illnesses as mysterious illnesses which required handling by traditional healers rather than western health professionals. Peace (1996) states that some patients gained spiritual strength from their local church. This shows that chronic illnesses go beyond the pathophysiological aspect of illness. They involve some aspects of social, psychological, economical, political, spiritual, physical as well as cultural influences.

Newby (1996) deals with the psycho-social aspect of chronic illness. Newby presented the importance of time phasing of the chronic illness. Outlines of the conceptual framework for analysing the interaction of chronic illness with family and individual life-cycles were presented. The chronic diseases in this paper were divided into those with an acute onset and those with a gradual onset. Those with a gradual onset allow the family time for adaptation. Those illnesses that strike quickly place the family into an immediate crisis. Some chronic illnesses are progressive in nature, like Alzheimer's disease, thus allowing the family to adjust their roles accordingly. Some illnesses have a constant course in which the condition stabilizes after an initial period of crisis and adjustment. A stroke can fall into this category.

## 2.9 CONCLUSIONS

The literature review shows the importance of research about traditional healers. Issues like the status of traditional healers and traditional medicines in the whole world have been addressed. The literature review addresses the legal status and practices of traditional healers as well as the categories of traditional healers. Collaborative and cooperative efforts have been discussed. Various authors give insight on why there is recommendation towards collaboration as against integration. The World Health Organization's positive stand as far as traditional healers and traditional medicines is concerned is highlighted by most authors. Countries (Swaziland, Ghana, Nigeria and the Republic of South Africa) who took initiatives to develop projects towards collaboration were also discussed by some authors.

Most of the authors recommended research in terms of collaboration between the two systems of health care delivery. It was also recommended that studies be done concerning the management of chronic illnesses by the traditional healers.

The fact that 80% of the African population visit traditional healers for their health problems before they visit western health care facilities, shows a reason for collaborative efforts in order to make the patient feel comfortable with both systems (Shai-Mohoko, 1996). This can help both systems to cross check with each other in terms of safe and effective health care delivery.

Research, symposiums, conferences and establishments of research centres for traditional medicine and traditional healers is on the increase. Discussions also centre around finding clues from traditional medicines in terms of treating HIV/AIDS. Most countries are engaged in some

form of traditional medicine analysis and laboratory testing. This wide spread of HIV/AIDS problem, have seen a rise in the trade of traditional medicines.

Because of the increased demand of traditional medicine by traditional healers and pharmaceuticals a new project to save medicinal plants from extinction, which would concentrate on five plants that are fast growing and popular among healers, was launched on the Worlds AIDS Day, December 1, year 2000, in Mpumalanga, South Africa. This project used the process of cloning to mass grow traditional medicinal plants. The goal of this project is to reduce pressure on wild stocks of *muti* ( traditional medicines) plants, which are being plundered by traditional healers and pharmaceutical manufacturers. The African potato is one of the plants which the project aims to grow in vast quantities. This plants is popularly used for treatment of HIV/AIDS patients because it boost the body's immune system. The other plants will include the wild ginger which is used for respiratory problems. The rest of the plants will be the climbing onion ( its bulb is used as a heart stimulant and diuretic), elephants foot ( its bulb has a high cortisone content) and *ikhathazo* (rhizome is used for the treatment of respiratory problems). This project was also launched based on the fact that the research by the South African Institute of Natural Resources, showed that trade in medicinal plants in South Africa is worth about 900 million a year, and the income from *muti* in KwaZulu Natal is worth two thirds of the province's maize harvest (Macleon, 2000).

Swaziland is also one of the countries which is engaged in finding out the medicinal plants flora in the country, organizing symposiums and conferences, and compiling reports about medicinal plants. Recently, Amusan, Dlamini ( the researcher of this study), Msonthi, Makhubu and Dlamini (2000) finished a survey of plants identified in the Manzini region of Swaziland. Traditional

practitioners were interviewed in their homesteads and ethnomedical uses of plants were recorded. The plants recorded were then collected from the wild with the assistance of the traditional healer who gave information on them. They reported on about twenty four of the plants giving details of their preparations and uses. The uses included treatments for diarrhoea, dizziness, heartburn, infertility, sores in the genitals, diabetes, hypertension, sexually transmitted diseases, increased libido, version of the foetus, and emetics. Some of the plants were used for magical purposes which made it difficult to explain them scientifically. Phytochemical analysis of the plants was carried out.

*Some examples of the plants collected and analysed were as follows:*

- a) the Liliaceae ( *hlakahla*) used for treating constipation,
  - b) Annonaceae ( *Umtelemba*) used for sexually transmitted diseases and for hysteria,
  - c) Orchidaceae( *imfeyenkawu*) used for version of a foetus,
  - d) *Ansellia gigantea* Orchidaceae ( *liphakama*) used as a cough remedy in children,
  - e) Rubiaceae ( *sirwati*) used for dysmenorrhoea and
  - f) Verbenaceae ( *umsutane*) used for treating hallucination and kidney problems
- (Amusan, et al, 2000).

The socioeconomic problems brought by chronic illnesses in all the countries and the association of most chronic illnesses with terminal illnesses like cancer and HIV/AIDS require a new approach in the solutions to deal with chronic illnesses. In this field, a lot of studies, clinical trials and strategies to improve health care delivery are being explored in most countries. Most authors recognized that traditional healers play a major role in the management of chronic illnesses.

Much as studies and projects have been conducted towards integration, collaboration and analysis

of traditional medicines, the solutions for a successful collaborative system between traditional healers and western health care workers is still being in the process of being realised in many countries. A few countries like Senegal and Nigeria are beginning to realize this dream, since they already have structures and departments of traditional healers being officialised. Countries like South Africa are in the process and some countries are beginning to establish such efforts. What is positive, is that most countries see collaboration between the two systems as a way whereby patient care would be improved and preservation of traditional medicines would be achieved. The traditional healing practice would be developed to a level of being a recognized discipline and hence traditional healers would establish a recognized and valued profession in society.

Gumede(1990), rightfully, states that it doesn't matter whether you are a traditional healer, a nurse or a doctor, what is important is that do you have love for the person that you treat, so that, the person being treated can also have love, develop a good relationship and healing would come by. 'Love is the basis of all medicine.'

The literature review was very useful to the researcher to provide a context for and acquire basic information as to the issues surrounding traditional healers, western trained health care personnel, as well as regarding collaboration between the two groups.



## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 STUDY DESIGN**

The study follows the Action Science (AS) and Action Inquiry (AI) methodology. It is also a qualitative study. According to Denzin and Lincoln (1994) action science and action inquiry focus on change of organizations and systems, not the politics of systems and systems change. Action inquiry and Action Science are forms of inquiry into practice that are concerned with the development of effective action that may contribute to the transformation of organizations and communities towards greater effectiveness and greater justice. They are concerned with harnessing change factors, and decreasing resistance to change, and thus transforming systems. The principles of collaborative inquiry are applicable in this study which is trying to facilitate collaboration. In collaborative inquiry, there is the element of shared reflection about collective dream and mission, and open rather than masked interpersonal relations.

In a qualitative design, things are studied in their own natural settings, attempting to make sense, or interpret some phenomena in terms of the meaning the people bring to them. Thus most concepts like collaboration, diabetes and hypertension were studied in relation to the meaning the participants bring to them (Denzin and Lincoln, 1994, p2 ). Hence, the theoretical essence of this study was derived from what the participant's meaning of collaboration was in relation to the documented collaborative concepts.

Qualitative research attempts to bring trust between the researcher and the participants, and that is ideal for collaboration. Raymond (1996) states that the researcher in a qualitative research enters the study without any formal theory. Eventually the researcher develops organizing principles, categories or other concepts until he or she is satisfied that the theory is accurate. Theories developed under qualitative study are less generalized beyond the situation under study. Qualitative research proceeds from the specific to the general level. The results are complex and rich and the interest is in the outcomes.

Qualitative research concentrates on the qualities of human actions. It can be used for the improvement of nursing practice. It is time-consuming, as the collection of data entails large quantities of handwritten notes that have to be sorted and analysed. Words rather than numerals are used as a basis ( Uys & Basson, 1995). Brink ( 1993) states that the very nature of qualitative research does not lend itself to statistical or empirical calculations of validity. The qualitative researcher seeks basically the same ends through different methods which are better suited to human subject matter. This implies that there are still significant elements of reliability and validity in a qualitative research. These elements have been covered under the ethical considerations in this study.

The principles of Action Research also underlie this study in the sense that the research is conducted to improve the practice of traditional healers and western health care workers for the benefit of the clients. Stevens (1997) states that action research is used as a means to improve practice through the implementation of the research itself. It emphasises participation and co-learning between practitioner-research and the participants throughout the intervention. The researcher in this study also learned a lot about the practices of the traditional healers and the

views of the clients about collaboration, and also the reality of practice of the western health care workers in their clinical areas. Action research aims at empowering participants through developing their problem solving-skills. In this study, the art of developing strategies began with self reflection and progressed to empowerment of the individuals with skills to solve the problem. In the focussed group sessions as well as in the series of joint meetings, individual participants were engaged in a dialogue trying to solve problems. Coming up with solutions that would benefit all the participants resulted in empowerment for all. In action research the participants should develop a sense of ownership of the interventions/research. Chosen strategies were viewed as part of the participant's contributions and ownership in this research.

Stevens (1997), like Stringer (1996) in her Community-Based Action Research, states that action research proceeds through a spiral of cycles from planning, to acting, to observing and reflecting. Participants were encouraged to critically reflect on their experiences and dialogue throughout the interventions, recognizing that their knowledge was valid and important. The key notion in action research is dialogue, which in this study was accomplished through the focussed group sessions and a series of meetings during the implementation of strategies. Participatory research, according to Cornwall & Jewkes (1995), raises personal, professional and political challenges which go beyond the bounds of the production of information. The participants control the research process in a participatory approach. This will be seen in the following chapters where there was emphasis on changing the Witchcraft Act of 1905. This discussion became more of a political and social issue.

This study also displayed some characteristics of community-based action research described by Stringer (1996). The primary goal of this type of research is solving problems experienced by people in their profession, community or private lives. Community-based action research is a collaborative approach to inquiry or investigation that provides people with the means to take systematic action to resolve specific problems. It assumes that all stakeholders should engage in the processes of investigation. The role of the researcher in this context becomes more facilitative and less directive. The following chapters will show all the actions the participants engaged to solve the problem of collaboration.

According to Denzin and Lincoln (1994) grounded theory is a qualitative research method that deals with theory development or theory modification. Theory may be generated from the data, or if existing, may be elaborated or modified as incoming data are meticulously being analysed. This study utilized some principles of a grounded theory in that during data analysis a traditional theoretical essence was explored and compared to the existing documented concepts of collaboration.

In a cooperation or collaboration process, some authors state that the participating groups should include the authorities responsible for health care delivery (Pretorius, 1991). In this study, the Ministry of Health and Social Welfare became the authority responsible for the delivery of health care in Swaziland. The participants in this study were the traditional healers, western health care workers (nurses and doctors) and clients suffering from diabetes and hypertension. The Ministry of Health and Social Welfare and the University of Swaziland were some of the participants involved in facilitating the process of data collection.

Data collection and data analysis were conducted in three stages. During the first stage data was collected to establish the profile and define the problem of collaboration by the traditional healers, western health care workers (doctors and nurses) and clients suffering from diabetes. The second stage involved a focussed group session. The purpose was to explore the problem jointly and develop strategies of solve it. The third stage was that of process evaluation and analysis of the chosen implemented strategies and also investigating the success of the implementation of the chosen strategies.

*The design of this study employed some of the principles of a format recommended by Stringer (1996, ) as follows:*

a). Resolving specific problems or crisis (problem of collaboration: first stage and part of second stage)

- \* Defining the problem,
- \* Exploring its context,
- \*Analysing its components parts,
- \* Developing strategies for its solution ( identified at the first stage and during the focussed group session).

B). Developing Special Projects and Programs (second and third stages of this study)

- \* Planning,
- \* Implementing,
- \* Evaluating.

### **3. 2    DEMOGRAPHY OF SWAZILAND**

Swaziland is a landlocked, kingdom country situated in the Southern part of Africa. It is situated between the Republic of South Africa and Mozambique. It is made up of four administrative regions as well as four topographic and climatic areas. The administrative regions are Hhohho in the north, Shiselweni in the South, Manzini in the middle to the Western side and the Lubombo region in the Eastern side of the country. The topographic regions are the Highveld, Lowveld, Middleveld and the Lubombo region. The projected population at a fertility rate of 6.6 is 1,220, 000 by the year 2010. Swaziland has a homogenous population which keep homesteads as their inhabitants. There are seven major hospitals in Swaziland with a large number of health centres and clinics. Cultural heritage is deeply rooted with traditions carefully protected and sustained ( Thompson, 2000).

### 3.3 SAMPLING

Morse (1989) states that the selection of a sample has a profound effect on the ultimate quality of the research. In qualitative research, the selection of an adequate and appropriate sample is as critical as it is in quantitative research. There has been lack of clear guidelines about sampling in qualitative research which has led to confusion. The researcher therefore used quantitative methods of sampling. In this study a convenience purposeful sampling was mainly conducted.

In a qualitative research four types of sampling are normally used, these being purposeful or theoretical sampling, nominated sampling, volunteer sampling and total population. In a purposeful sampling the researcher selects a participant according to the needs of the study. The researcher has to know who has the information before inviting the informants. In a nominated sampling, networking or snowballing, the researcher obtains informants by eliciting the support of assistance of a single informant already in the study to assist in the selection of another participant. The identification and selection of participants is controlled by the population of potential informants. Volunteer or solicited sampling is used when the informants may not be known to the researcher or to each other. The researcher may rely on the potential participants, who may be going through or have a particular experience of interest, identifying themselves. With the total population, a sample is used when all informants live or work in a confined area (Morse, 1989).

Some principles of all the types of qualitative sampling, described by Morse (1989), were applied in this study. For the selection of western health care personnel, one can conclude that a population sample was used on the basis of a location, i.e. they were all found in the same working area. They were also chosen as a purposeful sample since they fulfilled the need of the

study. They were considered as participants who had a broad, general knowledge of the topic and were mainly affected by the topic. When actual data collection took place, only those who identified themselves were involved on those particular days. Principles of volunteer as well as convenience sampling were used.

The clients who were found in health care centres were conveniently and purposefully sampled. These clients were identified in the health care centres when they came for their check ups. The focus was the clients who were suffering from diabetes and hypertension. With the traditional healers, principles of purposive sampling and nomination were utilized, since the researcher needed assistance to locate traditional healers' homesteads. The assistant had the control of choosing whom to locate. Selection was still purposive in that traditional healers who were chosen were those who had knowledge and who were affected by the study. Sampling was as follows: The convenience purposeful sampling was conducted in three stages, individual interviews, focus group session and implementation of strategies.

### **3. 3. 1 Sampling the Settings**

The researcher planned to select three areas. The first two were Sithobela and Dvokolwako Health Care Centres which are rural areas 200km apart. The third was an urban area being the Mbabane City, which is 150 km away from the nearest rural areas. Once the process of data collection started in the first stage, the researcher reached saturation of data after only working with two rural areas. Polit and Hungler (1995) describe the theory of saturation as a process when there is a sense of closure experienced by the researcher. It occurs when data collection ceases to yield any new information. The urban site was therefore not used in the first stage of data collection as will be seen below. The urban areas were only utilized during the third stage



where strategies were being implemented and evaluated. Sithobela is situated in the Shiselweni region and Dvokolwako is found partly in the Lubombo and partly in the Hhohho regions of Swaziland.

### **3. 3. 2 Sampling of the participants**

According to the proposal it was stated that the sample would consist of the traditional healers and western health care workers who manage chronic illnesses . This turned out to be impossible since it was very difficult to identify only the traditional healers who manage diabetes and hypertension. Most western health care workers were not currently managing chronic illnesses, but have been involved in the management of chronic illnesses in the past. It was easier to select the clients suffering from chronic illnesses.

The researcher chose a convenience purposeful sample of traditional healers, western health care workers and clients suffering from chronic illnesses. The authorities of health and representatives of the traditional healers organizations also formed part of the sample and were chosen as a purposeful sample, especially in stage one. During the meetings, any traditional healer, western health care worker and clients attended the meetings. There was no selection. During the third stage when selecting participants in the strategy to establish the safety of traditional medicines, a sampling process was followed ( for details, see the sampling procedure in Chapter Five number 5, 3, 188).

#### ***The Sample Size***

##### **a) Stage one individual interviews:**

##### **i) Establishing the traditional healers profile and defining the problem of collaboration**

From each rural area there were supposed to be 10 traditional healers, 10 western health care

workers and 10 clients selected for the study to make a sample of 30 per site( 60 in all) This was not possible since saturation of data was met. From Dvokolwako health care centre, seven traditional healers were interviewed and nine in the Sithobela area. There were ten western health care workers interviewed at Sithobela, while six were interviewed at Dvokolwako. Only two clients were interviewed at Sithobela, while 18 clients were interviewed at Dvokolwako. The sample in stage one for the individual interviews was reduced to 52 and was convenience.

**b) Stage two: Focus group session:**

**i) Defining the problem, exploring its context and developing strategies for its solution in a joint venture:**

The participants included the authorities of health, being the representatives from the Ministry of Health and Social Welfare and representatives from the Traditional Healers Organization and Tinyanga Temdzabu Organization, the clients, the nurses and doctors and the traditional healers. This turned out to be more of a meeting rather than a focussed group. The number of participants exceeded the number recommended for a focussed group. In Sithobela there were 41 participants, while in Dvokolwako there were 58 participants. Discussions were about the problems of collaboration, management of diabetes and hypertension by the two systems, and proposing strategies to facilitate collaboration by all the stakeholders.

A neutral person led the discussions in both centres so that there should be no bias from the researcher. The researcher acted as the secretary, writing notes and recording using the audio-tape to supplement the written notes.

**c) Stage three: Process evaluation, development of special projects and programmes**

**(Planning, implementation and evaluation):**

**i) Implementing and evaluation of proposed strategies.**

***a) Establishing safety and efficacy of traditional medicines in the control of diabetes and hypertension.***

The researcher purposefully selected six clients who utilised only traditional medicines to form one group. The second group comprised seven clients who utilized only western health care medicines. The control group was made up of six clients who utilised both types of medicines concurrently. This was done for the semi-experimental study where the researcher was trying to establish the efficacy and safety of the traditional medicines used in the control of diabetes and hypertension, compared to the western health care medicines used in the control of diabetes and hypertension. The ones who used only western health care medicines were conveniently and purposefully selected from Dvokolwako Health Care, because patients for diabetes and hypertension attend the clinic in this centre on Thursdays of each week, once per month, so it was easy for the researcher to find them. The clients who used traditional medicines only were selected conveniently from two traditional healers around Manzini and Mbabane urban cities. Two were selected through voluntary sampling. They happened to be employees at the same place as the researcher. The sample size was 19 clients and purposeful.

***b) Establishment of a legal office (Council of traditional healers) under the Ministry of Health and Social Welfare:***

For the initiation of an office of the traditional healers in the Ministry of Health and Social Welfare, the researcher conveniently targeted the leaders of the traditional healers organizations and the leaders of the Ministry of Health and Social Welfare. Meetings were held with groups of clients traditional healers and western health care workers to deliberate about this issue. Groups met at Dvokolwako and at Sithobela health care centre. This was done to make sure that the deliberations cover all traditional healers, including those who were not members of any organization, and also to solicit views from a larger number of traditional healers.

**3. 3. 3 Sampling of the illnesses**

It was intended that the study should be focussed, rather than unfocussed, to facilitate defining the problems of collaboration and developing strategies. Therefore the study addressed diabetes and hypertension as examples of chronic illnesses. Diabetes and hypertension were chosen in this study because western health care systems have a clear understanding of their management. Diabetes and hypertension comprise good examples of chronic illnesses in that they are never cured, but can be controlled, although they have a tendency to cause disabilities to the sufferers. Traditional healers also claim to treat diabetes and hypertension. The two are also problematic illnesses to any country, in terms of socioeconomic and political status.

In the United Kingdom about 2% of the population currently have diabetes mellitus and its prevalence increases with age as about 65% of people over 65 years are affected. Diabetes mellitus is an illness which results when a person does not produce enough of the hormone insulin,

which regulates how much glucose is in the blood (Willis, 1995). van Dellen (1993) states that these two illnesses are the common chronic diseases. Diabetes has been estimated to affect 2 million persons in South Africa by the year 2000. The two illnesses together are an added risk to the patients.

In Swaziland diabetes and hypertension have become such a cause of concern that both illnesses were discussed at parliamentary level. The members of parliament noted that both illnesses were not being treated properly at medical hospitals because of lack of facilities. Both these chronic illnesses are among the illnesses that cause the most admissions, outpatient treatment and high mortality rates in Swaziland (Dlamini, 1998). Traditional healers in Swaziland claim to treat diabetes and hypertension, and they place advertisements in the local newspapers. Both systems have a need to collaborate to ensure quality patient management of these chronic illnesses.

### 3. 4 DATA COLLECTION

Data collection in this study followed the triangulation method. This was an attempt to reach credibility, validity and reliability. Triangulation refers to the use of two or more data sources, methods, investigators, theoretical perspectives and approaches to analysis in the study of a single phenomenon and then validating the congruency among them ( Kimchi, Polivka, & Stevenson, 1991). In this way the validity of the study is increased. In this study triangulation was done through the use of different methods for data collection, from at least two different places using the same tools, from different topics and at different times. Data was collected using an interview guide, using two initial meetings, a series of meetings for the establishment of the legal body, checklist tool for the semi experimental project and instruments to measure hypertension. Sometimes in the meetings there would be new participants who helped in verifying some of the information provided by the primary participants ( Brink, 1993).

An unstandardized interview was utilized for the major part of the individual interview in order to obtain systemic data from all groups. Raymond (1997) mentions that in the unstandardized interview, the general nature of the questions is specified in advance, but the specific questions are not. The interviewer keeps the purpose of the research in mind, but determines the specific wording of the questions and their order. This allows for a naturalistic or informal interview in that the interviewer is free to ask questions in the order and manner that follow the natural flow of the interaction. A list of questions or question guidelines may be prepared, but a formal interview schedule is not generally used. A standardized interview consists of a list of questions with the specific wording and order of the questions predetermined and administered in a standard manner for all the interviewees. Series of meetings were also utilized. The two initial meetings were done to establish the definition of the problem. A series of meetings were utilized

during the implementation of the strategy of legalizing traditional healers. The only principle which was difficult for the researcher to observe was that of the number of participants, hence the planned focus group sessions turned into meetings. It was not easy to tell which traditional healer or client should attend. The number of participants exceeded the number recommended for a focus group. A focus group can be defined as a 'group interview centred on a specific topic (focus) and facilitated and coordinated by a moderator or facilitator, who seeks to generate primarily qualitative data, by capitalising on the interaction that occurs within the group setting.' It is generally felt that 8 -12 is a suitable number of participants for a focus group.. The idea behind the focus group method is that group processes can help people to explore and clarify their views in ways that would be less easily accessible in a one to one interview ( Sim, 1998).

The focus group method may encourage a greater degree of spontaneity in the expression of views than alternative methods of data collection. The sense of a safe forum is provided and participants may feel supported and empowered by a sense of group membership and cohesiveness. Data is collected on how they interact with one another (Sim, 1998). In this study the two initial meetings as well as the series of meetings that followed also allowed dialogue to take place between the participants.

A checklist tool was utilized for collection of data, concerning readings or levels of diabetes and hypertension in the clients who utilized only, or combined, western medicines in the semi-experimental study. Data was collected as follows:

### **3. 4. 1 Stage One: Individual interviews: Profile of traditional healers and defining of the problem**

#### ***Outlining the Profile of Traditional Healers***

During the individual interviews with western health care workers, it became clear that it was important to develop a descriptive profile of traditional healers. Western trained health care workers did not know much who traditional healers were and what they practice or treat in order for them to be in a position to collaborate with them. During the interviews, data was then collected about the traditional healers' profile. The profile included their age, type of traditional healer, number of years as a healer, types of illnesses being treated and how they were trained and by whom as well as their area of residence. Mainly the biographical data of traditional healers was collected.

#### ***Defining the problem, exploring its' context, analysing it and developing solutions***

An individual interview guide using an audio tape recorder and two initial meetings were utilised to collect data. Data collected at this stage related to knowledge about chronic illnesses and other illnesses, approach to the management of diabetes and hypertension, the nature of current interaction between traditional healers and western trained health care workers, perceived enhancers and barriers as well as recommended solutions for collaboration in general and in the management of diabetes and hypertension. The respondents were the western trained health care workers, the clients suffering from diabetes and hypertension and the traditional healers. This stage was aimed at collecting data about the analysis of the problem and also initiating the process of change. During this individual interview stage the researcher developed a very good rapport with the participants in preparation for the next stage of two meetings which was a critical one. The



next stage was very critical in that dialogue and ventilation of bottled up feelings between western health care workers and traditional healers was expected, based on responses the researcher received during the interview stage.

**a) Health care workers and the clients:**

Data collection through individual interviews was started in June, 1999, for the nurses in both health care centres. In Sithobela eight (9) nurses and one (1) doctor were interviewed and five (4) nurses and two (2) doctors interviewed from Dvokolwako health care centre. In Sithobela they used the integrated method of health care delivery for all types of patients owing to shortage of manpower.

Clients normally have their checkups on a monthly basis, so the researcher found that per day a lot of clients turned up for their check ups. Hence in Dvokolwako Health Care Centre the researcher managed to interview a larger group of clients since they all come every Thursday. Each client come on Thursday once a month. Each client or health care worker was interviewed alone in a room to avoid interruption and embarrassment as well as to boost his/ her confidence and free expression. The researcher would call the sister in charge to make an appointment for her visit to conduct the interviews. This meant that western health care workers and the clients expected that they were going to be interviewed, and this made the interviewing process easier. Extensive data was collected from the clients in Dvokolwako Health Care Centre, but less data collected from Sithobela Health Care Centre. In Sithobela, there was no set date for check ups, client came whenever they felt like. Sometimes there would be no client suffering from diabetes nor hypertension for the whole day or days. This was not easy for the researcher to meet a lot of clients.

## **b) Traditional Healers:**

### ***i) Dvokolwako Health Care Centre***

The researcher was assisted to locate the leaders of the community by a health inspector. The chief was contacted who, then through his runners, organized the traditional healers to attend a meeting with the researcher. This was arranged so that the research could be explained and to seek consent from each healer to participate in the study. Fifteen traditional healers turned up for the meeting. The purpose of the study and the stages of the study were fully explained to the traditional healers. After the meeting those traditional healers who consented arranged for an appointment to be interviewed, giving a place and time to the researcher. Only seven (7) traditional healers were interviewed and by then the researcher reached the saturation of data. All these traditional healers were interviewed. To locate their homesteads, the researcher utilized the services of an assistant who knew where to find them. The researcher had learned that the chief had ordered that all traditional healers in his area should participate.

### ***ii) Sithobela Health Care Centre***

A traditional healer who is also a member of the Community Health Care Centre Committee assisted the researcher by offering his son as a guide to locate traditional healers. In this community the leaders were not directly contacted, but the traditional healer reported the proposed study to the leaders and he reported that they were giving their permission. A meeting of traditional healers was organized. Only three (3) traditional healers turned up for the meeting. When data was being collected, most traditional healers showed interest. Nine (9) traditional healers were interviewed in their own homes in this community.

### **3. 4. 2 Stage Two: Two initial meetings ( defining of the problem, exploring it's context and developing strategies )**

Two meetings were conducted, one in each centre. This was the stage at which all the stakeholders came together to explore collaboration in the management of diabetes and hypertension and jointly develop strategies for collaboration. The stakeholders were the Ministry of Health and Social Welfare, traditional healers, clients suffering from diabetes and hypertension and western trained health care workers. They explored the problem of collaboration together and identified the strategies or ways by which collaboration could be facilitated.

A dialogue between the stakeholders was facilitated at which there was flaring of emotions, especially from the traditional healers, but as the discussions continued, these emotions settled down. When the Ministry of Health representative gave a report from the Ministry's authorities, the traditional healers expressed dissatisfaction with the statement that the Ministry perceived that collaboration between the traditional healers and the ministry was facilitated. After identification of strategies and solutions by different individuals on how best they could collaborate, ways by which they could be implemented successfully were explored. These decisions involved planning and setting of action plans as to when the strategies should begin to be implemented.

The researcher considered that a group of 15-20 individuals would be enough, but seeing that the research had stimulated extensive interest, especially in one of the communities, it was not easy to estimate the number who would attend. The other reason was that, in the rural setting it was not easy to select traditional healers to be excluded because of the fear of exceeding the recommended number of participants in a focus group. The researcher ended up with 41 participants in one community, and 58 participants in another. The participants were traditional

healers, clients suffering from diabetes and hypertension, the western health care workers, the Officials from the Ministry of Health and Social Welfare and from the University of Swaziland.

A neutral person was requested to be the chairperson and to lead the discussions. The researcher planned to involve somebody from the Rural Agricultural Development Department or one of the Rural Leaders who is not part of the participants. In this instance, the leader was a Lecturer from the University who is a Health Inspector under the Department of Environmental Health Sciences.

