AN INVESTIGATION INTO PREVENTIVE AND PROMOTIVE HEALTH CARE IN THE PRACTICE OF INDIGENOUS HEALERS

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BY:

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DEDICATION

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DECLARATION

Except for referenced citations in text, this is the researcher's original work

Signature _____ Date 17/12/02.

ABSTRACT

This study investigated the preventive and promotive health care in the practice of indigenous healers. It focussed on specific aspects of primary health care. The objectives of the study were to describe the current practice of indigenous healers with regard to preventive and promotive health care. The study also identified specific areas in which indigenous healers practices with regard to preventive and promotive health care can be enhanced. It also intended to describe the effect of a short training course for indigenous healers based on the assessment, with regard to their knowledge, beliefs and practice.

The study was a qualitative multi-phased research project which included three phases. The researcher's target population consisted of indigenous healers in Region D of KwaZulu-Natal. The researcher targeted indigenous healers living at Vryheid District under Hlahlindlela tribal Authority. Sisters at the clinics in Vryheid and Pietermaritzburg participated in the present study as well as western medical practitioners and nurses at Edendale hospital. Focus group discussions and individual interviews were conducted. A template method of data analysis was used.

Results revealed that indigenous healers practices were characterized by preventive and promotive health measures which were, to a greater extent African -culture related. Areas of concern where indigenous healers practices would be enhanced were identified by the formal health care workers. A short training course was designed and implemented by the researcher. Evaluation of the training course revealed that it was to a greater extent effective.

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CHAPTER ONE

INTRODUCTION

1.1. PROBLEM STATEMENT

Prevention and promotion constitute an important part of primary health care approach to health. Despite the fact that primary health care is multi-sectoral, the role and contribution of indigenous healers in the South African society is one that is either neglected or unduly brushed aside by "western" medical traditionalists thus contributing to inadequate health care service delivery(Holdstock, 1979, p.118). However, in order to further improve upon the initiatives done in incorporating indigenous healers into primary health care (PHC) system, their role in terms of health promotion and prevention of illnesses needs to be further explored.

Evidence reveals that successful attempts have been made in some African countries to formally incorporate indigenous healers into PHC. For an example, a study conducted for the Swaziland Ministry of Health (cited in Good,1988,p.88) revealed that 98% of the indigenous healers wanted to improve cooperation between themselves and physicians and nurses, and 91% were enthusiastic about receiving some kind of training in biomedicine to improve their healing skills. It should be noted that during the second phase of formal interaction between the western health care professionals and indigenous healers which started in 1984-85, the Swaziland Ministry of Health and the Swaziland Traditional Healers Society jointly sponsored a pilot project (Good,1988, p.90). The project was designed to build upon traditional beliefs and treatment methods to address the cause and treatment of eight

children's diseases. Topics such as nutrition, sanitation, personal hygiene, oral rehydration solution (ORS) and immunization were included. The project's objectives involved teaching traditional healers specific skills to prevent and control diarrhoea, malnutrition, malaria and immunizable diseases such as whooping cough and tuberculosis (Hoff, Hoff and Shapiro, cited in Good, 1988, p.90).

This project had a considerable positive impact upon indigenous healers. For an example, Good (1988, p.91) remarks that:

> "Those traditional healers who participated in the workshops increased their understanding of dehydration and the use of (ORS), the importance of safe water, good sanitation, personal nutrition and immunization. The traditional healers began to use ORS for treating diarrhoea in children, to refer patients to clinics for diarrhoea and "check ups" and to instruct their patients in good health practices. Personal health practices also showed significant improvement. For an example, all traditional healers in the workshop group had constructed latrines at their clinics and were using them properly (only 26% of the control group had them).While 48% of the workshop group had wash basins as part of their clinic equipment, only 4% of the control group had them."

Hoff and Maseko (cited in Good, 1988, p.91) further note that:

> "Overall, the project demonstrated that indigenous healers could, with proper training and support, assist in the development of more effective PHC at the community level. In general, attitudes of the nurses and indigenous healers

toward one another grew more positive, and communication and cooperation increased. Possibly the most significant outcome of the project was the way in which indigenous healers became enthusiastically involved and accepted responsibility for promoting good health practices and disease prevention"

It should, however, be noted that recent evidence reveals that incorporation of indigenous healers in primary health care may be associated with some limitations. For an example, Dlamini (2001,p.65)'s study conducted in Swaziland regarding facilitation of collaboration between indigenous healers and western medical practitioners shows that:

> "the supply of indigenous biomedical personnel who are interested in understanding and co-operating with traditional healers appeared to be limited. The traditional beliefs about health and disease are set within a holistic social and environmental framework and tend to involve supernatural phenomena. Formal or systematic methods for evaluating the outcome of therapy, that is, through measurement, verification and validation, are lacking for many traditional practitioners."

Ghana has been one of the African countries which have successfully demonstrated that formal involvement of indigenous healers in PHC improves health care service delivery. The Primary Health Training for Indigenous Healers (PRHETIH) program in Techiman, Ghana, involved health education and skills development for PHC in indigenous healers.

Like Ghana and other African countries, China is one of the leading countries in the whole world that has successfully

integrated indigenous healing system into formal primary health care. Akerele (cited in Heggenhougen, 1988, p.20) states that in 1985 the Chinese shared their experiences with health policy makers and planners from a number of countries. The seminar explored how these Chinese approaches could be adapted to the participants' own countries. Thus it is clear from the mentioned evidence that programs which include indigenous healers into formal PHC may be implemented in South Africa to improve the quality of health care delivery.

Before indigenous healers could be exposed to some of the biomedical ideas, it was imperative for the indigenous healers training program designers to have a profound understanding of indigenous healers' real situation. Good (1988, P.93) relates that:

> "Prior to designing the program, detailed information was gathered from the local indigenous healers concerning their beliefs, techniques, felt needs for a training course, and their desire to participate in such activities. It was also necessary to select and train the biomedical workers who would train the indigenous healers."

This implies that, before training on biomedical skills could be provided to indigenous healers, it is imperative to appreciate the nature and the manner in which their health care system operates.

Evidence reveals that although attempts were made by some countries to incorporate indigenous healers into PHC, the focus was mainly on curative aspect of care. Projects which were run in countries like Nigeria, Ghana and Swaziland dealt mainly with

treatment. It is not clear whether indigenous healers, whose main focus seem to be curative care, may be interested in increasing the preventive and promotive components of care in their practices. For example, Dlamini (2001, p.132)'s findings reveal that indigenous healers were explicit about their belief in cure versus control or maintenance of diabetes and hypertension. It is also not clear whether the western health professionals may have the willingness to interact with indigenous healers.

Therefore, lack of incorporation of indigenous healers in primary health care programs involving health promotion and prevention of illnesses may hinder effective health service delivery in South Africa. Due to the fact that indigenous healers are culturally acceptable to the majority of the South African population, they can provide an opportunity for effective integration and collaboration between the two systems of prevention, promotion and healing. Existing evidence also reveals the extent to which indigenous healers' practices may be enhanced in terms of developing their skills and standards. This would enable them to effectively handle preventable diseases which were traditionally not encountered in South Africa but were introduced from the outside through contact with explorers, missionaries and colonial forces. Thus the implementation of PHC approach that involves indigenous healers could make a significant impact upon the South African health care services.

Given the demand for intersectoral collaboration, and the favourable position of indigenous healers in the South African society, the question is therefore what indigenous healers currently do in terms of prevention of illness and the promotion of health and whether this role could be strengthened.

1.2. BACKGROUND TO THE PROBLEM:

Evidence reveals that the health status of many South African women and children remains problematic. For an example, According to KwaZulu-Natal Department of Health (April 1998 - March 1999, p.51), the health statistics reveals that neonatal mortality rate, the number of children per thousand who died when they were less than one month old in the province of the Eastern Cape was 25%, Mpumalanga Province 24%, KwaZulu-Natal 23%, Northern Cape 21%, North West 20%, Northern Province 18%, Gauteng 18%, Free State 10% and Western Cape 4%. South Africa had a neonatal mortality rate of 20%. Health statistics also reveals that South Africa is associated with high infant mortality rate which is the number of children per thousand who die before they reach their first birthday. Statistics, as KwaZulu-Natal Department of Health (April 1998 - March 1999, p. 52) points out, reveals that infant mortality rate in the Eastern Cape was 61%, KwaZulu-Natal 52%, Mpumalanga Province 47%, Northern Cape 42%, Free State 37%, North West 37%, Northern Province 37%, Gauteng 36% and Western Cape 8%. Infant mortality rate in the whole of South Africa was 45%. It is thus clear from the foregoing evidence that the health status in South Africa is a national concern.

Similarly, obstetric and gynaecological conditions are also found amongst the most common conditions in South Africa. Buso (1999), for an example, notes that the figures on pregnant women assisted during labour by a trained nurse or midwife are extremely low, at 54% national average. The primary causes of maternal mortality include pregnancy induced hypertension which constitutes 27%, chronic conditions with 18%, puerperal sepsis with 14% and AIDS with 13%. Despite the fact that malnutrition is not rated among the first twenty morbidity causes, it is among the first twenty

mortality causes (Buso, 1999, p. 54). It is therefore clear from this health statistics that the majority of the South African citizens are at risk if no appropriate alternative strategies are utilized.

Due to human resource constraint being experienced within the formal health sector in South Africa, it seems unlikely that the more complex human related problems can be adequately addressed. This appears to be a major factor leading to the deterioration of the health care services in South Africa. For example, according to KwaZulu-Natal Department of Health (April-September, 1998, p.77), about 377 medical posts and 4986 nursing posts were not filled in the province of KwaZulu-Natal. This implies that many clinics and hospitals in the public sector experience critical staff shortages. The professional health staff who are costly to train and employ, are not evenly distributed and are concentrated in the metropolitan areas (Sanders, 1985, P.95). In recent years South Africa saw a number of doctors leaving the country and this is not confined to doctors but it involves a great number of nurses (Sanders, 1985, p.95). It is important to note, as Sanders (1985) points out, that this is a global problem not only confined to South Africa. Sanders (1985, p.93) further states that:

> "Because of international migration known as the 'Brain drain' About 140 000 doctors work in countries other than the one where they were trained. Of these 120 000 work in just five countries: USA (77 000), Britain (21 000), Canada (11 000), West Germany (6 000) and Australia (4000)."

Recent evidence reveals that the South African Government is experiencing a serious problem the highly skilled people leaving

the country. For example, a political correspondent (cited in Natal Witness 2002, p.2) reported that:

> "Fifty percent of all community doctors currently working overseas are not coming back. Twenty six percent of doctors who graduated between 1990 and 1999 have left the country. About 5000 doctors who trained in South Africa are currently living abroad, To aggravate the situation, 300 nurses are leaving the country on a monthly basis."

It therefore becomes apparent that, because of the limited human resource, the South African formal health system can not cope.

Despite the fact that a primary health care approach based on multi-sectoral collaboration accommodates cultural diversity, the present South African National Department of Health does not accept indigenous healers into the formal primary health care system. For example, the World Health Organization (1996, p.1) states that:

> "Traditional medicine is a very important part of health care. Most population in the developing countries still relies mainly on indigenous traditional medicine for satisfying their primary health care needs. Traditional medicine has not however been incorporated into most national health systems and the potential of services provided by traditional practitioners is far from being fully utilized."

The process of implementation of primary health care which does not formally involve indigenous healers appears to be inappropriate and ineffective. Vital health information necessary

for health promotion and prevention of communicable diseases and malnutrition may not be accessible to the people, particularly those living in the rural areas (Sanders, 1985, p.95). This has led to the poor implementation of relevant programmes like Directly Observed Treatment (DOTS) programme.

Despite the fact that indigenous healers in South Africa are not formally recognized as health care service providers, many attempts have been made to initiate interaction between African indigenous healers and western medical practitioners. For an example, Abdool Karim, Ziqubu-Page and Arendse, (1994, p.11) state that:

> "An experiment in collaboration between African indigenous healers and biomedical personnel was conducted at MEDUNSA in which African traditional healers participated alongside biomedical personnel. Patients were referred by one group to the other and vice versa. Meetings to discuss drugs and other treatments were held. When herbal medications used by the healers were analysed at the university laboratories, therapeutically active ingredients as well as harmful agents were identified. Several other institutions have established professional meetings and exchanges between traditional healers and biomedical personnel, for example at the Valley Trust through the efforts of doctors H.H. Scott and I. Friedman, and in the Underberg under the auspices of Sr M. Nhleko. In the north eastern Transvaal, the Health Services Development Unit of the University of the Witwatersrand, which runs primary health care courses for nurses, invited African traditional healers to primary health care meetings and workshops at George Masebe Hospital. The problem of communication between healers and biomedical personnel was

discussed and it was agreed that there was a need to learn about each other from each other. In KwaZulu since the early 1970s, under the tutelage of the then Secretary for Health, Dr M.V. Gumede, traditional healers have been encouraged to form associations in order to facilitate registration and licensing. This continued under the KwaZulu Government secretary for Health, Dr D.B.T. Hackland. Traditional healers are being encouraged to stop 'hiding under the curtain of skin and gall bladder' and liaise with biomedical personnel in the rendering of health care to their respective communities."

It is important to note that some of the western medical practitioners are of the opinion that indigenous healers have a crucial role to play in the formal health sector where they could assist in the prevention of specific conditions. Ojanuga's study of western trained Nigerian doctors (cited in Abdool-Karim, Ziqubu-Page and Arendse, 1994, p.11) stated that (81%) of the physicians felt that indigenous healers need to undergo some form of training in biomedical techniques, treatment of common ailments and scientific aetiology of diseases in order to be formally accepted by the government health services.

This idea is supported by Heggenhougen (1988, p.23) who argues that:

" If it is appropriate to provide curative allopathic training to community health workers within a relatively limited training programme then why not also to indigenous healers."

Heggenhougen (1988) further proposes that when considering the training of indigenous healers, the content of training should focus mainly on health education, preventive medicine, simple curative tests and mental health. Indigenous healers, because of their status in their communities, can ensure the continuity of health care delivery. For an example, indigenous healers can help with the supervision of their TB patients who were treated by western medical practitioners so as to enhance compliance and further the health promotion strategies being promoted by the Department of Health (KwaZulu-Natal Department of Health, 1997). Therefore recent evidence reveals that indigenous healers who are largely unregulated and not part of formal health system are however being used by many South Africans (Mander, 1998). This implies that there is a tremendous opportunity to address inadequacies by involving indigenous healers in primary health care and taking the pressure off the formal health care services.