Stringer (1996) states that a meeting is best led by a neutral chair or facilitator, a person perceived as having no overriding loyalty to any of the stakeholding groups. The health inspector in this case was chosen on the basis that he was a health worker and had been involved in community work, so he had knowledge and skills about how to run community meetings. After each individual interview, the researcher discussed the possibility of a focus group session. Most of the participants interviewed showed interest in attending the meeting. An agenda for the meetings was developed, stating the purpose of the discussions and how discussions would be carried out. This was discussed with the chairperson beforehand. The meetings were held in common rooms of the health care centres. The researcher had planned to hold them in community halls, but that proved to take too long to arrange. In the end, all participants were comfortable with the venues, and the venue provided a conducive environment for traditional healers, clients and western trained health care workers to have a feeling of togetherness.

Stringer (1996, p75) states that the framework for description should have appropriate initiating questions, such as Why are we meeting today? or What is the Purpose ?, What are the problems?, How do they affect our work?, Who is being affected ?, Where are things happening ? and When

are things happening ? These meetings tried to address such initiating questions. The answers focussed on acts, activities and events related to the problem.

The next stage recommended by Stringer (1996) is the stage of analysis of interpretive accounts by means of which the participants would come up with categories or concepts. In the focussed group session it was expected that the participants would come up with a few strategies from all the discussions. It would be simpler to implement a few major strategies than to have a number of bits and pieces that need to be implemented. In this case there were a lot of strategies that the participants suggested. The problem of collaboration seemed to go deeper than the researcher had thought and this would be reflected in the presentation of results.

### **3. 4. 3 Stage Three: Process analysis/ evaluation and implementation of strategies**

#### ***Implementation of strategies***

**a) Experimental survey to establish the efficacy of herbs used by traditional healers vs western medicines for the control of hypertension and diabetes:**

The researcher utilized an interview tool and a checklist tool to view the health records of those using only western medicines to control their diabetes and hypertension. The medical records were looked into for comparing subjective and objective data. The levels of glucose in the blood and blood pressure using instruments for the clients who used only traditional medicines to control their diabetes and hypertension were also determined, after having collected the history of the course of the illness.

**b) Establishment of a legal office of traditional healers at the Ministry of Health and Social Welfare, establishment of traditional healers council and development of their constitution.**

For the initiation of the traditional healers' office, the researcher utilized open discussions with the traditional healers, leaders of their organizations and the Ministry of Health and Social Welfare Administrators. The Ministry of Health and Social Welfare Administrators were visited initially to try and find out how they viewed the issue of a legal office of traditional healers in the ministry.

A series of meetings were held thereafter with traditional healers, clients and the western health care personnel to discuss these issues further. In these meetings there was a process of action plans, progress and feedback followed by an action plan, progress and feedback and so on. Accounts of meetings and the ensuring deliberations will be seen under the 'special projects' chapter. In the Ministry of Health and Social Welfare, the meetings were held with the Director of Health Care Services in Swaziland. The two leaders of traditional healers were from the Traditional Healers Organization and from the Tinyanga Temdzabu Organization respectively.

Thereafter, several joint meetings were held either in Sithobela or Dvokolwako Health care centres. The meetings from these centres were followed by meetings held around Swaziland in areas where traditional healers normally meet. This was in order to obtain opinions of all traditional healers concerning these issues before sending the draft to the lawyer who will then put it into legal wording.

In these joint meetings, the researcher gave feedback on the progress of the research. The issue of an office was discussed further. A lot of information was gathered from the clients, traditional healers and western health care workers. Field notes were taken by the researcher. Some traditional

healers assumed the position of chairpersons to lead the discussions.

**c) Initiating the exchange of information and skills:**

In some of the meetings where the researcher gave feedback and discussed at length the legal traditional healers' office, the other agenda would also be the exchange of information. Each cadre came in with a prepared topic to share with the others as far as health issues were concerned. The researcher indicated how far the study had gone to the participants before they lost any track of the research. This was also to assist them to recall and emphasize their roles in facilitating collaboration.

### 3.5 DATA ANALYSIS

Audio-taped and written field notes were transcribed, carefully studied and analysed. Data analysis was done according to the editing analysis style described by Crabtree and Williams (1992, p 19-20). In this form of data analysis, the text is carefully studied, searching for meaningful segments, cutting, pasting and rearranging until the reduced summary reveals the interpretive truth in the text. Units were identified, sorted out and organized into categories. The patterns and themes that connected the categories were identified. The analysis proceeded to an interpretive phase in which the units and categories were connected into an explanatory framework consistent with the text. It was these final connections that formed the reported outcomes. This enabled the researcher to come out with the traditional theoretical essence of this study which was then compared to the documented collaborative concepts.

Constant comparison was utilized whereby the researcher was, after having created the categories from the data, revisited or reentered the data to see if the newly developed categories seemed to explain the data, which might lead to change or modification of concepts or categories (Raymond, 1996, p215). Some data were presented unchanged, especially quotes from individual participants which illustrated or were given as examples of the results from the data analysis.

The discovery of regularities was also done. The researcher tried to establish the connections or links between the categories or concepts identified. This was the first step in identifying the theory from the data. In this case the researcher was seeking explanations, trying to find out the 'why' part of the emerging themes and categories instead of only the 'what'. This type of analysis is described as theorizing (Tesch, 1992, p84-92).



The researcher also conducted data analysis simultaneously with data collection and data interpretation. Creswell ( 1994) explained that in qualitative research several simultaneous activities engage the attention of the researcher. The researcher takes voluminous amount of data and reduces it to certain patterns, categories or themes and then interprets this information using a particular schema.

Tesch (1992 ) also stated that the researcher gets the initial sense of the main factors, plots the logical relationships tentatively, setting them against the next wave of data collection, modifying and refining them into a new explanatory map, which gets tested against new cases and instances. Then the chain of evidence becomes confirmed and the conclusions are cast into the form of conceptual statements that represent the results of the study.

Initially the researcher planned to use a computer to analyse the data. The Nvivo programme was to be utilized as it has tools for handling all sorts of qualitative data. These tools help the researcher in different ways of indexing, Searching and Theorizing. Hence Nvivo provides the QRS's software packages and the acronym is called the 'NUDI Ist' programme. The researcher first learned about this programme by attending a demonstration. A computer specialist was engaged to assist the researcher in the continuation of data analysis using such a programme to make sure there was proper data analysis. This did not happen since the data was such that the researcher could use manual analysis.

The data collected through interviews using the audio-tape, was immediately transcribed into written form. The data in Siswati (local language) was translated into English for the purpose of analysis. Some of the data was already in the form of field notes. While creating categories as data

collection was going on, the researcher reached a point of data saturation. There was no new information gathered by which the researcher could create new categories. This occurred during the individual interviews and during the post focussed groups process evaluations. There was support for the construction of categories from the participants as there was no new information being added while data collection was on going. This support maximised verification of data and allowed for the evidence of validity in this qualitative study ( Polit & Hungler, 1995).

This study was analysed using the principles of content analysis for the first and second stages and process analysis was done only for the special projects. Tesch (1992) explains that in content analysis the many words of the text are classified under increasingly fewer categories. The basic procedure in content analysis is to design categories relevant to the research purpose and to sort occurrences of relevant words or other recording units into categories. Manipulating data in qualitative research is an eclectic activity, there is no one 'right' way. It is possible to analyse any phenomenon in more than one way, and each qualitative analyst must find his own process. The result of the analysis is some type of higher-level synthesis. The final goal is a larger consolidated picture.

### **3. 6 CREDIBILITY OF THE STUDY**

The methodology of this study has been presented clearly and the researcher followed the steps of data collection that were planned. The selection of participants was based on the fact that they would all provide relevant data for the research. The researcher reached a stage whereby theoretical sampling was done. Brink (1993) states that theoretical sampling is a method whereby the researcher continues to select participants according to the findings that emerge in the study until no new information is obtained. Polit and Hungler (1995) refer to this point as saturation of data. The collection and analysis of data led the researcher to be able to see the need to implement and evaluate some of the recommended strategies, hence increasing the significance and validity of the study.

Data analysis has been allowed to occur simultaneously with data collection. After collection of data from two areas, Sithobela and Dvokolwako health care Centres, the researcher entered the process of analysing the data after which gaps were filled in with data collected from individuals in the post-focussed group interviews and during the meetings held after the focussed group sessions. This led to the implementation of strategies based on the findings from the initial individual interviews and the focussed group sessions.

Special projects were identified and implemented. These special projects formed the base for collaboration. The project which looked into the efficacy and safety of traditional healers medicines attempted to establish some form of trust between the two which is very essential for collaboration.

All participants had to be at the same level for collaboration to take place, so the establishment of some legal structure and a constitution as well as trying to establish an office for traditional healers

in the Ministry of Health was seen as a way of empowering traditional healers. This step would bring them to the same legal and official level as the western trained health care workers so that collaboration could take place.

The data was critically analysed by the researcher to enhance the credibility of the various stages of the study. Apart from carefully describing every phase of the study, the researcher used quotes from participants to illustrate categories developed or themes identified. The researcher was engaged for a prolonged period of time. Triangulation was done by comparing data from multiple sources such as the individual interviews, two initial meetings, series of meetings and the experimental strategies (Kimchi, et, al, 1991). Brink (1993) states that triangulation's major goal is to circumvent the personal biases of investigators and overcome the deficiencies intrinsic to single-investigator, single theory, or single-method study, thus increasing the validity of the study.

In reaching the criteria of fittingness the theoretical essences of collaboration was derived from the data itself and was then compared with other sets of data such as the available literature, by Henneman and Langford.. An expert qualitative researcher was utilised to monitor clearly the decisions taken by the researcher within every phase of the study.

According to Denzin and Lincoln (1994) a qualitative study should address the experiences and qualifications of the researcher in relation to credibility. Thus the researcher in this study is best described as a facilitator..

### 3.7 ETHICAL CONSIDERATIONS

According to Cresswell (1994), first and foremost, the researcher has an obligation to respect the rights, needs, values, and desires of the informants. The researcher respected the participants' rights in the following manner:

Before the participants were selected, the Ministry of Health and Social Welfare was briefed on the study, because they are the authority that delivers health care services and also their permission was necessary. The Ministry of Health and Social Welfare granted permission for the study and referred the researcher to the Nurses' Association of Swaziland, Dental and Medical Health Care Services and to the two official Traditional Healers Organizations. (see letters of correspondence in the appendices)

After consultation with the Nurses' Associations the researcher had meetings with the authorities of the two health care centres and permission was granted. The researcher had two meetings with the traditional healers organizations, "Traditional Healers Organization and the Tinyanga Temdzabu where permission was granted verbally.

Permission to conduct the study was granted by the Ministry of Health and Social Welfare. The Swaziland Nurses Association and the Nursing Council never replied formally, but they offered the researcher an award for conducting research. This was a significant symbolic gesture of support. The Medical and Dental Association and the Traditional Healers Associations gave verbal permission. Seeing that the researcher is a lecturer at the University of Swaziland, permission to pursue the PhD study was requested from the Administrative Department of the University. The University of Swaziland, after careful consideration of the research in terms of ethical

considerations and validity as well as applicability in Swaziland, offered permission as well as financial support for the researcher to embark on the study.

This step was necessary since most participants are employees of the Ministry of Health. Nurses and doctors are members of their Associations or councils and most traditional healers are members of their Associations.

Because communities surrounding the clinics were going to be involved, a letter requesting permission for entry into these communities was written and directed to the Deputy Prime Minister's Office, because he is responsible to the chiefs in the different communities. There was no reply from this department. During this period the building of the Deputy Prime Minister was damaged by a bomb blast which might have destroyed this letter. The researcher wrote another letter which has not yet been replied to by the Deputy Prime Minister.

Participants' permission and commitment to the process was elicited during the first interviews. Their right to refuse was clearly communicated. The participants were also given a chance to ask questions about the study and its implications to them. Confidentiality of information was guaranteed and participants were welcome to use self-selected pseudonyms if they chose to do so. Most traditional healers proudly gave their names, which they said were names given to them when they underwent training. They called them ancestral names.

Information from the initial individual interviews and the focussed group sessions was presented in its aggregate form and was not traceable to the source. Participants were kept informed of the whole process and participated in the whole project by choice.

During the data collection on traditional medicines vs western medicines, the researcher came across patients who used only the traditional medicines, but who seemed to be having other problems. The researcher referred them to the hospital. The ones whom the researcher found to have high levels of glucose and blood pressure were sent to the hospital and then cancelled from the group. This of course was noted as a sign of being biased on the researcher side towards western medicine versus the traditional herbs.

During the establishment of the office and development of the constitution, the researcher had to go according to the pace of the traditional healers, giving them time to realise that this issue was theirs and they had to act accordingly. The issue of the traditional healers office, constitution and council had to be run by the traditional healers with the support of the clients and western trained health careworkers. The traditional healers had to bring together their own Acts of practice based on approved knowledge and practice. All actions had to be taken for the well-being of all traditional healers in Swaziland irrespective of either whether they were in organizations or not, of colour and gender as well as any type of traditional healer, Zionists, traditional birth attendants, *Sangomas*, Herbalists and any other traditional healer that would be accepted by their constitution..

## **CHAPTER FOUR**

### **THE RESULTS: THE PROBLEM**

#### **4.1 INTRODUCTION**

The results are presented in this chapter according to the stages set out in the study design. The profile of traditional healers and the problem of collaboration in the management of the two chronic illnesses, diabetes and hypertension, are discussed. The data came from the initial individual interviews and two initial meetings. The recommended strategies are also presented in this chapter.

#### **4.2 THE CONTEXT OF THE PROBLEM WITH REGARD TO DIABETES AND HYPERTENSION MANAGEMENT AND COLLABORATION.**

##### **4.2.1 Traditional Healers' Profile**

The profile of traditional healers covers the gender and age range, the training, practice and illnesses they claimed to manage.

There were 16 traditional healers interviewed during the initial individual stage. Among the 16 there were only 3 females and 13 males. The majority were aged between 50 and 70 years (see Table 1, p 123). The healers' training varied between 6 months to 3 years. There were those who had not been trained, but had received their instructions through dreams. The *sangoma* -herbalist underwent training for a period of 2 to 3 years. Most of these healers also learned a lot about



illnesses through dreams communicated to them by the ancestors. Other healers copied, or received on the job training through spending considerable time next to a healer. The practice of the traditional healers was such that they were classified as *Sangoma*-herbalist, faith healer-*sangoma* herbalist or pure herbalist. This classification emerged from the way they described their training and practice, and distinguished between the various types of practitioners. Pure *sangoma* never prescribe or prepare medicines, they only foresee, divines and “smells” and then they are supposed to tell the patient which herbalist should do the treatment. Herbalists are those who use bone throwing and they are the ones who prepare and prescribe medicines. Faith healers are those who were entered by the Holy spirit who lay hands on clients and use minerals for the treatment of illnesses Gort (1987) and (Makhubu, 1978). The term *sangoma*-herbalist in this study means that the traditional healer functions as a *sangoma* and also prescribes and prepares medicines. Some of the *tangoma* or *izangoma* mentioned that they first started as faith healers and then the ancestors took over and they became a *sangoma*. This cadre should be called ‘faith healer *sangoma*-herbalist’ since they also prepared and prescribed medicines to their clients. There were those faith healers who were also prescribing and preparing traditional medicines, who are normally known to deal with minerals, called “faith healer-herbalist” (see Table 2, p 123).

There were some overlaps in the management of illnesses. Most traditional healers mentioned a long list of illnesses that they can treat. The categories of treatment are different from the medical point of view where a doctor is a generalist or a specialist who handles certain parts of the body, for an example an ear, nose and throat specialist or a gynaecologist. With the traditional healers, one of them would be more or less equivalent of a “gynaecologist”, but would also be treating other illnesses like mental disturbances. So it was not easy to classify them according to categories used in the western medical field.

One traditional healer, who was a herbalist trained through dreams, said, *I treat the following illnesses: 'Lucabangu' (retracted sternum in babies), 'umvundliso' (diarrhoea), 'sinye' (uterine problems), 'kukhuphula' (correct threatening abortion) 'kusha ngaphansi' (sexually transmitted illnesses, such as gonorrhoea), 'umtimba lomubi' (lowered immunity manifested by boils, abscesses and lumps) and 'emehlo lalumako' (allergic eye problems)*"

A second traditional healer, who is a faith healer herbalist by practice, said, *"I normally treat the following illnesses: 'kufa luhlangotsi (hemiparesis or stroke) 'lichubu' (back deformity), 'sifo sashukela' (diabetes), 'sifo sehayihayi' (hypertension), 'kukhukhumuka sisu' (ascites and pseudopregnancy) and 'umklwebho' (arthritis)."*

From these examples one can already note that it is not easy to classify traditional healers according to the illnesses they treat. They seem to treat all illnesses they come across. The first quoted traditional healer's stated illnesses, given the western way of classifying, would make him equivalent to "a gynaecologist" or a "paediatrician" or an "obstetrician", but also an "ophthalmologist". Most traditional healers seem to be generalists practitioners who manage all illnesses they come across( see Table 3, p.124).

The ways of diagnosis included bone-throwing, spiritual laying on of hands, sniffing ( 'kubhula') and 'kufemba' (to sniff the illness and the causes as well as the cure while in a trance-like state, then give an account of the diagnosis and treatment ).

All traditional healers in this sample have their homesteads about 2 to 5 km from the Health Care Centres chosen for this study. This should make it relatively easy for collaboration to take place

between the two sectors of health care delivery.

**TABLE 1: TRADITIONAL HEALERS' AGE RANGE AND GENDER**

AGE RANGE	FEMALES	MALES	TOTAL
20-29		1	1
30-39	1	2	2
40-49	1	2	4
50-59		2	2
60-69	1	4	5
70-79		2	2
Total	3	13	16

**TABLE 2: TRADITIONAL HEALER'S TRAINING AND PRACTICE**

PRACTICE	Number of healers	Number who trained	Training period	Trained through dreams only
Faith healer-Herbalist	8	3	6-12 months	5
Faith Healer- <i>'Sangoma'</i>	5	5	2-3-years	nil
Pure Herbalist	3	3	2-3-years	nil
Total	16	11		5

The last column of Table 2 shows the traditional healers who trained through dreams. This is significant in that these healers stated that they would know about the patient before he or she came, and know what the patient would be suffering from. They would be shown what herb to use, where to get it from, how to prepare it and how to administer it. The patient would come to them that morning with exactly the illness which have been revealed to them through the dreams.

**TABLE 3. LIST OF ILLNESSES TRADITIONAL HEALERS MANAGED.**

Illnesses that can be treated by traditional healers	Number of healers who can treat these illnesses.
Gynaecological and obstetric problems, under five years children's problems and sexually transmitted illnesses including HIV/AIDS symptoms	7
Diabetes, hypertension, heart problems, kidney problems	8
Mental illnesses, confusion, hallucinations, bad spirits and hysteria	5
Backache, paralysis, wounds, abdominal ulcers and arthritis	3
Illnesses treated by all:- dental problems, diarrhoea, body abscess, lowered immunity, headaches, allergic reactions, correcting infertility, hastening labour, preventing lightning from striking at home, chest pains and palpitations, pseudo-pregnancy, menorrhagia, threatening abortion and impotence.	16

#### **4. 2. 2 Chronic Illnesses ( Diabetes and Hypertension)**

**Traditional Healers** (All the vernacular words are explained in the Glossary, p273)

About 50% of the traditional healers stated that they did not treat hypertension and diabetes. Some of these said they did not know whether they were treating these illnesses or not since they did not have a traditional name for them. They said that if they treated these illnesses they did not know whether they were the ones bringing the improvement or whether it was the western health care workers. Some of them claimed to treat hypertension only or diabetes only. The majority of

traditional healers were handling diabetes more than they did hypertension. There were similarities in the description of the signs and symptoms of the two illnesses, diabetes and hypertension. There were also similarities in the types of plants that were used to make the herbal mixture for both illnesses. What was noted was the perception of achieving a cure rather than control of symptoms. Traditional healers were explicit about their belief in cure vs control or maintenance.

The discussions of hypertension and diabetes were not exclusive, but other illnesses were also discussed. In most of the joint meetings all participants would talk about HIV/AIDS. The traditional healers expressed their concern that the western trained personnel had not included them in the quest for treatment for this illness. The traditional healers felt that western trained health care personnel were treating this illness as their own, whereas the traditional healers were also now and then confronted by patient with AIDS. Traditional healers mentioned that they did not know how to handle malaria and how to replace blood, hence patients who were presenting with symptoms of malaria and lack of blood ( anaemia) were all referred to the western medical facilities. Some traditional healers mentioned that if collaboration took place they would be willing to be involved in the prevention of teenage pregnancies through traditional ways of counseling and the use of some herbs to prevent unwanted pregnancies for those who could not control themselves sexually.

One traditional healer stated in a newspaper, that the Ministry of Health was refusing to give him nurses and doctors to work in a western clinic which he built in his homestead so that he can work with them on a referral system. This traditional healer stated that he also treats HIV/AIDS patients, apart from cancer, diabetes and sexually transmitted diseases. He said “ *I advise the patients to come for treatment before the disease is fully blown-up*” (Yende, 2000).

Mental illnesses were also discussed and most traditional healers claimed to manage some of the mental illnesses. The researcher witnessed one patient who was admitted to a traditional healer's home from a western mental institution. This patient came in mentally disturbed and was having some body tremors owing to side effects of some of the psychiatric drugs. This patient had insomnia and was hallucinating, talking to himself all the time. The traditional healer was worried about the insomnia and the continued tremors. The researcher explained to this traditional healer that the tremors might be caused by some side effect of drugs used in the mental hospital. After two weeks, when the researcher visited the traditional healer, the traditional healer reported that the patient was now able to sleep at night and the tremors had improved. The researcher saw this patient and he was now communicating sensibly, though he was not yet fully recovered. Perhaps, the tremors subsided since the patient was not receiving modern drugs, as there was some improvement from the traditional healer's herbs.

In another traditional healers' homestead the researcher found a young boy of 14 years old tied with iron shackles or chain. The traditional healer explained that this boy was mentally disturbed and was very violent. The other problem was that this boy could not sleep at night, could not eat anything and he had wounds caused by his violent nature. He really looked stuporous with a far away gaze. The researcher advised them to contact the mental hospital so that they could have some advice from them on what to do. This was done, but the traditional healer did not receive any co-operation from the mental hospital. He continued with his medicines. After a year, when the researcher visited this healer, the researcher was met by this boy in his full senses and was able to tell her where the traditional healer was. He was now communicating and was no longer in leashes or chained. This showed that the particular traditional healer was able to handle mental problems.

## **a). Diabetes**

**i). Definitions:-** There was no proper definition given except that most traditional healers mentioned that this illness was a new one to them.

**ii) Causes:** - causes were stated as follows: eating sweet and fatty foods, eating foods rich in sugar, alcohol, eating a lot of red meat, smoking, low immunity, eating too much nice food, doing less work.

**iii). Signs and symptoms:** palpitations, impotence, chest pains, hyperventilation, swelling, sweating, tiredness, thirst, sores that are failing to heal, passing a lot of urine, change in urine colour, slow heart beat, dizziness and hunger.

**iv). Diagnosis:** A few of the traditional healers claimed that they used their bone-throwing to establish whether the patient was suffering from diabetes or not. The majority stated that they sent the patients to the clinics or hospitals for proper diagnosis since they did not have the same instruments or equipment for diagnosis. Some patients who are diagnosed in the hospital would come and inform the traditional healer.

### **v). Management:**

a). Types of medicines given: called herbal mixture.

b). Different names of plants, preparation, doses, frequency, duration and side effects/contra-indications:

\* *Umetjiso*: About 30g of this plant would be grounded into powder and added to a 1L of water and boiled for 1 hr. A tablespoonful of the herbal mixture would then be administered orally, three times a day (t.d.s) for a period of one week. No side effects or contra-indications stated.

d. *Siphanga semkhaya, inovi yesihlahla, inhlitiyo yabanana, godide*

and *halibhoma*: About 30g of each would be grounded into powder and then added to 5L of water and boiled for 1hr. The mixture would then be administered orally with a tablespoonful, (t. d. s.) for one week. No side effects or contra-indications stated.

- e) African potato and candidiasis plants ( *luhlanga*): Fifty grams of each would be cut into small pieces and boiled for 30 minutes. Then the herbal mixture would be administered orally with a tablespoonful, two times a day (b. i. d.) for a period of one week.

\* Sugar would be added in the preparation of the herbal mixture. The traditional healers stated that the sugar would be added to reduce palpitations and destroy the poison caused by the sugar in the diabetes.

\* Aloe, sugar, African potato, *godide* and *sikhondze senuku*: Fifty grams of each would be cut into small pieces and added to 1L of water and boiled for 30 minutes. The mixture would be administered orally with a tablespoonful, (b. i. d) for a period of one week.

\* African potato, *godide*, *munankulu*, and *luhlanga*: (candidiasis plant). About 50g of each would be grounded into powder, then added to a 1L of water and boiled for 1 hr. A tablespoonful of the mixture would be administered orally, (b. i. d), for a very long time or until the patient feels better. The side effect stated was that the African potato when used alone has a tendency of draining the kidneys and could remove essential fluids and hence leave the



patient with dehydration.

From the plants used it is clear that the African potato and *godide* form the base of treatment for diabetes. Most traditional healers were reluctant to specify the names of plants and their preparations. Some stated that they did not want to give away their knowledge until they were sure there was proper collaboration.

c). Advice/counseling given:- There was no specific advice given to the clients about diet, their illness or change of life styles. The advice given was either that they should take the herbal mixture concurrently with the hospital medications or to alternate the herbal mixture with the hospital medications to see the difference. Most traditional healers advised their clients to go for check ups in the hospital to see if their herbal mixtures were working or not, as they did not have proper diagnosing machines.

d). Improvement:- Improvement in the patients' condition was to take place within three to seven days. A few traditional healers mentioned that improvement can be seen after a month or sometimes it took as long as three months.

e). Collaboration between traditional healers and western health care workers in the management of diabetes:- Traditional healers sent patients to the hospital only to test their own herbal effect rather than for proper collaboration.

#### **b). Hypertension:**

i). **Definition:** Traditional healers stated that it's an illness where there is increased blood in the body.

ii). **Causes:** This illness occurs when one gets very angry, is not doing a lot of work. You grow up with the illness. One eats food that does not agree with the body. It is caused by the food we eat nowadays such as fatty foods, sweet foods, lack of traditional foods and

lack of bitter foods.

iii). **Signs and symptoms:** Heart problems, weakness, tiredness, palpitations, sweating, chest pains, it is a symptom of stomachache, severe headache and tuberculosis.

iv). **Diagnosis:** A few traditional healers who are herbalist, claimed that they used their bones to recognize this illness. The majority of healers stated that they obtain information concerning the diagnosis made from the clients who were diagnosed in the hospital.

**v). Management:**

a). Types of medicines:- Herbal Mixtures

b). Name of plants, doses, frequency, duration and side effects/contra-indication:

As in diabetes, some traditional healers were reluctant to furnish the plant names and their preparations except to mention that they provide patients with a herbal mixture. A few traditional healers mentioned the following:

\* *mavumbuka* and *umzimuko*: About 50g of each would be ground into powder and added to 1L of water and boiled for 30 minutes. The mixture would be administered orally with a tablespoonful, (b. i. d.) for one week. No side effects or contra-indications stated.

\* *Ingwavuma*: About 30g would be ground into powder, added to 1L of water and boiled for 1hr. The mixture would then be administered orally with a tablespoonful, (t. d. s.) for three months.

\* African potato, *godide*, *sikhondze senuku*: These plants are similar to the ones used for diabetes, the only difference was that there was no addition of sugar. Thirty grams of each would be grounded into powder, added to 1L of water and boiled for 30 minutes. The mixture would be administered orally with a table spoonful, (b. i. d.) for one week.

\* *Nunankulu*, *godide*, African potato, *inkakha* and an aloe: Fifty grams of each would be cut into small pieces, added to 5L of water and boiled for 30 minutes. The herbal mixture would then be administered orally with a tablespoonful, b. d. until the patient feels better.

c) Advice/counseling:- similar to diabetes.

d). Collaboration:- Similar to diabetes.

e). Improvement:- Similar to diabetes since a lot of traditional healers claimed that there was improvement in three to seven days time. A few of them stated that the patient had to take this herbal mixture for a long time before improvement was seen.

f). The goal of treatment for most traditional healers was cure. Only two traditional healers mentioned that the illnesses are never cured.

### ***Western Trained Health Care Workers***

There were 16 health care workers interviewed. All these health care workers had knowledge about these two illnesses and they were managing chronic illnesses.

#### **a) Diabetes:**

i). **Definition:** The following definitions of diabetes were provided by the western health care workers: -Poor control of blood sugar, inability of the body to regulate or control sugar, a high level of sugar in the blood, blood sugar level of above 2.5-8 mmol, sugar illness, failure of the insulin to function, insulin deficiency, insufficient insulin to care for the carbohydrates taken, failure of insulin to process glucose, a chronic disease.

ii). **Causes:** eating rich food, problems with the pancreas failing to produce enough insulin

to cater for the glucose metabolism, hereditary, stress, eating a lot of sugar, high levels of cholesterol, obesity, taking alcohol, eating fatty foods and malnutrition,

iii). **Signs and symptoms:** frequency of micturition, thirst, itchy vulva, loss of weight, tiredness, hunger, laziness, sweating, tightness of the chest, loss of libido and impotence.

iv). **Diagnosis:** Laboratory test of fasting blood sugar level or testing of urine.

v). **Management:-**

a). Types of medication:- Tablets and insulin injections.

b). Names of drugs, doses, frequency, duration, side effects and contra-indications:

\* Dionil one tablet: About 250mg would be administered orally, t. d. s. ( three times a day), or if the level of glucose in the urine is 1+, insulin 10 units would be administered subcutaneously. This regime would be followed by the patient for one week initially, then after the review, if the level of sugar is controlled, the patient would continue with the dose, if not controlled the dose of the tablets and the insulin would be increased and other factors explored.