1.3.AIM OF THE STUDY:

The study aims to do an investigation into the illness prevention and health promotion activities in the practice of indigenous healers. Because of the comprehensive nature of the concept of primary health care, specific aspect of health promotion and prevention of illness was chosen to focus the study which is primary prevention. These are prevention and promotion focussed on children and women.

1.4.RESEARCH OBJECTIVES

1.4.1 To describe the current practice of indigenous healers with regard to preventive and promotive health care including the following aspects:

- Knowledge of nutrition (children and pregnant women), environmental health and prevention of infection.
- Beliefs about prevention and promotion
- Practices which are seen by indigenous healers as preventive and promotive.

1.4.2 To identify specific areas in which their practices with regard to illness prevention and health promotion can be enhanced.

1.4.3 To ascertain the views of western health professionals regarding knowledge and skills necessary for indigenous healers in order for them to make a contribution in preventive and promotive health, especially as this relates to pregnant mothers and children.

1.4.4 To describe the effectiveness of a short training course for indigenous healers based on the assessment, with regard to:

- Knowledge
- Beliefs
- Practice

1.5. CONCEPTUAL FRAMEWORK

In order to enhance indigenous healers practices through their interaction with western health care professionals, the primary health care(PHC) perspective of which health promotion concept forms part and the primary care (PC) perspective which is associated with prevention of illness, need to be revisited. The

PHC approach, which may be defined as the process of enabling people (individuals and communities) to increase control over the determinants of health so as to improve it, requires the western health professionals not to confine themselves to the rendering of clinical and curative health care services but to include a health promotion approach sensitive to cultural differences (Dennill; King; Lock and Swanepoel,1995, p.12). The primary care approach, on the other hand, constitutes an essential component of the biomedical model. To improve the potential role of African indigenous healers with regard to health promotion and prevention of illnesses, we need to find methods and concepts that could accommodate both systems of health care delivery without violating the fundamental beliefs of either. Primary Health Care, a multi-sectoral approach, as McElmurry et al.(1992) point out, is essential health care made universally accessible to individuals and families in the community (p.36). They further argue that health care is made available to the communities through their full participation, and is provided at a cost that the community and country can afford. The community as a whole, according to McElmurry et at.(1992, p.36),

> " is considered client. Unlike primary care, primary health care delivery is a pattern in which the consumers of health care are partners with professionals and participate in achieving the common goal of improved health."

In order to understand the concepts of the levels of prevention which originate from primary care model, we need to locate them within a historical medical context. For instance, McElmurry, Swider, and Watanakij (1992, p.36) state that:

" Primary Care is one of the essential components of the bio-medical model that divides health care into primary, secondary and tertiary levels of care of which prevention and promotion form part."

Primary care, unlike primary health care, as McElmurry et.al (1992) argues, focuses usually on the individual or an individual family (p.36). Primary care refers, according to McEmurry et.al (1992), to the delivery of health care that may be directed by medicine, nursing or other specialised branches of health care system (p.36).

Primary Prevention is the level of prevention which is referred to by Laevell and Clark (cited in de Haan, 1988) as the period of prepathogenesis, is the stage whereby the person is not ill, and it consists of two stages. These stages include health promotion and specific protection. During health promotion stage, specific measures are taken to promote optimal health in individuals and communities. This can be achieved, as de Haan (1988, p.13) points out, through:

"Ensuring adequate nutrition, promoting high standards of environmental hygiene through the provision of suitable housing, satisfactory ventilation and the prevention of overcrowding, efficient disposal of refuse and excreta, the provision of safe water supplies, the control of rodents and insects, encouraging satisfactory standards of personal hygiene and cleanliness, ensuring suitable working conditions and the elimination of occupational hazards, provision of genetic counselling, promoting optimal psychological health through marriage and vocational

guidance, the use of psychological desirable child-rearing practices and the use of effective health education."

Specific protection, as de Haan (1988) further states, can be achieved through:

> "Immunization, the use of protective clothing in industries, the wearing of seatbelts in cars and crash helmets on motorcycles, the prophylactic use of drugs to prevent disease such as malaria, elimination of the vectors of disease and control of diseases in animals."

Secondary level of prevention is, according to de Haan (1988, p.14), the period whereby:

> " the person is already suffering from a disease and the measures taken are directed at preventing the spread of the disease and halting its advance in a shorter time as soon as possible."

This level involves early detection of illnesses and prompt treatment.

Tertiary Level of Prevention is the period of intervention which is achieved, as de Haan (1988, p.14) points out, through:

> " returning the person to his community, and ensuring that his remaining capacities are fully utilized and that further deterioration will be prevented. Where necessary, physiotherapy, sheltered employment, and social services such as disability grants should be available."

Therefore, primary care, because of its association with reductionistic and mechanistic approach to health care, seems to be somehow different from Primary Health Care.

Interaction between indigenous healers and western health professionals may be based on primary health care approach in which both health care systems may complement each other. It should also include prevention of illnesses. Although three levels of prevention have been highlighted, the interaction between indigenous healers and western health professionals may take place exclusively at the primary level of prevention which includes certain aspects of health promotion. The second and third levels of prevention are concerned mainly with treatment interventions and are not the focus of the present study.

It is encouraging to learn that some of the modern scientists have changed their mode of thinking which was, to a greater extent, inextricably bound to Newtonian science. They are more systematic and open-minded. This is reflected when Angel (1977,p.134) states that:

> "The present upsurge of interest in primary care and family medicine clearly reflects disenchantment among some physicians with an approach to disease that neglects the patient. They are now more ready for a medical model which would take psychosocial issues into account. Even from within academic circles are coming some sharp challenges to biomedical dogmatism."

This change within the behavioural and biomedical sciences is observed by Schwartz (1982, p.1040) when he remarks that:

> "traditional boundaries between disciplines are currently being broken down, and new interdisciplinary fields are emerging at a remarkable rate."

It should, however, be noted that this does not imply that those who did not change are inhumane in their approach but they, unfortunately, exclude the psycho-socio-cultural context from which most human-related problems arise.

It is important to note that human related phenomena are complex and that reductionistic approaches may not address them adequately. This becomes highlighted when Engel (1977, p.132) notes that:

> "The boundaries between health and disease, between well and sick are far from clear and never will be clear. They are diffused by cultural, social and psychological considerations. Traditional biomedical view led to the belief that some people with positive laboratory findings are told that they are in need of treatment when in fact they are feeling well, while others feeling sick, are assured that they are well."

This author further illuminates the problems associated with narrow approaches when he remarks that:

> "While reductionism is a powerful tool for understanding, it also creates profound misunderstanding when unwisely applied. Reductionism is particularly harmful when it neglects the impact of non-biological circumstances upon biological processes. And, some medical outcomes are

inadequate not because appropriate technical interventions are lacking but because our conceptual thinking is inadequate."

In order for western health professionals to interact effectively with indigenous healers at the primary level of prevention which is associated with health promotion, a bio-psycho-socio-cultural approach may be considered to facilitate interdisciplinary thinking. It should, however, be noted that Schwartz (1982, p.1049) challenged the effectiveness of bio-psycho-social model in practice as an alternative to the medical model. For an example, he argues that:

> "the systems approach argues that many specific disciplines, by looking "microscopically," tend to lose the forest for the trees. On the other hand, it could be argued that the systems approach, by looking "macroscopically," may lose the trees for the forest. I have observed that the co-ordinating physician, in an attempt to think comprehensively about the patient, may sometimes miss key details because of his or her focus on the larger picture."

Thus it becomes apparent in the foregoing statement that, in order for interaction between indigenous healers and western health professionals to be effective, with regard to health promotion and prevention of illness, a team approach would be more appropriate.

1.6. THE SIGNIFICANCE OF THE STUDY

It is essential that the strengths and limitations of indigenous healers be recognised and developed. Indigenous healers can make

a great impact provided their skills are developed and utilized. We should build on the existing knowledge of indigenous healers to maximize the delivery of health care to our communities. This implies that the study has the potential to establish and implement some of the important components of comprehensive primary health care. For example, by increasing the preventive and promotive components of care provided by indigenous practitioners the study may ensure that health services become accessible to the majority of people particularly those living in the remote areas.

Training may develop indigenous healers with greater skills in primary health care. Appropriate information for influencing policy may arise from the study. It may also result in improved health care in the project area. A framework for indigenous healers' skills development including training materials was developed. The study will also lead to indigenous healers' greater awareness of the western practitioners role and vice versa within the two health care systems. As a result, both groups of health care practitioners may be sensitized to each other's cultural framework thus increasing their level of mutual understanding. It may also help propose a new model of health care delivery in South Africa that will encourage both integration and collaboration thus improving the quality of health care being rendered by both indigenous healers and western health professionals.

1.7. TERMINOLOGY

1.7.1. Indigenous healers

Indigenous healer : means a person who has satisfied the

requirements (training) necessary to become an indigenous healer. An indigenous healer is defined by WHO (cited in Pretirius, de Klerk and van Rensburg, 1991, p.5) as:

> "Someone who is recognised by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as the prevailing knowledge, attitudes and beliefs regarding physical, mental and social well-being and the causation of disease and disability in the community)."

Indigenous healers may be divided into three main categories.

1.7.1.1. Isangoma (diviner)

Isangoma is defined by Abdool Karim, Ziqubu-Page and arendse (1994, p.7) as:

> "a traditional diviner and diagnostician who not only defines illness but also divines the circumstances of the illness, that is, the ultimate cause in terms of African concept."

1.7.1.2. Inyanga (herbalist)

Izinyanga (plural) are defined by Abdool Karim, Ziqubu-Page and arendse (1994, p.7) as a category of indigenous healers who:

> "specialise in the use of herbal medicine because they possess an extensive knowledge of curative herbs, natural

treatments and medicinal mixtures of animal origin. Their comprehensive curative expertise includes preventive and prophylactic treatment, rituals and symbolism as well as preparations for luck and fidelity. Some treat only one disease and become renowned experts on that disease. These include military doctors, rainmakers and specialists in diseases of specific organs, for an example, the heart, kidney or lung disease consultants. They are similar to western doctors in that their main role is that of treating various illnesses. However, they differ from the western doctors in that they have the ability to prepare herbal remedies, a role that is similar to that played by a pharmacist in western medicine."

1.7.1.3. Umthandazi (faith healer)

According to Abdool Karim, Ziqubu-Page and arendse (1994, p.7) faith healers are defined as a category of healers who are:

> "Usually professed Christians who belong to one of the missions of African independent churches. They heal mostly through prayer, by laying hands on patients or providing holy water."

A faith healer is defined by Makhubu (1988, p.77) as someone who symbolically uses elements for healing. For an example, he states that:

> "Water is the main element used. It is regarded as God's greatest natural gift to be used for healing. All life depends on and exists because of water. Water from natural springs is taken to faith healers for prayers and blessings.

Sea water is used for healing purposes and for the protection of the home. Ash is said to be clean and pure because all the impurities have been consumed by fire. Ash is mixed with water for drinking and baths. Ordinary rough salt is used for enemas. All the elements mentioned are not used alone, but are accompanied by prayer, in whatever form they are applied. Prayer to God, to Jesus and the holy spirit is used to heal the sick. The laying on of hands, and placing them on the spot where pain is, is also done."

1.7.1.4. Current practice

This means knowledge and actions shown by indigenous healers during their practices.

1.7.1.5. Western Health Professionals

These are health workers who practice their profession independent of their cultural background, and are licenced and / or paid by the state.

1.7.1.6. Effectiveness

This means a change in knowledge, beliefs and practice.

1.7.1.7. Formal health system

This is a system that has been professionalised or has a legal status.

1.7.1.8. Illness prevention

This means the concept which originated from primary care model that divides health care into primary, secondary and tertiary levels of care (McElmurry, Swider, and Watanakij 1992, p.36).

1.7.1.9. Health promotion

Health promotion, according to Dennill et al., may be defined as the process of enabling people (individuals and communities) to increase control over the determinants of health, and thereby improve it.

CHAPTER TWO

LITERATURE SURVEY

2.1. ATTITUDES TOWARDS INDIGENOUS HEALERS

For the formal health care delivery system to be more effective and relevant in South Africa, an appropriate and comprehensive health care system that would integrate indigenous practitioners into the formal primary health care approach may be necessary. However, in order to critically discuss the integration and the role of indigenous practitioners, which is associated with a lot of controversy, we need to locate it within a particular socio-economic and political context.

It is important to note that during the middle ages, long before the establishment of the medical profession, indigenous practitioners especially women, played a very important role of healing. They were the informal medical practitioners and anatomists serving the western society (Ehrenreich and English, 1973, p.19). These authors also point out that the lay medical practitioners played a number of roles. For example, they were involved in pharmacy, midwifery , doing home visits from village to village and growing of healing medicinal plants and exchanging secrets of their uses. It should also be noted that these women discovered drugs some of which are currently used today. For instance, Sanders (1985, P.112) argues that:

> "It was they who discovered and administered herbal remedies still important today such as ergot for labour pains,

belladonna to inhibit uterine contractions during threatened miscarriage and digitalis for treating heart ailments."

Because of these services the lay practitioners rendered in their communities, they were called wise women by the people, especially the peasants, although authorities referred to them as 'witches' (Ehrenreich and English, 1973, p.19).

Evidence reveals that these lay practitioners were highly competent in their medical practices, and their practices were safer and more effective than the formal medical doctors. For instance:

" in 1527 Paracelsus, known as the father of the modern medical profession burned his text on pharmaceuticals, confessing that he had learned from the sorcerers all he knew (Ehrenreich and English, 1973, p.33)."

A study conducted by John Hopkins University professor in 1912 in the United States (US) also reveals that most American doctors were less competent than the lay midwives (Ehrenreich and English, 1973, p. 51). These authors also point out that a highly respected physician known as Oliver Wendell Holmes, Sr, stated that:

" If all the medicines used by the medical doctors in the United States were thrown into the ocean, it would be so much the better for mankind and so much the worse for the fish (Ehrenreich and English, 1973, p.41)."

However, the popularity and effectiveness of the lay practitioners became a serious political, religious, and sexual

threat to the Protestant and Catholic churches alike as well as to the state (Ehrenreich and English, 1973, p.23). The big threat posed by the lay practitioners to the church and the state during the medieval Europe led to the drastic steps being taken to eliminate such practitioners. For an example, from the fourteenth to the seventeenth century, countries like Germany, Italy, France and England started executing thousands and thousands of the lay practitioners particularly in the form of live burnings (Sanders, 1985, p.112). At the same time doctors, who were also supporting the executions for medical reasons, were busy struggling to take over control of the healing practices rendered by the lay practitioners and this was known as the suppression of witches (Ehrenreich and English, 1973, p.24). It is pointed out that the medical doctors played a pro active role in the suppression of the healers. As Sanders (1985, p.112) states:

> "The lay practitioners also threatened the emerging medical profession, who earlier on ensured their exclusion from the universities. English doctors petitioned parliament concerning the 'worthless and presumptuous women who usurped the profession' and requested that fines and long imprisonment be imposed on any woman who attempted to 'use the practise of Fisky'."