\* Diabinese: One tablet would be administered once daily or (b. i. d). depending on the levels of glucose and Vitamin B. complex, one tablet would administered once daily to boost the immune system of the patient and hence bring about energy.

\* The tablets are administered to adults above 40years and teenagers are administered insulin.

\* If after the review in about one week, the tablets were found to be not effective, then insulin would be administered.

\*The western trained health care workers stated that the tablets are contra-

indicated to pregnant women, if insulin is taken in large amounts it can cause hypoglycaemia and patients with liver problems are not given the tablets since the liver has to deal with processing of the tablet and hence could lead to more damage of the liver.

\* Tolbutamol: This tablet will be administered orally with a dose of 250mg, (b. i. d.) ( two times a day) for one week.

\* They mentioned that they would advise the patient to avoid sugar in their diet.

c). Advice/counseling given:- Diet was often mentioned, but there there was not enough information specific about the diet. There was general advice on taking food with less sugar and starch and eating a lot of sorghum. There was no counseling in terms of change of life styles, such as exercises, reducing alcohol, checking of the feet, avoiding infection, attending to common colds as fast as possible, eating a diet rich in vitamins, minerals, and proteins to build up the immune system and cessation of smoking . Patients were advised to adhere to treatment regime by making sure they take their medications appropriately and come for checkups initially after the first week of taking medications, after that to come once monthly. Patients were also educated on how to inject themselves with insulin. The teenagers were admitted to be taught about insulin handling. They were advised to note signs of severe thirst which might indicate high sugar level and signs of dizziness which might indicate a low sugar level. .

d). Improvement: normally would be noted after one week when the patients came for their check up.

e). Collaboration with traditional healers in the management of diabetes:- they all stated that they were not collaborating with traditional healers. Four western trained health care

workers stated that they believed that the hospitals or clinics were able to handle these illnesses. Two western trained health care workers did not believe in traditional healers. About 13 of them did not know who among traditional healers could treat diabetes.

f). Goal of management:- For about fourteen (14) out of 16 of them it was control and maintenance.

## **b) Hypertension:**

i). **Definition:** is a blood pressure level of above 130/90, increases pressure of blood in the vessels, it is a slow killer that brings fear of death, a problem of the heart and the blood vessels, illness of elderly people, increased blood pressure, blood pressure above 140/90 in successive readings, it is an illness similar to diabetes.

ii). **Causes:** stress, obesity, smoking, personal problems, hereditary, worries, age, pregnancy, high levels of cholesterol and arteriosclerosis,

iii). **Signs and symptoms:** persistent and severe headache, paralysis, dizziness, tiredness, insomnia, cramps and numbness on the feet and hands, blurred vision, nose bleed, fatigue, palpitations, oedema, aching bones,

iv). **Diagnosis:** Some stated that if the blood pressure is high and there is family history of hypertension, then that information supports the possibility of hypertension. Others stated a high blood pressure reading above 140/90 in young adults in three successive readings confirms essential hypertension.

### **v). Management:**

a). Types of medications: Tablets for mild to moderate hypertension and injections for severe hypertension.

b). Names of drugs, dosages, frequency, duration, side effects and contra-

indications:

\* Diet was stated as the first line of treatment, followed by diuretics and the real hypertensive drugs.

\*Aldomet, 250mg: would be administered orally ,( t. d. s).

Urirex K.: this would be administered together with Aldomet , one tablet would be administered orally once a day or (b. i. d.) if the blood pressure is severe.

\* Neprosil: injection would be administered as a stat dose when the blood pressure is very high, systolic above 200 and diastolic above 100 in hypertension.

c) Contra-indication and side effects stated: Urirex K was contra-indicated for persons with renal problems. Aldomet and neprosil could result in impotence and dryness of the mouth if taken for a prolonged period. Urirex K would not be given to diabetic patients, since it could raise the blood sugar level. If the dose of this drug is high, hypotension can occur.

d). Advice/ counseling: similar to diabetes. There was only advice about check ups. There was no advice on specific diet, except to tell them not to eat salt. Life style changes like regular exercises, cessation of smoking, stress reduction, reduction of alcohol intake and reduction of weight were not explicitly stated.

e). Improvement: normally noted in a weeks' time when patients come for check up. In those admitted the improvement was noted in three days time.

f). Collaboration: There seems to be no collaboration taking place between the traditional healers and western health care. The reasons are similar to the ones stated under the management of diabetes

## ***The Clients***

There were 20 clients interviewed . About 14 of these clients had both illnesses. All the clients who had both illnesses were emphasizing diabetes as being the main problem they had. Hypertension was only mentioned as just another illness. They all stated that they were not feeling any problems with hypertension except that they were being told in the hospital that they had it. Only 2 of them had only diabetes and only 4 had only hypertension.

### **a) Diabetes:**

**1) Definition:** - They were not forthcoming with the definition of these illnesses. They only mentioned that these illnesses were 'new illnesses'. About fourteen (14) of them stated that they never heard of any parent or forefather and mother who died from these illnesses. They only learned about these illnesses when they went to the hospital not feeling well and they would be told they were suffering from diabetes or hypertension. Only two of them mentioned that their immediate parents had suffered from these illnesses. Perhaps, this ignorance is due to the fact that in the past there were no diagnostic measures, so most Africans in the middle to late ages did not know what their grandparents died from. Fourteen of the clients showed some understanding about the signs and symptoms of diabetes and hypertension. One client said *"I passed a lot of urine, became thirsty and started to feel very weak with loss of weight. I then suspected diabetes since my mother had these signs before she was diagnosed. So I went to the hospital and it was confirmed."*

**ii). Causes:-** They thought causes were problems and worries, for instance one client mentioned that the problem was the poor relationship between herself and her children and another mentioned that she had problems of losing her children through death.



iii). **Signs and symptoms:** They were stated as some of what they experienced before the illness was diagnosed, such as thirst, polyuria, weakness, sleeplessness, crystals seen in urine when the toilet was not used, continuous headache, tiredness, itchy vulva, loss of weight, hunger and dryness of the mouth. One client said *“When experiencing these symptoms, I decided to pass urine on the ground where it can dry, when the urine was dry, I found that it has formed crystals, then I knew I had sugar in the urine.”*

iv). **Diagnosis:-** All was confirmed in the hospital through blood tests. One patient stated that she had been admitted for malaria when the diabetes was discovered.

v). **Management:-** Types of medications:- Tablets and injection

a). The name of the medicine, doses, frequency, duration and side effects/contraindications: The patients only knew that they received tablets, but the names of the tablets were not known. Some mentioned that they took the tablets first and the sugar level was not controlled, then they were given the injection. The name of the injection was stated as insulin by some patients while others did not know the name of the injection. A few of them were started on the injection when the illness was diagnosed. The frequency of the tablets was one tablet, (b. i. d.). The units administered were stated as ranging from 10 units in the morning and 30 units in the evening depending on the urine testing sugar level in the morning. No side effects or contra-indications were stated.

b). Advice/counseling given: The patients were taught how to inject themselves with insulin. Fourteen (14) patients mentioned that they were advised to eat a diet low in sugar and starch, and to eat a lot of vegetables. Four (4) patients mentioned that they were advised on diet, but they were not specific as to what type of diet. Twelve (12) were only taught how to self administer insulin without being advised

on any diet. There was no advice on change of life styles.

c). Consultation with traditional healers: Thirteen (13) of the clients consulted traditional healers and some herbal mixture was given to them. Some of them received advice from traditional healers on what to use apart from the hospital treatment. Examples of traditional medications used by the clients were as follows:

- aloe and *emaphoti*: the two plants would be combined to make a herbal mixture,

- Self- administration of the African potato was stated by some patients,

- The use of *inkakha* would be done, whereby the *inkakha* would be boiled in water and drain the juice. The juice would be taken orally with a tablespoonful twice a day.

Eleven (11) clients were advised by the healers to take the herbs concurrently with the hospital medication. Two of the clients were told to alternate the herbal mixtures with the hospital medications.

Apart from the traditional medicines used, they also used traditional foods such as black jack (*cucuza*), *umdzayi* and *inshubaba* as vegetables.

d). Improvement: Fourteen (14) clients stated that they felt improvement in about one week's time, but as they continued with the tablets the sugar level became high and did not respond to the medication. Ten clients were given injections and there was improvement. Half of the clients stated that they felt improvement when they started to use the hospital medication concurrently with the traditional healers' herbal mixtures.

e). The goal of management for all the clients was to get rid of the illness.

f) Compliancy with the management regime: Ten (10) clients stated that they were

not complying with the diet owing to financial problems. Some were defaulting on the check ups since they did not have the money for bus fare, checking the blood and other hospital expenses. Eight (8) clients mentioned that they did not have support from their family members seeing that the majority of them were old males and females, ranging from 50 to above 70 years. They followed correctly the taking of medications such as the tablets and the injections when available.

**vi). Complications experienced:** About twelve (12) of them were experiencing mainly eye problems. Signs of dehydration such as dryness of the mouth, severe thirst, lose of skin turgor and sunken eyes were also noted, but the researcher could not possibly relate these to either the antidiuretics given in the hospital or the herbal mixtures. These signs of dehydration were among those who had diabetes and those who had hypertension.

#### **b). Hypertension:**

Fourteen (14) clients who were having both illnesses were reluctant to talk about hypertension, only those who had only hypertension discussed this illness. The reasons given by most of them were that they did not feel any problems caused by hypertension, but diabetes caused them a lot of problems. Some stated that they were told in the hospital that they had hypertension, while they did not feel anything. Most literature stated hypertension as a silent killer where the majority of patients sustain strokes without having experienced any signs of illness ( Kniesl & Ames, 1986).

**i). Definition:** hypertension was defined by clients as the disease of 'high blood'.

**ii). Causes:** causes were stated as being worries and problems,

**iii). Signs and symptoms:** Seven (7) clients who mainly had first diagnosis of diabetes and then developed hypertension mentioned that they never experienced any signs of hypertension. They were told in the hospital that they had hypertension as well. The four

(4) patients who had only hypertension stated the following experiences: painful joints, some experienced neck pain on one side, sweat, hot flushes, severe frontal headache,

iv). **Diagnosis:** They were diagnosed mainly in the hospital through routine checking of blood pressure when they came for diabetic check ups..

v). **Management:** it was mainly tablets:

a). Name of the tablets, dose, frequency, duration and side effects: There was no name of medication given except that clients stated that they were taking tablets. One type of tablets was taken as one tablet once daily, the other type was taken twice daily. The tablets were mentioned in terms of colours. Nine (9) clients stated that the other type of tablets taken was one tablet, (b. i. d). and the other type was one tablet (t. d. s). There were no side effects or contra-indications given.

b). Advice/counseling:- All clients were advised to eat traditional foods such as *emahala* (certain type of aloe), *inkakha* and *umdzayi* as well as to reduce salt and sugar intake. There was no advice on change of life styles. They were advised to eat a diet low in salt and fat only.

c). Consultation with traditional healers: All clients stated that they consulted traditional healers and were given herbal mixtures. Eleven (11) clients were advised to use the herbs concurrently with the hospital medications. Two (2) of the clients were told to alternate the medications.

d). Improvement: Seventeen (17) clients stated that they felt some improvement after a very long time. One of them stated that it was after five years when he started to combine the hospital medications with the traditional food and traditional herbs that she felt some improvement in her daily living.

e). Compliance with the treatment:- Three (3) of those suffering from only

hypertension mentioned that they were complying with the recommended diet and medications. The fourteen (14) clients who also had diabetes stated that they were failing to handle two illnesses and the change of diet was too much for them to handle. Also the issue of financial shortage came into play. There was a suggestion that government should allow them to have free medical expenses especially when they come for the check ups since they feel the hospital is their home and they are also the senior citizens of Swaziland.

f). The goal of management: Similar to diabetes. They seek for a cure.

vi). **Complications being experienced:** Four (4) clients already sustained a stroke. Otherwise twelve (12) clients mentioned that they felt nothing.

#### 4. 2. 3 Summary

From the above data one can see that there are similarities and differences in the management of chronic illnesses. The traditional healers' and western health care workers' definitions of diabetes and hypertension seem to be similar. The causes also seem to be similar. One can conclude that both parties know what hypertension and diabetes are. This shows that traditional healers are indeed coming across or handling patients with diabetes and hypertension, though it is not known whether they are able to treat these illnesses. About thirteen (13 ) traditional healers agreed that they were not able to confirm the signs and symptoms owing to lack of proper instruments. They depended on the western health care workers in that sphere.

There were a lot of differences between the plants used by traditional healers and medicines used by the western health care workers. There were of course similar plants used for hypertension commonly with all traditional healers like the aloe and '*inkakha*'. Again, these plants were also

used for diabetes. The addition of sugar for diabetes is also questionable. One can note that the aloe and *inkankha* are very bitter plants to take orally, and perhaps the sugar helps to dilute that bitter test. The traditional healers who used the sugar stated that the sugar was for destroying the poison caused by the increased glucose levels in diabetes. This aspect of adding the sugar still needs advanced laboratory investigations.

Clients also used similar traditional foods to reduce diabetes and hypertension, being *emaphoti*, *inshubaba*, *emahala*, *cucuza* and *umdzayi*. All these traditional foods have a bitter test. There is no evidence as to how they help patients control their diabetes and hypertension. Hence the need to analyze these types of traditional foods to find out their pharmacological effects.

All the health care workers stated that they did not have any formal collaboration. Although the clients stated that they contacted both systems for their illnesses, collaboration between these systems was not seen to exist. Western health care workers stated that the traditional healers were sending patients to them, but that the collaboration was informal. When they sent patients to them, traditional healers always prescribed what needs to be done and if the western health care workers did not do what the traditional healer wanted, that was interpreted as if the clients and traditional healers were ill treated and looked down upon by the western health care workers.

What was noted was that even among western health care workers there were differences in the management approach, including whether or not they were advised to return for follow-ups. The same thing applied to dosages. For an example some, stated that Aldomet should be one tablet, other said 250mg, twice a day and some said three times days. None of the health care workers and traditional healers commented explicitly on the diet to be followed by these clients. None of

the clients were aware of any recommended diet. Both traditional healers and western trained health care workers seemed to be focusing on the curative aspect of management rather than health maintenance since there was no emphasis on educating patients about the fact that these illnesses are chronic and hence the need to change life styles, such as reducing or stopping alcohol and smoking, eating an appropriate diet for these illnesses, avoiding infections and emotional stresses, checking of the feet on a regular basis, attending to all common colds seriously and the importance of regular checkups and counseling. There was giving of herbal mixtures by traditional healers and western medicines and teaching clients how to inject themselves with insulin by western trained health care workers, but nothing was said about explicit advice on diet and change of life styles in both systems. The health care workers could have also utilized the services of a dietician, but provision was not made for this. In both Health Care Centres there was no dietician nor a nutritionist. One client showed the researcher a diet plan for diabetes which she received from a private clinic. This particular client stated that when she followed the diet with the medication her sugar level dropped towards normal.

It was also noted that most clients stated that their hypertension and diabetes did not improve until they used the herbal mixture. It was clear that most of them started in the hospital for the management of their illnesses. What is clear from this information is that traditional healers do treat hypertension and diabetes as do western health care workers and that clients visit both and value both systems. It was also of importance to note that there is no collaboration in the management of these illnesses between the two systems of health care delivery.

## **4.3    DEFINING THE PROBLEM OF COLLABORATION WITH REGARD TO THE MANAGEMENT OF DIABETES AND HYPERTENSION**

### **4.3.1   Barriers for collaboration**

The following concepts were identified as the barriers to collaboration after the analysis of data from the initial individual interviews and the two initial meetings.

#### ***Naming of the diseases and treatment***

Western health care workers had a definite name for diabetes and hypertension while traditional healers relied on diagnoses made by western health care workers and communicated to them by the clients. Traditional healers did not have a traditional name for diabetes and hypertension. Western trained health care workers had a clear definition of the illnesses while the traditional healers did not have one. Most of the clients illnesses were based on signs and symptoms. The traditional healers mentioned that these illnesses were new to them. This novelty might be related to the fact that in the past their fathers and grandfathers died of illnesses which were never diagnosed by the modern methods. Traditional healers and western health care workers had similar descriptions of symptoms and signs of these illnesses, but did not share a language to enable them to communicate. Traditional healers had a tendency of mixing up signs and symptoms of hypertension and diabetes. The western health care workers used definite methods or objective methods for diagnosing these illnesses while the traditional relied on diagnosis made in the western health facilities, communicated to them by the clients. Traditional healers did not have standardized methods of assessment, treatment and care of patients with these illnesses. One western health care worker said “*at present we get a lot of different information about the same illness from the traditional healers so that we end up not knowing whether it is the same illness they are*



*referring to or another illness, especially when it comes to diabetes and hypertension” One traditional healer said “ We do not have names for diabetes and hypertension in our traditional medicine.”*

### ***Giving and taking credit for the cure***

There was a big question as to who takes credit and who is given the credit for a cure. Traditional healers stated that it was not clear who had treated the illness if the patient combined western health medicines and traditional health medicines. In most cases the traditional healers end up taking the credit as they always claim they cure while western trained health care workers would only control the illness. One western health care worker said *“Patients end up not knowing whether the help came from the herbs or from the western medicines, so patients should take one type of medicine at a time to see where the help comes from.”* One traditional healer said *“ When a traditional healer successfully treated someone , no one ever gave praise.”*

Some clients stated that even if there is collaboration, one side will win in terms of getting the credit, but they will not say which side. Traditional healers have a tendency to claim ability to treat all illnesses and they win a lot of clients this way, but some clients doubt their ability to treat all illnesses. One western trained health care worker said *“ The hospital alone can manage these illnesses.”* Western health care workers normally take credit when a client needs a medical certificate since the traditional healers do not have such recognizable medical certificates and as such have nothing to show that the client was treated by them. Sometimes western health care facilities benefit from payment made by clients for medical certificates for a successful treatment from the traditional healer.

Another issue in this regard is that in traditional practice large payments ( or fees) are connected with achieving a cure. This makes it essential for traditional healers to make such claims and exclude the western practitioners from the 'cure'. This is not true with regard to the western practitioner. Their fee is not dependent on achieving a cure.

### ***Ethical differences in practice***

There are basic differences between the two systems which make practitioners believe it to be unethical to collaborate with the other group. This is true particularly of western trained healthcare workers, who feel they endanger clients through collaboration. Such feelings do also exist amongst the traditional healers.

#### **a) Different requirements of training/education:**

This difference was identified as a barrier to collaboration among the traditional healers themselves. Some traditional healers take 2-3 years of training while others take 6 months and some claim to have been trained through dreams only. Some learn from observations of what another traditional healer does. Some traditional healers at the end become faith healers, *sangoma*-faith healer or herbalist or a *sangoma*-herbalist.

Western trained health care workers need to first learn about how each type of traditional healer functions and what and how traditional healers manage and treat illnesses. It is not clear whether collaboration is part of their training or not. Although the nurse's pledge states that they should collaborate with other professionals, some western trained health care workers stated that the curriculum of health care workers does not incorporate collaboration with traditional healers. One western health care worker during the focused group session said "*collaboration with*

*professionals or health workers involved in alternative medicines is very important, but the problem is with the orientation towards these other fields of health care delivery during the training periods of doctors, and this of course includes the homeopathy practitioners as well as traditional healers and others.”*

Traditional healers themselves displayed doubt about the practice of many other traditional healers. They stated there were a lot of traditional healers who were bogus and that a lot of traditional healers had lost their knowledge about traditional practices. Traditional healers do not have an explicit, “official” and systematic way of managing illnesses as do the western health care workers.

**b) Lack of transparency:**

The clients, some traditional healers and western health care workers, stated that most traditional healers maintain secrecy about their medicines. This was demonstrated by one traditional healer who said “*I cannot tell you what I use to treat diabetes and hypertension, since you western trained people steal our knowledge and medicines, you study them in your laboratories and then you come out saying you have now discovered a cure, while I am the one who gave you the knowledge and the plants.*” Surprisingly, they are not open even with another traditional healer. Due to the lack of transparency there is the danger of combining both traditional and western health care medicines resulting in some unwanted reactions or interactions as well as over-dosages and exaggerated side effects, without the awareness of the other health care worker. Most western trained personnel complained that traditional healers and clients together, with the family care givers, give them problems in the hospital when they secretly administer traditional herbs on top of the western medicines that are being given. This in most cases has resulted in a lot of over dosage problems which the western trained health care worker ends up having to deal with, without

being aware of what has gone wrong.

**c) Different perspectives about illnesses:**

Traditional healers view illnesses differently from western health care workers. Traditional healers also believe that if a client is ill, that client has been bewitched. The traditional healers' management of illnesses concentrates mainly on signs and symptoms rather than the pathophysiology of the illness. Most of their treatment is based on removing the signs and symptoms. For them this is a cure. Western trained health care workers, while they aim to relieve symptoms, also look into the issue of curing or dealing with the underlying cause.

Western trained health care workers believe in natural causes of illnesses which can be found in the body. They therefore differentiate between cure versus maintenance or control, especially in chronic illnesses. Most western trained health care workers stated that they could control hypertension and diabetes. On the other hand traditional healers believed that they could cure illnesses, and one of them stated that when they treat a patient with diabetes and hypertension they remove the illness altogether. They do not ever consider control of illnesses as an option. Some traditional healers look down upon western medicines, claiming that they are not as strong as the traditional herbs, since if they were as strong they would bring about a complete cure of an illness. Some western trained health care workers look down upon or ridicule traditional healers' practices. One western health care worker said "*I do not want to collaborate with traditional healers because I do not believe they know what they are doing and I feel we are able to diagnose and treat illnesses, so we do not need them. Collaboration is not recommended for diabetic patients since traditional healers make cuts and the diabetic patient can be infected.*"

Another example quoted is of children with diarrhoeal diseases who have been seen diagnosed as overdosed by traditional healers through taking their blood samples..

#### **d) Safety and efficacy of traditional medicines and differences in practice:**

Traditional health care medicines are not screened and the doses are very different from one healer to the other. The measurements of doses and administration of medications are not clear to the clients or to western health care workers. One of the western trained health care workers said *“Patients who tend to combine both medicines end up with some over dosage reactions.”*

The safety and effectiveness of the traditional healer's medicines was doubted by most western health care workers and some clients. They stated that traditional healers' herbal mixtures are not screened and they did not use proper dosages like the western health care medications. It was stated that traditional healers are thought to send their clients to hospital when their herbal mixtures caused problems.

Traditional healers noted ethical practices which they did not understand about the western health care workers. Traditional healers stated that western health care workers give injections for illnesses which are considered traditionally to be those where you are supposed to give something orally and not inject the client. In most cases these injections have resulted in fatal situations, especially in patients who have illnesses called *“emakhubalo”* ( meaning sexually transmitted illnesses or an illness whereby one have crossed over some spills a ‘witch’ has put on his path to affect him/her). Gumede (1990) calls this *“Umeqo”* meaning to cross over which will manifest by fleeting joint pains or rheumatic arthritis. The patient feels very ill, in pain and unable to walk. Thus traditional healers claim that such patients who present with these symptoms should not be injected, but should immediately be referred to the traditional healers who would know how to manage the patient. Using injection on such patients with these symptoms, described by Gumede, causes the patient to die.

These claims still need further research by the western trained health care workers. Traditional healers still need to educate the western trained health care workers about such illnesses and objective research should be carried out to find out what exactly causes the fatality when a patient present with these symptoms..

### ***Differences in power***

Traditional healers are not legally recognized in Swaziland. They do not have a regulatory body. They do not have a proper policy nor a constitution recognizing them as healers. Much as they have the two associations, “Traditional Healers Organization” and “Tinyanga Temdzabu” these associations or organizations do not have any legal powers and they cannot force any traditional healer to be one a member, like a council would do.

Traditional healers are legally called “witch-doctors” based on the Witchcraft Act of 1905. They are not officially known, since no official register of all the traditional healers is kept in Swaziland. The two associations have tried to register their own members under the organizations. An association is a voluntary body, while a council is a legal body for most health professionals.

Traditional healers are self employed and since their practice is not regulated by any official body, they are not in a position to sue anyone who does not pay them. This is a disadvantage brought by the lack of a legal structure within traditional healers’ practice.

Much as traditional healers follow a systematic form of training, their training is not documented so that anyone who is not a traditional healer would not understand their system of training.

Their training is also not regulated and some become traditional healers without any form of

training.

The system or process of their practice is also not documented and there is no uniformity maintained. One of the organizations tried to systematize their practice. They copied the western process of dealing with illnesses and developed their own forms. They also developed a medical certificate, so that clients can be on sick leave, but these certificates are not recognized by most companies, since no accrediting body or government officiated their practice as well as the medical certificates and other forms they have developed.

Western health care workers, on the other hand, are functioning legally in defined institutions. They have a regulatory body and their practice as well as their training is well defined and legal. They are all known through registration after completing their defined training. Most western health care workers are employed and have a regular income. Those health care workers who are in private practice are well known and registered and their charges are regulated by a recognized body, called the Council. All this formal and legal standing gives the western health system more power in the formal structures of the country than the traditional healers, but in the rural communities, the traditional healer is considered a leader and they are influential. One western health care worker said “*you cannot take it out from the people’s minds that they want to be treated by the traditional healers and that they should not start with the traditional healer if they have health problems.*” One client stated that “*traditional healers are looked down upon because they happen to be blacks and everything brought by a black person is always looked down upon. The western health care medicine came with missionaries and then everyone holds it higher*” and to him this issue of collaboration was political and also indicative of prejudice.

Formal education is another issue that brings about differences in power. Most traditional healers' formal education may be interrupted by being possessed with ancestors and the spirits, hence they never finished their formal education properly, only a few of them might have this formal education. This type of education equips any person with a vast amount of knowledge and skills to understand national and international issues apart from understanding one's profession. Western trained health care workers, especially the doctors and some nurses who have advanced in their professional education, have knowledge about a lot of principles more than traditional healers would understand. Henneman (1995) stated that knowledge is power.

***Lack of a Traditional Healers' Legal structure for Collaboration (Council of Traditional Healers): Lack of a traditional healer's office in the Ministry of Health and Social Welfare***

Most clients, traditional healers and western health care workers stated that the Ministry of Health should do something about collaboration. Traditional healers did not have an office in the ministry like all other healers in the country and did not receive any subventions or assistance from government. Most of the participants felt that the lack of such structures for traditional healers led to them not being recognized. This also led to the lack of control of traditional healer's training and practice including their charges for services.



### *Differences in perception about payment*

The western health care system charges at present an amount of E20 (*Emalangi*) for the whole treatment of diabetes and hypertension in the government sectors. The charges in the private sectors are higher than in government sectors, but the majority of patients suffering from hypertension and diabetes mainly attend government health care centres.

The cost in the government sectors compared to the traditional healers' cost, shows a difference in perception of payments. There is a perception that the Government should provide western health care services free while traditional healers expect to be paid, since traditional healers are self employed. Each time Government raise the fees even by a small amount, the public would perceives that as being too expensive. In contrast, traditional healers charge a consultation and diagnostic fee of about 20 to 50 *Emalangi*, then a fee for opening the medicine bag ranging from 50 to 250 *Emalangi* and when the illness is cured there is a 'cow' to be paid which might be a live cow or in the form of money ranging from 400 to 1500 *Emalangi* depending on the illness. This figure can go up to E2000 if one needs preventive or protective medicines.. For follow up care, most traditional healers charge E10-00 to E20-00 per two litres of their herbal mixture and that takes them one to two month to finish. Hence this difference in terms of payment makes it difficult to collaborate ( See the glossary, p 273 for the equivalence of *Emalangi*)

The payment for a cure brings a bias towards cure rather than maintenance among traditional healers. Western trained health care workers working for government have a salary each month, so they do not bother about how much patients pay, their concentration was mainly on doing their work. Hence, it was easy for them to apply the principles of maintenance or control when it came to chronic illnesses, since they expected no monetary gains from the patients.

This comparison was not made between the traditional healers and the western trained private practitioners, who might have higher charges than the traditional healers. Though, one might argue about the different status, that private practitioners do not work in their homes, they are forced to hire certain employees and spend on other facilities like water and electricity, while most traditional healers work in their homes and gather herbs from the wild. The traditional healers refer patients mainly to the government hospitals as well as does the private practitioners. This cadre of private practitioner was left out, since collaboration between traditional healers would be mainly with government hospitals and clinics.

#### **4. 3. 2 Enhancers for Collaboration**

Much as there were many barriers for collaboration, some possibilities for collaboration were also identified. Most participants expressed readiness to collaborate and saw the need for collaboration to exist. The motivations or readiness for collaboration were stated as enhancers or motivators.

##### ***Similarities about the concept of collaboration***

There were similarities in the way that the western trained health care workers, clients and traditional healers defined collaboration. This showed that they all have a similar understanding of what collaboration is all about. They all mentioned statements such as “*working together*”, “*sharing ideas*”, “*seeing one’s idea together*”, “*connecting two things*”, “*managing illnesses together*”, “*going deeper in a relationship*”, “*helping one another*”, “*working hand in hand*” and “*coming together.*” They all had an understanding of the meaning of collaboration, hence when they collaborate they would all know what they were doing.

### ***Importance of facilitating collaboration:***

All the participants shared a similar sentiment that collaboration was very important between the two systems. More than 80% of the participants were positive about the need for facilitation of collaboration between traditional healers and western health care workers in the management of chronic illnesses. There were statements such as collaboration '*is important*', '*is necessary*', '*is needed*'. Participants stated that some conditions or illnesses need the western intervention by nature and some illnesses need the traditional way. The majority of western trained health care workers stated that collaboration is necessary since people have to make informed choices as to where they would like to be treated and it is clear that clients want both systems.

Other reasons were that clients with chronic illnesses start with the traditional healers. When they use western medicines and see no improvement they then consult traditional healers, and vice versa. Traditional healers handle the psychological aspect of the client. One traditional healer stated that when he passed the clinic or hospital he sometimes noticed clients suffering from a traditionally related illness and since there is no openness between the two systems, he cannot give his opinion.

Some traditional healers mentioned that there are certain procedures they are not able to perform such as surgery as well as increasing blood when a client is in need of a blood transfusion. So collaboration would help in that they can refer clients who need surgery and those who need blood to the western facilities without any fear of being ridiculed. Most clients combine the treatments. Clients value traditional healers and they live with them in the community. One of the western health care workers during the focused group sessions stated "*we need traditional healers and they also need us*".

#### 4. 3. 3 Consequences for Collaboration

Collaboration will make traditional healers feel free to offer first aid and refer patients to western health care facilities. Traditional healers will feel free to bring the patient in the western health care facilities in time, without any fear of being ridiculed, instead of keeping the clients for a long time even if they realized that they cannot treat the illness. One western trained health care worker said *“in hypertension collaboration is recommended since clients who took herbs came with a low blood pressure.”* Collaboration will facilitate the treatment of many complicated illnesses such as HIV/AIDS which no one profession can handle alone. Some traditional healers were concerned about adolescent pregnancies. One traditional healer said *“If we can collaborate with the western health care workers, we traditional healers can bring about traditional ways and medicines on how to prevent teenage pregnancies. We do have herbs which a teenager can take to prevent a pregnancy. This is a problem for all of us. Our children are falling pregnant at an early age and leave school and the families are suffering. Let us collaborate and we can help”*. All parties involved realized how collaboration could bring important and positive results when applied appropriately.

#### **4. 4 SPECIAL PROJECTS AND PROGRAMMES ( Strategies resolved)**

The following strategies were recommended during the individual interviews, during the focused group sessions and throughout the series of meetings.

##### **4. 4. 1 Regulatory Body of Traditional Healers /Council**

During one of the focused group sessions one of the western health care workers, supported by all the traditional healers, stated the importance of traditional healers having their own governing body or a regulating body and the establishment of their traditional healers' department where this regulating body could function. The western health care worker said, "*Like in Nigeria there is the Department of Traditional Healers which is managed by traditional healers.*"

They all agreed that there should be an umbrella department of traditional healers in the Ministry of Health and Social Welfare. This would assist in the proper governing of all traditional healers whether or not they are members of the established organizations. This office or department would facilitate the recognition of traditional healers and regulate their training and practice. The office could also facilitate the patenting and preservation of traditional medicines. In this office all traditional healers' issues could be handled whether individuals belong to an organization or not. This office should enable traditional healers to plan and implement strategies. There could be facilitation of collaboration initiated and carried out through this office with other cadres of western health care professionals. This office should be administered by well educated traditional healers themselves. In this way the Ministry of Health and Social Welfare could use this office as a vehicle to reach all traditional healers and involve them in many issues that affect the health of the Nation including HIV/AIDS and related illnesses. Government would be able to apply control

and traditional healers would be treated as part of those who also render health care services in the country.

All traditional healers should be encouraged to join their organization so that they are all known and can easily affiliate into the formal structure. One traditional healer said “ *Government should recognize us and the Ministry of Health should be enabled to control traditional healers and not treat us as if we are not part of those rendering health. We feel that we have to be recognized as healers, not as witch doctors.*” Traditional healers felt that in this way they would have resources allocated to traditional healers during the governmental budgets and allocations and some donations could be negotiated for them to reach and serve the majority and minority of traditional healers to further improve their practices.

The establishment of such an office should accompany the development of a constitution by the traditional healers. This would hasten a policy development in Swaziland by the traditional healers themselves. Traditional healers could be registered here and their practices and locations known whether they belong to an organization or not. During the focused group session one medical practitioner said, “*you traditional healers have upon yourselves to work towards a situation like in some of the countries such as Nigeria where there is an official department of Traditional Healers. This can then facilitate proper and formal collaboration*” Traditional healers were urged to start by developing their traditional healers constitution or a regulatory act of traditional healers.

#### **4. 4. 2 A register of traditional healers**

While such formal structures like the 'council of traditional healers' , are still not in place, they all recommended that traditional healers should register their names, location, gender, how they trained, type of healer and illnesses they can handle with the present organizations. The traditional healer's organization would then send the list of traditional healers who are in the surrounding areas of the health care centres to the health care centre for referral purposes. Some specialist traditional healer's names will also be sent even if that specialist is not near the health care centre. The administrators of the community would be involved in sending names of the traditional healers who are not members of the organizations.

Traditional healers should have official clinics where they could do their work openly. This can facilitate successful formal referrals. Most health care workers emphasized that there should be a register of traditional healers which should be official and be updated every year to add new members so that they can know to whom and where to refer cases when the need arises.

#### **4. 4. 3 Formal referral**

Western trained health care workers, clients and traditional healers felt that there should be the development of referral forms or cards to be used by traditional healers and western trained health care workers when referring patients. Traditional healers and western health care workers should be allowed to follow up clients they have referred. One traditional healer stated that western health care workers should visit the homesteads of traditional healers and traditional healers should be allowed into the hospital to visit the clients they have referred. Traditional healers insisted that they did not want to be integrated into the hospitals since some of them have different mystic/supernatural background, whose approach may be in conflict with those clients and other

practitioners, such as the inhalants which they burn. Some stated that verbal referrals should also be allowed. There was a suggestion to involve the Rural Health Care Motivators to work as liaisons between the traditional healers and the western trained health care workers.

#### **4. 4. 4 Change of attitudes**

Traditional healers and the clients stated that western trained health care workers should have a positive attitude towards traditional healers and clients visiting the hospitals after they have consulted with traditional healers. Also traditional healers were requested by western trained health care workers to have a change of attitude towards one another and have an attitude of trust and openness. They should be open towards western trained health care workers and not conceal information and live in secrecy. When they come to western health care facilities they should avoid prescribing for their clients, but should explain about the problem that brought them there. One western trained health care worker said *“for instance some traditional healers would come and tell us that we should give blood to the patient, before explaining as to what is wrong with the patient and allowing us to carry out our own investigations.”*

#### **4. 4. 5 Open communication and regular contacts**

Some stated a need to have regular meetings at least three times a year, and be involved in workshops, seminars and conferences organized by both traditional healers and western trained health care workers. There is a need to teach each other about what each healer knows. This would enable the traditional healers and western health care workers to discuss problems they meet during the process of referral. This would provide a forum for educating one another about health issues that each came across and realized that the other health care system needs to know about in order to assist the patients they both serve.



One of the western trained health care workers came prepared to give a presentation on diabetes and hypertension during one of the focused group session. The healer covered the western aspect of definition, causes, diagnosis, management and treatment, and distributed a pamphlet of a recommended diabetic diet. A lot of traditional healers started asking questions which were well answered by most western trained health care workers.

Exchange of knowledge and skills should be part of the communication process and regular contacts. Traditional healers stated that they need to show the western health care workers what they could do and how they do what they do. Western trained health care workers stated that, if they worked together they could learn from one another and could explain how they recognized illnesses and how they treated them. Traditional healers and clients should know that diabetes and hypertension are not curable illnesses, but that they can be controlled. Clients need to be educated by both traditional healers and western trained health care workers so that they make informed choices. One western health care worker said “ *Clients should be educated to stop taking medicines from traditional healers concurrently with the western medicines to avoid over dosage.*”

Traditional healers should be taught how to measure sugar levels in the blood and how to take blood pressure so that they can recognize the increase or decrease in the levels and know what that means. There should be no hiding of information. The traditional healers should know what the western health care workers are doing and how they do what they are doing and vice versa. There should be teaching about hygienic practices of handling and storing medicines by traditional healers. One traditional healer said “*Western health care workers should visit the traditional healers homesteads to be able to supervise the cleanliness and teach about it.*”

#### 4. 4. 6 Survey on traditional healers and traditional medicines

Western trained health care workers expressed a great need for research to be conducted so that traditional healers practices can be understood and evaluated. Traditional medicines should also be evaluated to find out wether they do lead to cure and how safe they are. Western trained health care workers noticed that the western medicines have some side effects and contra indications, but traditional medicine only achieves a cure without mentioning the side effects and contraindications.

The traditional healers also expressed a concern that their medicines should be tested to find out what they contain that brings about the cure. They also suggested that a patient who had been scientifically diagnosed by western trained health care worker could be sent to some of the traditional healers. The traditional healer could then treat this patient and show how he did it, so that the effective practice of traditional healers would be demonstrated. They also requested that western trained health care workers should visit them in their homes where they manage clients, to see the illnesses traditional healers treat as well as preparations of the medicines. One traditional healer said *“I manage diabetes and hypertension. I do not know what my medicine contains that bring about the healing properties. I would like any one who has the know how to test and find out what is in my medicine. A lot of clients reported improvement in their symptoms after taking my medicine.”*

#### **4.5 CONCLUSION**

In this chapter the results have been presented according to the design recommended by Stringer (1996). Part A of the results focused on the resolution of specific problems or crisis. This involved defining the problem, exploring its component parts and analyzing those components as well as identifying or developing strategies for its solutions. This format of Stringer(1996) is similar to the objectives of this study which aimed at looking into the profile of traditional healers, defining the problem in terms of collaboration in the management of diabetes and hypertension by the western trained health care workers and the traditional healers. This covered the presentation of barriers and enhancers of facilitating collaboration. Lastly, the joint discovering or establishment of strategies that can facilitate collaboration were discussed. Part B of Stringer's design deals with Developing Special projects and this will be dealt with in the following chapter.

## **CHAPTER FIVE**

### **THE RESULTS: PROJECTS AND PROGRAMS IMPLEMENTED TO ANALYZE THE PROCESS OF FACILITATING COLLABORATION**

#### **5.1 INTRODUCTION**

According to the research design, the second stage involves joint strategies to address the problem. In this study two major strategies were decided upon and these will be described below. These strategies were chosen since they were identified as a major part of facilitating collaboration between the two health care systems. It was found that traditional healers do not have any legal body to control their practice in Swaziland and the strategy recommended was the development of an office or department of traditional healers within the Ministry of Health and Social Welfare by first working on a traditional healer's democratic constitution. Secondly, the western health care workers doubted the efficacy and safety of traditional medicines and it was recommended that research be done to compare the care and outcome of patients managed by the traditional health care system with those managed by the western health care system. This would ensure that western trained health care workers could feel free to refer patients to traditional healers. The researcher engaged in joint implementation of these two strategies and the results are described below.

## **5.2 ESTABLISHING THE TRADITIONAL HEALERS' CONSTITUTION, OFFICE UNDER THE MINISTRY OF HEALTH AND SOCIAL WELFARE AND THE COUNCIL.**

### **5.2.1 The Process**

A series of meetings to encourage the process of establishing the office and developing the constitution of traditional healers were conducted. The results were as follows:

#### ***Meeting with the Ministry of Health and Social Welfare***

The Principal Secretary recommended that the issue be handled by the Director of Medical Services in Swaziland. There were discussions with the Director who showed appreciation and approval of this proposal. It was suggested that the traditional healers should meet and develop their own constitution which should be drafted for them by a lawyer. The Ministry of Health would then take this document through to parliament to be debated and if it passed, the King would sign it. This document should have all the logistics of how the traditional healers would develop their office and how they think it would function with resources (equipment, personnel and some buildings) within the Ministry of Health and Social Welfare.

#### ***Meeting held with 'Tinyanga Temdzabu Organization'***

The organization's leaders expressed their gratitude for this move. They saw this initiative as their road to freedom. When it came to actual implementation of the legal body, they were not forthcoming. They stated that their organization was experiencing some internal problems. They could only participate by making sure that the registered members be informed and by providing a list of their members so that they can be contacted and not left out in these developments.

### ***Meeting with the vice chairperson of the Traditional Healers Organization***

This traditional healers organization has a long history. The vice-chairman mentioned that this was not the first time an office had been requested. It was started in 1975. This followed the request made by the late King Sobhuza that the Ministry of Health should organize traditional healers. The Minister at that time was Dr. S. Hynd. He also failed to organize or form a legal body of traditional healers. After 1975, when nothing was done about traditional healers, the King appointed Mr. Nhlavana Maseko to be trained in Germany to organize traditional healers.

In 1984 Prince P. Dlamini, the then Minister of Health, was the only one who managed to contact traditional healers. He held a series of workshops with the traditional healers in that year. The traditional healers communicated their problems to him, such as building of pit latrines at their homesteads, having telephones to be able to liaise easily when they need an ambulance, and clearing of roads leading to the homes traditional healers for easy access. Maseko also attended the workshops in 1984, and in 1985 he formulated the Traditional Healers Organization of which he is still the leader. He opened gates for all healers in Swaziland including the Zionists to register under his organization. Attempts were made to create a traditional healers office, but the administrators of the Ministry of Health called them “witch doctors”. The traditional healers were then discouraged by such labels.

### ***Meeting held at Sithobela Rural Health care Centre with Traditional healers and Western Trained Health Care Workers and Clients***

This was the first meeting with all traditional healers, western trained health care workers and client to discuss about how to proceed with the establishment of the regulatory body. In this meeting the participants were informed about how the leaders from the Ministry of Health and

Social Welfare and from their organizations felt about this move as well as conveying their opinions.

Traditional healers in this meeting decided that they needed a small office in Sithobela. They expressed concern that the faith healers were left out of this initial meeting since there was only one faith healer, a Zionist. They decided that they should formulate a committee and from the committee they would choose two members to work on this issue and report back to the committee. They stated that for this project to be implemented fast, all *tinkhundla* (constituencies) of Swaziland should be involved. There should be two members chosen from each constituency and all these members would then form a group of traditional healers that would work on the development of the constitution and report back to their constituencies. These members would represent each constituency and would put forward ideas from their own committees.

They also realized that there are 55 administrative constituencies and 220 chiefdoms in Swaziland, and that this process might therefore take a long time. They suggested that from each of the four regions of Swaziland they should deal with only two constituencies and that would make 8, choose two members from each of these 8 constituencies and this would make 16 members to work on the constitution. After the constitution has been drafted all traditional healers should be able to review it in their respective constituencies. After they were all satisfied, then a lawyer can be hired. After the lawyer had worked through the document, they would review it to see if the wording still corresponded with their proposals or deliberations. When they were satisfied, the document would be submitted to the Ministry of Health by the 16 traditional healer delegates, and the Minister would take it to the Prime Minister who would then take it to the Prime Minister who

would present it to Parliament.

They formulated a committee consisting of nine members. The committee realized this move required some resources such as financial support. It was decided that traditional healers would all contribute towards a fund which will be looked after by the treasurer. This money would be used for traveling expenses of the two traditional healers chosen to go around publicizing or disseminating information about this project and participating in the development of the constitution. The two traditional healers from each constituency would work with the researcher. The meeting adjourned with all of them expressing hope for the future.

#### ***Meeting held with the leader of the Traditional Healers Organization***

The leader of this organization was very positive about this development of the traditional healers' constitution. He mentioned that he was trained in Homeopathy in Germany, after which he came back to establish the Traditional Healer's Organization. In his organization he had developed forms for admission of patients, medical certificate and a passbooks as well as referral forms. These forms were only used by traditional healers under his organization. He would like to see the traditional healers having a Ministry of Traditional Healers. He had a dream of all traditional healers organizing to build their own clinics and hospitals which would be controlled by the Traditional Healers Organization Department.

He mentioned that his organization started a long time ago working for the establishment of an office with the Ministry of Health, but they were not successful. They also participated in primary health care activities in the years 1985 to 1987 when they worked with western trained health care workers to hold workshops which were funded through World Health Organization. This issue



of collaboration was not new to him. The only problem was the change of politicians, as a result of which initiatives never developed into permanent structures. Traditional healers also participated in immunization campaigns proposed by the Ministry of Health.

One of the problems they faced with the Ministry of Health was the issue of HIV/AIDS since they felt that the ministry withheld information from the traditional healers. They would have wished to treat a patient suffering from this illness to see if traditional medicines failed or not, before the Ministry of Health claimed that traditional healers cannot treat HIV/AIDS patients. At present the Traditional Healer's Organization is part of the structure developed by the Government with all Government sectors to develop strategies on how the HIV/AIDS pandemic could be controlled in Swaziland.

*Meeting with clients, traditional healers and western trained health care workers at Dvokolwako Health Care Centre*

This was the first meeting in this area to discuss about the process to follow when establishing the legal body of traditional healers.

In this meeting most traditional healers asked questions about the establishment of the office. They discussed a lot of issues about ensuring they had official referral forms and that they were allowed in the hospitals. The leader of the Traditional Healers Organization was present. The whole meeting changed focus. They began deliberating about the affairs of the Traditional Healers Organization and soliciting for new members to join. At the end it was decided that another meeting should be held to discuss about how to go about implementing this project.

The leader of the Traditional Healers' organization rejected the Act of 1905 ( see Addendum, p. 276) in which traditional healers were named as 'witch doctors'. He explained how traditional healing developed in Swaziland from the time they were called 'witch doctors' to the time when efforts were made by King Sobhuza 11 to put in place the " Order in Council' for them to be able to function in Swaziland. The leader of the Traditional Healers' Organization dominated the discussions, such that no one had any chance to talk. The whole meeting lost direction and that is why it was rescheduled.

#### **5. 2. 2 Analysis of the problems of establishing the legal structure of traditional healers**

Six months into the process an assessment was done to identify why moves to establish such a body were not successful, and what was delaying the current process. A number of factors were identified, as described in the following paragraphs:

##### ***Organization and Exclusion***

It would seem that in the past plans to have such an office were made by one of the organizations, the "Traditional Healers Organization". These plans excluded traditional healers who were under the other organization, Tinyanga Temdzabu, and those who were not under any organization. Hence this exclusion led to the failure of the office being established, since most traditional healers did not perceive this move as their own. Even if it had succeeded, the other traditional healers would have felt left out.

### ***Leadership style***

The leaders have been doing things without the knowledge of the majority of traditional healers. This came out when one traditional healer said *“Much as we claim we have a leader, we do not feel we have one, since the one we have never communicates most things with us, he only brings things to us. We strongly feel that we need a strong leader who will be democratic and be open with us.”* Traditional healers perceived the lack of leadership and lack of shared governance in the leadership styles of their organizations. The other organization, “Tinyanga Temdzabu”, also expressed concerns with their leader who was failing to call and hold meetings so that such issues can be discussed.

### ***Traditional and Cultural Structures of Swaziland***

The cultural structure of having constituencies and having several chiefs under one constituency delays progress, since one chief cannot take any decision until all chiefs in that constituency agree. Making an appointment with a chief means one has to go three or more times to be able to meet with the target group. First, one has to visit the chief to explain why the target group is being called for a meeting. The chief will then meet with his runners to explain to them, then the runners will call the target group to discuss a specific date to meet the speaker. The speaker will then be called to discuss the date of the meeting. After that the meeting will be announced through the constituency and by radio. By the time the meeting takes place one has been to see the chiefs or the authorities of the constituency more than three times, and maybe after the explanations, the target group will not decide until they have met with their respective chiefs. Then another meeting will be scheduled to discuss the issue and decide the way forward without the outsider being present. It is therefore a very slow process in the rural constituency areas to implement any project.

### *Lack of resources, especially in terms of Finance*

Traditional healers have to finance their own activities. The lack of financial support from government makes it difficult for traditional healers to implement their plans in a timely fashion.

Some traditional healers also complained that their leaders would request monetary donations from certain organizations, but never have any feedback on how the money was utilized. One traditional healer said *“We need to have our own bag in our own constituency where we could monitor how we use that money. We are tired of our leaders who request us to pay some money to the organizations, but we never see where our money goes to. Up to now we do not know what they do with our money. So we better have our own treasurer whom we can control. We all have to pay the money for this project to continue”*. In this constituency they chose a committee early in the process, had a treasurer and they decided how much each traditional healer would have to pay.

Traditional healers do not have the skills and knowledge for soliciting funding from organizations such as WHO. Owing to the lack of proper traditional healers’ official structure, money donated for traditional healers’ welfare ended up not being utilized by them. Funding cannot be channeled to organizations, since some traditional healers do not belong to these organizations and it is also difficult to give donations to individual traditional healers.

Apart from finance, they did not have resources like a central office through which traditional healers can be reached, no do they have communication systems like transport and telephones, and importantly they also lack technical assistance in terms of developing a constitution.

### ***Poor Communication***

From the discussions it was found that traditional healers themselves lack ways of communicating with one another. Traditional healers have a tendency of looking down on one another. If one traditional healer called a meeting, other traditional healers will not turn up. They would only attend if someone other than a traditional healer called them. They also respond when the chief summoned them since they feared penalties.

Traditionally, the culture of traditional healers requires them to show the utmost respect to their senior traditional healers. The writer noted in one of the meetings that most of the traditional healers could not eat in front of their leaders, as a sign of respect. One therefore wonders how they could constructively communicate with one another. It seems communication is mainly from leader to members, and there is a lack of a two-way system of communication. The researcher noted that the leader is impatient with the lack of cooperation when he said “*I am sick and tired of telling them what to do and they do not act accordingly, I have now decided to go with those who are willing and leave those who are not willing.*” It is not clear whether he ever used a more inclusive and democratic approach to ensure commitment.

### ***Change of Politicians due to elections or reshuffling***

The other problem which caused delays was that the politician's term of office would expire before the traditional healers had implemented their proposal for an office. When a new politician was elected or came into office after a reshuffling, the whole issue was treated as a new case. Sometimes that politician might not be interested in handling traditional healers' issues, since he or she might have other priorities. For instance, one traditional healer stated that in 1975 traditional healers did not have an organization. When they contacted the Minister at that time to propose

an organization of traditional healers, the Minister did not have any interest in their case. In 1984 they met a new Minister of Health who did show an interest and they were able, through his efforts, to form the present Traditional Healers Organization. They also started attempts to have a traditional healer's office in the Ministry of Health at that time, but unfortunately the Minister's term of office ended and the new Minister who was elected, as well as her Principal Secretary, did not have any interest in traditional healers. Traditional healers were then discouraged from continuing with this issue.

### ***Lack of a proper plan of action and a time frame***

From the time the researcher started work with traditional healers, it was noted that they did not attach any time frame to their plans of action. They acted as if they had all the time in the world. They did not have target dates and did not identify people to complete specific tasks and decide when to report back to all the traditional healers. When there was a meeting, some traditional healers would not turn up. When another meeting was called, there would be new faces and the same issue had to be clarified again and again. This lack of a proper plan for attending meetings delayed implementation since by the time one thought it was time to implement the issues, the traditional healers who were coming for the first time were still asking questions which had been repeatedly debated. This delayed progress and a proper grasp of what was going on.

### ***Diversity of traditional Healers categories***

Traditional Healers by nature of their training, type of ancestors or spiritual possession and the way they practice are very diverse. They have a tendency to believe that one type of traditional healer is more important than another type. This element brings about a lack of contact and cooperation. Among faith healers there are also different types who treat their own type as better than the other

types, and ridicule the other's practice. This applies also to the traditional healers who are either possessed by ancestors or trained through dreams or learned from their fathers how to treat patients. They also believe what they are is more important than other types of healers. It becomes very difficult when they have to make decisions, since it will depend on the majority of which type of traditional healer is present for a positive conclusion to be reached.

### **5. 2. 3 Action Plans**

After the above analysis of problems leading to the delay in implementing the proposal of establishing an office of traditional healers, the researcher held meetings with traditional healers where feedback about causes of the delay was given. After the feedback traditional healers elected some of their members to work on this issue and set specific target dates that will be discussed

#### ***Establishment of Committees***

In Sithobela they had already established a committee to represent the Shiselweni region and two members from that committee were to be members of the committee to work on their constitutional document. At Dvokolwako in one of the meetings two committees were formulated, one committee was to represent Manzini region and the other committee to represent the Hhohho region. From each committee two members were voted to be part of the bigger committee to look into the issue of the constitution. At this meeting it was decided that they would choose two members to represent the Lubombo region. Eight members would work on the issue of establishing this office. They would start with the constitution formulation which would direct how, where, and when the office would be. They decided that these members would rotate venues when doing their work. They named the eight member Committee the "Traditional Healer's Constitutional Development Committee".

### ***Responsibilities of these committee members***

They would organize meetings in the four regions where traditional healers could state what should be contained in the constitution in terms of establishing the office of traditional healers with the Ministry of Health and Social Welfare. They would also visit organizations such as UNDP and WHO to seek finance and technical assistance in order to accomplish the process of developing their constitution. They would visit the Director of Medical Services now and then to give a feedback on the progress. They would also involve the Ministry of Justice to discuss about the Witchcraft Act of 1905 and request that the Ministry show them other legal documents or develop laws that might govern them. They would also involve the Ministry of Agriculture and Natural Resources who would assist them in formulating appropriate statements when addressing the issue of ploughing and conservation of medicinal plants in the constitution.

### ***Target Dates***

In one of the meetings the Traditional Healer's Constitutional Committee deliberated on the target dates to facilitating a fast movement of the process of developing a constitution, and the content to be included in the constitution. The target dates were as follows:

**a) October, 2000:** During this month the committee will conduct meetings to obtain views from all traditional healers. They would visit the Ministry of Health to give feedback on the progress to the Director of Health Care Services in Swaziland. They would visit one traditional healer who is a member of parliament to brief him about the development of the constitution, so that when the document comes to parliament he can be able to defend it.

1<sup>st</sup> week of October: Meeting of traditional healers at Sithobela to seek their views.

2<sup>nd</sup> week of October: a meeting of traditional healers at Dvokolwako to seek their views

3<sup>rd</sup> week of October: a meeting with the Director of Health Care Services and the Member



of Parliament as well as WHO.

4<sup>th</sup> week of October: the lawyer would be contacted to see the document and start to work on it.

**b) November, 2000:** In the 3<sup>rd</sup> week and the 4<sup>th</sup> week there will be meetings for a feedback session to the traditional healers.

**c) December, 2000:** This month will be used for corrections, additions and finalization of the document.

**d) January, 2001.** This committee and their lawyer will submit the document to the Ministry of Health and Social Welfare and the Director of Health Care Services in Swaziland.

**e) February, 2001.** The Ministry of Health will forward this document to Parliament.

They hoped by April 2001 they will have their constitution formalized and signed by the King when he approves all Government Budgets.

### ***Proposed Contents of the Constitution***

This was discussed during the first meeting held by the traditional Healer's Constitutional Committee where plans were made to include the following contents of the constitution. Some of these contents were adopted from the Regulatory Bodies For Nursing and Midwives in Africa (Uys, 2000).

a) The rationale for establishing such a constitution:- this rationale will highlight the present status of traditional healers ( their practice, training, categories and their opinions about the policy that governs them which is the 1905 Witchcraft Act).

b) Relate the nature of all traditional healers in Swaziland and include ideal categories of traditional healers such as traditional birth attendants, faith healers, sangoma and herbalist in this

constitution.

c) Highlight how this council of traditional healers would relate to associations or organizations of traditional healers.

d) The importance of having the council.

e) The Council Body ( members elected, their functions, how they would be paid, term in office, other members involved either than traditional healers, disciplinary actions imposed on council members, remunerations and other duties imposed on by traditional healers).

f) Building or offices of traditional healers ( one situated at the Ministry of Health and Social Welfare Buildings and several small ones in each constituency or region).

g) Proposed training, practice and discipline of traditional healers and faith healers ( include registration of all healers and trainers).

h) How to become members of this council ?

i) Funding of this Council.

J) Licensure (licensing, temporary license, limited licencing, duties of licensees).

k) Offences and penalties (violation, penalties and criminal proceedings).

l) Discipline and Proceedings.

m) Proposed date to effect the constitution.

n) How collaboration between other traditional healers and western trained health care practitioners will be facilitated.

o) Trading with traditional medicines/ export and import of traditional medicines.

p) Conservation ( cutting or picking as well as planting of traditional medicines)

q) Liaison with the media.

#### **5. 2. 4 Progress**

Much as action plans were set and deadlines made, some of the plans were implemented on time while others could not be implemented. Series of meetings held by traditional healers, western trained health care workers and clients continued where they discussed further about the constitution, previous plans reviewed and new plans being proposed. Realizing the slow process of the constitution, in one of the meetings the participants decided that all traditional healers should be given a copy of the content of the constitution, then they can write their views in paper to be presented during meetings.