This was followed by the rise of the medical profession. For instance, Ehrenreich and English (1973, p.20) maintain that:

> " political and economic monopolization of medicine meant control over its institutional organizations, its theory and practice, its profits and prestige."

It is therefore apparent that the medical doctors, who had enormous support of the church and state, owe their victory not so much to their own efforts but to the intervention of the ruling class they served, both medically and politically (Ehrenreich and English, 1973, p.21).

Indigenous healing system in South Africa, like in Europe, has for centuries been denied the right to function as a legitimate health care system and many efforts have been made to eradicate it. Gelfand (1944) maintains that indigenous healers, because of their influence in the African population, prevents people from appreciating the merits of hospital treatment. This become evident when this author states that:

> "The greatest obstacle to such an outlook is the influence of a witch-doctor. This will and must eventually be destroyed; but its destruction presents a problem which, as I see it, can only solve itself after many years. The power of the witch-doctor will decay, just as, centuries ago in Europe, the power of the oracles decayed. But until that time the sick African will endure much unnecessary suffering (Gelfand, 1944, p.8)."

Contrary to what happened in Europe (persecutions of thousands of indigenous healers), in Africa, attempts to eliminate indigenous healing system took another form. For example, Gelfand (1944, p.8) maintains that:

> "The only way to eradicate witch-craft is by education. Conversion to the Christian faith has done much to shake the coming generation's belief in witch-craft. Much could be done by training large numbers of Natives to become

> orderlies, nurses, midwives and even doctors to attend to their own people and to disseminate our methods of medical approach. There are already Native orderlies, nurses and midwives; but there are not enough."

The suppression of indigenous practitioners in South Africa, like in Europe, may be attributed to the economic threat they pose to western doctors and this has obviously led to their loss of legal status they once possessed. Recent evidence, according to Barron (cited in Sunday Times, 2000, p. 20), reveals that:

> "The South Africa's best known traditional healer, Sosobala Mbatha, who was born and practised in Nqutu near Dundee in the Midlands of KwaZulu-Natal and whose patients came from the whole of Southern Africa and even from Britain and the United States, made considerably more money as a traditional healer than most medical doctors. He lived in a four-storey mansion in Nqutu, and had a fleet of around ten cars including mercedes-Benzes, BMWs, a couple of 4X4s and a couple of bakkies, at least two farms and several supermarkets and bottle stores. Although his business generated a lot of wealth, he built them up on the back of his considerable earnings as a traditional healer. To keep up with the growing demand for his skills, he bought a six seater aircraft, and later leased a 33 seater Dakota with an SAA-trained pilot at the controls. The press dubbed him the "flying doctor". He was planing to buy a helicopter when he died."

Although in the province of KwaZulu-Natal indigenous healers possessed government licences which enabled them to practice their healing profession, doctors were, however, amazed and

embarrassed when they discovered this new type of legalised competition (Schimlek, 1950 p.84). This author also points out that their shock might have been due to the fact that in Europe and United States lay practitioners were suppressed many centuries ago and what doctors discovered in South Africa was unexpected. For instance, a Catholic priest points out to Dr Kohler that:

> "the native herbalists of Natal have, moreover, formed a 'Natal Medical Association' for the protection of their own members who are licensed, particularly the town practitioners and those doing the cure-by-post business. A certain number of them still possess a government license to practice (Schimlek, 1950, p.88)."

The researcher speculates that the medical profession, because of authority and support it receives from the state, was able to influence the state to discredit indigenous healing system. For instance, Friedson (cited in Dawes, 1986, p.32) states that:

> "medical doctors are 'the only full professionals' in the health field because only they have the authority to direct and evaluate the work of others without in turn being subject to formal direction and evaluation by them"

Consequently, indigenous healers, because of economic factors, were deprived of their legal status thus becoming non registered health practitioners.

Lambo (cited in Holdstock,1981) attributes the reluctance to accept and respect the framework of indigenous cultures to the unfortunate effect of the moral arrogance of the 19th and 20th

century whereby Europe sets up its civilizations as the standard by which all others are to be measured (p.124). Last and Chavunduka (1986) state that the colonial governments and early Christian missionaries, probably due to ignorance, despised indigenous healing system and attempted to discourage people from using traditional medicines (p.29). There seems to be a number of reasons why traditional practices were prohibited, negated, undervalued and scorned. As an illustration, Last and Chavunduka (1986, p.30) note that:

> " Many colonial governments officials and missionaries did not know that traditional medicines are effective in curing many illnesses. They thought that a traditional healer was just a deceiver who prevented many patients, who would otherwise be treated effectively with modern drugs and surgery, from reaching government and mission hospitals. It was also believed that traditional healers encouraged the belief in witchcraft which was regarded as one of the greatest hindrances and stumbling blocks in the way of Christian missionary work. Indigenous practitioners, instead of worshipping God, were regarded as worshippers of devils."

Consequently, patients who used the services of indigenous healers also suffered for using such services. For instance, these authors point out that if doctors and nurses knew that patients had been to a traditional healer before coming to them, they would often insult, reprimand or blame them.

Cultural prejudice and discrimination against indigenous healers is as old as the colonial era. Hammond-Tooke (1989) has remarked that in the genre of African colonial literature, `witchdoctor' has always occupied a semi-allegorical role and such literature

could make the young English generations more vulnerable to developing prejudice due to false beliefs being reinforced by the spreading of an inaccurate information about indigenous healers(p.103). This author also notes that:

> "the pages of the boys' magazines of an imperialist past such as boys' own paper and Chums; which fed the imaginations of generations of youngsters, are filled with stories of derring-do in the wilds of the continent where the intrepid District commissioner, representing civilization and the forces of light, is opposed by the sinister figure of the witch-doctor, the epitome of evil, primeval cunning and the dark forces of barbarism."

Colonial writers seem to have, explicitly or implicitly, influenced the younger generations how to perceive the world, how to experience it emotionally and how to respond in relation to 'witch-doctors' (Helman, cited in Swartz,1998, p.6). Through media, the youngsters seem to have been socialized to develop negative attitudes towards indigenous healers. According to Hammond-Tooke (1989) such stereotyping affected adult popular fiction as well, and even the work of black writers. Indigenous healers have been scorned as "witchdoctors" by westerners, a misconception which has been, and is often reinforced by sensational press reports of the alleged use of human tissue associated with sorcery. This concept is not synonymous with indigenous healing. Media, therefore, seems to have played a crucial role in the maintenance of cultural prejudice.

Despite the fact that the concept of culture seems to play a very important role in any form of therapy, in South Africa, it has been used as a basis for the government's ideology. Schweitzer

(1983,p.111), for example, has summarized the criticism of the South African uses of the culture concept. He notes that:

> "differences in culture indicate unequal levels of development of different nations or peoples and this rationalises the political and socio-economic structure of the previous South African non democratic government. The previous government policy, and hence the pattern of South African society, was embodied in the concept of pluralism. Pluralism tends to emphasize cultural differences between the various ethnic groups and the right of different cultures to be protected from influences which would otherwise weaken or disrupt them. It asserts that divisions and inequalities between groups of people in South Africa are rooted in differences in culture. The government policies were aimed at maintaining and strengthening the existing divisions and were supported by this argument."

Prejudice against indigenous healers may be attributed to the product of the world view and value system which were established in the 16th and 17th centuries and had laid a solid foundation of the western culture. This world view was based on reason and faith and its main objective was to understand the meaning of things. However, In the 18th and 19th centuries, due to the tremendous shift in the way people pictured the world and in their whole way of thinking, modern science developed which viewed the world as a machine. The shift has led to the idea of reductionism in science, the belief that all aspects of complex phenomena can be understood by reducing them to their smallest parts. For example, a patient suspected to be suffering from tuberculosis can have a sputum taken so that the invisible T.B. germ known as T.B. bacilli can be identified and isolated as the

root cause of the patient's disease. The problem is that scientists, due to encouragement by their successes in treating living organisms as machines, tended to believe that even human beings are nothing but machines (Capra, 1983, p.47).

The limitations of this mechanistic approach becomes apparent in medicine, where the adherence to the Cartesian model of the human body as a machine has prevented the medical practitioners from understanding many of today's major illnesses (Capra, 1983 p.48). In another instance, the western medical practitioners may believe that mental illnesses are universal and that their role is to focus cross-culturally to find evidence of the universal conditions. Evidence in many parts of the world including Africa, as Swartz (1988) points out, reveals that people do not show personal distress in the same way. The western medical practitioners, as a result, may attempt to reveal, for instance, that a person in Zululand complaining of shoulder pains without organic reason may be suffering from depression. However, according to the author's observations, pain in the shoulders without organic pathology may be perceived by the African people who have preserved their historical culture as being associated with the ancestral spirit possession. The western medical practitioners seem to forget that their scientific approach and assumptions represent the western values and these may influence the way they perceive the world (Swartz 1998 p.13).

Some psychiatric illnesses may be inextricably bound to specific cultures (Shezi and Uys, 1997) and may have features similar to those of the universal conditions like schizophrenia (Shezi and Uys, 1997). This may prevent the western medical practitioners, associated with western values, from entering into the emotional worlds of the people they are studying and treating (Swartz,

1998). DSM IV (a diagnostic statistical manual) which tries to show the universality of many culture-bound psychiatric conditions is essentially an American document and its relevance in different cultural setting is still questionable (Jones and Kerson, cited in Shezi and Uys, 1997, p.83). This idea is also supported by Green (cited in Arthur, 1997, p.64) when he says:

> " a world view based on supernatural and other belief systems is in contradiction with, and cannot be understood by, the modern western medical practitioners."

It is therefore clear that prejudice against indigenous healers may also be attributed to different world views between western medical practitioners and indigenous healers.
Furthermore, prejudice against indigenous healers may also be associated with the process of social differentiation which led to the replacement of traditional forms of life by the modern social life associated with technology (Stehr, 1994). According to this process, as Stehr (1994) points out, social institutions like education, religion, health care etc. are clearly demarcated and this forms part of the sophisticated modern social life which is compatible with the modern medical system. For example, western medicine is exclusively based on natural phenomenon subject to investigation by scientific methods (Coe, cited in Arthur, 1997). On the other hand, the traditional societies do not differentiate among the social institutions and therefore remain undifferentiated. African indigenous healing system, unlike the western health system, incorporates physical, social, spiritual and religious factors and this renders it non scientific (Elling, cited in Arthur, 1997, p.64). Therefore, because indigenous medicine is associated with undifferentiated

traditional societies, it may be judged by the modern medical system as backward and of less value (Swartz, 1998).

Marginalisation of indigenous practitioners may also be linked to specific historical events, during which, psychologists were busy classifying almost all the populations of undesirable cultures as mentally handicapped. At the same time many anthropologists were proposing the concept "primitive", which may be associated with the idea of being backward, ignorant, superstitious and illiterate (Montaque, cited in Hilliard, 1985, p.19).

Some community health professionals and those found within the academic world of information processing, theory building and research are, to a certain extent, accountable for the neglect and avoidance of indigenous practitioners whose role has been acknowledged even by the World Health Organization (Holdstock 1979, p.118). This is also noted by Paranjpe (1981) who argues that ideas and opinions of indigenous people have historically been neglected by mainstream academics; and the conceptual frameworks of indigenous people were treated as if they did not exist (p.10).

Probably due to an inappropriate approach and strategy being used when offering training to indigenous healers, Leclerc-Madlala (1997) also observed that even post training, indigenous healers claim that some members of the modern health care personnel despise them, do not have confidence and respect for them and view them as dirty and uneducated. Despite the fact that indigenous healers are familiar with local medical structures and personnel, efforts must be made to make their work more appreciated by the western medical practitioners (Leclerc-Madlala, 1997, p. 5). It thus becomes clear that western

civilization seems to have had a great influence upon people's attitudes towards indigenous practitioners.

Hilliard (1985) states that there is nothing inherent in culture or technology that automatically leads to inequality and oppression. He points out that for many years the minority cultural groups living in the homelands did not have the political and economic power in order to be able to participate in professional matters. Any kind of interference with the minority people in the homelands, according to the non democratic South African government's rationalisation, would mean total disruption of people's traditional and cultural life (Scweitzer,1983, p.111). Consequently, this obviously led to the lack of development of African indigenous healing system. This, as Hilliard (1985) points out, was due to political oppression whether it was formal or informal, overt or covert, conscious or unconscious. By looking at the concept of culture one can see how group oppression is maintained. It therefore becomes clear from the foregoing that the South African Government has used the concept of culture to discriminate against indigenous healing by neglecting the development of this sector, just as the development of Black languages was neglected.

Hilliard (1985) also speculates that in any society where people have been severely oppressed, the oppressed are more likely to identify with their oppressors and consequently become prejudiced against their own culture which, in the South African context, involves, to a greater extent, the belief in the ancestral spirits by the previously oppressed Black South Africans. This idea is supported by Thorpe (1982) who observes that the nursing diploma students, having gained their psychiatric knowledge from western orientated psychiatrists, doctors and nursing staff, tend

to abandon traditional values and knowledge and become highly sceptical about information which is not found in psychiatric books (p.5). Motlana (1988), a black physician, for instance, argues that health care professionals including psychologists must stop romanticizing the evil degradations of the Sangomas. Jarrett-Kerr (1960, p.33) also notes that:

> " it is now European doctors and medical theoretician who are more ready to allow a place and function for the traditional healer or for African concepts of sickness, whereas the African qualified doctors and nurses are much more anxious to make an immediate and clean sweep of ancient tribal custom and to assert their recently acquired western knowledge."

The indigenous healing system seems to have been neglected by the formal health care system. It is also important to note that the rejection of indigenous practitioners may, to a greater extent, be attributed to the historical stigmatization of undesirable cultures. For example, van Rensburg, Fourie and Pretorius (1992) mention that the South African Medical and Dental Council (SAMDC), according to the 1974 Health Act, prohibited any formal collaboration between the formal health care medical practitioners and non registered healers (p.336). It is, however, important to note that although the foregoing obstacle (ethical rule 9 (2) published by SAMDC under act No 56 of 1974) has been deleted, no rule has been published under the new act encouraging collaboration between the two forms of healing.

However, it should be noted that, despite the fact that the concept of culture seems to have been contaminated by the government's ideological issues, some people have not undermined

its therapeutic value. It is encouraging to observe that a positive attitude towards indigenous practitioners has developed. For instance, traditional healers have been observed to be a very caring people, and extraordinary skilled in psychotherapy and counselling (Kale, 1995, p.1182).

Buhrmann's personal experience with the African world and her rejection of cultural prejudice, as Schoeman (1985) points out, is based on a deep compassion and sincere respect of the black man (p.17). In another instance, Paranjpe (1981, p.10) argues that:

> " Over the past few years an increasing number of Eastern as well as Western psychologists have not only recognized the importance of the natives' views of the world but have also turned to the Eastern intellectual heritage for inspiration and insight."

Robbertze (cited in Holdstock, 1979, p. 120) relates that the therapeutic efficacy of indigenous healers appears to be superior to that of psychiatrists, psychotherapists or medical doctors in treatment of certain conditions.

Natal Provincial Administration (cited in Natal Witness Supplement, 1993) reports that at present they have not seen one tetanus case in the last six years. Patients with tuberculosis are regularly referred to the hospitals by the healers and are now being seen early, as are people with sexually transmitted diseases and those needing psychiatric care (p.3). Natal Provincial Administration also states that, under supervision,

the indigenous healers are giving treatment to those suffering from leprosy, T.B. and those with psychological problems.

However, poor care and inability by some traditional healers to effectively handle specific illnesses may be attributed to their neglect by the formal health sector. For instance, The Natal Provincial Administration(NPA)(cited in Supplement to the Natal Witness, 1993, p.3) states that:

> " Many patients who suffered from tuberculosis reached the hospital in the late stages of the illness. A number of people were already disabled by the time they reached the hospital. Sexually transmitted diseases reached an advanced stage before being treated by a doctor. Epileptic and psychiatric cases were often chronic before being treated. Diarrhoea was a killer."

It is further noted that some of the practices of indigenous healers seem to be injurious to the lives of their patients. For instance, Kale (1995, p.1185) maintains that:

> "The adverse effects of traditional remedies on the bowel have been described. A Swazi infant may receive as many as 50 enemas a year, and a member of the Zulu community may use as many as three enemas a week. The ingredients may have profound effects on the mouth, tongue, stomach, duodenum and jejunum; a 'ritual enema induced colitis' has been described. Other complications known to occur are peri anal excoriation, anal canal necrosis, haemorrhagic ulcerative proctocolitis and gangrene of the perineum. Poisoning with cardiac glycosides, and with potassium dichromate have been described."

It is, however, not clear whether members of the formal health sector are aware of the fact that some of these illnesses, like tuberculosis, were traditionally introduced from the outside through contact with explorers, missionaries and colonial forces and that indigenous healers may not be able to treat them but could play a crucial preventive role (Kris 1988 p.9). It may, therefore, be apparent that an unregulated system of healing in which genuine indigenous healers can not be differentiated from charlatans predisposes communities to a potential health hazard.

However, lack of understanding by western medical practitioners of their patients' value system may have a negative impact in terms of the quality and effectiveness of services they provide. For instance, medical students who conducted a study under the supervision of the Department of Paediatric Surgery at the University of Natal Medical School in Durban, to find out what traditional medicine had been given to children before they were brought to a hospital or clinic, maintain that:

> "Doctors working with children in multicultural localities need to have an understanding of the customs and attitudes of the people among whom they work. This is particularly true of South Africa where, historically, there has been restricted contact between different races and population groups. This ignorance about other cultures can persist if the curriculum in medical schools fails to deal with these issues. Consequently, many doctors may be unaware of the type of treatments their patients may have received before consulting them and the impact of traditional therapies on the presenting signs and symptoms (Lusu, Buhlungu & Grant, 2001, p.270)."

It should also be noted that indigenous medications administered prior to arrival at formal health facilities could influence the diagnosis that could be arrived at by the western practicians. For instance, Lusu, et al, (2001, p.270) state that:

> "The types of traditional therapies varied enormously. They were usually harmless, but occasionally they were dangerous and endangered the child's health, or altered the signs and symptoms of the underlying complaint."

In order for the formal health sector to work more effectively in the multicultural South African society, it should consider the integration model as an instrument which may integrate both indigenous healers and western medical practitioners into comprehensive primary health care model, thus extending the role of both medical systems beyond primary care which seems to be limited and curative in nature. This may, hopefully, lead to the mutual understanding between indigenous and western medical practitioners.

Therefore, in order for a western medical practitioner to work more effectively in the multiracial South African context, it is imperative that he or she have a sound knowledge of the culture of the clients served. However, the boundaries created by apartheid among various racial groups, which may be linked to a historical process based mainly on economic and political institutions, seem to have led to lack of mutual understanding between indigenous healers and western medical practitioners.

2.2. INTEGRATION OF INDIGENOUS PRACTITIONERS WITH THE WESTERN HEALTH CARE SYSTEM.

Lack of integration of indigenous practitioners into the formal primary health care delivery system appears to have resulted in less effective health services being rendered to the South African population. For instance, the researcher speculates that western trained biomedical practitioners may not be aware of the fact that African culture-related diseases may be treated, but may not be cured by western trained bio-medical practitioners, psychologists and psychiatrists. It is universally accepted, as Cheetham and Grifiths and Cheetham and Rzadkowoslki (cited in Shezi and Uys, 1997), that mental illness is relative to the culture concerned and mental illness concepts (p.83). North Americans, for instance, attribute mental illness to social norms with more focus upon willpower, dependence and environmental influences in aetiology. On the other hand, Germans and the British conceptualise mental illness as being entirely biologically determined. The public health and medical social science literature invariably document the recognition of the value of western medicine on the one hand and its limitations on the other (Foster and Anderson; Singer and Velimirovic, cited in Kris, 1988 p.15). Kris (1988, p.15) also states that:

> " practitioners of both allopathic and traditional medicine are consulted for the same ailment (and interchangeably for other ailments), throughout both developing and the developed world."

In addition Sinna (1981, p.6) states that:

" the awareness of the inadequacies and limitations of the current formal health care delivery system seem to have produced a strong urge towards integration."

van Rensburg, Fourie and Pretorius (1992, p.341) also reveal the merits of integration by concluding that:

" An added benefit to modern medicine would be that the excessive demands now being made on its insufficient number of health care workers, could be greatly alleviated if local resources and health care are mobilized to share the workload."

Evidence reveals that indigenous healers have a potential to make a positive impact in the formal health care delivery system. For instance, Green (1994, p.218) states that:

"Informal interviews suggests that AIDS Control and Prevention training has boosted the healer's reputation in the community and may have improved the healer's practice as measured by an increase in clients."

This author further remarks that several healers reported that human relations with local health facilities and users had improved. For instance, he points out that:

"One trained healer in Alexandra township sent a patient to the local clinic whose STD symptoms kept recurring for HIV testing. The clinic nurse was surprised to see a patient who had been referred and properly advised about HIV testing by a traditional healer. The clinic now refers patients to that healer (Green, 1994, p.218)."

It should therefore be acknowledged that there are many diseases and that there is no single system of health care delivery that can claim to be able to treat all of them effectively. This implies that integration is justified by epidemiological and practical concerns, that is, realities of health care delivery.

It is also important to note that various studies conducted also reveal a positive attitude towards integration. For instance, Chiwuzie et al. (cited in Kris, 1988, p.16) state that in a study of 150 medical doctors and 150 medical students in Benin City, Nigeria, it was reported that:

> "Most doctors and medical students agreed that certain aspects of traditional practice were useful and as many as 70% of the doctors and 58% of the medical students felt that some form of integration was desirably."

In a similar study carried out in Malaysia in 1978 by Heggenhougen (cited in Kris, 1988), it was found that the majority of the 98 sampled western medical practitioners supported closer contact between traditional Malay and allopathic practitioners. Research evidence by Edwards (1985) reveals that:

> "73% of black South African university students, (non psychology students), 60% of urban residents and 45% of rural residents preferred modern western medicine. However, a large group (20% of university students, 29% of urban black students, 42% of rural residents) preferred modern treatment in combination with indigenous African treatment methods."

Based on a South African Survey, Lachman and Price (cited in Thorpe, 1982) also claim that:

> "80% of South African medical doctors believed that indigenous practitioners have an important role to play in the South African medical team particularly in the field of psychology."

Evidence therefore reveals that, when dealing with such a sensitive issue like integration, we may need to have contributions, not only from the policy makers, but also from bio-medical practitioners, indigenous practitioners as well as the health care consumers.

According to the researcher's observations, modern treatment can be administered along with traditional treatment under certain conditions. For instance, one functional model, as Bhatia and Neumann (cited in Neumann, 1982,p.221) point out, is a pragmatic adoption by indigenous medical practitioners of certain western remedies "because they work faster." They also note that this does not represent any modification of traditional belief systems. In another example, Neumann (1982, p.221) states that:

> " Patients obtain quick relief from symptoms by visiting a biomedical practitioner, while the traditional practitioner administers herbs and other traditional medications that attack the root causes of the problem."

Lambo (cited in Neumann, 1982, p.222) remarks that his work in Nigeria with psychiatric patients provides one of the best examples of the true functional integration. In his practice the patients were primarily in the care of a western medical

practitioner at one stage of their illness. At another stage, the bio-medical practitioners work together with the indigenous practitioners.

This model, as Neumann (1982, p.222) points out, represents a task orientated approach that recognizes the strengths and weaknesses of each school of healing. The client being served, according to van Rensburg, Fourie and Pretorius (1992, p.34), would probably benefit most from such integration. They believe that accessibility to health care, and also the quality and appropriateness of care, could be significantly improved in an integrated system with specified standards of care (van Rensburg et al. 1992, p.341). They also remark that joining of the two systems would moreover facilitate appropriate referral in cases of serious or uncommon disease or injury (van Rensburg et al. 1992, p.341).

It is important to note that two specific current models/ positions which have led to endless and fruitless controversies regarding the role of indigenous practitioners in the South African Health care delivery system have been proposed. These would include the relativist and the universalist positions. The relativist model, according to Korber (1990, p.50), states that different cultures exist which give rise to unique illness. This model is, as Kober (1990) points out,

> " being criticised of lending support to the apartheid ideology notion of separate but equal because it considers other methods of healing as relatively separate, different and discrete."

On the other hand, the universalist model, as Boonzaier (cited in Kottler, 1988, p.7) states, is the one that suggests that strengths and weaknesses of each system of healing should be considered. It has, however, been perceived as seeking to impose western medical values upon other cultures. This position, as Kottler (1988) remarks, neither derogates nor romanticizes African medicine (p.8). It acknowledges similarities between African and Western medical practices but also points to the differences (Kottler,1988,p.8). Fabrega (cited in Kober, 1990, p.50) also argues that,

> " although the two positions are contradictory, it is not problematic to argue that while there exist certain universals, there exist simultaneously certain differences."

Kober (1990) also suggests that the separation and division of facilities and people should not be seen as the solution to opposing health care models. Within the South African context, the two models could rather be allowed to enrich each other. In addition, Good et.al, Mac Cormack, Nchunda, Rappaport and Dent (cited in Kris, 1988, p.15), state that:

> " One approach for greater contact between different kinds of health care resources or systems would be for each to see what it could learn from the other and what aspects of the other system could appropriately be incorporated within each."

Despite the fact that various models have been proposed in South Africa regarding the status of indigenous healing systems, there are three distinct models which have been legally recognised and adopted by many countries all over the world with South Africa

being no exception. These models would include Exclusive systems, Tolerant systems as well as Integrated system.

2.2.1. Exclusive systems

Exclusive Models totally deprive indigenous practitioners the right to legal status. This model, according to van Rensburg et.al (1992, p.336), is characterised by a strict, total and forced monopoly. This model exclusively gives legal status to the bio-medical health system. Other forms of healing, as van Randburg et.al (1992), points out, are subjected to exclusion and preventive sanctions.

2.2.2. Tolerant systems

These systems, like the exclusive systems, recognize only those forms of healing based on modern medicine (van Rensburg, et al. 1992 p.336). Traditional healers, according to this model, are totally ignored, yet allowed a space in the sun. Traditional healers as van Rensburg et al,(1992, p.336) points out, are allowed freedom to work for a fee, provided that they will not pose as doctors.

2.2.3. Integrated model

Unlike the two above mentioned models, integrated model, according to van Rensburg et al.(1992), unite both the biomedical health system and indigenous healing systems in respect of training and practice together in a unique health system. Integrated training of practitioners is official policy. van Rensburg et al.(1992, p.337) state that it is becoming

increasingly apparent that neither the exclusive nor the tolerant legal models can be tolerated to operate for a long period.

2.2.4. Collaborative model

A collaborative model is being proposed as a kind of resolution (Abdool Karim, Ziqubu-Page and Arendse, 1994). These authors state that indigenous practitioners are heavily relied upon by the majority of the population in South Africa and they constitute a national health care resource. Abdool et al., (1994, p.14) propose collaboration between indigenous and biomedical practitioners for the following reasons:

> " They are already widely accepted and respected by the general public for their skills in providing curative, preventive and rehabilitative care;
> They are already available (no need for importation or repatriation), ubiquitous, and in most cases share the same culture, beliefs and values as their patients;
> Their methods are effective in certain illnesses (e.g. psychosomatic illnesses), as is their use of local herbs and medicinal plants for therapeutic purposes;
> They are skilled in interpersonal relations, including counselling; They can fill the vacuum in health care created by the shortage of biomedical health personnel for delivery of primary health care and they are prepared to consider changing to safer practices or possibly eliminating those traditional remedies and practices which have proved harmful to patients."

These authors also argue that:

> " The question of ethics also needs to be investigated. If a private company accumulates unique and useful knowledge through trial and error, it patents that knowledge and receives a percentage of the profits from its use. Traditional healing knowledge has been accumulated in a similar manner but has been made public with no patent rights attached to it. Adequate compensation for the secret knowledge of African traditional healers should be considered (Abdool Karim et al.,1994, p.14)."

Both exclusive and tolerant systems models seem to have some disadvantages. They seem to be reinforcing the medical model to remain a closed system with very limited opportunities to grow in order to effectively understand and address complex human related phenomena. The integrated model may, on the other hand, encourage mutual understanding between bio-medical practitioners and indigenous practitioners. This can help eliminate existing prejudices hindering the process which may lead to growth of both health care delivery systems.