Traditional healers managed to give feedback on their progress to the Director of Medical Services, who was quite pleased with the way they were proceeding. The Director emphasized that all their dealings with the Ministry of Health and Social Welfare would depend on their constitution. So the constitution is the foremost thing which traditional healers should hurry to finish.

A meeting was also held with the University of Swaziland Vice Chancellor who promised to launch a seminar for traditional healers where they could present their draft constitution. The Vice advocated that this could be done in March, 2001 in the presence of the legal bodies, Ministry of Health Authorities, the media, Ministry of Agriculture and Natural Resources, as well as other organizations like WHO and UNDP.

Another meeting held with the UNDP Country Representative and her Vice was also successful. Traditional healers went to them to seek for resource support while carrying out the process of developing the constitution. The UNDP representatives promised to handle their needs together

with WHO representatives in Swaziland. They also emphasized that such an endeavour by traditional healers was very good for any development of a country in terms of health care delivery.

A meeting held with the Authorities of the Ministry of Justice was also a success. Traditional healers stated that they were requesting an amendment of the Witchcraft Act of 1905, not necessarily its removal. They emphasized that they did not consider themselves as witch-doctors, but this Witchcraft Act could be referred to when one of the traditional healers committed some witch practices. They requested that any statements referring to traditional healers should be removed, since traditional healers were now engaged in developing their constitution. They also requested the Ministry to provide them with traditional healers' constitutions from other countries so that they could refer to such. They also requested legal advice from the Ministry. Luckily, the authority was the Principal Secretary of the Ministry of Justice, who also stated that he had an interest in seeing the traditional healers having their own constitution. He promised to take their requests further and that a reply would come in due time once he had contacted certain people in his Ministry to discuss about this issue of a traditional healers' constitution.

#### **5. 2. 5 Conclusion**

This process of developing the constitution of traditional healers would still be ongoing until the constitution and an office or council of traditional healers are established. The researcher would act as a facilitator even after completing of this thesis. There are still meetings and seminars to be held, follow up discussions with stakeholders and the involvement of a lawyer and a consultant to be conducted for the completion of this process.

### **5.3 THE PROJECT TO DETERMINE THE EFFICACY AND SAFETY OF TRADITIONAL HEALERS' MEDICINE IN THE TREATMENT OF DIABETES AND HYPERTENSION**

#### **5.3 1 Introduction**

The following results were found by comparing a group of clients suffering from diabetes and hypertension treated with only western medications, another treated with only traditional medicines and a third group who combined both treatments, western and traditional. This group was also used as a control group.

*These groups were chosen as follows:*

These are the 19 clients who were mentioned in chapter three, stage three under sampling, number 3. 3, p 102.

The selection of the clients who used only western medicines or both medicines was based on a convenient sampling method. The clients with this diagnosis who were found at the clinic on the day of the researcher's visit, were all interviewed and, from the interviews, the researcher purposely placed each client in either the group which used only western medicines or the group which combined both treatments. From the responses they gave, one could tell that they were using only western medicines or both.

The clients who used traditional medicines only were identified through their traditional healers, two of whom were themselves suffering from hypertension and using only traditional medicines.

There was some snowball sampling since the traditional healers referred the researcher to some of their clients who used only traditional medicines to control their hypertension. The first informant

interviewed was invited to suggest another participant, and the researcher used this referral to invite the second person to be part of the study ( Morse, 1989 ).

The researcher collected data from the two groups ( utilizing only western and only traditional medicine) evaluating the blood pressure and glucose levels for six months, on a monthly basis. The researcher followed up the clients who used both medicines concurrently by checking their level of blood pressure whenever they came for their visits to the clinic.

The group that used only traditional medicines were discovered to have no diabetes diagnosed and their levels of glucose ranged between the normal levels of 3.8 to 6.7 mmol/L. Because of these findings it was not possible to compare the glucose levels of the ones combining medicines and those using western medicines only. This project was then directed towards comparing only levels of hypertension.

There were eight clients using only traditional medicines and two of them were excluded during the study period because they visited the hospital and started to use both traditional and western medicines. Seven clients were followed who utilized only western medications. Six clients used both traditional and western medicines from the beginning. Three of these clients stopped using the traditional medicine during the six months period of data collection. Two of the three stated that they stopped because they did not see any improvement. The other one stated that she stopped because she did not have money to purchase more of the herbal mixture, but she had experienced some improvement.

Two clients who used traditional medicines only, ended up joining the group that combined both treatments, since their blood pressure readings were very high and they were advised to seek help from the western facility by the researcher. They did not stop using the traditional medicines, but they used both. The group that used both medicines were made up of five participants by the end.

### **5. 3. 2 Clients utilizing only traditional herbs**

**Profile:** There were two males and four females. The ages of the males were 54 and 74. The ages of the females ranged from 41 to 59.

**Illness:** They all mentioned that they had hypertension. Five of them had their hypertension diagnosed in a western medical facility, while one of them diagnosed her hypertension through her own description of symptoms. None of them mention that they had diabetes nor were they diagnosed with diabetes.

**Initial signs and symptoms:** They stated the following as initial symptoms: - weakness of the body, headache, impotence, painful shoulders, palpitations, general body malaise, swollen and painful feet and joints and hot flushes.

**Signs and symptoms when the blood pressure is high:** They stated that they could tell from the following symptoms tiredness, sleepiness, chest pains, hot flushes, nose bleed, weakness and depression.

**Management:-** Four of those who were diagnosed in western facilities used western medication after diagnosis for a short period, then stopped, and started to use some herbal mixture to control their illness. One of those diagnosed in the western facility did not take western medication at all and the other client who diagnosed herself started to use some herbal mixture, immediately. Three of them made their own herbal mixture and the other three normally brought it from some traditional healers who were known to have herbs for

diabetes and hypertension.

**Traditional Herbs utilized:-** There were some similarities in some of the plants that they combined. The combination was as follows:-

**Group one:-** flower of a banana tree, marijuana, *nhlziyonkulu/lilukuluku*, leaves of a peach plant, *sibiba* (cape aloe) and leaves of a paw-paw tree. The leaves were cut into small pieces of about 50g and boiled for one hour, making two litres of the herbal mixture. The dose was one tablespoonful administered orally, three times a day .t. d. s. for one week. Improvement was normally felt in 24 hours.

**Group two:-** Marijuana, *inshubaba* , *inkakha*, *nhlziyonkulu/lilukuluku*, peach leaves, flower of a banana tree and a flower of a non-producing paw-paw tree. Preparation:- Plant material was cut into small pieces of about 50g , added into two litres of water and boiled for 5 minutes. The dose was administered orally, tablespoonful, t. d. s. for one week. The improvement was felt within 24 hours.

**Group three:-** small aloe, large aloe, flower of a banana tree, roots of a paw-paw tree, seeds of a banana, *inshubaba* . Preparations:- about 50 g of each kind of a plant was added into two lt of water. The mixture was not boiled but kept for one day before the herbs were used. Half a cup was taken orally, b. i. d. for 3 days. The aloe could be combined with the bark of *umganu* ( marula ) tree, ground together, added to 5 lt of water and then administered as an enema. The first herbal mixture is taken orally for three days, while the second mixture is administered rectally only once when the blood pressure was high.

**Diagnoses of improvement:-** They stated that when they felt the disappearance of the symptoms, they knew that their condition was improving.

**Follow up results:- blood pressure reading:-** The researcher took the blood pressure and measured blood glucose levels of these clients at their own homes and the readings were



as follows:

***Blood pressure levels of the clients who utilized only traditional medicines ( see Table 4, p. 193 )***

The reading of the levels of hypertension in these clients ranged between 140/90 to 160/100. Initially the blood pressure was 160/100. The client, though advised to seek help from the western health care facility, decided to use traditional herbs and on review after one week, his blood pressure reading was 140/90. Another client whose blood pressure was also 150/100 used his herbal mixture and within one week it was found to be 130/90. His readings ranged between 130/90 and 150/100. One client's blood pressure was found to range between 120/80 and 140/90.

The readings of the client who did a self diagnosis were found to range between 120/80 and 130/90. The client said ***“I felt the following symptoms:- periods of amenorrhoea alternating with periods of menorrhagia, tiredness, generalized body pains, constipation, then I concluded that I might be suffering from hypertension. I based these symptoms from what my husband suffered from when he was diagnosed in the hospital to be suffering from hypertension. When taking the herbal mixture, all the symptoms disappeared.”*** (See table 4 below)

**Table 4: CLIENT'S LEVELS OF BLOOD PRESSURE ( those utilizing only traditional medicines)**

clients	1 <sup>st</sup> visit	2 <sup>nd</sup> visit	3 <sup>rd</sup> visit	4 <sup>th</sup> visit	5 <sup>th</sup> visit	6 <sup>th</sup> visit
1	160/100	140/90	140/100	150/100	140/90	140/90
2	150/100	130/90	140/90	140/90	130/90	130/90
3	130/90	150/90	140/100	130/90	130/90	150/100
4	140/100	130/90	150/100	130/90	130/90	140/90
5	140/90	120/80	120/80	120/80	140/90	130/90
6	130/90	120/80	120/80	120/80	120/80	130/90

**Glucose levels:-** for all of them the readings taken with a glucometer ranged between 4.5 to 6.8 mmols/L. That showed they did not have problems of diabetes since their levels were within the normal range of being 3.8 to 6.7mmol/L ( Kneisl & Ames, 1986).

***Changes of life styles and diet:-*** Those who went to the hospital reported that they were advised to stop salt and sugar in their diets and to eat less fat, starch and spicy foods. They all admitted that they were not keeping up with this advice. Two of these clients admitted to be taking a high content of alcohol, especially during the marula seasons. They also stated that they experienced terrible symptoms whenever they had taken alcohol the previous day. One client said “ *I wish I could stop drinking alcohol since I nearly died one day after a drinking spree of marula with some friends*”.

The researcher noticed that they were not taking the herbs continuously, since after they were diagnosed and found to have high readings of blood pressure, they then took the medication. They also mentioned that when they experienced the symptoms which they suspected to indicate high blood pressure, they would then take their herbal mixture.

### 5. 3. 3 Clients utilizing only western medicines

The majority of these clients had both illnesses. As has been mentioned before, they would state that they had diabetes and when further questioned they would mention that hypertension was diagnosed in the hospital. All of them felt that hypertension was not a problem. One client said *“diabetes seems to be causing a lot of problems for me like vision, thirst, passing a lot of urine, aching of the body with cramps and with the blood pressure I do not feel anything, I am only told by the health workers that today it is high or it is normal, but I do not feel anything.”*

**Profile:-** There were two males and five females. The ages of these clients ranged between 31 and 60 years of age. One male was 45 years old and the other male was 58 years old.

#### **Illnesses:- Hypertension:**

**Initial signs and symptoms reported by clients:-** The majority of the clients mentioned that they did not experience any signs and symptoms. Two of them mentioned the following signs and symptoms:- earache, tinnitus, blocked ears, nose bleed, severe continuous headache and palpitations.

**Signs and symptoms when blood pressure is high or low:-** they stated that when they felt very weak, tired, nose bleed and dizziness they would suspect that their blood pressure was high. When it was low they felt very weak. Most of them stated that they did not feel anything. They were told by the nurses or the doctor when the blood pressure was high or low.

**Diagnoses:-** Most of the diagnoses were done in the hospital, though one client mentioned that she went to several hospitals until one private doctor used a machine to diagnose her blood pressure instead of the sphygmomanometer.

**Management:-** The drugs identified for all the hypertensive patients were Aldomet 250mg, Lasix 40mg or hydrochlorothiazide with slow K. Most of these clients would also be given vitamin supplements like vitamin B complex or multivitamin tablets. They would initially be given these tablets for one or two weeks x 3, then they would be given a monthly supply so that they could re-attend the hospital once every month for check ups.

**Improvement:-** They could tell when they did not feel any signs and symptoms, normally after one week of medication. Some of them stated that the nurses would tell them the readings of their blood pressure, then they would know if there was any improvement or not.

**Blood pressure levels-** The blood pressure readings of two clients ranged between 110/70 and 150/90. The blood pressure readings of three clients ranged between 130/90 and 150/100 and the readings of the remaining two clients ranged between 120/80 and 170/100 (see table 5).

**Table 5: LEVELS OF BLOOD PRESSURE (clients who utilized only western medicines)**

clients	1 <sup>st</sup> visit	2 <sup>nd</sup> visit	3 <sup>rd</sup> visit	4 <sup>th</sup> visit	5 <sup>th</sup> visit	6 <sup>th</sup> visit
1	140/90	160/100	150/100	140/100	130/90	170/100
2	130/90	150/100	120/80	160/100	170/100	130/70
3	150/100	140/100	140/100	130/100	130/90	130/90
4	150/100	150/100	150/90	110/70	130/90	130/90
5	140/90	130/90	150/100	150/90	120/80	130/90
6	150/100	150/100	130/90	130/90	110/70	110/70
7	130/90	140/100	130/90	150/100	150/100	140/100

The advice given on life styles was mainly about diet. One client said “*I was told not to eat any food rich in salt, fats and sugar. I was taught to eat vegetables, milk, polony, cheeses and eggs and to go to the hospital for check ups once a month.*”

**Table 6: SYSTOLIC CHANGES PER VISIT ( clients using only traditional medicine)**

clients	1 <sup>st</sup> visit	2 <sup>nd</sup> visit	3 <sup>rd</sup> visit	4 <sup>th</sup> visit	5 <sup>th</sup> visit	6 <sup>th</sup> visit	status
1	160	-20	-20	-10	-10	-20	I
2	150	-20	-10	-10	-20	-20	I
3	130	20	10	0	0	20	W
4	140	-10	10	-10	-10	0	I
5	140	-20	-20	-20	0	-10	I
6	130	-10	-10	-10	-10	0	I

**I: Improved**

**W: Worsened**

**Table 7:      DIASTOLIC CHANGES (clients using only traditional medicines)**

clients	1 <sup>st</sup> visit	2 <sup>nd</sup> visit	3 <sup>rd</sup> visit	4 <sup>th</sup> visit	5 <sup>th</sup> visit	6 <sup>th</sup> visit	status
1	100	-10	0	0	-10	-10	I
2	100	-10	-10	-10	-10	-10	I
3	90	0	10	0	0	10	W
4	100	-10	0	-10	-10	-10	I
5	90	-20	-20	-20	0	0	I
6	90	-10	-10	-10	-10	0	I

**Table 8:      SYSTOLIC CHANGES (clients using only western medicines)**

client	1 <sup>st</sup> visit	2 <sup>nd</sup> visit	3 <sup>rd</sup> visit	4 <sup>th</sup> visit	5 <sup>th</sup> visit	6 <sup>th</sup> visit	status
1	140	20	10	0	-10	30	W
2	130	20	-10	30	40	0	W
3	150	-10	-10	-20	-20	-20	I
4	150	0	0	-40	-20	-30	I
5	140	-10	10	+10	-20	-10	I
6	150	0	-20	-20	-40	-40	I
7	130	+10	0	+20	+20	+10	W

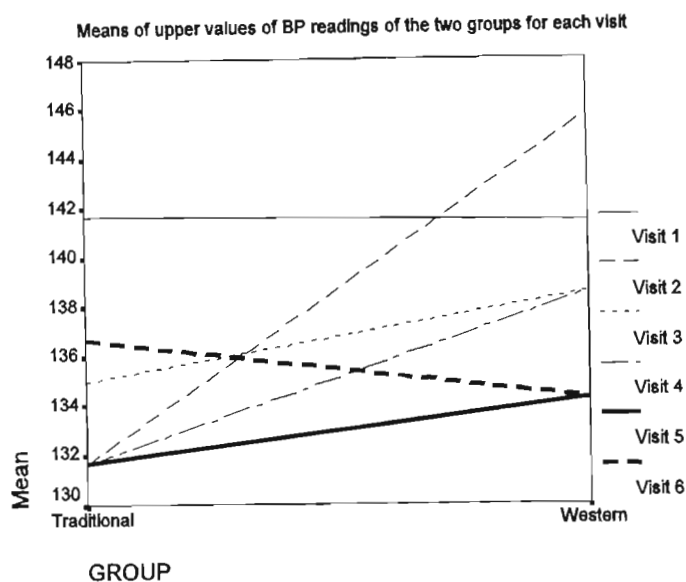
**Table 9:      DIASTOLIC CHANGES (clients using only western medicines)**

Clients	1 <sup>st</sup> visit	2 <sup>nd</sup> visit	3 <sup>rd</sup> visit	4 <sup>th</sup> visit	5 <sup>th</sup> visit	6 <sup>th</sup> visit	status
1	90	10	10	10	0	10	W
2	90	10	-10	10	10	-20	W
3	100	0	0	0	-10	-10	I
4	100	0	-10	-20	-10	-10	I
5	90	0	+10	0	-10	0	I
6	100	0	-10	-10	-30	-30	I
7	90	10	0	10	10	10	I

**5. 3. 4 Statistical manipulation of the diastolic and systolic levels of hypertension for both groups**

**Figure 1. Mean systolic of both groups these were found when comparing table Table 4 and 5.**

Refer to the graphs that follow and some descriptions of what one sees happening in them.



The above graph show the MEAN values for the systolic value at each visit comparing the 'traditional' group with the 'western' group.

At visit 1 the mean for both groups is about the same and both above 140 - with the 'western' group means slightly higher than that of the 'traditional' group.

At visit 2: the mean for the traditional group has lowered, that



of the western group has gone up. The traditional mean is much lower than that of the western groups' mean.

At visit 3: The traditional mean has gone up since visit 2, the western group has gone down since visit 2. Trad mean is still lower than west mean.

At visit 4: Trad mean has gone down since visit 3. West mean has stayed the same since visit 3. Trad mean still lower than west mean.

AT visit 5: Traditional mean has stayed the same since visit 4. Western mean has dropped since visit 4. Traditional mean still lower than western mean.

At visit 6: Traditional mean goes up since visit 5. Western mean stays the same since visit 5. Now the traditional mean is higher than the western mean.

of the western group has gone up. The traditional mean is much lower than that of the western groups' mean.

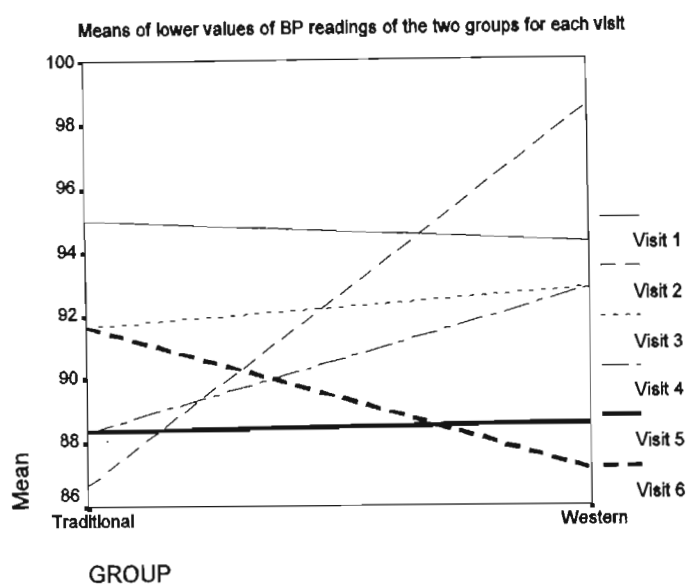
At visit 3: The traditional mean has gone up since visit 2, the western group has gone down since visit 2. Trad mean is still lower than west mean.

At visit 4: Trad mean has gone down since visit 3. West mean has stayed the same since visit 3. Trad mean still lower than west mean.

AT visit 5: Traditional mean has stayed the same since visit 4. Western mean has dropped since visit 4. Traditional mean still lower than western mean.

At visit 6: Traditional mean goes up since visit 5. Western mean stays the same since visit 5. Now the traditional mean is higher than the western mean.

**Figure 2: Diastolic mean values of both groups**



**Diastolic readings of the blood pressure levels in table 4 and 5:**

The pattern for these scores is almost the same in terms of how they vary across visits and comparing traditional mean with western mean as for the systolic scores.

### 5. 3. 5 Discussions about the two groups

One has to understand what hypertension is and when it is considered normal. Symptoms attributed to hypertension include headaches, epistaxis, tinnitus, dizziness and fainting. Sometimes it can be asymptomatic until organ damage occurred ( Smeltzer and Bare, 1995).

#### *Classification for diastolic and systolic hypertension*

<u>Diastolic(mm Hg)</u>	<u>Category</u>
<85	<i>Normal blood pressure</i>
85 to 89	<i>High normal blood pressure</i>
90 to 104	<i>Mild hypertension</i>
105 to 114	<i>Moderate hypertension</i>
≥ 115	<i>Severe hypertension</i>

<u>Systolic (mm Hg)</u>	<u>Category</u>
<140	<b>Normal blood pressure</b>
140 to 159	<b>Borderline isolated systolic hypertension</b>
≥160	<b>Isolated systolic hypertension</b>

Hypertension exists when the diastolic pressure is greater than 90 mm Hg. The systolic pressure may be normal or elevated. Isolated systolic pressure is normal in adults above 65 years old and is normally due to atherosclerosis ( Kneisl and Ames, 1986).

### ***Similarities/ differences:***

#### **a) Range of levels of Blood Pressure:-**

When comparing the range of readings of blood pressure for those who used traditional medicines only and those who used western medicines only, the difference was not detected as being significant . They all had some fluctuations of blood pressure readings, at times being low and at times being high, hence the difference in terms of levels was not significant. The fluctuations for all the groups showed that these illnesses can only be controlled and not cured. Although most clients who combined both treatment reported that they felt better after the combination, their levels of blood pressure did not show any difference from the two groups who used only traditional medicines, or western medicines. As this group was small, it was difficult to come up with some realistic statistical values in terms of the differences. Differences in the levels of blood pressure could be due to chance or other factors unrelated to the use of the medicines, hence it was not possible to come up with conclusive statements about the differences. Some statistical manipulation was attempted which showed no significant differences, because the sample size was too small ( see tables 6, p. 191, 7, 8, p. 192 and 9, p. 193. as well as figure 1, p194 and 2 p. 196). Some of the differences are higher for those who used only traditional medicines and at times they are lower for them and higher for those who used only western medicines and also lower for them.

#### **b) Diagnosis:-**

Most of the clients, including those who utilized traditional medicines only, were diagnosed in western facilities except for one client who did a self diagnoses.

#### **c) Signs and symptoms:-**

The signs and symptoms were also similar between these groups. Those who used

traditional healers' herbs also experienced some improvement in 24 hours, while those who used western medicines felt improvement in about seven days.

**d) Management:-**

The western health care workers emphasized change of life style only in terms of diet. They also did not cover the other aspects, such as exercises, alcohol reduction, giving up or secession of smoking and stress reduction. Traditional healers did not mention anything about life style changes.

### **5. 3. 6 Analysis of Results**

#### ***Efficacy and safety of the medicine***

It would seem that the traditional herbs could also be effective, as those patients who used their herbs when the blood pressure was high, found that the blood pressure was reduced. There was also no difference in terms of turning to the other facility when no improvement was felt. Clients who started using western medicines only stated that they turned to traditional herbs when they felt no improvement or started combining the two and also those who used traditional herbs, started to combine the two when they did not experience any improvement. One client said *“for four years I used the western medicines and I felt some improvement but I could not engage in any activities since I did not have any strength and I had a lot of problems in my body. I then started to use a herbal mixture. I inject myself with insulin in the morning and take a sip from the herbal mixture twice a day. For the first time I feel so much better that I am able to engage in activities at home which I have not been able to perform since these illnesses and the nurses told me that my blood pressure reading and the sugar level is improving. I thank the herbal mixture and my son who brought it for me”*. Also one of the clients who was sent to

utilize the western medicine reported much improvement when combining the two medications. His blood pressure dropped from 150/100 to 130/90 when he started to use the western medicines, although while continuing with both treatments, fluctuations also occurred of high and low levels. Perhaps the difference was in the fact that, when they combined both types of medicines, they reported to have gained strength to perform activities they had no longer been capable of performing, but they also reported problems like signs of dehydration such as dry mouth, loss of strength, dryness of skin, loss of skin turgor and excessive thirst as they continued with both treatments. There was no effect in terms of the levels of blood pressure.

The other difference is that western medicines have been scientifically tested, while traditional herbs rely on removal of symptoms to conclude that they achieve a cure. In that light there is still a need to test scientifically traditional herbal mixture's safety and efficacy in laboratories without any additions, subtraction or distortion of their components. There is a need for a thorough analysis of the pharmacodynamics, pharmacotherapeutics and pharmacokinetics of these traditional medicines. Pharmacodynamics is the study of how chemicals produce their biological effects on living tissues, pharmacotherapeutics is the branch of pharmacology that deals with drugs or chemicals that are used in medicine for the treatment, prevention and diagnoses of disease and pharmacokinetics is the scope of pharmacology that deals with the study of absorption, distribution, metabolism and elimination of drugs in the body. In addition posology (science of the dosage of drugs) should be explored for traditional medicines as well as toxicology (a science which deals with the poisonous effects possible from a medicinal drug) (Sheridan, Patterson and Gustafson, 1985).

It was not clear whether combining the medications brought about the referred to problem of dehydration. Most of the herbs produced a diuretic effect, while some of the western medicines also had a similar effect and hence dehydration could have been a sign of an overdose.

It was difficult to establish the safety of the traditional medicines since most traditional healers and clients stated that there were no side effects from these medications. There is a need to analyze these herbs in a laboratory to find their active principles and possible side effects, since all drugs in the western systems have some side effects and contraindications. This shows the need for traditional healers to patent their medicines under a controlled system of patenting traditional healers' medicines. Such a system would promote more information about safety. One could, however, conclude that since no client had any unwarranted abnormalities which could be associated with the use of the traditional herbs, they were reasonably safe.

Looking at the blood pressure levels of client number five, who did a self diagnosis, one can tell that she did not have any hypertension.

### *Differences*

Most clients who attended western facilities had been diagnosed as having both illnesses. This might be explained because they were having check ups on a regular basis, while those using traditional herbs did not have any regular check ups, relying only on signs and symptoms after an initial diagnosis at a facility providing western medicine.



**a) Advice:**

Those clients using traditional herbs were not given much knowledge on life style changes and diet to assist in controlling their illnesses, while the ones using western medications reported some advice about diet.

**c) The amount, frequency and duration of medicine:**

Traditional healers' herbs had to be taken in large amounts irrespective of the active principle. The clients had to take one litre of the herbal mixture for one week and drink half a cup, three times a day. Once symptoms had disappeared, the client would stop taking the herbs until the symptoms resurfaced. There was no emphasis on continuously taking the herbs even if the symptoms had disappeared to keep control of the blood pressure.

Western medicine is precisely measured in small doses. The frequency of the western medicines depended on the type of medicine and levels of hypertension. Some medications are to be taken once a day, for example the diuretic drugs, or twice a day in the case of hypertensive tablets like Aldomet. At times some of the clients who had stable blood pressure levels were taking Aldomet 250mg only once a day.

### 5. 3. 7 Feedback of findings to the participants

After feedback there were some questions and contributions from western trained health care workers, clients and traditional healers. There was appreciation expressed by the traditional healers when they heard that there was not much differences in terms of the fluctuations of the levels of blood pressure and glucose among all the groups. They also suggested that the dehydration might be caused by their herbs since they gave herbs that removed fluids from the body. One traditional healer explained about the pathophysiology of what he believed had gone wrong when a client had diabetes and hypertension as follows *“When the sugar level is very high there is problem of feeling some coldness moving from the head going down as if you are going to have a stroke. Diabetes is caused by the manure in the food which we also eat and a lot of fats. The manure builds up water in the blood and this water gives a problem to the pancreas which is supposed to deal with the sugar. Once the pancreas has a problem, then it cannot deal with the sugar. Then all this sugar will affect the body especially the liver and the kidneys. Then kidney stones will be formed and hence a problem with urination. Then we give herbs through an enema to remove these stones and help the pancreas to deal with the sugar.*

*High blood pressure is caused by some fat which lodges in the blood vessels, then interferes with the pumping of the heart. Since the heart is not pumping well, then there will be oedema of the lower extremities, hence we provide herbs that have to remove this water and thus reduce the swelling and help the heart to pump blood properly.”*

They felt there should be a further analysis of the herbs to find out what they contained and a lot of health education should go on in terms of life styles and diet.

### 5. 3. 8 Strategies developed

During the meetings where feedback was given, the participants proposed the following strategies:

#### *Health education*

Western health care workers proposed that they need to educate the clients about health concerning the use of traditional herbs. Although the herbs had been found to work, they strongly felt that clients should not combine them with western drugs because of the problems of dehydration and perhaps other problems of over dosage. If clients were using the herbs, they still needed checkups in the western facility so that improvements and complications could be detected, particularly, as the safety of traditional herbs had not yet been scientifically proven.

There was also a need to educate the traditional healers in terms of counseling clients concerning life style changes and diet. Western trained health care workers realized that traditional healers needed to know how these life styles changes could make an impact in the control of diabetes and hypertension. There was also a need to convince clients and traditional healers that diabetes and hypertension were not curable, but could be controlled and hence life could be prolonged.

#### *Issue of combining the western medicine and herbal mixture concurrently*

All participants felt that there was no need for clients to combine the two types of medicines in controlling their illnesses, especially, after the feedback that those who combined both treatments had some problems of dehydration.

It was noted that the traditional herbs do bring about increased strength and clients were able to engage in activities they were not able to do before taking the medications, it was then stated the herbal mixture could be taken for those reasons. One traditional healer said “ *When I gave one*

*old lady my herbal mixture, she reported increased gain of strength and was able to do certain activities, but she then stopped using the western medicines, but when she came to the clinic, she was told that her blood pressure level was too high. So I realized that much as the herbs are giving her strength, they were not reducing the blood pressure levels. It was not easy to convince her to take the western medications, she insisted on taking the herbs. In the light of this study it means as a traditional healer, I have to try and make sure she takes the western medicines for a while and when the level of blood pressure is low, then I can give the herbs to bring about strength."*

#### ***Emphasize evaluations in the hospital***

Traditional healers and the clients accepted and communicated that they relied on symptoms for diagnosis and monitoring. They realized that someone might not have any symptoms, but at a western health facility they would diagnose the client and tell him or her that the blood pressure was high. Emphasis would be put on clients to attend western health care facilities so that evaluations could be made even if they used only traditional herbs.

#### ***Proposed monthly meetings***

It was decided in these meetings that there should be monthly meetings between traditional healers and western trained health care workers to discuss these issues and hence facilitate collaboration in the management and help that they can both give clients suffering from hypertension. Western trained health care workers stated that they would discuss this issue of meetings in their own meeting which is normally held on the first Tuesday of each month and the traditional healers would discuss this issue in their meeting which is normally held on the last Wednesday of each month.

### ***Research (Analysis) of the traditional healer's herbs***

They decided that there should be further research done to analyze traditional healer's herbs. There is a need to isolate what the combination of plants contains that brings about treatment and to find out whether it is the combination or the action of one or two plants. The traditional healers felt they needed to know what their herbs contained that brought about the reduction of hypertension. One traditional healer decided to take his herbal mixture to the Director of Health Services in Swaziland in an attempt to find out his herbal mixture contained. One traditional healer said *"My herbs do work, since the pregnant women who are diagnosed in the hospital to have hypertension, once they start taking my herbs, they come back reporting that the doctors said their blood pressure is controlled. I also rely on the hospital diagnoses. I do not give the herbs to anyone who has not been diagnosed in the hospital first. After giving them the herbs, I tell them to use it for one week and then go back to the hospital for diagnoses. The problem I have is that, I do not know what is in my herbs that brings about the control. So, I request the Authorities of Health to freely test my herbs and see what is there that brings about the control"*.

### **5. 3. 9 Conclusion**

This was a useful small study which showed that there were clients using only traditional herbs. From the results of the blood pressure monitoring, one could say that traditional healers herbs also work, since if they did not work, worse levels of blood pressure would have been identified. Much as the safety was difficult to establish without doing tests over a longer period of time under controlled situations in a laboratory, one could still conclude that there was some safety, since the clients did not show any abnormalities which could be associated with the use of traditional herbs. This study formed a base where other in-depth studies of clinical trials could be done as well as

further analysis of the traditional herbs one by one.

## **CHAPTER SIX**

### **DISCUSSION OF RESULTS AND RECOMMENDATIONS**

#### **6.1 INTRODUCTION**

The discussions and recommendations presented in this chapter are based on the two phases of the study as follows:

***Phase 1:* Context of the problem**

- a) The description of the profile of traditional healers, management of diabetes and hypertension and the views about collaboration.
- b) The diagnosis of problems leading to the lack of collaboration, which in the study were called barriers for collaboration, and diagnosis of positive possibilities of collaboration called the enhancers for collaboration.
- c) Strategies proposed by all the participants during the individual interviews and the initial two meetings followed by a series of joint meetings held throughout the study.

***Phase 2:* Implementation and process evaluation.**

**Strategy One**

- a) Discussions were organized concerning the implementation of the strategy. One focus was the development of the constitution of traditional healers, another move towards the establishment of an office of traditional healers under the Ministry of Health and Social Welfare and finally accompanied by the formulation of a "Traditional Healers Council".

- b) Diagnosis of what caused delays in this process in the past and what has caused the current delay in this process.
- d) Strategies developed and implemented to speed up this process, including action plans, progress and feedbacks.

**Strategy Two:**

- a) A small survey was organized to establish the safety and efficacy of traditional herbal mixtures given to patients who are suffering from diabetes and hypertension. This was done as an attempt to bring about some trust between the traditional healers and the western trained health care workers;
- b) Diagnosis of similarities and differences in traditional medicines and western trained health care medicines and their management of hypertension. The efficacy and safety of the traditional medicines was also analyzed. Feedback of the process and results was done;
- c) Strategies were developed to include a way forward for the traditional healers, clients who suffer from hypertension, and the western trained health care workers.



## 6. 2 PHASE I. CONTEXT OF THE PROBLEM

### 6. 2. 1 Traditional healers' categories

In this study traditional healers' gender was found to be significant. There were more males than females, though all the females who were met during the individual interviews and during the series of meetings were all basically being *sangoma*. Gort (1987) observes the same trend like the researcher, that traditional healers' trend was changing whereby more women were found to be herbalist or both. In the Zionist gender difference was found to be irrelevant. Though Gort (1987) stated that in the past there were more female *tangoma* than male *tangoma*, in this study most of the males had been *tangoma*. These males either started as a faith healers and progressed to being *tangoma*

Three categories of traditional healers were identified. There was no distinct category which did not include some form of herbalism as some of the authors stated. The categories were as follows:

- a) Faith-healer-*sangoma*-herbalists
- b) Faith-healer-herbalists
- c) Herbalists

These traditional healers' categories were developed from descriptions of how they were trained and how they practiced. With the first two categories there was progressive training and the last category were those who were trained in that categories and had not progressed to any other category in terms of training and practice. The herbalist is also called the medicine man. This means that the herbalist can prepare and prescribe medicines and can be trained by learning from one who was also a herbalist. The herbalist does not necessarily need to be possessed by ancestors or the Holy Spirit. He learns and acquires knowledge about plants. The faith healer only prays and

prescribes minerals and holy water, but no herbs. In this study faith healers were also prescribing herbs. The description of the category of herbalist agrees with the description of a herbalist by Makhubu (1978). Gort (1987) stated that the faith healers originated around the 1930's and they were considered a new category. It was also learned from the traditional healers themselves that faith healers were perceived as being better than pure traditional healers since they used ashes. To the traditional healers, this perception could be argued that, faith healers are not better nor are they different since ashes come from plants.

What was observed in these traditional healers' categories, was the progressive training from one healer to another. Some traditional healers started training as a Zionist, and went on to train as a *sangoma*, then as a herbalist. There were no lines of demarcation between these categories as some authors like Makhubu (1978), Gumede (1990) and Edwards (1986) described. Gort (1987) also agreed with findings of the study, that with modernization lines of demarcation between traditional healers are no longer observed.

#### **6. 2. 2 Practices of traditional healers**

There was the comprehensive roles of all the traditional healers when it came to diagnoses and management of illnesses. In the past a *sangoma* would only divine and carry out certain rituals, while the herbalist was the one who prepared and prescribed the herbs. In this study all traditional healers were engaged in all the functions of diagnosing, preparing and prescribing medicines.. Gort (1987) states that this comprehensive practice came with changing traditional medicines and the socioeconomic status. Griffiths and Cheetham (1982) also mentioned that the role of the *sangoma* is extensive. Which means they are in agreement with what was discovered in the study. It is observed that with changing traditional medicines, most healers have a tendency of doing both divination and dispensing medicines. The *sangoma*, for instance, can also perform social

relationship roles, such as counseling families on relationships. She does this through systematized rituals and ceremonies and observations of taboos. She often becomes aware of disturbed relationships within the home or the clan. Hence the prescription she would make will be directed towards resolving the conflict ( Griffiths and Cheetham, 1982).

Not only the herbalists mentioned that they used bones to diagnose, but also some of the faith-healer herbalist and some of the faith healer-*sangoma*-herbalists. The researcher did not know whether these classifications or categories came about since everyone wants to have some payment for all the practices or it was some evolution in the traditional healers categories or some form of modern development for traditional healers.

In the western system of health care there would be different professionals dealing with one patient such as a nurse, doctor, social worker, occupational therapist, surgeons, anaesthetists dieticians and many more, but the traditional healers have few categories. One traditional healer may act as a nurse, doctor, dietician, obstetrician, ophthalmologist, a social worker and many more. Hence Edwards (1986) states that traditional healers are all-in-one type of healers.

### ***Management of Chronic Illnesses ( Diabetes and Hypertension)***

Much as traditional healers stated similar symptoms of hypertension and diabetes, it was clear that they considered these illness new in their field. One of the reason being that they relied on the western facilities for diagnosis. It would have been better if traditional healers came with their own traditional naming of these illnesses. The lack of a traditional healers' name, lack of adequate knowledge about the pathophysiology and lack of an objective diagnosis of hypertension and diabetes, strongly emphasize that traditional healers should collaborate with the western health care

workers in the management of these two illnesses. They could not handle them alone.

Most clients did not find hypertension as important as diabetes . This perception indicates that most of them would not take precautions as far as hypertension was concerned. This could be that hypertension might be asymptomatic. Diabetes on the other hand would show with certain symptoms, except for the type 11 diabetes which might show no symptoms. Authors like Kneisl and Ames (1986), Smeltzer and Bare (1995) and Phipps et al (1995) described that hypertension for most clients would kill them silently, and by the time they are diagnosed, most organs would be damaged. This calls for screening programmes to diagnose clients early and educational programmes to show clients that hypertension is as serious as diabetes. Having both illnesses at the same time would be an added risk ( van Dellen, 1993)

When it came to management of these illnesses, most clients consulted both systems searching for a cure. Lindsey (1996) described chronic ill patients as having a healthy situation within an illness. In the concept of health within illness , the experience of illness can accelerate personal growth through awareness and transformational change. Most clients in this study with chronic illnesses, such as the diabetic and hypertensive patients, experienced a lot of personal growth and self care activities as well as transformational changes when they searched for medical treatment from both systems of health care, traditional and western, as well as changes in life styles such as trying to eat the appropriate diet. They did this because of the existence of health within the illness, regardless of the physical condition. Western trained health care personnel's notion was the concept of care rather than cure when dealing with patients who had chronic illnesses like diabetes and hypertension.

Traditional healers used the elements of culture when handling illnesses and hence most clients prefer to consult them since traditional healers understand their cultural background that the western trained personnel does not acknowledge. Culture includes customs, beliefs, knowledge, morals and laws of a region and is fundamental to our proper evaluation of a fellow human being under stress. Cultural sensitivity is highly regarded in the western trained health care personnel. In order to assist such a person the bio-psycho-social approach, taking into account cultural and spiritual needs, offers the only comprehensive treatment modality (Wessels, 1985). Chavunduka (1979) states that traditional medicines is successful because of its tendency to treat the 'whole man,' that is to deal with both physical and psychosocial needs.

Some client would move between private to general hospitals in search of a cure. This shows that much as the western trained health care workers emphasized that these illnesses cannot be cured, but can be controlled, the clients themselves still believe there might be a cure or better treatment somewhere else. Temmink, et al (2000) who stated differences in the health care systems policies, related that in industrialized countries, government policy focuses on the improvement of care by encouraging ongoing and patient tailored care. However, good quality, affordable care for chronic patients is often difficult to provide owing to organizational gaps in health care systems.

#### ***Traditional medicines used by the traditional healers***

Traditional healers have groups of herbal plants which they use for making herbal mixtures for diabetes and hypertension treatment. The researcher noticed that there were a few differences in the groups of plants from one traditional healer to the other. It was also noted that similar plants were used for both illnesses. The plants used, the *inhlaba* (aloe), *banana flower*, *marijuana*, *nhliziyonkulu* and *inkakha* or *inshubaba*, were commonly used in combination for both illnesses.

Traditional healers claim that these herbs work, as do other authors who might have done studies on traditional medicines. Plant (1993) mentioned that there has been a resurgence of interest in home remedies which are none other than herbs. Natural remedies, tried and trusted for centuries are enjoying revival, with more and more people turning to alternative medicine and conventional medical care. Trevelyan (1993) stated that herbal medicine refers to the use of whole plant remedies in the promotion of healing and maintenance of health whereas allopathic medicines seek to isolate the active principle or ingredient in a plant. Herbal mixtures are said to have three effects in the body: detoxification and elimination of wastes, strengthening and healing and building up of organs. They can be made from a combination of herbs or from a single herb. In this study most traditional healers combined their herbs.

Sofowora (2000) states that throughout the entire world, interest in medicinal plants has increased tremendously in the past decades. The untapped wealth of the plant kingdom has become a target for multinational drug companies and research institutes for new drugs and compounds. In addition western cultures have become increasingly interested in natural sources of drugs with the public at large acquiring herbal preparations from a plethora of various retail outlets. The trend now is to go back to nature for every cure and 80% of the population of the third world use traditional medicinal plants for their cure.

### **6. 2. 3 Defining the problem of collaboration with regard to hypertension and diabetes**

#### ***Introduction***

Barriers and enhancers for collaboration were identified in this study. The definition of collaboration was well explored by the traditional healers as well as the clients and western trained health care workers. They all agreed that collaboration could bring about positive consequences.

#### ***Collaboration***

##### ***a) Enhancers of Collaboration:***

The western trained health care, traditional healers and the clients suffering from diabetes and hypertension had similar descriptions of what they understood collaboration to be. Most of them stated that collaboration was necessary and important. People have to make informed choices about which type of care delivery they prefer. Although there is the western system of health care delivery, traditional healers promise greater cultural value for Swazi society. The concept of collaboration and how important it is in health care delivery as stated by these participants was very similar to what is going on at present, as most people believe in collaborative care or collaborative efforts even in the field of research. Collaborative models have been developed by authors like Henneman, et al (1995) and Langford, (1988). Henneman et al, (1995) had similar views to the findings about collaboration in this study when they stated that collaboration is sought after as a means to improve working relationships and patient outcomes. Collaborative effort in health care delivery should be patient centred.

The concepts of collaboration found in this study were not different from concepts found in existing literature. Collaboration has been used synonymously with cooperation. It is derived from the Latin word which means *working together* or *working jointly*. In this study the participants also had similar descriptions such as *working together*, *seeing one's idea together*, *connecting two things*, *managing illnesses together*, *going deeper in a relationship*, *helping one another*, *working hand in hand* and *coming together*. Henneman, et al (1995) went further in stating that collaboration is a process with the expressed goal of satisfying the patient's wellness and illness needs, while respecting the unique qualities and abilities of each professional. Collaboration is non-hierarchical in nature. It assumes power based on knowledge or expertise as opposed to power based on roles or functions. Phipps, et al (1995) introduced the notion of cross-checks in collaboration when they state the concept of collaboration as a framework in which each self care remedy is determined if it is detrimental and whether it will antagonize a patient's regimen. The participants had similar notions when they suggested that collaboration efforts would enable further research into traditional healer's practices and their medicines in a collaborative manner. Traditional healers stated with enthusiasm that they needed the western trained health care workers to visit their homesteads and assist them in terms of cleanliness and to see how they derived their medicines and treated their patients.

The initiative by the Swaziland Government through the University of Swaziland and the Ministry of Agriculture to establish a collaborative research centre for medicinal plants is in line with what the participants recommended as far as collaboration in research is concerned.



The participants in this study stated similar sentiments to those of Green and Makhubu (1983) in terms of collaboration versus integration. Hence it is more important to make a distinction between incorporation or integration and cooperation or collaboration. Cooperation or collaboration means better working relationships between the two health care sectors in which appropriate referrals between sectors become more routine, certain traditional healers' skills upgraded, and the cultural sensitivity of modern health care workers increased. It was felt by all participants that the element of divining and rituals might cause problems in terms of integration. The solution arrived at was that all the participants felt that collaboration or cooperation would better fit in both systems without interference of ancestors and Holy spirits, but both systems would collaborate in terms of client management which all traditional healers are doing.

There was strong emphasis on formal two-way referrals, since most traditional healers have experienced one sided referrals, whereby traditional healers would refer to western facilities and not the other way round. The one sided referral system was also mentioned by authors like Upvall (1992, p 33) who also had statements where nurses said “*if they refer patients to us, it is very good. Since there are some conditions they wouldn't treat and they should know them and refer patients to us*”. These statement had an underlying tone of some hierarchical notions seen in the western facilities where referrals would be from small hospitals or clinics to bigger hospitals or clinics as well as from general practitioners to specialist practitioners. Such hierarchical notions do not exist in collaboration. Trust is the gist of collaboration, hence the participants need to come to a level where they trust one another.

#### **b) The Barriers for Collaboration Between the two systems:**

Most of the participants in this study expressed some positive willingness for collaboration to take place and agreed that it was long overdue, but they noted certain barriers. This was also noted in Upvall's study where most nurses perceived collaboration positively, but implied certain barriers which if they can be dealt with, collaboration would be facilitated. Some authors referred to these barriers as differences between the traditional healers and the western health care workers which need to be tolerated by both in order for collaboration to take place ( Troskie, 1995).

Most of the differences discovered in this study, were also discovered by other authors. The major difference being that traditional healers are not a legal profession while the western trained health care practitioners are a legal profession. The fact that traditional healers are still classified under the Witchcraft Act of 1905 which dates back to Act 6/1889 prohibits the functions of traditional healers in Swaziland. Authors such as Stott and Browne (1973), Shai-Mohoko (1996) and Henneman (1995) state similar concepts as being barriers of collaboration such as the lack of a scientific body of knowledge of traditional healers, and the differences in historical background, socialization and philosophies between both systems.

Not only were traditional healers uncomfortable with this Act which was brought in by the Colonial Rule in 1889, but King Sobhuza 11 also expressed his concern in this regard. Infact the King was supportive of traditional healers and their practices as stated in the literature review ( Green & Makhubu, 1983).

It should be re-emphasized in terms of collaboration that the two medical systems are based on different philosophies, theories, histories and geographies, different aetiologies of disease, educational and training backgrounds, and diagnostic and treatment methods Hyma and Ramesh,

1994). Such differences would make it not easy for collaboration to take place in a simpler way.

The training of traditional healers was also perceived as informal since it was noted that there was no documented system of a formal educational structure applicable to all traditional healers, while that of the western trained health care professionals is considered formal. Shai-Mohoko (1996) in the Republic of South Africa observed that there were indications that the African indigenous healer has been rejected by South African medical practitioners who were trained according to the western models. The indigenous healer is often considered as a witch-doctor, a purveyor of superstitions and a medical hazard. Much of this became evident in 1994 during the processes of discussion forums for health policy formulation and reconstruction in the North West Province. Much as there are no similar documentation in Swaziland, most doctors in Swaziland were trained in the Republic of South Africa.

Although there is no formal structure, traditional healers do undergo some form of training and they do take care of patients. This was emphasized by some authors like Shai-Mohoko (1996) and Sofowora (2000) when they stated that there is evidence that 80% of patients visit traditional healers before they visit the hospital. Despite such evidence, there is still denial by the western trained health team that indigenous healers are involved in health care at the community level.

Both traditional healers and western trained health care workers showed that they had very little understanding of one another's categories. In most cases traditional healers equate themselves to the doctor category. They refer to nurses as assistants of doctors or another rank which you climb on your way to becoming a doctor. There is, thus, a lot of looking down upon one another. Traditional healers, since they perceive themselves as doctors, felt collaboration would be best

facilitated if they collaborate straight with doctors and not nurses.

The other major difference identified which hinder collaboration was the fact that traditional healers are private practitioners who expect direct payment for their services, whereas most western health care workers earn a salary. This difference agrees with the traditional healer's belief in cure versus control, since traditional healers expect to be paid a final payment for curing. They could not jeopardize their financial status by accepting that an illness may be impossible to cure, but can be controlled. So they must be seen to achieve a cure.

Although attention was focused on barriers between traditional healers and the western trained health care workers, in the process it was discovered that barriers between collaboration also existed among traditional healers themselves, and also among western trained health care professionals. Some authors like Henneman (1995) stated that nursing carries the blame for the lack of collaboration between the western trained health care professionals. The blame for nursing was based on the two philosophies of nursing, which Henneman (1995) identified as the logic positivism and paradigmaticism in nursing.

Traditional healers expressed awareness about the lack of collaboration among themselves.

#### **c) Strategies proposed for collaboration to be successful.**

In order for collaboration to be facilitated the participants were in line with Henneman (1995) when they proposed that there should be a regulatory body of traditional healers, formal referrals, change of attitudes, open communication and regular contacts as well as research on traditional healers and traditional medicines.

In this research, the strategy of formulating the constitution, council of traditional healers and an official office of traditional healers became the most important elements which were viewed as a vehicle for facilitating collaboration between two systems, as well as establishing some form of trust between them. The former strategy was looked at as a way of liberating all the traditional healers from the Witchcraft Act and empowering them.

The establishment of an office under the Ministry of Health and Social Welfare would enable traditional healers to come to a level where they understand the principles of Intellectual Property Rights (IPR). Mshana (2000) describes IPR as ownership rights over intellectual property which are exclusive rights granted by a state authority for a given period of time for certain products of intellectual effort and ingenuity. The rationale behind IPR is the desire to compensate an individual for time and expense spent in developing an invention. It does not in any way assure a return and all commercial rewards would accrue from commercial sales.

Traditional healers depend upon plants which grow in the wild for their supply of medicines. Hence those plants need to be conserved to avoid depletion. Conservation of traditional medicines and traditional healers practices would also be facilitated by the traditional healer's constitution. Hoft (2000) states that the success of an overall conservation strategy depends on how well it is integrated in policies made at both the international and national levels.

There were strong feelings about open communication through referrals, face to face interactions, workshops, seminars and conferences for the sharing of information and exchange of ideas. All the participants felt they were lacking some form of these processes. These processes were also viewed as being important for collaboration to take place. Most authors have similar notions that for

collaboration to take place there is need of an open system of communication. Kyle(1995) and Henneman(1995) also saw communication as the 'warp' and 'woof' of a healthy collaborative relationships. Change of attitudes towards one another would seem to be part of a positive communication system.

Research into traditional healers and their medicine or herbs was emphasized as a way of increasing understanding of traditional healers and building up a scientific base of knowledge of traditional medicine and traditional practice. Such research efforts could also analyze the measurements used by traditional healers in relation to documented measurements normally used in the western world. These traditional healer's measurements include the following ' hand,' 'finger', 'thumb', 'mouthful' and a one litre bottle.

The suggestion that traditional healers and their medicines should be further researched is echoed by moves in South Africa where some traditional plant research centres have been developed and in Swaziland where they are in a process of developing a multidisciplinary ethnobotanical research centre. The South African Traditional Research Group (SATMERG) has an important initiative of continually striving to add value to indigenous knowledge through scientific investigation of traditional medicines. It is hoped that an important and comparatively neglected research and public health field will be addressed. A comprehensive database of traditional medicines and their safety and rational use is being established and dialogue will be facilitated between traditional healers and western practitioners. The protection of indigenous knowledge, ethnopharmacology, involves the study of plant knowledge of ethnic communities and the utility of diverse plant life as a potential source of medicine ( Pefile & Folb , 2000).

The researcher was also, concurrently with this study, engaged in an ethnobotanical study with the aim of developing the Swaziland traditional healer's pharmacopeia. This pharmacopeia together with the proceedings of the Symposium on African Medicinal and Indigenous Food Plants and The Role of Traditional Medicine in Health Care are efforts which aimed at fostering collaboration among researchers in academic institutions and those in industries, with the traditional medicine practitioner ( Amusan, 2000). These are projects in line with the development of the Traditional Healers and Traditional Medicines Research Centre in Swaziland, where collaboration with traditional healers will be emphasized through working together in ethnobotanical research endeavour.

Sofowora (2000) mentions that the World Health Assembly (WHA) 40.33 of 1987 affirmed that a comprehensive approach to the study of medicinal plants in the health services is encouraged. Member states were urged to initiate comprehensive programmes for the identification, evaluation, preparation, cultivation and conservation of medicinal plants used in traditional medicines, and to ensure quality control of drugs derived from traditional plant remedies by using modern techniques and applying suitable standards and good manufacturing practices.

## **6.3 PHASE TWO, STRATEGY ONE: ESTABLISHMENT OF THE TRADITIONAL HEALERS' LEGAL STRUCTURE IN SWAZILAND**

### **6.3.1 Introduction:**

This strategy is intended to facilitate the development of the Constitution of the Council of Traditional Healers in Swaziland which comes with the establishment of an Office of Traditional Healers or Department of Traditional Healers, under the Ministry of Health and Social Welfare, and the establishment of the Council of Traditional Healers.

It has been envisaged that the strategy will be implemented after April, 2001, when the document will have been debated in Parliament and signed by the King.

### **6.3.2 Process**

Change is hard and slow. The researcher had this topic under discussion with all participants for a long time before they initiated any actions. It was not easy to push them since development of a constitution has to take a democratic stance so that the people can own and maintain whatever democratic decisions they make themselves. The traditional healers took full control and the researcher became a facilitator. All traditional healers became very enthusiastic about these developments. People who are involved in recognition of their needs are more likely to assist in identifying solutions to the problem. Similarly, those who are involved in the identification of potential solutions will be more willing to work towards implementing the solutions (Stevens, 1997).



The traditional healers underwent a process of self reflection or reflective thinking, while holding meetings about the issue of developing a constitution to facilitate collaboration. What resulted from this reflective thinking was self or personal transformation when they eventually took some actions ( Brown and Gillis, 1999). They also experienced some motivation through the realization that they were being empowered. Empowerment may be defined as an ability to self-direct, allowing people to take responsibility and authority for decisions that affect them. It permits speed in decision making, allows people to collaborate freely and promotes the cultivation of creativity, quality and true liberation of the human spirit, hence accelerated change and increasing complexity require an empowered workforce ( Trofino, 1995). Reflective thinking occurs through dialogue and discussions. This reflective thinking took place during the joint series of meetings for all the participants and those stakeholders who were contacted, such as the Director of Health Care Services, Vice Chancellor of the University of Swaziland, UNDP representatives and the Principal Secretary of the Ministry of Justice.

By engaging in developing the constitution, traditional healers were undergoing a process of personal transformation in terms of their training and education, and were also beginning to develop their own theory or scientific based knowledge. Throughout their practice and training, although it is systematic, there was no documentation or formal curriculum that all traditional healers follow. Their practice and training is not guided by any legal formality or rules. At this point they experienced some professional transformation in the fact that they were formalizing their own training and practice including the categories of their profession ( Wade, 1998).

### **6. 3. 3 Diagnosis of the problems that caused delays**

During the analysis of the process a number of problems which led to some delays were identified. Perhaps the major one was the traditional and cultural structure in Swaziland. Other significant pressures were lack of resources . Some delays were also brought by the notion of over ridden by the traditional healers organizational leaders on the issue of legalizing traditional healers with the exclusion of those who were not members of the traditional healers organizations, an undemocratic leadership, change of politicians due to reshuffling, lack of a systematic way of doing things ( proper plans and time frame) and the diversity of traditional healers categories with elements of looking down upon one another.

Most traditional healers expressed concern about the type of leadership. They have a type of autocratic leadership. They expressed that they needed a leadership that would be the transactional type, which some authors defined leadership as a style in which relationships with followers are based upon an exchange for some resources valued by the followers. Interaction between the leader and the followers is usually episodic, short-lived and limited to the exchange transaction ( Trofino, 1995).

They implied in their discussions that they would prefer a transformational leadership style in the organizations. This kind of leadership occurs when one or more persons engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality. Through the transforming process, the motives of the leader and the followers become identical. This relationship transforms both leader and follower to the desired level of human conduct and ethical aspiration ( Trofino, 1995)

The cultural structure and practice under the constituency ( *Tinkhundla*) systems delays a lot of progress in that it becomes a very slow process to have any meeting with anyone. A constituency in Swaziland normally has several chiefs who never cross each other's boundaries. If there is an issue for discussion you have to have permission from all these chiefs. By the time they give permission the time has passed for whatever you wanted to implement. You may find that you have to go to one chief more than three times before you are allowed to meet his people. Most traditional healers respect their chiefs, since they are culturally valued, and healers have to pay fines if they show no respect.

Culturally, Swazis by nature are slow in acting and this has affected their economy as well as social proceedings. They take time to make decisions since they all fear to make one in case another person does not agree. Culture is "the mediation that appears to 'rob man' of his nature and locate his action under practices within an endowment of socially produced symbolic forms" ( Earle, 1991, p. 6). Traditional healers are not immune to the cultural practices of the Swazis. The Chiefs are viewed as people who have to see to it that all society abides by the recommended cultural aspects which are learned, but never formally taught, from generation to generation. Dawes (1986) states that culture is an important factor in communication. Culture is like a security blanked and thus it cannot be discarded easily.