2.3. TWO DOMINANT MODELS OF WESTERN HEALTH CARE

2.3.1. Prevention in health

In order to understand the concepts of the levels of prevention which originate from primary care model, we need to locate them within a historical medical context. For instance, McElmurry, Swider, and Watanakij (1992, p.36) state that:

" Primary Care is one of the essential components of the bio-medical model that divides health care into primary, secondary and tertiary levels of care of which prevention and promotion form part."

Therefore, primary care, because of its association with reductionistic and mechanistic approach to health care, seems to be somehow different from Primary Health Care.

Primary care, unlike primary health care, as McElmurry et.al (1992) argues, focuses usually on the individual or an individual family (p.36). Primary care refers, according to McEmurry et.al (1992), to the delivery of health care that may be directed by medicine, nursing or other specialised branches of health care system (p.36). In contrast, Primary Health Care, as McElmurry et al.(1992) point out, is essential health care made universally accessible to individuals and families in the community (p.36). They further argue that health care is made available to the communities through their full participation, and is provided at a cost that the community and country can afford.

The community as a whole, according to McElmurry et at.(1992, p.36),

" is considered client. Unlike primary care, primary health care delivery is a pattern in which the consumers of health care are partners with professionals and participate in achieving the common goal of improved health."

Prevention and promotion form part of preventive medicine which, as de Haan (1988) states, operates at three levels (p.36). These levels include primary, secondary and tertiary levels of

prevention. Primary prevention, for instance, involves health promotion and specific protection. Secondary prevention includes effective treatment and limitation of disability. Finally, tertiary prevention involves rehabilitation.

Primary prevention, referred to by Laevell and Clark (cited in de Haan, 1988) as the period of prepathogenesis, is the stage whereby the person is not ill, and it, according to de Haan (1988) consists of two stages (p.13). These stages are health promotion and specific protection. During health promotion stage, specific measures are taken to promote optimal health in individuals and communities. This can be achieved through:

> " Ensuring adequate nutrition; promoting high standards of environmental hygiene through the provision of suitable housing, satisfactory ventilation and the prevention of overcrowding; the efficient disposal of refuse and excreta, the provision of safe water supplies and the control of rodents and insects including flies; encouraging satisfactory standards of personal hygiene and cleanliness; ensuring suitable working conditions and the elimination of occupational hazards; providing genetic counselling; promoting psychological health through marriage guidance, vocational guidance and the use of psychological desirable child-rearing practices, and the use of effective health education to achieve these aims and objectives (de Haan,1988, p.13)."

On the other hand, specific protection is, according to de Haan (1988) ensured through:

" immunization; the use of protective clothing in industries; the wearing of seat belts in cars and crash helmets on motorcycles; the prophylactic use of drugs to prevent decease such as malaria; the elimination of vectors of disease as well as the control of diseases in animals."

Secondary level of prevention is, according to de Haan (1988, p.14), the period whereby,

" the person is already suffering from a disease and the measures which are taken are directed at rendering the patient non infectious in a shorter period as soon as possible thus preventing the spread of the disease."

Intervention at this stage occurs, according to de Haan (1988, p.14), through the following steps:

"early diagnosis; appropriate treatment, including isolation where necessary; case finding so that all persons suffering from the condition may be traced and treated; notification of the disease to the appropriate authorities and the treatment and control of the contacts."

Due to the fact that many conditions may be disabling, this level of prevention's main focus is, according to de Haan (1988), on stopping the progress of the disease and preventing complications (p.14)

Tertiary level of prevention is the period of intervention which is achieved, as de Haan (1988) states, through:

" returning the person to his community, and ensuring that his remaining capacities are fully utilized and that further deterioration will be prevented. Where necessary, physiotherapy, vocational guidance, retraining programmes, sheltered employment and social services such as disability grants should be available."

The South African western medical practitioners use the prevention model of health care. However, because of being inextricably bound to the scientific approach, they seem to have been unsuccessful when implementing the preventive and promotive strategies. For example, Werner and Sanders (1997, p.15) stated that:

"The most serious shortcoming of the western health care model, is the way it almost entirely ignores the underlying socio-economic and political causes of health problems."

They further stated that,

" the health professions have helped spread the idea that the ill health of people living in poor countries is largely due to ignorance and overpopulation, rather than to the systematic underdevelopment of the third world by the first world (p.15)."

Despite its merits, the medical model seems to be less effective when applied to complex human related phenomena. For instance, malnutrition, a condition which results when people do not get enough and right types of food to grow well and to prevent illnesses, is an intersectoral problem which seems to be the key behind the major killing conditions in South Africa (Felhaber and

Mayeng, 1999, p.10). The South African Health Review (1996, p.19) also reveals that:

> "much of the burden of disease is due to preventable causes of mortality, morbidity and disability."

Like HIV infection, malnutrition can be fatal to both mother and her baby especially during pregnancy, delivery and after delivery. For example, Felhaber and Mayeng (1999, p.10) state that:

> "Poor nutrition during pregnancy causes weakness and anaemia in the mother and increases the risk of her dying during or after childbirth. It can also lead to miscarriage (losing the baby early in pregnancy), or the baby being born too small, dead or not formed properly."

These authors maintain that malnutrition in children can lead to severe diarrhoea and even death. Werner and Sanders (1997), in another instance, state that 12,500 children continue to die from diarrhea each day (p.33). Sanders (1985, p.71) also note that :

> " The real problem is not inadequate food production, but is inappropriate food production and inequitable distribution. Underdeveloped countries are unable to develop their agricultural potential because of grossly unfair land distribution."

Wilson and Ramphele (1989, p.100), as another illustration, state that:

"South Africa is one of the countries in the world which normally exports food in considerable quantities. Yet it is also a country in which there is widespread hunger and malnutrition, and where diseases associated with poor nutrition take a heavy toll in deaths, particularly among children."

They further point out that:

"Evidence suggests that for many people diet today is considerably worse than it was for their grandparents. For instance, Zulu diet included meat from periodic feasts, quantities of *amasi* (sour milk), and a wide range of vegetables including sorghum, millet, pumpkins, yams various nuts and indigenous beans etc. (p.105)."

This evidence suggests that in South Africa most diseases which seem to be related to poverty were not encountered. For example, de Beer (1986, p.14) maintains that:

" Black people in South Africa, and again the African population in general, manifest the pattern of diseases of poverty. You have heard about TB — - other major killers are the infectious diseases, like typhoid, measles, or like gastro-enteritis which causes diarrhoea, which kills you if you are malnourished."

As another illustration, this author further states that:

"There was no TB, and really a hundred and fifty years ago there was very little malnutrition. There are African languages that have no word for malnutrition, and I think

> that's an indication that it didn't exist. There was starvation in times of war, there was starvation in times of drought, but there was not a kind of ongoing process of chronic malnutrition as it exists at the moment (de Beer, 1986, p.15)."

It becomes clear that the deteriorating situation implies that the western medical practitioners are making little impact if any regarding health promotion and prevention of diseases. Despite the fact that a number of communicable diseases can be prevented, millions of people still die from diseases of poverty. Phillips (1990, p.36) points out that:

> "A significant number of infectious diseases may be preventable or curable sometimes at a considerable personal and economic cost, but as recent trends show, a significant number of old killers still exist and new ones such as AIDS sometimes emerge."

The South African Health Review (1996) in another instance reveals that:

> "Many of the infectious diseases are preventable and access to Primary Health Care during pregnancy and child birth is known to reduce maternal and perinatal morbidity and mortality (p.22). However, despite the availability of effective drugs, TB remains a serious public health problem and the most frequently notified disease (South African Health Review, 1996, p.23)."

Furthermore, UNICEF (cited in Lovel, 1989, p.10), reveals that of 14 million deaths in children under 5 years old each year, 10

million are attributed to diarrhea, measles, acute respiratory failure and neonatal tetanus. Kibel and Wagstaff (1995, p.96) also state that:

> " The malnourished child suffers more frequent and more severe infections, which increase metabolic demands at a time when food intake may be reduced and losses from diarrhoea and vomiting increased."

Zamenhof, (cited in Myron, 1974) discovered that:

> "due to intrauterine malnutrition, the brain structure could be altered in the uterus and that the effects would persist post natally with markedly increased impairment in the presence of malnutrition that continued after delivery."

The implication of this, according to Myron (1974, p.2), is that in the presence of malnutrition, the population would be breeding a nation of idiots. This idea is also emphasised by Kibel and Wagstaff (1995) when they remark that malnourished children may later become poor achievers and consequently remain impoverished(P.97).

It is therefore clear from these illnesses that for the bio-medical profession to be more effective it may need to expand its subject matter to encompass other factors like social factors. The current strategies should not focus exclusively on child survival but should also ensure that those children who survive are going to be the most productive members of our society.

Lessons of what actually happened in other countries should encourage the medical practitioners in South Africa to adopt more

appropriate strategies. They should consider involving themselves in comprehensive primary health care and supporting community health programs. For instance, Sanders (1985, p.73) states that the population of England and Wales increased from 9 million in 1801 to 33 million in 1909. However the death rate in the very young and old fell. The decline in mortality rate, for example, was overwhelmingly due to a reduction in the prevalence and the effects of communicable diseases (Sanders, 1985, p.73). It is also stated that:

> " In the nineteenth-century England and Wales improved nutrition and later wide spread environmental improvements led to a sustained drop in mortality from communicable diseases (Sanders 1985 p.77)."

It is therefore clear that both indigenous and the bio-medical health care systems have assets and limitations. Formal interaction between indigenous healers and the formal medical health practitioners can result in both systems complementing each other thus improving the health status of our communities.

2.3.2. Comprehensive primary health care model

This model was established as a response to the limitations of the bio-medical model in addressing effectively health related issues. Unlike the bio-medical model which puts more emphasis on prevention of diseases, Comprehensive primary health care(CPHC), as Dennill; King; Lock and Swanepoel (1995, p.12) point out,

> "requires that the health sector move beyond the provision of clinical and curative services, to a health promotion approach sensitive to cultural differences."

Health promotion, according to Dennill et al., may be defined as the process of enabling people (individuals and communities) to increase control over the determinants of health, and thereby improve it. Health education is a central tool in this process. (p.82).

According to WHO (cited in Dennill et al.,1995), health promotion approach is acknowledged as an intersectoral activity (p.83). Given the fact that health promotion is inextricably bound to the tenets of CPHC which include equity, accessibility, effectiveness, affordability, community participation, intersectoral collaboration and community empowerment, it may not be considered to be the preserve of the medical services.

This is well illustrated by the OTTAWA CHARTER (Dennill et al. 1995, p.11) on health promotion which states that:

> " health promotion must go beyond health care by making health care an agenda item for all policy makers (p.11). It requires that obstacles to health promoting policies be identified in non-medical sectors and that ways be found to remove them. Communities must be empowered and have control over their own initiatives and activities. Health professionals must learn to work with communities and provide them with necessary information and technical support to enable them to share in opportunities and take responsibility regarding their own health. Personal and social development must be enhanced by providing health information and health education to help people develop the skills they need to make healthy choices. Such development should take place in schools, at home, at work and in community settings."

In order for health promotion to be successful, the re-orientation of health service authorities, health facility staff, and communities seems to be necessary. The responsibility for health promotion must be shared by individuals, health professionals, community groups, health service institutions and government departments (Dennill et al.,1995, p.12). It is important to ensure the sustainability of health promotion programme. This, according to Ottawa charter, could be achieved by intensifying social and political action for health (Dennill et al. 1995). Political and social commitments are pre-requisites for success of primary health care programmes. However, it is important to note that the value of political commitment is limited if it is not supported by the necessary finances and structural re-arrangements, the appropriate policies and adequate leadership. On the other hand, social action need a support from individual citizens, groups of people in the community and national and international organizations (Dennill et al., 1995, p.13).

For Comprehensive Primary Health Care programmes to be successful, leadership seems to play a central role. For instance, Ottawa Charter (cited in Dennill et al., 1995) states that:

> " the quality of leadership and the availability of sufficient leadership is a pre-requisite for Primary Health Care programmes. In addition, leadership should be established through training and development at community, district and national levels to meet the challenge."

2.4. TRADITIONAL HEALING SYSTEM

It is important to point out that there are many diseases which the current formal health care delivery system may not be able to cure and these may exclusively be treated and cured by the indigenous practitioners. These conditions are referred to by the author as the African culture-bound physical as well as psychological conditions. For example, Ngubane (1977) states that:

> " It is believed that non Africans do not understand those notions of health and disease and causation of diseases that are based on Zulu cosmology. Diseases of this particular category are referred to as *ukufa kwabantu* "diseases of the African people."

These conditions, therefore, can only be prevented and treated by the indigenous practitioners.

In order to be able to conceptualise how traditional healers prevent and treat culture-bound conditions, explanation of causes of such diseases seems to be imperative. For instance, Ngubane (1977, p.24) points out that:

> "The ideas about the ecological influence on health are one instance of the causality of illness as interpreted within the scope of Zulu world view and this constitutes a second level of operation of the natural forces in the sphere of health and disease"

It is also believed as Ngubane (1977, p.24) points out that,

> " according to the African world view, when people travel long distances away to areas very different from where they normally live, they become contaminated by undesirable foreign elements either through inhalation or through touch or stepping over. On their return, people, as carriers, introduce such undesirable dangerous elements back home."

Ngubane (1977) further states that, some wild animals and birds are known to travel long distances and on their return may introduce something foreign. For instance, poisonous snakes also leave dangerous tracks behind.

This author further states that:

> "In stepping over or contact by touching, the joints of the bone structure are said to be the most vulnerable points through which evil elements enter the body. A pregnant or lactating mother can become contaminated and her baby becomes sick as a result (Ngubane, 1977 p.24)."

According to the African cosmology, certain diseases can be removed from a patient and be discarded as a definite material substance. However, Ngubane (1977, p.24) points out that the discarded diseases may hover around in the atmosphere or remain localized until it attaches itself to someone passing by (p.24). It is also important to note that the environment, as Ngubane (1977) relates,

> " is not only populated by dangerous tracks or what is discarded in healing. It is also made dangerous by

sorcerers, who place noxious substances on a particular pathway to harm any passers-by with a condition of *umeqo*."

It is therefore important to note that a variety of culture related supernatural diseases, some of which may be fatal, do exist. These diseases cannot be prevented or treated by the scientific bio-medical approaches that rely heavily upon observations based on our five senses. However, the fact that it has been emphasized that culture-bound diseases are best treated and prevented by traditional healers does not automatically imply that they do not treat diseases originating from natural causes.