Swaziland is not a rich country. It is still a developing country with scarce resources. The traditional healers are people living in Swaziland who are also hard hit by the socio-economic status of the country. The lack of resources led to delays and poor attendance at some of the meetings. The socio-economic indicators in Swaziland are as follows: Total population in 1997 was recorded at 978238 in a country which is about 17,000 sq km. The population growth in 1992

was recorded at 3.4. The crude birthrate 1996 recorded at 42.8. The crude death rate 1996 recorded at 10.1. Infant mortality in 1992 was 98 and the under five mortality rate in 1992 was 141. Maternal mortality rate in 1993 was 110. The life expectancy in 1992 was 57. The total fertility in 1991 was 5.6. Contraceptive prevalence rate in 1990 was 16 %. The adolescents per total population in 1996 was 24.6. The GNP per capita in 1995 was 2, 880. The GNP growth rate in 1986-91 was 4.6 % and the inflation rate in 1992 was 11%. ( Swaziland National Statistics, 1998).

#### **6. 3. 4 Action Plans**

Despite all these problems, the participants through being motivated tried to engage in action plans to have their constitution developed. They bypassed some of the cultural systemic communication channels by using the health care centres as venues, instead of *Tinkhundla* (constituency). Regular meetings were conducted and action plans for further activities developed each time there was a meeting, and these meetings and the traditional healers rotated from one place to the other.

Principles of a community development theory were employed in the process of developing action plans. Community development is a process of working in collaboration with community members to assess the collective need and desires for a healthful change and to address these priority needs through problem solving. All the participants have entered a process of solving problems identified by themselves for their own healthful change. Traditional healers and western trained health care workers by engaging in these activities, showed a willingness to improve their quality of care. The clients would benefit from this collaboration in care given by both as far as management of illnesses is concerned. A community development process implies that community members participate in assessment, planning, development, and delivery of services. Health must be

generated from within the community through working in partnership with its people. Through empowerment, individuals and communities are enabled to effectively control and participate in transforming their lives and environment ( Glick, Hale, Kulbok, & Shetting, 1996).

In applying the community development theory, the change agent is regarded as a partner, rather than an authority who is responsible for improving community members' health. To achieve this, the nurse assumes the role of learner and gleans information from the community members about their specific perceived health needs, as well as their culture, mores and values. The researcher in this process has been regarded as a partner( Glick, et al. , 1996).

The researcher learned a lot about the culture of the people in the rural community. The way interactions occurred between health care worker, traditional healers and clients was fascinating to learn. The process of chieftdoms and respect paid to the chiefs was also something very interesting. The traditional healers had a nickname *vuka* ( a name given to some of their plant which is used with other medicines to stimulate those medicines to function at a higher level) which literally meant a catalyst. The nurses told the researcher how to dress when coming to this community. These were but a few of the ways which showed that the community was in control of this whole developmental process.

### **6. 3. 5 Progress**

The action plans were implemented by the participants through a series of meetings at which they developed the content of the constitution. They also applied principles of lobbying when contacting the members of parliament, international organizations such as UNDP and WHO, and other key people to assist them in the development of the constitution. Development of this constitution has

been viewed by the traditional healers as a way of promoting their occupation. Concerning the reasons for development of this constitution, they had views similar to that of Uys (2000) in her discussions of a regulating body for nurses. Uys (2000) states that the reasons for developing the Regulatory Body for Nursing and Midwifery is to ensure that there is control of entry into the occupation, control of quality of education, that nurses should practice ethically, continuously updating knowledge and skills as well as keeping and disseminating reliable information about nursing and midwifery. The process taken by traditional healers is also similar to that stated by Uys, in that they are presently trying to obtain sufficient consensus amongst all traditional healers, sufficient support from politicians and the Ministries of Natural Resources, Agriculture, Justice and Health.

The traditional healers already have plans and target dates as to when the draft will be discussed before being handed over to government to be launched in parliament. Through the development of the constitution, the logistics of setting up the regulatory body have been thoroughly discussed.

The progress is still ongoing and they are still at a level where all traditional healers are being involved in the whole process. This has been seen as a way of facilitating collaboration through empowering the traditional healers. This constitution would be a way of defining the professionalism of traditional healers in Swaziland as well as developing a discipline of traditional healers. Grossman and Hooton (1993) state that the aim of a discipline is to specify its proper place in society and define the parameters of knowledge required for its practice. Therefore, it must explicate its historical, social, philosophic and learning traditions in order to understand its connectedness to others in the field of epistemology, and to prove a meaningful context of its methods of enquiry and its content areas of practice.

## **6. 4     STRATEGY TWO: ESTABLISHMENT OF THE EFFICACY AND SAFETY OF TRADITIONAL MEDICINES**

### **6. 4. 1 Introduction**

The researcher did not come across any literature which dealt with the efficacy and safety of traditional medicines. There was some literature on traditional pharmacopeia and the analysis of some traditional medicines but few of these mentioned traditional healers control of hypertension. As a result a lot of information about this strategy will be covered under Recommendations.

It was difficult to establish the safety seeing that the period was so short and the sample of clients was very small. The researcher did not have any instruments nor a laboratory nor the know-how to find out the safety of traditional medicines. Though it was stated that there was some element of safety with traditional herbs, it is known that all medicines, irrespective of whether they are traditional or western, do have some side effects as well as contra-indications.

The traditional healers' herbal mixture was proven to be effective as it has been stated that in those clients who were found to have high blood pressure levels their symptoms improved after using the herbal mixture and their levels of blood pressure were reduced from high to a lower level. Although not necessarily reaching the recommended averages of hypertension. This was also seen with the clients who utilized western medicines only. Although the differences in the levels of hypertension were not conclusive, the similarities in fluctuations of the levels of blood pressure at each visit showed that both medicines do control hypertension to some extent.

#### **6. 4. 2 Comparison of similarities and differences in signs and symptoms**

All the clients had similar signs and symptoms which led them to seek help as well as signs and symptoms which made them note whenever the blood pressure was high. Common signs and symptoms were severe headaches, palpitations, weakness, tiredness and nose bleed. Differences were that in addition the clients using traditional medicines only reported that they also had chest pains, hot flushes, swelling and joint pains, while the ones who used only western medicines reported in addition that they felt tinnitus and blocked ears. Some of them did not feel any symptoms, but were told by nurses that their blood pressure was low or high. Hypertension has been called the silent disease or silent killer because clients are often asymptomatic until a cerebrovascular accident, myocardial infarction, renal failure or sudden death occurs. Persistent uncontrolled hypertension whether mild, moderate or severe causes some degree of organ damage to the heart, brain and kidneys (Kneisl and Ames, 1986).

Documented symptoms of hypertension include dizziness, palpitations, chest pains, weakness, epistaxis, haematuria, and brief episodes of memory loss (transient ischaemic attacks) and, less frequently, severe hypertension may cause occipital headaches that are present when the client awakes in the morning and subside spontaneously within hours. Most clients did not experience any symptoms (Kneisl & Ames, 1986 and Phipps. Et al, 1995). These symptoms are similar to what the clients using traditional medicines and those using western medicines mentioned. They did not mention any haematuria nor any signs of transient ischaemic attacks.

In terms of diagnosis it was noted that traditional healers did not have instruments and the know-how to diagnose, hence they relied on diagnosis by western trained health care personnel. On a positive note, they made a strategy that while clients are receiving traditional herbs, the



traditional healers would encourage them to visit the clinics, so that they could have their blood pressure levels checked on a regular basis like the ones who used western medicines. This would help in the reliance on removal of signs and symptoms only. To ensure accurate measurements, the equipment ( cuff and sphygmomanometer ), environment and the client's state of physical and psychological state must be optimal ( Kneisl and Ames, 1986).

#### **6. 4. 3 The management of hypertension**

Management normally involves nonpharmacological and pharmacological therapies. The traditional healers only used pharmacological therapies since they gave their herbal mixtures without any emphasis on nonpharmacological aspects. Nonpharmacological therapy includes weight reduction, dietary sodium restriction, moderation of alcohol intake, regular exercise, smoking cessation, stress reduction and serum cholesterol reduction if needed ( Phipps et al, 1995). Although the traditional healers did not include nonpharmacological management, the western trained health care workers only advised clients about diet. The management of the psychological part of the clients and application of rituals by traditional healers could be stated as forms of nonpharmacological interventions.

In the use of pharmacological therapies, there seemed to be one drug of choice utilized for hypertension. This drug was given almost to all clients, irrespective of whether the blood pressure was high or low. The drug was Aldomet (methyldopa). Clients were given medications on the first reading of raised blood pressure where as most authors state that they should start to receive therapy after a proper establishment of essential hypertension which is established after two or more blood pressure readings showing a diastolic pressure greater than 90mmHg or a systolic pressure greater than 160mmHg, in three successive visits. The western trained health care

workers utilized mainly Aldomet ( methyldopa) and diuretics( hydrochlorothiazides) with slow K ( potassium) for all the patients. The reason for giving all the patients these drugs may have been that methyldopa can be used for all degrees of hypertension and the diuretic potentiates the effects of methyldopa and assists in reducing fluid retention, thereby decreasing hypertension. The slow K is a potassium which has to replace the potassium lost with the diuretics, unless potassium sparing diuretics like aldactone are used (Sheridan, et al, 1985 & Phipps, et al 1995).

The western trained health care workers did not follow the recommended hypertensive stepped care. The stepped care is as follows:

- a) **Step one:** On initial diagnosis of an elevated blood pressure, the patient should be put on completely nonpharmacological care. If they still come back with an elevated blood pressure, when it is mild, some diuretic will be prescribed. If the diastolic pressure remains above normal >90 mm Hg. treatment will advance to step two.
- b) **Step two:** It is whereby adrenergic blockers, to name a few, methyldopa, clonidine, atenolol, prozasin, captopril and nifedipine can be utilized.
- c) **Step three:** It is used when a combination of step one with step two drugs do not achieve any blood pressure control. The medication in step three is vasodilators such as hydralazine and minoxidil.
- d) **Step four:** Is entered when there is severe hypertension which is difficult to control. At this stage, a step two agent is substituted and guanethidine is often used. This approach in prescribing one drug could also depend upon what was on tender by the Government ( Phipps, et al , 1995).

Manship (1994) mentions that there is reluctance to treat the elderly patient who is more than 65 years old due to lack of research in hypertensive clients above this age. In elderly hypertensive clients above 65 years old it was concluded that diuretics rather than beta blockers are now considered to be the mainstay of treatment. In the past beta blockers were extensively being used. This was the case in this study when it came to the western health care facilities or western medicines, in which the beta blockers were used even for elderly patients above 65 years old.

It was discovered that the combination of drugs used by the traditional healers had some similarities as has been mentioned. It is not known whether some of these drugs are diuretics or are purely anti-hypertensive drugs. No one knows whether they are also adrenergic inhibitors, vasodilators or peripheral adrenergic antagonists (Sheridane, et al, 1985). The use of aloe is very widely spread in the management of diabetes. At least the aloe has been analyzed and proven by certain authors to have anti-diabetic properties. Gundidza and Chinyangaya (2000) also conducted studies by studying combination of plants for diabetes and hypertension as well as other illnesses. In this study, the traditional healers also utilized the aloe as one of the combinations of plants.

For both types of medicines, traditional or western, all depends on the client's adherence to the treatment regime. In the western trained facilities, the continuous measuring of blood pressure is seen as a way of evaluating whether clients are adhering to the regimen. It has been documented that adherence is very difficult, since the nonpharmacological treatment requires some life style changes and the pharmacological drugs come with side effects and have to be taken daily for the rest of the client's lives. Also contributing to poor compliancy is the asymptomatic nature of the illnesses, hypertension and diabetes type 11. In this study most clients had type 1 diabetes which is diabetes mellitus. This is in line with what most clients stated and how they viewed

hypertension. They mostly stated that hypertension was not the major problem. One wonders as to whether they were taking the medications for hypertension diligently, if they viewed it as not being a problem. The illness which was viewed as a problem was diabetes.

Hypertension affects human beings, whom it is very hard to study under controlled circumstances. Human beings have to comply or adhere to their own treatment regimes. It is difficult to follow them at their homes and see what exactly it is that they are doing. For clients to comply they need to believe that they have a diagnosed illness and that the illness is harmful, the prescribed treatment will help and the benefits of the treatment outweigh the disadvantages. Many clients see the physician and have their problems diagnosed, but do not adhere to the therapeutic regimen. The reasons are many and varied, some are intentional and others are unintentional. Predicting the noncompliant patient is not easy since every person is a potential defaulter. Patients with chronic illnesses like hypertension and tuberculosis may become discouraged with extensive therapy that does not produce immediate recognizable results ( Sheridan, et al, 1985).

Much as client compliancy is difficult to establish, such studies are valuable in giving some idea of how medicines work and how effective they can be. There is a need for extensive education so that clients reach an acceptable level of compliancy. This would also help the traditional healers to educate the clients on change of life styles which was an element lacking in their management of this illness..

#### 6. 4. 4 Strategies chosen in this study

This study enlightened the participants that traditional medicines do have some positive effects in terms of bringing down the levels of hypertension. The western trained health care workers got feedback on how they themselves manage hypertension. They stated that they would improve where they have been found to be lacking. What was positive was that there was a willingness to work hand in hand or collaborate with one another.

The strategy whereby traditional healers accepted that they would educate their clients to utilize the herbs continuously, whether they felt well or ill was a very good one, since it was noted that those clients who used herbal mixtures, did so only when they felt ill.

The process of collaboration in this study was summarized as follows:

#### 6. 4. 5 Summary of the identified traditional collaborative model

<u>Defining attributes</u>	<u>barriers</u>	<u>strategies</u>	<u>consequences</u>
working together sharing ideas connecting two things deeper relationships helping one another working hand in hand coming together seeing one's idea together	Naming of illnesses Ethical differences Difference in education/training Lack of transparency different perspectives about illnesses Doubt about safety and efficacy of traditional medicines	Legalization of traditional healers Two-way comm. Exchange of information Research on traditional medicines	Formal control of traditional healers Improved quality care of clients Increased scientific body of traditional healers & medicines Empowerment of Traditional healers Informed choices Facilitated.

#### 6. 4. 6 Comparing the Traditional Collaborative Model to the Modern One

##### *Similarities*

i) Both models are still theoretical. Henneman et al (1995) stated that collaboration has not been well studied, hence its consequences are primarily theoretical.

ii) The defining attributes are also similar in that the traditional model have attributes like '*working together*', '*sharing ideas*', '*seeing one's idea together*', '*connecting two things*', '*working hand in hand*' and '*coming together*'. These attributes have similar applications to the model collaborative attributes which are '*joint venture*', '*cooperative endeavour*', '*willing participants*', '*shared planning*', '*shared responsibility*' and '*non-hierarchical relationship*'.

All these attributes apply concepts like sharing, joint decision making and open communication as well as equability of members in the collaborative venture.

iii) Though most concepts under antecedents or strategies are not similar, they all have a two-way communication, conducive environment and good leadership styles.

iv) Some concepts under consequences are also similar. The traditional model stated consequences such as improved patient quality of care and informed choices, while the modern model stated concepts like improved productivity and patient outcome. The traditional model stated that traditional healers would be empowered, while the modern model stated that there would be reinforcement of confidence, self worth and importance of all participants.

##### *Differences*

The traditional model came up with barriers of collaboration while the modern model did not explicitly address barriers, but they were implied under the antecedents. The traditional model did not address any empirical reference, while the model did.

## **6. 5    RECOMMENDATIONS**

### **6. 5. 1 Further research**

From this study and other studies it is clear that research on traditional medicines and traditional healers, especially in relation to illnesses traditional healers are managing, need to be conducted in order to have a reasonable scientific body of knowledge. The interest that has been regained by researchers, as well as efforts that have been established by countries in Africa to develop research centres for ethnobotany and medicinal plants at higher levels should be supported by all government and non-governmental organizations. There is also a need for studies where the researcher becomes part of the community and does collaborative research with the traditional healers through building trusting relationships. In this way the traditional healers would be in a position to feel that they are part of the research process.

The research done on traditional healers and their medicines should aim at making sure that the traditional healers benefit. Once some healers see tangible benefits, it will be easier for others to participate. Such research could be geared to educating them about certain western care skills, educating them on how to identify and analyze their own medicines and know the active principles, the potentials of having their medicines patented while safeguarding their property rights, conserving and planting their own medicinal plants so that they cannot lose them to economic development of agricultural pursuits such as sugar cane growing or cotton growing.

Other studies could also involve in-depth studies of patients using traditional medicines who could be followed up to establish the therapeutic as well as non-therapeutic properties of the drugs used. Collaborative research could include all sectors such as educational institutions, natural resources,

agriculture, health, economics, justice and Home Affairs. The study of systemic ways of education or training of traditional healers according to categories and their practice would be of value.

The research analysis of plant constituents with the formulation of a traditional medicines pharmacopeia should continue in all the countries the Organization of African Unity has targeted. The building of ethnobotanical and medicinal plant research centres could be a base for all sorts of collaborative research efforts. Apart from increasing the scientific body of knowledge, the traditional ways of traditional healers could also be preserved, which otherwise might be lost on the way as development takes place in many countries. Mshana (2000) states that in order to preserve traditional knowledge, all stakeholders (the scientific community, governments, business and the general public) should have a new commitment and a determined concrete plan of action to ensure that traditional knowledge continues to provide services that address the needs and aspirations of the people. Such traditional knowledge should concern traditional medicines and indigenous food crops.

Similarly, some authors have suggested that research efforts concerning medicinal plants in Africa should be carried out in a collaborating manner focusing on the following categories: ethnobotanical surveys, phytochemical and biological screening of the plants, collaboration in research and development ( R & D), Inter-African cooperation, trade in and cultivation of medicinal plants, prospects, problems and constraints with respect to industrial utilization of African plants, processing of medicinal plants in Africa and the protection of intellectual rights in Africa ( (Sofowora, 2000).



The area which most urgently needs collaborative research with the traditional healer's involvement is in the traditional medicines that are said to treat symptoms of HIV/AIDS. This illness is causing a lot of socio-economic and development problems in every country.

#### **6. 5. 2 Formal education of traditional healers**

Traditional healers have vast knowledge and systematic ways in their own practice which are not documented since most traditional healers are illiterate. Because they claim that ancestors make them withdraw from formal schools, traditional healers should be encouraged to obtain their formal education when they have finished their training to become a traditional healer. This type of education can broaden their minds and their practices, since they would be able to read and write and hence implement strategies acceptable to the civilized society. They would then be in a position to participate in the formalization of their training and practice, as well as in conducting research and being able to document traditional medicines. This documentation is being done at present by a cadre that does not belong to the traditional healers and hence some of the information from traditional healers might be distorted and it might not be complete, since traditional healers fear that the so called 'educated' might steal their knowledge.

Formal education of traditional healers could enhance a healthy collaborative process, and traditional healers could be in a position to make themselves professionals. Professional respect would enhance the relationship between traditional healers and western health care workers. Stott and Browne (1973) states that the medical profession had little in common with the 'witchdoctor' and that their relationship was one of tolerance more than of professional respect. Traditional healers need to be formally educated in the process of collaboration which would also enable them to collaborate amongst themselves.

Stott and Browne ( 1973) also recognized the need for traditional healers to be trained so that they would have a systematic process in term of clinical diagnosis as well as in practice. The traditional healers' training that exists at present for all the different categories needs to be documented to identify similarities and differences so that it will be possible to concentrate on strengths rather than weaknesses. This identification could form the base for future training and education of traditional healers.

Hyma and Ramesh (1994) stated that modern technology and science had been applied to the Chinese traditional system of health care delivery, and that the Chinese government intended to develop legislation to promote further collaboration at all levels of the health system and in all its functions: health care delivery, research, education, training and in standardization and quality control of traditional remedies. There was also strong financial support for these traditional remedies. Most African countries, especially Swaziland, can learn from the Chinese development of their traditional medicines to the level of acceptance where it is at present.

#### **6. 5. 3 Incorporation of western and traditional health in the training of traditional healers and western trained health care workers**

For collaboration to take place successfully, the western trained health care workers should start to be oriented on this collaboration while in training. The curriculum of this cadre should include courses that address and equip students with collaborative efforts, especially with traditional healers. Good (1988) stated similar recommendations about the curriculum of the western trained personnel. Some of the traditional healers who are themselves educated could be utilized to be part of the curriculum reviews and as educators on issues about traditional healers and traditional medicines.

The traditional healers themselves should work on a system where their training is formalized for the different categories. Once they have a formalized well documented system of training, the collaboration process should become part of the contents. They should also learn principles of western health care systems, so that they could be in the same levels of understanding as to what exactly these western trained personnel do when they manage illnesses. They could then see how they differ and where and how they could collaborate.

One of the western trained health care workers said “*it is due to our orientation during training that we miss the learning about traditional healers and their medicines. Much as we know as Africans that they do work, our training and education need to reorient us so that we can incorporate it in our daily practice without any untoward stigma attached to it.*”

#### **6. 5. 4 Health Education Programmes**

The majority of Africans do consult traditional healers, but they are still afraid of most of the traditional healers and do not know what exactly they do and how important they are in society. There is a strong need to have open educational forums about traditional healers and their medicines. This could be made through workshops, seminars and conferences organized jointly by western and traditional healers in order to make sure the public accepts and feels free with traditional healers. Health educational programmes in the media concerning traditional healers and run by traditional healers, should be put in place. It was very interesting to see clients freely stating their views in the meetings where traditional healers and western trained healthcare personnel were present.

One traditional healer showed concern about the misuse of the plant called an African potato. This traditional healer stated that she felt the public should know that this plant should not be used alone

since it can drain the kidneys seeing that it produces some diuretic effect. Secondly the public was using it without boiling it, and she felt they were not destroying its poison. Her concern was she could not tell the public since she did not have any forum with the media and she was not allowed to say anything on the radio.

#### **6. 5. 5 Dual, traditional and western health care systems being officiated**

Multiple systems of health care delivery and medicine which may be traditional, western or folk can give multiple choices to individuals. Much as the people utilize both systems, the traditional health care delivery system is not official in the sense that traditional healers are not recognized legally, only informally. In the discussions, most clients stated that those clients who have visited traditional healers have suffered at the hands of the western trained health care workers because traditional medicines is not recognized officially. Governments, especially the Ministry of Health and Social Welfare, should recognize traditional healers and support them in their efforts to legitimize themselves.

The stand which has been taken by the Swaziland traditional healers to formulate their constitution of a Council of Traditional Healers and to establish themselves within the Ministry of Health and Social Welfare, need to be fully supported. Hyma and Ramesh (1994) also recommend that medical pluralism can denote the coexistence of multiple systems and give individuals choices. This pluralism could allow these individuals access to various levels and types of care. They further state that the Chinese experience of combining two vastly different systems of medicine to obtain comprehensive health coverage for its population is widely admired. The skillful intertwining of traditional healing practices with contemporary medicine has been most successful in solving the ever present health care needs in China (Liu, 1984).

### **6. 5. 6 Projects and studies to facilitate the chosen strategies of collaboration**

Apart from the strategies chosen or recommended, there is still a lot to be done before a full fledged collaborative effort can be realized, and its outcomes, can be achieved which is improved patient care in both systems. An evaluative process of the strategies chosen can be done to find out whether they are being implemented or not. Since this study was conducted in two health care centres, these strategies could be implemented and evaluated in other areas, not necessarily only in Swaziland.

Further in depth research could be done concerning the efficacy of traditional medicines and their safety with treating illnesses in order to facilitate collaboration. Action participatory research would be ideal with all the principles of community development process in order to equip and make traditional healers able to sustain and maintain any developments through being fully involved.

The laboratories could be utilized to analyze constituents of plants said to treat illnesses such as HIV/AIDS, Mental illnesses, family planning , asthma medicines, arthritis and many more chosen by researchers. From this study it was realized that the sample was small and the follow up period was too short to cater for other extenuating factors, the human elements of self administartion of other alternative medicines, such from the allopathy. Studies like this could take longer periods, than the one taken in this study, doing follow up care and analysis of the medicines in order to come up with concrete and conclusive results.

Other projects that could be implemented would include studies that aim to empower the elderly population of Swaziland who are the hardest hit by chronic illnesses without any socio-economic

support from the government. One of the projects could look into the fact that elderly clients have to pay for services each time they attend clinics while they are considered dependants at the ages of 60 and over.

These elderly clients become regulars of the hospital or clinic since they have to come once every month. They are still faced with the same situations where they have to pay fees and que up for measurements of their blood pressure or diabetes as well as collecting their medicines. This effort could be strenuous and could lead to non-adherence to the treatment regime. So projects and research on the needs of the elderly should be done to look into the welfare and improvement of health care services for this cadre for whom the hospitals become their second homes. For instance Manship (1994) mentions that there has been little medical research carried out on the clinical implications of treating hypertension in the elderly, from 65 years old and above. So projects like support groups could be implemented and evaluated.

The issue of collaboration versus integration of traditional healers into the western health care system should be examined. A few of the traditional healers think integration would help to bring them to a level equal to that of the western doctors, while the majority strongly preferred collaboration. On the same view Hyma and Ramesh (1994) questioned the relationship in the integration model, as to whether it would be one where traditional healers played a complementary, supplementary or subordinate role, or a co-operative and mutually supportive role?

## 6.6 CONCLUSION

From the introduction and the literature review throughout the process of this study, the importance and significance of this study was brought to light. From the time WHO called upon all nations to recognize and legalize the practice of traditional healers in 1977, through the periods when the WHO and O. A. U. made efforts to encourage, through research, technical and resource support, the recognition of traditional healers and traditional medicines, it has been noted how important traditional medicine is to the more than 80% of the population who visit and utilize traditional healers, especially in Africa. The resurgence of research into traditional medicines and traditional healers by individuals and organizations in many countries proves the significance of considering and recognizing traditional healers and their practice.

This study's focus was the analysis of the process of facilitating collaboration. The participants identified barriers to collaboration. These differences brought the participants to a level where they felt they needed to collaborate. They have to acknowledge these differences in order for collaboration to take place. These difference brought an understanding of the roles of traditional healers in the community, which are different from the roles of the western trained health care personnel. Troskie (1995), in agreement with the views about barriers to collaboration, states that unless the western health care systems acknowledge the reality of the differences between the two spiritual worlds in the Republic of South Africa, the western trained health care workers will not be able to develop skills to collaborate with traditional healers in the primary health care services. To address this issue of differences or barriers the western health care system is challenged to build a relationship without expecting everyone to be the same. There should be an attitude of tolerance and accept that once the traditional African way of thinking is different from that of the West.

Despite these differences, all parties involved should realize that there are both good and bad characteristics in both worlds.

The participants in this study also positively stated enhancers of collaboration which were considered as similarities between the traditional healers and the western trained health care workers. These included the definitions of collaboration, importance of collaboration and the consequences of collaboration. They then came up with strategies of collaboration. These strategies could be divided into two categories as follows:

*a) The establishment of the regulatory body for the council and the establishment of a department of traditional healers within the Ministry of Health and Social Welfare*

The establishment of the regulatory body which utilized principles of a development theory, form the base for all strategies. This strategy showed that the internal structure of traditional healers had problems. Their structure is inherent in the rural setup of the community. The structure had problems because of the lack of an organized methodology of practice without any formal structure or legal structure. Success of the other strategies, which are discussed below, is based on the legalization of traditional healers.

What was noted in this study was that the process of establishing formal legal structures of the traditional healers could not occur unless there were external factors in place. The principles of community development implied that community members participate in assessing, planning, development and delivery of services and that this should be generated within the community through working partnerships (Glick, et al 1996). Because the fundamental problem of the lack of a methodology of traditional healers is structural and rooted within society at a national and not



merely at a local level in the rural community, solutions must also be at a national level, hence there was a need to have some external forces, such as the involvement of the Ministries of Health and Social Welfare, Justice, Agriculture and Natural Resources, The University of Swaziland and organizations like WHO and UNDP, as well as the researcher. The community development theory advocates the intervention of a facilitator to bring about any developments in a community.

In this strategy the participants, especially the traditional healers themselves, participated with the assistance of the facilitator in identification and interpretation of the problems, needs and opportunities to form their own choice of action. They needed technical knowledge and other resources like funds and materials in order to facilitate this strategy of legalizing and having a structural methodology for their own training and practice.

This was done so that they could work towards the proper development of their own unique discipline in the long run. This development towards a known discipline is in agreement with Somjee (1991, p.2) who states that the manner in which various disciplines developed, and have been fortified by their corpus of theoretical knowledge, allows us to zero in on common or related problems of development only as specific branches view them. Under such constraints, development problems are not allowed to be viewed as problems belonging to phenomena of their own, but as part of the territory to which specific disciplines have extended. Consequently, in what we come to know about development, the disciplinary dimension, with its limitations, is a major factor. This was the development process for the traditional healers so that they could have a structural frame of reference for the other strategies to be able to function successfully in a methodological fashion.

***b) The other strategies recommended by all participants in the study***

The process of the other strategies could take place without external factors or influences. The strategies are the ones recommended as follows by western trained health care workers, clients and traditional healers being formal referrals, change of attitudes, open communication and regular contacts with exchange of information for practice and skills and research endeavours on traditional healers and traditional medicines. All these strategies are mainly interpersonal and they could be successful if the above strategy of establishing formal structures of traditional healers was in place. To achieve this, internal forces or motivation of the traditional healers and the western trained health care workers are needed. Once the legal structure is well established, these strategies will be the processes taking place under that structure.