Indigenous practitioners, like the bio-medical practitioners seem to be applying all levels of prevention of illnesses when delivering their health care services. For instance, they intervene at a primary, secondary and tertiary levels of prevention, although preventive strategies seem to have been applied more in African culture-bound illnesses compared to illnesses arising from natural causes like infectious diseases.

2.4.1. Primary prevention

Regarding primary prevention, indigenous practitioners seem to put more emphasis on specific protection than health promotion. For instance, Chavunduka (1986,p.31) points out that a large part of indigenous healer's practice is concerned with prescribing remedies and preventive charms. In another instance, Ngubane (1977) argues that in order to survive in spite of the prevailing environmental dangers, everyone must be frequently strengthened to develop and maintain resistance. This is, according to Ngubane (1977), due to the fact that some people are considered much more vulnerable than others to the environmental dangers (p.28) These

would involve, for example, infants, strangers in the territory, people who have allowed a long stretch of time to elapse between treatments and finally people considered polluted. An infant, as Ngubane (1977) points out, is not only a stranger to the environment but it also has a fragile bone structure, with wide joints, such as the fontanelle (*ukhakhayi*) which is considered a weak point against the hazards of the environment (p.28). Ngubane (1977) also notes that:

> " several miscarriages, still-births, and infant mortality may be associated with the undesirable elements in the environment usually contacted by a pregnant or nursing mother and affecting the baby."

Specific protection is provided by the ancestors as well as by the prescription by indigenous practitioners of preventive charms. For example, Gelfand, Mavi, Drummond and Ndemera (1985) state that various types of charms are worn to prevent diseases. They further state that,

> " The Zango is one of the frequently used charm. It is made up of a single root or several types of roots and various other small items such as pieces of skin, stones or feather. All these constituents are stitched up in a piece of cloth which is then attached to a string and is often worn around the arm by adults or around the neck or waist by children (Gelfand et al.,1985, p.42)."

This zango, as Gelfand et al., (1985) and Chavunduka, (1986) point out, is designed not only to prevent diseases but also to ward off evil spirits. In another instance, van Rensburg et al.(1992, p.33) also point out that:

" traditional taboos aim at prescribing appropriate health behaviour on the one hand, and at prohibiting health-threatening behaviour on the other."

As it has been pointed out earlier, the ancestors also play a vital role in the protection of their survivors.

For instance, Ngubane (1977, p.51) states that:

" the child is placed under the protection of the ancestors by a sacrifice of a goat known as *imbeleko*. This goat provides the first wrist skin band for the baby. By this sacrifice the ancestors are thanked for, and are also requested to protect the baby."

Therefore, it is apparent that primary prevention in traditional healing system is, to a certain extent, similar to primary prevention practised by the bio-medical health system. For instance, during this stage traditional healers intervene in the absence of any illness with the intention to prevent and protect individuals against diseases. Contrary to the bio-medical model, the ancestors seem to play a vital role in indigenous healing system particularly, in preventing diseases which may arise due to sorcery.

2.4.2. Secondary level of prevention

Indigenous healers seem to intervene at the secondary level of prevention which is associated with early diagnosis of illness and prompt treatment. This may be the case particularly, with African culture-bound diseases. Coe (cited in Chavunduka, 1986, p.32), for example, states that:

" If an individual is bitten by a snake, the traditional practitioner might open the wound further and suck out the poison or what he believes to be the evil spirit which has entered. In doing this, he/she extracts the venom from the wound, thus accomplishing what is essential in objective scientific terms for curing the patient."

Although traditional healers may intervene quite effectively in culture-related conditions, they may not, however, intervene appropriately when dealing with the universal conditions particularly communicable diseases.

2.5. CONCLUSION

Indigenous practitioners are well placed in the community where they are respected and play a crucial role of being opinion leaders. It is therefore essential that we recognise the strengths and limitations of indigenous practitioners and develop and improve upon them. Indigenous practitioners can make great impact provided their skills are developed and utilized. We should build on the existing knowledge of indigenous practitioners to maximize the delivery of health care to our communities.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. INTRODUCTION

Because the present study is exploratory in nature, a qualitative methodology appeared to be appropriate. This chapter describes the research design, population and sampling, data collection, processing and analysis of data, limitations, auditing and ethical aspects.

3.2 DESIGN

The design is a qualitative research method which included three phases. During the first phase which focussed on the current practice of indigenous healers with regard to preventive and promotive health care and identification of specific areas in which their practices with regard to preventive and promotive health care could be enhanced, the researcher used a qualitative research method. During the second phase, the researcher designed and implemented a short training course. The third phase involved evaluation of this training course.

A design is determined by specific procedures that will be employed. These procedures which are at the heart of the design chosen by the researcher included convenient sampling, purposive sampling, interview schedule, focus group discussions as well as data analytic procedures (Lincoln and Guba, 1985, p.222).

During the first phase, a focussed group and individual interviews were used to determine the current practice of indigenous healers with regard to preventive and promotive health care and identification of specific areas in which their practices with regard to preventive and promotive health care could be enhanced. Western health professionals were also interviewed to ascertain their views regarding knowledge and skills necessary for indigenous healers in order for them to make a contribution in preventive and promotive health, especially as this relates to pregnant mothers and children.

During phase two the implementation process of training to improve preventive and promotive practices was described. The training was planned based on the current and potential roles described in phase one, and was subsequently evaluated.

Phase one : Describing current practice

Unstructured individual interviews were initially conducted during this phase. Two focus groups were conducted after the interviews. This process helped the researcher to know what individuals say in private and what they say when they are in the presence of others (Morgan, 1998, p.20). It also helped in developing rapport between the researcher and participants. Focus groups are much more appropriate for exploration and discovery, particularly when we have to learn about either topics or groups of people that are poorly understood. This was more applicable to this study. Because of context and depth associated with focus group discussions, it was easy to understand the background behind the people's thoughts and experiences. Participants were encouraged to investigate the ways that they are both similar to and different from each other. Like other

qualitative methods, focus groups excel at interpretation, that is, they have enabled the development of an insight as to why things are the way they are and how they got to be that way (Morgan, 1998, p.12).

Respect between the researcher and the respondents was positively related to the quality of focus group results of the inquiry. The belief in the valuable wisdom of the informants was demonstrated irrespective of their level of education, experience or background. Krueger (1998, p.4) notes that:

> " lack of respect quickly telegraphs to participants and essentially shuts down meaningful communication."

The researcher ensured that his role would be to guide his discussion and listen to messages being conveyed by informants instead of participating, sharing views, engaging in discussions or shaping the outcome of the group interview. The researcher also ensured that his personal views on the topic of an inquiry were suspended.

One general question was asked. Detailed probe questions were then asked depending on how informants responded to the first general question. Data was collected regarding the indigenous healers knowledge of nutrition (children and pregnant women), environmental health and prevention of infection. Information was gathered regarding indigenous healers' beliefs about promotion and prevention as well as information about practices which are seen by indigenous healers as preventive and promotive. There was identification of specific areas in which indigenous healers' current practices with regard to preventive and promotive health care could be enhanced.

Unlike in the case of indigenous healers, only unstructured individual interviews were conducted with western health professionals. The data collected from the western health professionals revealed the knowledge and skills necessary for indigenous healers in order for them to make a contribution in preventive and promotive health, especially as this relates to pregnant mothers and children.

Phase two : Training process and evaluation

The implementation process was described and a program of training was implemented. With the assistance of the registered nurse who is working at Vryheid and currently working for the Primary Health Care Project in Region D, the researcher identified indigenous healers who were going to undergo training. The training manual was developed and its content was based on the areas which doctors and nurses recommended that indigenous healers can be involved in Primary Health Care activities. It was also developed from indigenous healers training needs. Relevant training material was provided including the training programme. A three days training workshop was conducted for indigenous healers. The researcher conducted both formative and summative evaluation. Neuman (2000) defined formative evaluation as built-in monitoring or continuous feedback on indigenous healers after the training regarding their knowledge, beliefs and practice (p.28). A summative evaluation, which looked at final program outcomes, was used after a month period (Neuman, 2000, p.28).

3.3. POPULATION AND SAMPLING

3.3.1. Indigenous healers

The target population consisted of indigenous healers in Region D of *KwaZulu* Natal and health professionals both in Region B and D. During phase one of the research project, indigenous healers living under *Hlahlindlela* Tribal Authority in Vryheid District were targeted. Random sampling procedures seemed to be impossible with indigenous healers due to lack of a proper sample frame (Neuman, 2000, p.201). The sample was chosen according to indigenous healers' availability (convenient sampling). Subjects consisted mainly of *izangoma* (diviners) and a few *izinyanga* (herbalists). They were chosen from a black, Zulu speaking cultural background. Herbalists consisted mainly of male respondents whereas diviners consisted mainly of female respondents. Individual interviews consisted of five respondents of which four were female diviners and one was a male diviner. The researcher also had two focus groups with each group consisting of four diviners and two herbalists.

3.3.2. Western health professionals

The researcher used purposive sampling in selecting health professionals because they are especially informative (Neuman, 2000, p.198). The respondents consisted of two clinic registered nurses from *Hlahlindlela* Tribal Authority in Vryheid district, six registered nurses working in hospital, seven registered nurses working in the Pietermaritzburg District clinics and six

doctors working at Edendale hospital. The average age for nurses sample was 45 years. The average age for the doctors sample was 52 years.

The researcher, with the assistance of a registered nurse who is based at Vryheid and currently working for the Primary Health Care (PHC) project in Region D, started to interview indigenous healers found in *Hlahlindlela* Tribal Authority. For instance, Flick (cited in Neuman, 2000, p.196) relates that:

> " for qualitative researchers, it is their relevance to the research topic rather than their representativeness which determines the way in which the people to be studied are selected."

This implies that qualitative researchers are more inclined to use non probability or nonrandom samples. Neuman (2000, p.196) further maintains that qualitative researchers rarely establish the sample size beforehand as in the case of researchers using a positivist approach and have limited knowledge about the population from which the sample is drawn.

This author also said that:

> "the qualitative inquirers choose respondents gradually with a specific focus of the study determining whether it is chosen or not (Neuman, 2000, p.196)".

After considering the procedures and instruments to be used in the present study, the researcher concluded that purposive sampling was the most appropriate sampling method (Silverman, 2000 p.104). It is defined by Silverman (2000) as a method that

demands that we think critically about the parameters of the population we are interested in and choose our sample case carefully on this basis.

Using convenient sampling, the researcher began with a few people and then started to spread out on the basis of links to the initial cases. For instance, the researcher began with four indigenous healers who do not know each other. Each healer named two other healers. The researcher then went to these eight healers and asked each to name one healer. This implies that each participant in the sample was directly or indirectly connected to the other. The researcher eventually stopped selecting cases due to information saturation (Neuman, 2000, p.199).

During phase two, twenty indigenous healers were recruited with the assistance of a nurse in the Vryheid District for the training workshop. Of the twenty indigenous healers eighteen were diviners, sixteen female diviners and two male diviners. The other two healers were herbalists. Eleven of the twenty diviners were interviewed during the training evaluation workshop which was part of the third phase.

3.4. DATA COLLECTION

3.4.1. Process of data collection

In order to gain entry into the area of operation in Region D, permission was requested from the local *inkosi*. Meetings with clinic registered nurses and indigenous healers' associations were organised where the researcher explained the purpose and objectives of the study. Registered nurses and indigenous healers associations helped in identifying respondents. It was explained

where and how the interviews would take place. Interviews were audio taped to capture all the responses of the respondents with minimal interruption. Data was collected in Zulu and translated into English.

The researcher conducted individual interviews as well as focus group discussions as part of many kinds of special surveys (Neuman, 2000, p.274). A focus group, as Neuman (2000) points out, is a special kind of interview that is highly qualitative in nature (p.274). The focus groups consisted mainly of the moderator (researcher), indigenous healers and assistant moderator also referred to as a recorder, observer, analyst or even consultant (Krueger, 1998, p.70). The moderator directed the discussions and kept conversation flowing and on topic. Notes taken by the moderator were to identify a few key ideas or future questions that needed to be asked.

The assistant took comprehensive notes, operated the tape recorder, handled environmental conditions and logistics (refreshments, lighting, seating etc.) and responded to unexpected interruptions. The assistant also observed the participants' body language throughout the discussion. The assistant asked additional questions near the end of the discussion or probed the response of a participant in more depth.

(Krueger, 1998, p.70) further mentions that:

> " focus group discussion are useful in exploratory research where they contribute in the generation of new ideas and for hypotheses, questionnaire items and interpretation of results."

Twelve indigenous healers were gathered to discuss issues related to preventive and promotive aspects of health care as well as indigenous healers' current practices for one to two hours. Neuman (2000, p.274) states that the moderator, who introduces issues and ensures that not a single individual is allowed to dominate, needs to be flexible, keep people on the topic, and encourage discussion. It was ensured that participants were homogenous enough to reduce misunderstanding and conflict.

In order to gain entry into the health facilities of Region B and D, the researcher requested permission from the authorities of KwaZulu-Natal Department of Health to conduct research. Authority to conduct research was then granted provided that prior approval was obtained from the Head of each institution involved (for example, medical superintendent), confidentiality was maintained, the Department was acknowledged, and the Department received a copy of the report on completion. Permission to conduct research in some of Indlovu Health Region clinics was granted by the Regional Director of Indlovu Health Region. The District Health Coordinator of Pietermaritzburg/Lions River/Mooi River and Vulindlela District Health Service granted the researcher permission to conduct research at clinics in the Lions River Sub-District. Permission to conduct research at Edendale Hospital was granted by the Chief Medical Superintendent. A Meeting with Vulindlela and Lions River District health authorities was held. During this meeting the researcher explained the purpose and the objectives of the study (See annexure A). Discussions involved clinics which were going to be targeted and the manner in which interviews were going to be conducted. The district health authorities then communicated with registered nurses at the clinics in order to explain the purpose of the study and to arrange convenient times for the interviews. The researcher had

to sign an indemnity form. At Edendale hospital, the researcher had meetings with doctors and registered nurses where the purpose of the study was explained (see annexure A).

Similar to indigenous healers, all interviews were audio taped. However, the data was collected in English. The researcher interviewed registered nurses and doctors using an interview schedule. The researcher did not use an assistant. He operated the tape recorder, handled environmental conditions and logistics (refreshments, lighting, seating etc.) and responded to unexpected interruptions. He also observed the participants' body language throughout the interviews. The researcher asked questions and probed the response of participants in more depth.