These strategies ( formal referrals, change of attitudes, open communication and regular, contacts, and research endeavours) have principles of socialization and personal change. Both socialization and personal change involve learning the content of the professional role and the values, attitudes and goals of the profession are integrated into the person. While participants of this study interacted and exchanged ideas and views, socialization into the principles of collaboration took place in an internal manner as well as in an interpersonal manner. These strategies were stated as anticipatory experiences which had to bring about personal changes ( Buckenham, 1998). The process of personal transformation described by Wade ( 1998) took place as interactions occurred towards the realization that collaboration was necessary, and actions were taken to facilitate collaboration.

The research process provided opportunities for such reflective and critical thinking to take place by allowing these participants to be part of this research enquiry and action science. The results

have been that actions were taken to develop plans and implement some of these strategies such as holding meetings on a regular basis, developing the legal body of traditional healers, some change of attitudes towards one another and the research on efficacy and safety of traditional medicines. The process is still continuing to put in place the legal structure of the traditional healers.

*Lastly, the whole process of facilitating collaboration between the traditional healers and the western trained health care personnel achieved the following:*

- a) Identification of barriers and enhancers for collaboration
- b) The categories of traditional healers were established
- c) Strategies were established to accomplish a successful collaborative process between the two systems.
- d) The management of diabetes and hypertension was analyzed for both traditional healers and the western trained health care workers
- e) Involvement of the clients in the whole process was well established, and the close contact of the western trained health care workers and the traditional healers brought exchange of ideas and better understanding through the meetings.
- f) A small survey of the efficacy of traditional medicines brought into light the fact that, there are clients who utilized only traditional medicines in Swaziland for the management of hypertension and that some of them do combine the two types of medicines. The groups of plants used by traditional healers were also identified. Some efficacy of traditional medicines in the management of hypertension was verified.
- g) The strategy of legalizing traditional healers in Swaziland brought the initiative of implementing the process of a constitution development by the traditional healers themselves for themselves.

h) A traditional collaborative model was identified which was compared with an existing western style of a collaborative model.

The researcher also underwent a lot of limitations in terms of situations, finance and other resources. Dealing with the rural communities was hard. They have their own time frame, cultural norms and values. Patience and perseverance were necessary when it came to holding meetings and explaining certain issues. Strategies which needed joint development were delayed since participants would not all participate at the same time.

The researcher gained a lot of experience in working with the communities through the process of facilitating collaboration and through the information gained about traditional healers' profile, the treatment of hypertension and diabetes by the western trained and traditional healers, strategies developed and mostly the willingness and motivation of all the participants in this process throughout the study and beyond. The involvement of the clients in the whole process was an additional experience where clients gave a lot of information and strategies on how they viewed collaboration between the two systems for their own benefit.

This study provided the researcher with further knowledge about attitudes and skills in facilitating discussions in meetings between traditional healers and the western health care personnel. The researcher gained skills in organizing and facilitating during implementation of these projects, through holding several meetings. The researcher also acted as a facilitator when it came to the development of the constitution. As the development of the constitution, establishment of an office and Council of traditional healers is a long process, the researcher pledged to continue with the traditional healers in this process until the end. She will then compile an additional report, even

after the completion of this research. It is hoped that such information will be utilized by the health services areas of the traditional healers and the western trained personnel as well as the health educational institutions.

The collaborative process involved considerable financial resources and the study required such other support as transport, venues, instruments for collecting data as well as some incentives for participants. The researcher organized with the nursing sisters to use the common rooms of the health care centres for the focussed group sessions and the meetings. Transport, meetings proceedings and honoraria for the research assistants were arranged through sponsorship by the Research Board of the University of Swaziland. Though a budget proposal was written to seek financial help from organizations such as WHO, U. N. D. P. and O. A. U. as well as the Ministry of Health in Swaziland, the appeal was not successful. The University of Swaziland funded the research data collection, but financial support could not cover the whole study. The issue of developing a constitution, establishing the office and council of traditional healers takes time to be finalized, and require major financial and technical support.

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## GLOSSARY

Lilangeni ( singular)/Emalangeni (plural) of Swaziland:      Equivalent to One Rand of South Africa and to about 7 US Dollars.

### Vernacular Terms

### English Translations

iSangoma/isanusi

Diviner

Umfembi

Sangoma used as medium for evil spirits that bewitched someone.

Inyanga

Traditional healer

Lugedla

Herbalist

Kubhula

Communication through a trance with supernatural powers who reveal to the diviner a source of the patients problem. Makhubu (1978)

Kwetfwasa

Training process of a sangoma or umfembi, ancestors manifest their presence in the subject who will eventually become a traditional healer. Ancestral spirit possession. Makhubu (1978) and Wessels (1985)

Gobela

Traditional healer specialist and a trainer who has been long in the field with more experience ( Hall, 1998).

Emadloti/Amadlozi	Ancestors ( Makhubu, 1978)
Umtsakatsi	Evil doer/witch doctor ( Gumede, 1990)
Kufemba	Rituals made by the umfembi ( Hall, 1998)
Amandiki	Caused by wandering spirit of a deceased male from a Northern country who died away from home ( Wessels, 1985).
Amandawe	Diagnosticians ( Gumede, 1990) Diviners
Mhondoro	Shona word for those who are down underground ( Gumede (1990).

## **NAMES OF MEDICINES AND INDIGENOUS FOOD USED BY CLIENTS/ TRADITIONAL HEALERS**

### **Vernacular names**

### **Botanical Names**

Ingwavuma	Tranvaalensis/amoana (Gardenia) or albitrunca (Boschia) ( Dlamini, 1981)
Inshubaba	Momordica (clematidea, foetida) ( Dlamini, 1981)
Inkakha	Momordica (involucrata) ( Thwala, 1999)
Insangu	Canabis ( Dlamini, 1981)
Inhlaba	Aloe( Dlamini, 1981).
Emahala	Saponaria or aloe vembulenii
Umdzayi	Asclepias affinis or xysmalobium

Emaphoti	not available
Nunankulu	Not available
Chuchuza	<i>Bidens pilosa</i> ( Thwala, 1999)
Umzimuko	Not available
Mavumbuka	Not available
Nhiziyonkulu	<i>Dombeya</i>
Halibhoma	Not available
Sikhondze Senuku	Not available
Ndwendweni	<i>Scilla nervosa</i>
Siphanga semkhaya	Not available
Godide	Not available
Umetjiso	Not available
invovi yesihlahla	<i>Loranthus dregei/ pedistylis galpnii</i> or <i>tapinanthus kraussianus</i>

## ADDENDUM

### THE WITCHCRAFT ACT OF SWAZILAND (1905)

*“ Criminal law and procedures: Act 6/1889, WITCHCRAFT: imputations of witchcraft:-*

75     *Any person who imputes to another the use of non-natural means in causing any disease in any person or property or in causing injury to any person or property or shall name or indicates anyone as being responsible for the cause of any injury to any person, animal or thing shall be guilty of an offence and on conviction liable to a fine of one thousand ‘emalangeni’ or imprisonment not exceeding five years.*

*Witch doctor naming another as a wizard or witch:-*

76     *any person who having named or indicated another as a wizard or witch or having by means of pretended supernatural power indicated another as being responsible for the cause of an injury to any person, animal or thing and who is proved to be by habit or repute a witch doctor or witch finder shall be guilty of an offence and on conviction liable to a fine of one thousand ‘emalangeni’ or imprisonment for life.*

*Employing a witch doctor :*

77     1. *Any person who by himself or by an agent or messenger employs or solicits a witch doctor or witch finder as such to exercise his pretended power of*

*divination or other pretended supernatural power shall be guilty of an offence and liable on conviction to a fine of four hundred 'emalangen' or imprisonment not exceeding one year and the agent or messenger so employed shall also be guilty of an offence and punishable in like manner.*

*2. any person who counsels, procures, incites, persuades, recommends, directs or orders any other person to employ or solicit any witch doctor or witch finder resident or outside Swaziland to exercise his pretended powers of divination or other pretended supernatural power shall be guilty of an offence and liable on conviction to the penalty provided in sub-section 1.*

*3. Any person who proceeds beyond the borders of Swaziland for the purpose of employing or soliciting either on his own or any other person's behalf any witch doctor or witch finder as such to exercise his pretended supernatural power shall be guilty of an offence and liable on conviction to the penalty provided in sub-section 1.*

*4. In this Part-----*

*"Witch doctor" or "Witch Finder" includes the persons described in 'siSwati' by the words 'Umngoma' or 'isangoma' or 'inyanga yokuphengula'*

*(Amended A. 18/52).*

*Witch Doctor supplying advice for witchcraft with intent to injure:*

78     *1. Any person professing a knowledge of witchcraft or use of charms who advises any person applying to him how to bewitch or injure person, or animals or other property or who supplies any person with the pretended*

*means of witchcraft shall be guilty of an offence and on conviction a fine of two hundred 'emalangeni' or imprisonment not exceeding six months.*

*2. any person who is found wearing any charms, dress, ornament, emblem or insignia which according to "Swazi" custom indicates the wearer as a diviner , witch doctor or witch finder shall be guilty of an offence and liable on conviction a fine of two hundred 'emalangeni' or imprisonment not exceeding six months*

*Persons using witch medicine with intent to injure.*

*79 Any person who on the advice of a witch doctor or of his pretended knowledge of witchcraft and with intent to injure, use or cause to be put into operation such means or processes as he believes to be calculated to injure persons or property shall be guilty of an offence and liable on conviction to a fine of one thousand 'emalangeni' or imprisonment exceeding ten year.*

*Pretending to use supernatural power for purpose of gain:*

*80 1. Any person who for purposes of gain pretends to exercise or use any kind of supernatural power, witchcraft, sorcery, enchantment or conjuration or undertakes to tell fortunes or pretends from his skill or knowledge in any occult science to discover where or in what manner anything suppose to have been stolen or lost may be found guilty of an offence and liable on conviction to a fine of four hundred 'emalangeni' or imprisonment exceeding one year.*

*2. Any person who practices as a diviner, or witch doctor or witch finder*



*shall be guilty of an offence and liable on conviction to a fine of four hundred 'emalangeni' or imprisonment not exceeding one year".*

When looking at this Act, one can notice that the words witchcraft was mixed up or was used synonymously with healers (*Sangoma*, prophets and herbalists). The Act also has the undesired paragraph where it prohibits the practice of traditional healers and clothing of people as traditional healers as well as the acts of prophesing. This act was developed by the colonial powers when they were formulating or introducing the Roman Dutch Laws without the understanding and culture of the locals. If this Act applied only to Witches as described by Gumede (1990), there would be no problems with true traditional healers whose aim is to heal rather than being evil. Traditional healers should in their constitution reject certain parts of the Act and leave some parts that apply only to the 'witch doctor or witch practice' so that even a traditional healer who is found to practice witchcraft can be tried using this Act. The parts that define all traditional healers as witches should be removed and the part that prohibit all traditional healers from practicing their art of healing and diagnosis should be removed as well as the prohibition of wearing clothes that show you are a traditional healer.

Amendments made on this Act reflects that the Act was revised in the around the 1980 's, since before that Swaziland utilized Rands as their money. Emalangeni were introduced in the 1980's.

This is the only legal document available in Swaziland prohibiting traditional healers (*isangoma*, *Zionists*, *inyanga* and *tingedla*) to practice and use traditional medicines for healing purposes.

## **APPENDICES**

### **ANNEXURE 1: INDIVIDUAL INTERVIEW GUIDELINE:**

#### **PART ONE: PROFILE OF PARTICIPANTS DATA COLLECTION TOOL**

1. Community ( sigodzi)-----Hospital/Clinic-----
2. Chief-----Indvuna-----
3. Nurse-----Doctor-----Client-----traditional healer-----
4. Female-----Male-----
5. Age-----
6. home language-----
7. Other languages-----
8. Highest Education-----
  - std 0-3-----
  - std 4-9-----
  - std 10-11-----
  - After high school education-----

## **ANNEXURE 2: TRADITIONAL HEALER'S INTERVIEW GUIDE**

### **PART TWO: THE MANAGEMENT OF DIABETES AND HYPERTENSION:**

1. How did you become a healer ?
2. How best can you describe your practice ( herbalist, sangoma/diviner, or faith healer)
3. List illnesses that normally treat
4. a) Diabetes: 1. tell me about diabetes, its causes, diagnosis and treatment
  - a) how do you recognize it ?
  - b) how do you treat it
    - i) name of medicine or treatment protocol
    - ii) preparation
    - iii) dose and frequency
    - iv) method of administration
    - v) contra-indications and side effects.
    - vi) duration
2. How do you recognize improvements
3. What advice do you give your clients, state them

Hypertension: same as above

### **PART THREE:**

#### **COLLABORATION**

1. What do you understand by the word collaboration ?
2. Is it necessary/important that the two systems of health care collaborates? give your reasons.
3. Did you send any patient to the hospital/clinic
4. If yes, what happened to your patient in the clinic/hospital
5. Did any of the western trained health care workers send their patients to you

If yes, was the referral formal or informal

If no, what are the reasons for not sending a patient to you

6. What is your relationship with the clinic/hospital workers ?
7. Are there ways or means by which you collaborate with the western health care workers ? Please state them.

a) How effective are those ways in facilitating collaboration?

b) What enhances these ways to facilitate collaboration ?

c) What barriers hinder these ways from facilitating collaboration..

d) If there are problems, how can they be solved for collaboration to take place ?

If no, a) What are the reasons for collaboration not to take place between the two systems.?

b) What could be done to facilitate collaboration between the two systems ?

c) How can the strategies you suggest be successfully implemented ?

8. Can you state any practice in your field and the western health care field that you think can be improved to facilitate collaboration.
9. How can collaboration be facilitated in the management of diabetes and hypertension.
10. What would be the consequences of a successful collaborative strategy

**ANNEXURE 3: WESTERN TRAINED HEALTHCARE WORKERS' INTERVIEW**  
**GUIDE**

**PART TWO**

**MANAGEMENT OF DIABETES AND HYPERTENSION**

1. Tell me about diabetes, its' causes, diagnosis and treatment
  - a) How do you recognize it ?
  - b) How do you treat or manage it ?
    - i) name the medicines or treatment protocol
    - ii) preparation
    - iii) dose and frequency
    - iv) method of administration
    - v) contra-indications/side effects
2. How do you recognize improvement in your client
  - a) How long does it take your client to show any improvement

Hypertension: same as diabetes.

**PART THREE**

**COLLABORATION:**

1. Tell me about the concept of collaboration
  - a) what does it mean to you
2. Is it necessary/important for the two systems to collaborate with one another.  
  
Give reasons
3. Have you ever sent any patient to a traditional healer ?

a) If yes, was it formal or informal, please explain

b) if yes, what happened to the patient you sent to the traditional healer ?

c) Did any traditional healer send a patient to the clinic/hospital. explain what happened.

4. Are there ways by which traditional healers and western trained health care workers collaborate with one another /

If yes, a) are these ways effective in facilitating collaboration

b) What factors enhance or motivate these ways to facilitate collaboration

c) State the barriers that hinder these ways to facilitate collaboration

d) How can these ways be improved to facilitate collaboration

If no, a) what are the reasons for collaboration not to take place ?

b) what could be done ?

c) how can the strategies you suggest be successfully implemented ?

5. can you state any practices in your field and in the field of traditional healers which you think can be improved to facilitate collaboration

6. In your opinion, how can collaboration be facilitated in the management of diabetes and hypertension.

7. What would be the consequences of a successful collaborative strategy ?

## **ANNEXURE 4: CLIENTS' INTERVIEW GUIDE**

### **PART TWO:**

1. Which illness do you suffer from ?

Hypertension

Diabetes

or both

2. How long have since you have been diagnosed ?

3. Where was your illness diagnosed ? ( hospital, clinic or traditional healer )

4. Tell about your illness ( causes, diagnosis, treatment, advice given or health education given to you, by whom ?)

5. do you do regular checkups ?

If yes, how often ?

6. have you consulted the traditional healer about your illness ?

a) If yes, did you start by consulting the traditional healers before the western facility ?

b) What did the traditional healer do for you ?

c) Are still having check ups with your traditional healer ?

d) Do you feel any improvement, how long did it take for you to feel any improvement ?

7. a) What did the hospital do for you

b) Do you feel any improvement ?

c) How long did it take you to feel better ?

8. are you using both the traditional herbs concurrently with the western medicines ? Explain.

### **PART THREE:**

#### **COLLABORATION**

1. Tell me about me about collaboration
2. is it necessary for the western and the traditional systems to collaborate ? Give your reasons.
3. Is there any collaboration going on between the two systems ?
  - a) if yes, state them
  - b) If no, what are the reasons
  - c) How could they collaborate
4. have you ever been referred to the hospital by a traditional healer and vice versa ?
  - a) If yes, how was that done ?
  - b) If no, what do you perceive the reasons to be ?
  - c) how can that be corrected ?
5. What practices do you think the traditional healers and western health care need to change or improve in order for collaboration to take place ?
6. How can the two systems facilitate collaboration in the management of your illness ?
7. if they do collaborate what do you think would happen to the way you are being managed ?



## **ANNEXURE 5: INVITATION TO A FOCUS GROUP SESSION OR MEETINGS**

Following the individual interviews, it was noted that joint discussions of western trained health care workers, clients and traditional healers was needed.

The purpose of the meeting is to explore strategies and ways by which collaboration can be facilitated.

You are kindly invited to come and have your own contribution or or to listen to the contributions about the recommended types of collaboration that will be ideal to all parties concerned.

Date:-----

Day:-----

Venue:-----

Time:-----

**(FEEL FREE TO ATTEND AND DO NOT MISS THIS OPPORTUNITY)**

## **ANNEXURE 6: FOCUS GROUP SESSION AND MEETINGS.**

### **PURPOSE:-**

1. TO DISCUSS ABOUT COLLABORATION:-
2. TO LOOK INTO THE TWO ILLNESSES BEING DIABETES AND HYPERTENSION
3. TO FIND WAYS BY WHICH COLLABORATION CAN BE DONE
4. HOW THOSE WAYS CAN BE IMPLEMENTED AND BY WHO AND WHEN SHOULD THE IMPLEMENTATION BEGIN.
5. HOW TO EVALUATE THE SUCCESS OF THE CHOSEN STRATEGIES OF COLLABORATION.

### **SESSION GUIDE FOR THE LEADER**

1. WELCOMING REMARKS WILL INVOLVE STATING THE PURPOSE OF THE SESSION
2. BEGIN WITH INTRODUCTION:- AN OVERVIEW OF RESULTS FROM THE INTERVIEWS (BY THE RESEARCHER)

### **DISCUSSION**

3. DISCUSS OPENLY ABOUT COLLABORATION
4. LOOK INTO THE MANAGEMENT OF THE TWO ILLNESSES
5. WHAT SHOULD BE DONE FOR COLLABORATION TO TAKE PLACE ( STRATEGIES OR WAYS BY WHICH COLLABORATION CAN BE IMPLEMENTED)
6. HOW COULD THE CHOSEN STRATEGIES BE IMPLEMENTED

WHEN ?

WHO ?

HOW ?

7. HOW CAN THE SUCCESS BE EVALUATED ?

### **PROGRAM**

1. OPENING WITH PRAYER

2. WELCOME REMARKS BY THE LEADER

3. INTRODUCTION BY THE RESEARCHER

4. DISCUSSIONS LED BY THE LEADER:- ABOUT COLLABORATION AND THE TWO ILLNESSES BEING DIABETES AND HYPERTENSION AND IDENTIFICATION OF STRATEGIES FOR COLLABORATION.

5. REMARKS FROM THE AUTHORITIES OF HEALTH

6. REMARKS FROM ANY MEMBER REPRESENTING THE COMMUNITY

7. CLOSING REMARKS FROM THE RESEARCHER

8. CLOSING PRAYER

**REFRESHMENTS !!!!!!!!!!!!!!!REFRESHMENTS !!!!!!!!!!!!!!!REFRESHMENTS !**

## **ANNEXURE 7: LEADERS GUIDE FOR DISCUSSIONS**

1. WHAT IS COLLABORATION ?
2. DO YOU THINK THERE IS ANY COLLABORATION BETWEEN THE TRADITIONAL HEALERS AND THE WESTERN TRAINED HEALTH CARE WORKERS ?
3. WHAT ARE THE PROBLEMS ?
4. WHAT CAN BE DONE
5. WHO SHOULD DO WHAT, WHEN, AND HOW ?
6. HOW WOULD YOU TELL THAT THERE IS NOW COLLABORATION ?
7. WHAT DO YOU THINK HYPERTENSION AND DIABETES IS ?
8. HOW DO YOU NORMALLY TREAT IT ( TRADITIONALLY AND WESTERLY)
9. WHAT IS HAPPENING TO PATIENTS RELATED TO THE LACK OF COLLABORATION
10. IF THERE IS COLLABORATION, WHAT DO PATIENTS BENEFIT ?
11. DO YOU PERCEIVE COLLABORATION IN THE MANAGEMENT OF THESE ILLNESSES, EXPLAIN
12. HOW WOULD YOU COLLABORATE ?
13. WHAT WOULD BE THE CONSEQUENCES FOR COLLABORATION

**ANNEXURE 8: LETTER TO THE PRINCIPAL SECRETARY SEEKING FOR  
PERMISSION**

FACULTY OF HEALTH SCIENCES

P.O. BOX 369

MBABANE

4-01-1999

THE PRINCIPAL SECRETARY

MINISTRY OF HEALTH

P.O. BOX 5

MBABANE

**RE: APPLICATION FOR CONDUCTING A RESEARCH**

Dear Sir,

I am kindly applying for permission to conduct a research in the hospitals and clinics in Swaziland in the year 1999.

The research is in fulfillment of a PhD which I am pursuing in the University of Natal. The title is "TOWARDS COLLABORATION BETWEEN THE HEALTH CARE WORKERS AND THE TRADITIONAL HEALERS IN THE MANAGEMENT OF DIABETES AND HYPERTENSION."

Data will be collected from doctors and nurses in the hospitals and clinics and from traditional healers in all the four regions of Swaziland.

The study will attempt to would determine how traditional healers and modern health care workers treat diabetes and hypertension and then identify strategies by which these two can collaborate in

the management of these illnesses. This would then facilitate proper collaboration; and thus improve patient care in the long run. This study's aim is to provide some scientific knowledge in the management of these illnesses by the traditional healers . It would also form a base for collaboration in the treatment of other illnesses.

I hope the Ministry would give me the needed support and permission to carry out this study.

I thank you in advance for your cooperation and hope to hear from you soon.

YOURS FAITHFULLY

PRISCILLA S. DLAMINI

**ANNEXURE 9: LETTER GRANTING PERMISSION TO CONDUCT THE STUDY**

**MEMORANDUM**

**FROM:** Principal Secretary  
MOH&SW

**TO:** Priscilla S. Dlamini  
Depart. of Nursing Siences  
UNISA

**DATE:** March 15, 1999

**Ref:**

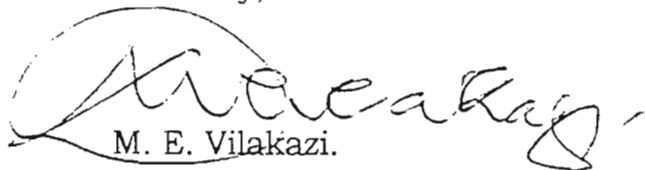
**RESEARCH PROTOCOL: TOWARDS COLLABORATION BETWEEN THE  
HEALTH CARE WORKERS AND TRADITIONAL HEALERS IN THE  
MANAGEMENT OF DIABETES AND HYPETENSION**

Please be informed of the fact that the proposal you submitted to the Ministry of Health and Social Welfare for a review of ethical concerns under the above noted title has been **approved**.

Subsequent to this clearance, it is recommended that you seek the permission of study sites leadership and informants.

We wish you success in your studies and request that you provide the ministry with a copy of your dissertation upon completion

Sincerely,



M. E. Vilakazi.

CC: The Secretary General  
Swaziland Nurses Association

The Secretary General  
The Swaziland Medical and Dental association

The President  
The Traditional Healer's Organization (THO)

The President  
Tinyanga Tenzdabuko

**ANNEXURE 10: LETTER SEEKING PERMISSION FROM THE TRADITIONAL  
HEALERS**

FACULTY OF HEALTH SCIENCES

P.O. BOX 369

MBABANE

27-07-1998

THE CHAIRPERSON

TINYANGA TEMDZABU

**RE: APPLICATION TO CONDUCT A RESEARCH WITH HEALERS**

Dear Sir,

I am kindly requesting for permission to conduct a research with the traditional healers in the year 1999.

The research title is "TOWARDS COLLABORATION BETWEEN TRADITIONAL HEALERS AND THE MODERN HEALTH CARE WORKERS IN THE MANAGEMENT OF HYPERTENSION AND DIABETES."

I would like to collect data from traditional healers who are managing diabetes and hypertension.

This study would determine what the traditional healers do and what the modern health care worker do when they manage these illnesses. Then strategies for collaboration would be identified when they both know what the other is doing as far as diabetes and hypertension is concerned.

These strategies would then be utilized to facilitate a two-way collaboration between the two whenever the need arises.

I am also requesting for some assistance in the identification of those traditional healers who manage these illnesses in all the regions of Swaziland.

This study is in fulfillment of a PhD which I am pursuing in the University of Natal.



I hope you will give me the necessary support and permission to carry out this study successfully.

I thank you in advance for your cooperation.

YOURS FAITHFULLY

PRISCILLA S. DLAMINI

**ANNEXURE 11: LETTER SEEKING PERMISSION FROM THE CHIEF NURSING**

**OFFICER**

FACULTY OF HEALTH SCIENCES

P. O. BOX 369

MABANE

27-7-1998

THE CHIEF NURSING OFFICER

MINISTRY OF HEALTH AND SOCIAL WELFARE

P. O. BOX 5

MBABANE

**RE: APPLICATION TO CONDUCT A RESEARCH**

Dear madam,

I am kindly applying for permission to conduct a research in some of the hospitals and clinics in Swaziland. The study looks concerned collaboration between the western health care workers and the traditional healers. Data would be collected from doctors, nurses and clients suffering from diabetes and hypertension in the clinics.

The study is in fulfillment of a PHD which I am pursuing in the University of Natal. I hope you would give me the necessary needed support and permission to carry out this study seeing that nurses would be involved.

Thank You

Yours Faithfully

Priscilla S. Dlamini

**ANNEXURE 12: A LETTER SEEKING FOR PERMISSION FROM THE MEDICAL**

**DIRECTOR**

FACULTY OF HEALTH SCIENCES

P. O. BOX 369

MBABANE

27-11-1998

THE MEDICAL DIRECTOR

MINISTRY OF HEALTH

P. O. BOX 5

MBABANE

**RE: APPLICATION TO CONDUCT A RESEARCH**

Dear Sir,

I am applying to conduct a research in the hospitals in Swaziland in the year, 1999. The study is in fulfilment of my PHD which I am pursuing with the University of Natal. The research address the issues of collaboration between traditional healers and the western health workers. Data would be collected from doctors and nurses, as well as clients suffering from diabetes and hypertension.

I hope I would receive the necessary support and permission to carry out the study.

Thank you

Yours Faithfully,

Priscilla S. Dlamini

**ANNEXURE 13: LETTER GRANTING PERMISSION FROM ONE HEALTH CARE  
CENTRE**

Sithobela Health Centre  
P. O. Box 36  
KUBUTA.

1st June, 1999

Faculty of Health Services  
P. O. Box 369  
MBABANE

**RE - REQUEST TO CONDUCT A RESEARCH**

Dear madam,

Your letter was received well *in time* sorry *for the* delay in replying you.

Your request has been approved *ed* you will continue to do your research at our Health Centre.

We are ready for you and to help where ~~ne~~ necessary.

Thank you

MINISTRY OF HEALTH  
SITHOBELA HEALTH CENTRE  
DORIS BLAMINI  
SISTER - INCHARGE - 1

P.O BOX 36  
KUBUTA SWAZILAND

**ANNEXURE 14: SELECTION GUIDE FOR CLIENTS USING WESTERN OR BOTH**

**MEDICINES**

profile:

name:-

age

sex

residential area

distance from home    a) to the health care centre

   b). to the traditional healers homestead

Illness suffering from: diabetes

Hypertension

Both

How long did you have this or these illnesses ?

Where were they diagnosed ?

What type of medications are you using ?

Have you consulted the traditional healers ?

If yes, When ?

Are you using both medications, one from the traditional healer and the one from the western health care workers ?

Are you experiencing any improvements ?

How do you tell that you are improving ?

Do you think you are being helped by the medications you are using ?

What other advice were you given by those treating your illness ?

If yes, do you follow those advice ?

If no what are the problems ?

If using the traditional healers medicines, is it possible for you to show me your traditional healer so that we can discuss about your illness

Thank you.

#### **ANNEXURE 15: AN INTERVIEW GUIDE AND REVIEW OF HEALTH RECORDS**

1. profile: name, gender, age, and type of illness.
2. what were the signs and symptoms of your illness.
3. when was your illness diagnosed
4. where was it diagnosed
5. what treatment are you using ?
6. can you state the preparations, dosage, frequency and duration
7. did you see any improvements
8. did you try other methods of treatment ? Explain
9. Do you think traditional medicines works ? Explain
10. **Review of record for clients using only western medicines or both**  
initial readings, subsequent readings and present readings.
11. for those using only traditional medicines:  
blood pressure and glucose levels taken using instruments.
12. When your blood pressure is high or low, how do you feel ?
13. Explain about advice on life style changes that you have received from where you are being treated