3.4.2. Credibility

Credibility refers to the truth and correctness of the statement. It is stated that a credible argument is sound, well grounded, justifiable, strong, and convincing. It is also pointed out that credibility is important in all seven stages of an interview investigation. These stages would include thematizing, designing, interviewing, transcribing, analysing, auditing and reporting (Kvale, 1996, p. 237).

Gorden (cited in Bailey, 1987) argues that unstructured interview can sometimes be more credible than the highly structured interview. He notes that the strength of unstructured interview occurs where communication would be hindered by the use of a rigid, highly structured interview schedule with all questions specified in advance. It is stated that unstructured questionnaire is said to be more valid where the respondent is experiencing memory failure. An unstructured interview may be

able to provide a relaxed and unhurried atmosphere that is not stressful to the respondent.

> " Unstructured questionnaire may also be more credible if the universe of discourse varies from respondent to respondent so that the interviewer must change the question wording to meet the understanding of the respondent (Bailey,1987, p.192)."

Unstructured interviews, therefore, seem to be more credible when exploring dynamic human related phenomena.

Because of the qualitative nature of the study, the researcher chose credibility as a criterion against which the truth value of the investigation could be evaluated, instead of internal validity, a criterion appropriate in quantitative studies (Sandelowski, 1986, p.30). A credible study is described by Sandelowski (1986, p.30) as:

> "the one which presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own. A study is also credible when other people (other researchers or readers) can recognize the experience when confronted with it after having only read about it in a study."

In order to ensure that credible findings and interpretations would be produced, the researcher established an investigator - informant relationship(Sandelowski, 1986, p.30). In this relationship the investigator described and interpreted his own behaviour and experiences as researcher in relation to the

behaviour and experiences of informants. This implies that the researcher established a professional rather than a social relationship. A professional relationship enabled the researcher to separate his experiences from informants. He did this by intentionally focussing on how the researcher influenced and was influenced by a subject (Sandelowski, 1986, p.30).

A social relationship between investigator and informants, on the other hand, may cause both investigator and informants to become so enmeshed that an investigator may have difficulty separating his / her own experiences from his or her informants. It should therefore be noted that while the closeness of the investigator - informant relationship is crucial in enhancing the truth value of a qualitative study, it may, at the same time, pose a serious threat to the same truth value.

As another measure of ensuring credibility, the researcher built trust within informants. He achieved this by having several meetings with indigenous healers in Region D before he began his investigation. During these meetings the researcher demonstrated to the informants that he was not going to disclose what they had confided in him. He reassured the informants that they would remain anonymous. The informants were informed that the hidden agendas, either those of the researcher or local figures, were not being served. The researcher, through interaction with the informants, demonstrated that his interests as well as those of the informants would be honoured. These meetings were called by members of KwaZulu-Natal Traditional Healers Council. This enabled the researcher to learn more about the healers' cultural context thus overcoming his personal distortions which could influence his data (Lincoln and Guba, 1985, p.302). The last meeting of indigenous healers in which the researcher was

formally introduced to indigenous healers and *izinduna*, was called by *inkosi* M of Hlahlindlela Tribal Authority.

To further increase credibility of the study, the researcher exclusively focussed in observing the healers' practices in terms of health promotion and prevention of illness. This implies, as (Lincoln and Guba, 1985, p.304) points out:

> "that the purpose of persistent observation is to identify those characteristics and elements in the situation that are most relevant to the problem or issue being pursued and focussing on them in detail."

3.5. PROCESSING AND ANALYSIS OF DATA

3.5.1 Transcription

Since the researcher tape recorded Zulu speaking respondents, it has been necessary that the recorded oral data be transcribed into writing. To transcribe means to transform, to change from one form to another. It was at the researcher's advantage to type one or more pilot interviews himself. This sensitized him to the nature and quality of the recording and encouraged him to concentrate on asking clear and audible questions. This, in turn, resulted in equally clear answers in the interview situation. The researcher used English codes, but would not translate data into English before coding. Only those sections quoted in the text were translated. The researcher then translated the data from Zulu to English. He established a panel of three people who reviewed the translated data. The panel made suggestions which enabled the researcher to make corrections with regard to the translation. Thereafter, data analysis had to be initiated.

3.5.2. Data Analysis

Analysis, as Webster(cited in Tesch, 1990) points out, is

> "a detailed examination of anything complex made in order to understand its nature or to determine its essential features (p.113)."

On the other hand, Bogdan and Taylors(cited in Tesch, 1990) define data analysis as:

> "a process which entails an effort to formally identify themes and to construct hypothesis as they are suggested by data and an attempt to demonstrate support for these themes and hypothesis (p.113)."

3.5.2.1. Process of data analysis

Data was coded using the decontextualization technique. During this process, data was separated into its meaningful units. It was then categorised using the recontextualization procedure. Through the process of decontextualization and recontextualization, the researcher invariably identified emerging themes which were eventually interpreted.
The researcher, after considering a number of approaches used in the analysis of qualitative data, decided to use a template analytic technique using an analysis guide. The guide, as Crabtree and Miller (1992) point out, was applied by the researcher to the text being analysed (19). This implies that the researcher did his analysis based on his research questions. It is important to realise that the basic pattern or template underlying all the template analytic techniques is more open-

ended and undergoes revision after encountering the text (Crabtree & Miller, 1992, p. 19). The researcher, first of all, applied the template to the text with the intent of identifying the meaningful units or parts, and these units, as Crabtree and Miller (1992) state, could either be language or behaviour units (p.19). Language units included words, phrases, utterances and folk terms. Modifications and revisions were made by the researcher and the text was reexamined where it revealed inadequacies in the template.

The researcher ensured that the interaction of the text and template involved several iterations and included the collection of more data until no new revisions were identified (Crabtree & Miller, 1992, p.19).

During the interpretive phase of data analysis, the researcher, as Crabtree and Miller (1992) point out, connected the units into an explanatory framework consistent with the text and it is these final connections that formed the reported outcomes (p.19).

3.5.3. Academic Rigour

3.5.3.1 Trustworthiness

For any study to be trustworthy, it should adequately address the following questions:

> "How can one establish confidence in the "truth" of the findings of an inquiry for the respondents with which and the context in which the inquiry was carried out? How can one determine the degree to which the findings of an inquiry may have applicability in other contexts or with other

respondents? How can one determine, whether the findings of an inquiry would be consistently repeated if the inquiry were replicated with the same or similar respondents in the same or similar context? How can one establish the degree to which the findings of an inquiry stem from the characteristics of the respondents and the context and not from the biases, motivations, interests, and perspectives of the inquirer (Lincoln and Guba,1985, p.218)?"

It is important to note that although these questions are appropriate whether the study is qualitative or quantitative in nature, the criteria for trustworthiness established by the mechanistic researchers may be inappropriate when applied to a qualitative research paradigm. Such criteria would include internal validity, external validity, reliability and objectivity. Using the above criteria, it may become very difficult for a qualitative researcher to ensure trustworthiness particularly when:

" the results do not correspond with the reality the researcher claims to describe, reality becomes characterized by multiple and intangible factors, the study is not carried out under conditions of probability sampling, the results are not stable and replicable and there is no instrumentation interposed between the inquirer and the objects of an inquiry (Lincoln and Guba, 1985, p.218)".

It is therefore clear that unless appropriate criteria for qualitative research perspective are developed, the criteria established by conventional perspective will remain irrelevant when researchers investigate complex human phenomena. As Guba (cited in Lincoln and Guba, 1985) points out, relevant criteria

for a qualitative paradigm would include credibility which replaces internal validity, transferability instead of external validity, dependability instead of reliability and confirmability instead of objectivity. This author moreover provides operational techniques to be utilized so as to establish credibility, transferability, dependability as well as confirmability (Lincoln and Guba, 1985, p.219).

3.5.3.2 Dependability

Dependability is the consistency of the research findings. Due to the subjective nature of the present study, reliability as one of the important criteria for establishing trustworthiness seems inappropriate. This is well illustrated by Sandelowski (1986, p.33) when she states that:

> "qualitative research emphasizes the uniqueness of human situations and the importance of experiences that are not necessarily accessible to validation through the senses. Variations in an experience, rather than identical repetition, are sought."

As Guba and Lincoln (cited in Sandelowski, 1986, p.33) propose, the researcher used auditability as the criterion of rigor relating to the dependability of qualitative findings (see auditing process reflected in table 1). The dependability of the interviewer in interview research seems to be one of the potential problems(Kvale,1996). In order to achieve dependability, the researcher ensured good recording quality. He improved the quality of transcriptions by providing the typist with clear instructions about the procedures and purposes of the transcription (Kvale, 1996, p.163). The researcher also

administered the interview schedule to a few informants so that he could be able to identify its flaws and make some corrections. It is therefore clear that although interviews are associated with high credibility, they may, if necessary precautions are not taken, have low level of dependability.

3.5.3.3 Confirmability

In order to establish confirmability the researcher was supposed to use an operational technique known as the confirmability audit(Lincoln and Guba, 1985,p.318). In order for the auditor to conduct an audit, the researcher was supposed to provide him/her, according to Lincoln, with records including the following:

> "Raw data, including electronically recorded materials such as audio-tapes, written field notes; data reduction and analysis products, including write-ups of field notes, summaries such as condensed notes, theoretical notes, including working hypotheses and concepts; data reconstruction and synthesis products, including structure of categories (themes, definitions and relationships), findings and conclusions (interpretations and inferences) and a final report, with connections to the existing literature and an integration of concepts, relationships and interpretations; process notes, including methodological notes (procedures, designs, strategies, rationale); trustworthiness notes (relating to credibility, dependability and confirmability); material relating to intentions and dispositions, including the inquiry proposal; personal notes (reflexive notes and motivations) and instrument development information including preliminary schedules (Lincoln and Guba, 1985, p.319)."

Due to financial constraints and the fact the researcher would be unable to have an independent auditor who would do assessment of confirmability, the auditing process took the following form reflected in table 1.

Table 1. Auditing of data

TASK	WHO DOES	AUDITOR
Transcription	typist	researcher
Coding	researcher	Zulu masters student
Analysing	researcher	supervisor

3.6. ETHICAL ASPECTS

The researcher obtained an informed consent from the research informants to indicate their willingness to participate in the study. Informed consent, as Moustakas and Yow (cited in Kvale, 1996) state, means informing the research informants about the overall purpose of the investigation and the main features of design, including any possible risks and benefits from participation in the research project. An oral consent was sorted out from respondents. It is also stated that informed consent involves getting voluntary participation of the subject with his or her right to withdraw from the study at any time (Kvale, 1996, p.112). The researcher also ensured confidentiality, which, according to Kvale (1996), means that private information identifying the subjects will not be reported (p.114). Findings will be reported in aggregate form. In an

investigation which involves publishing information potentially recognizable to other, the subjects need to agree to the provision of identifiable information.

3.7. CONCLUSION

It should be pointed out that three phases of the qualitative research design were implemented. During phase one, qualitative data was collected from both indigenous healers and western health professionals, using unstructured interviews and focus group discussions. Following appropriate processes, the researcher analysed the transcribed and translated data. During the second phase, the researcher designed and implemented a training program. It is also noted that the researcher fulfilled ethical requirements and ensured trustworthiness of his study, particularly through a criterion called credibility. However, it is also highlighted that the study was associated with some limitations especially with regards to trustworthiness criteria called dependability and confirmability.

CHAPTER FOUR

RESULTS PHASE ONE: THE CURRENT SITUATION

4.1. INTRODUCTION

This chapter highlights the steps taken to accomplish phase one as well as the results of phase one. It includes data collection and analysis, process of data analysis, major themes from indigenous healers, major themes from the western health professionals including doctors and nurses as well as the merits and limitations of indigenous healers.

Initially, there was a meeting with the members of KwaZulu-Natal Traditional Healers Council. The meeting was held at the Provincial Health Department (Ulundi). At this meeting the researcher introduced himself and explained the purpose of the study. The members of the council gave their approval that the study could be conducted in Region D.

Vryheid was chosen as the most appropriate and convenient area of operation. In order to gain entry into the area, the researcher accompanied by Mr P, a current leader of *Izinyanga* National Association, met a well known business man with whom plans were made to meet the local *Inkosi* M who is in charge of the Hlahlindlela Tribal Authority. Inkosi, after having extensive discussions with the researcher and Mr P, welcomed the research project in his area and offered to indigenous healers his old court. He perceived the research project as being an important part of development of indigenous healers.

Inkosi then organized a meeting for the researcher and Mr P to meet with all indigenous healers in the area including *izinduna*. This meeting took place at Hlahlindlela Tribal Authority court. The respondents were informed that interviews and focus groups were going to be conducted. *Inkosi* M recommended that his new Hlahlindlela tribal Authority court be utilized as the venue. In this meeting, dates and time were set up for both individual interviews and focus groups.

Two focus groups were conducted. Both focus groups consisted of six informants each. Of six informants, four were female diviners and two were male herbalists. Prior to the focus groups sessions, snacks and lunch for the respondents were organized through the assistance of a professional nurse of the Primary Health Care project. Respondents participated to discuss issues related to preventive and promotive health as parts of health care as well as current practices of indigenous healers. The discussions took an hour. The moderator introduced issues and ensured that no one person dominated. He created a more relaxed atmosphere so as to facilitate discussions. He also kept the respondents on the topic and encouraged the discussions. Responses were tape recorded. All informants were from Hlahlindlela tribal Authority. The moderator was a well trained professional nurse with experience in focus group interviews. The researcher had guiding questions.

Seven informants were interviewed individually at their areas of operation (homes). After finishing an interview with one informant, the(informant) would then introduce the researcher to another informant. Interviews were tape recorded. Individual interviews included one male and six female informants.

4.2. MAJOR THEMES FROM INDIGENOUS HEALERS.

4.2.1 Indigenous healers beliefs about health promotion.

Health promotion seems to be a complex phenomena which can be enhanced by involving many aspects of life. These aspects would include, for example, the role of the ancestors in the lives of black people, the role of *isangoma* (diviner), attitude toward current African indigenous health care practices and belief in indigenous healers. It is, therefore, apparent that healers seem to have a comprehensive African culture related view of health.

The ancestors, according to the informants, constitute the basis of the health status of the black people. In the absence of the ancestors, the lives of African people (blacks) may become vulnerable. This implies that the ancestral spirits have a major role to play in the lives of African people especially in the detection of supernatural causes of illness. Such a role involves the provision of general protection, good health and prosperity to their dependants. This is clearly demonstrated by the informants when they state that:

> ***"An individual can use his/her ancestors to ensure a safe environment. A special sacrifice to reintegrate ancestors with the homestead must be performed. (Reason for protection) This is done to ensure future safety for the people within the home environment. It is a way of preventing future dangers. Such dangers involve a harmful concoction (called umeqo) of a sorcerer which will later bring illnesses. They also involve the supernatural agents***

of the sorcerer. Whatever may be introduced to the home environment by the covert action of a malicious human being who employs magical means to injure his / her victim, cannot have the desired effect. It can be easily identified and eradicated. This is done through the use of protection charms to drive away bad spirits."

It is through the diviners that the ancestors (*amadlozi*) are believed to protect and defend their descendants against the forces of evil. They guard their descendants against the serious attacks by the witches. It is important to note that dreams are an important channel of communication between the living people and the ancestors. A great number of informants claim to hear the ancestors saying things to them. A diviner is a person who can reveal the secrets of the ancestors. She reveals the causes of the troubles. For instance, she points out the place where the destructive medicines have been placed, or if the cause of the misfortune is not due to witchcraft but legitimate and moral anger of the ancestors. The ancestors not only discover witches and reveal their intentions, but they also fight them. In very close co-operation with the ancestors, a diviner is said to be a defender of men. For instance, many informants have stated that:

"Diviners can see specific diseases before their onset and then apply preventive measures. Sometimes the ancestors visit an individual in a dream and tell him about the imminent danger. For example, it may be a bird that may attack the head of the family. They (the ancestors) may even show you the healer who should come and strengthen the family to prevent the bird. If you are a healer yourself,

they tell you to strengthen yourself. Because of our ability to communicate with the ancestors, we are sometimes told if there is impending danger. An illness may be revealed to me in dreams. I may have a dream about what is going to happen. I may also be told what steps I should take. For example, I might have to fortify the homestead through sprinkling and spreading of medicine. I can fortify people by making incisions. I may encourage people to use herbal emetics. This is done so that when the illness comes, it does not have debilitating effects. If the ancestors are present at home, the placement of harmful medicines (umeqo) may affect a dog, cow or chicken instead of a human being. This is where the livestock plays a crucial role in an African homestead."

It should be noted that, for continued health, a variety of African cultural activities should be performed. However, such activities which are, in most cases, prescribed by the ancestors through diviners, should be carried out according to the prescribed procedures. Otherwise they may not be accepted by the ancestors thus hindering progress. This becomes apparent when the informants stated that:

"You must ensure that African cultural activities are performed properly. Black people have cultural activities which include performance of cultural rituals or sacrifices as well as strengthening or fortifying the home. You fortify the home both inside and outside. You must know the times when to perform such cultural activities for the people at home. This implies that people within the home context must, during specific periods, be strengthened so as to keep them

protected. After strengthening the people you must also ensure that there is no witchcraft through a familiar (the supernatural agent of a witch). The environment with a familiar is not safe. The foregoing supernatural agent causes interpersonal disorder among all family members. People appear to be ill due to this supernatural agent. Such an agent can disturb young children who may experience sleepless nights. Children become scared at night. A home with a familiar experiences financial difficulties. A supernatural agent must be discarded. After discarding the agent all the people must be fortified and should have izincweba (strings put around the waist in adults and around the neck in children) so as to prevent a familiar from coming back to the people."

A serious concern has been expressed by indigenous healers about the fact that some African people have abandoned historical African cultural practices and do not believe in traditional healing system. This might be due to the fact that some of the black people may have exclusively identified with the western culture. This may predispose them to illnesses caused by the witches. For example, indigenous healers believe that:

"Culture related Illnesses are a serious problem. However, some African people have a problem which has been long standing. For example, certain homes do not believe in what we are (indigenous healers)."

4.2.2 Environmental Health

In terms of environmental health, indigenous healers seem to have expanded their focus by including the spiritual, physical, social, and psychological aspects of the environment. Although less attention was paid to the physical aspect of the environmental health, indigenous healers have, to a certain extent, expressed an understanding of the germ theory.

a) Spiritual environment

Indigenous healers have expressed a positive attitude toward the current African indigenous health care practices regarding health promotion. They have put more emphasis upon protection measures being taken against environmental dangers which may be culture related. One stated, for instance, that:

> ***"Evil spirits affecting children at home must be eradicated through fortification of one's home environment. We, Zulu people, fortify and strengthen our home environments against danger like sorcery. We strengthen people by making small incisions (scarifications) for the insertion of curative medicine mixtures."***

b) *Physical environment*

Although very little attention was paid to the physical aspect of environmental health, indigenous healers have expressed a positive attitude toward western health care practices in terms of health promotion and illness prevention. One of the informants, for example, maintains that:

"Nowadays an individual must use one razor blade for each person. You must not use the same blade for more than one person because it may spread communicable diseases (prevention of infection). Each and every person should have his or her own blade."

Indigenous healers further state that:

"You can ensure a safe environment by keeping the place clean without any waste. Diseases are caused by a filthy environment. In a clean environment children cannot suffer from a variety of illnesses. A healthy home is home with good environmental hygiene. Premises are kept clean."

c) Social environment

In terms of social environment, indigenous healers seem to believe that the health status of the black people could be enhanced by adhering to African social values which put more emphasis upon co-operation and interdependence as opposed to western values associated with competition and individualism. This is reflected when respondents state that:

"We must command respect and behave in a dignified socially accepted manner. People should learn to help each other. For example, if an indigenous healer has a problem, he/she should seek assistance and advice from another indigenous healer. This will lead to good social welfare and economic development. An individual should also learn to look after him/herself and try to develop potential talents acquired

from God and the ancestors. She/he should get assistance from and share ideas with his/her neighbours."

d) Psychological environment

In terms of the psychological environment, the informants have indicated that people need to grow and reach maturity. This could be achieved though the proper socialization and setting of realistic goals and by taking appropriate actions toward achieving such goals. For instance, they have pointed out that:

"Members of the family should go out and work hard so as to achieve what they need. This may prevent jealousy and worry about other people's belongings. People should work hard and organize their family members and teach them to do things for themselves."

4.2.3 Knowledge of illnesses

Informants pointed out that illnesses may be divided into three categories. The first category includes illnesses which are exclusively related to African culture. The second category includes ordinary illnesses which may arise due to natural factors. The third category involves ordinary illnesses with a familiar clinical picture but are caused by African culture related factors. As a result, some black people, probably due to ignorance, may suffer from culture-related illnesses which may be fatal of which they may not be aware. This is expressed, for instance, when indigenous healers maintain that:

"There may be an illness at home which may be difficult to treat despite consultation with a medical doctor. There are diseases which cannot be treated by western medical practitioners, but can be treated by indigenous healers. For example, a sick person can be taken to hospital. This person may not recover from an illness despite western medical intervention. Eventually, this person may be isolated thus waiting for his time of death. Sometimes the person may be discharged home with some palliative treatment. An individual might in fact be suffering from illnesses associated with spirit possession attributed to sorcery and the covert action of a malicious human being who employs magical means to injure his / her victims. Western medical practitioners, unfortunately may not be able to diagnose such illnesses. It becomes very difficult for certain families to seek assistance from people like myself because such families, in many instances, look down upon us. Perhaps it might happen that they might be ignorant regarding the kind of people we are."

Indigenous healers further believe that they can be particularly effective in terms of illness prevention particularly with regard to illnesses related to African culture. This becomes clear when they point out that:

"Culture related diseases may be prevented from gaining entry. I was bewitched in such a manner that I could develop a condition called unhlangothi (which is similar to a condition referred to by the western medical practitioners as stroke). Although I could feel the symptoms that an attack of such a condition was imminent, I could not suffer

from such a condition because I fortified myself. There are diseases which can reveal their presence through symptoms when they start to attack an individual. There are those, on the other hand, which may not warn an individual but just attack him/her vigorously. You may, for example, sleep without experiencing any illness but wake up the following morning with an illness. Such conditions are difficult to prevent prior to their onset, but you start treating them after their onset. This implies that some diseases may have a gradual onset while others may have a sudden onset. In most cases diseases are best treated after their onset when they can be well identified and appropriate interventions are applied to cure the disease."

a) Culture specific diagnosis

Informants distinguished between diseases which occur due to witchcraft and those which may be due to displeasure of the black ancestors. Most of these diseases are life threatening. Sometimes patients may, for example, complain of physical symptoms without any physical dysfunction. Sometimes a patient may suffer from a physical condition which may be due to sorcery, ancestral displeasure, or a calling from the ancestors that may eventually require him / her to become a qualified *isangoma* (diviner). These conditions are referred to as the African culture related diseases. These may be well handled by indigenous healers. For example, this may become clear when one of the informants states that:

"I would also like to say that if an illness is culture related, it can be diagnosed through divination. It is

necessary to divine if an illness has been revealed through dreams. Sometimes the ancestors may reveal illnesses through dreams when in actual fact they may be requesting something to be done. If an illness has been revealed through dreams you must burn impepho (medicinal plant) and ask the ancestors to clarify the nature of an illness, that is, whether it is an illness that requires treatment or it is something that needs to be rectified. If something needs to be rectified, is an indication that the problem is associated with ancestors. An individual would then talk to the ancestors informing them as to when he / she would meet their requirements. After talking to the ancestors, an illness, if any, would cease to exist. It ends there. However, if a person is possessed by the ancestors, you can treat him / her with curative medicines called amagobongo. Sharp pains in the chest and headache may, invariably, be illnesses associated with the ancestors. With the assistance from the ancestors, an indigenous healer can successfully treat and eradicate all such illnesses. You can treat an individual even if he does not have a calling from idlozi (ancestral spirit), but if her/his illness needs similar intervention. If an illness is not related to the ancestors, an individual may, after consulting a diviner, go to the herbalist for specific treatment appropriate to the diagnosed illness. Sometimes your ancestors tell you to wake up and fortify your homestead through sprinkling and spreading of medicine or fortifying your home against danger which may be due to sorcery."

4.2.4 Practices which were seen by indigenous healers as preventive.

Unlike the western medical practitioners, indigenous healers, when preventing illnesses at a primary level, "immunize" not only the concerned individual or individuals but also the environment in which the client lives. Their preventive practices are mainly directed at culture specific illnesses and are totally different from those carried out by the western medical practitioners. Healers prevent mainly supernaturally caused diseases both at primary and secondary levels of prevention. This is clearly stated by respondents when they say:

> ***"Strengthening an individual means protection. This can be done by strengthening the home environment and the people. An individual can , for example, suck hot medicine from finger tips (ukuncinda). He or she may inhale treated smoke (ukunuka). We prevent unhlangothi by fortifying a person through incisions. Incisions are made for the insertion of curative mixtures. When the strengthened individual is attacked by unhlangothi he may not become paralysed. Another disease is called umeqo, a condition culturally attributed to having stepped over dangerous tracks. It may also be attributed to placement of harmful medicines. A person suffering from umeqo, having been strengthened prior to contacting it (umeqo), can experience symptoms and eventually be able to consult an indigenous healer where he/she would discover the root cause of his/her problem. Such an individual can also use prescribed herbal remedies which he/she can drink and / or take as an enema. Umeqo, like unhlangothi, can also be prevented by licking and***

sniffing powdered curative mixtures, and sucking hot medicines from finger tips (ukuncinda) as well as fortifying the homestead through sprinkling and spreading of medicine. Another problem that we can prevent from occurring is lightning. Lightning does not have a specific time to strike a home. This implies that every spring one must take measures to prevent lightning. Sometimes lightning strikes the home first and thereafter preventive measures are taken to prevent it from striking again. Such measures include strengthening and fortifying the home against danger that might be caused by lightning. Preventive measures are employed during spring. Lightning is one of the things that hurt people which can be prevented from occurring."

4.2.5 Illness prevention

a) *Prevention of illnesses in adults.*

It is important to note that although indigenous healers prevent mainly supernaturally caused illnesses, they also do show the potential to prevent some universal conditions (naturally caused illnesses found cross culturally). However, their preventive measures may be totally different from those employed by the western medical practitioners in certain conditions. This becomes clear when the respondents stated that:

"We protect adults from an illness called inyoni(bird). It strikes and hurt adults. When struck by this bird, an adult person falls down. This is one of the diseases we can treat. We also prevent headaches associated with epistaxis and death. Regarding otikoloshe (the supernatural agents of

a witch), we prevent them from entering a home by fortifying with medicines which are sprinkled and spread around the homestead. These supernatural agents are problematic in young children because they cause a number of illnesses. We also protect the homestead by expelling such agents. Another illness that we can prevent is called idliso (poisoning attributed to sorcery). An individual who has been fortified or strengthened cannot be affected by severe effects of idliso.

Adults may be vulnerable to stress. Emotional disturbance can lead to the onset of various diseases. Old people must be well cared for and protected from any stressful situation. An emotional state of an adult seems to be fragile. Adults can become too much sensitive. This can lead to diseases like stroke. An old person may become easily confused. Once you become old, you become easily disturbed. Emotional disturbance may be more severe than physical illness. An individual can die due to emotional disturbance.

Another illness that we can prevent is known as isifo samehlo (eye condition) It is a communicable eye condition. We intervene by a using some herbal mixtures. These mixtures can be used even by people who have not yet been infected. Another preventable condition is asthma which may be hereditary. If an individual is asthmatic it may be possible for his/her children to develop asthma. You can use the

remedies that have been used by the individual who has been suffering from asthma to try and prevent it from occurring in his/her children.

In adults we can prevent high blood pressure and diabetes. You can prevent these illness through the use of curative herbal mixtures (izimbiza). You can experience the symptoms and observe the signs of blood sugar. When, one day, you discover that your blood sugar level is very high, you must use herbal preparations. These preparations also help prevent high blood pressure. They help maintain normal blood sugar levels. Blood sugar is something that takes time to reveal its presence. Therefore you must prevent it by continuously taking herbal mixtures as a prophylactic treatment and having checks up done by health workers at the clinic. An old person can suffer from hypertension. Stress in the family can cause palpitations.

We have also learned that cholera can be prevented through the use of jik to cleanse contaminated water. We have been told that we can put ½ teaspoon of salt and 8 teaspoons of sugar in 1 litre of water. This solution will give an individual with cholera more strength prior to taking him/her to hospital. Another disease effecting the chest is called isifo sesifuba (chest disease). This disease is common in winter. At the beginning of winter, a person with such a condition is given specific treatment by indigenous healers to use. This is done to offer protection. When a person is being attacked by this disease, his/her condition does not become very threatening due to prior protection.

Herbal remedies can prevent AIDS from having an immediate negative impact upon the individual. There are various types of venereal diseases. There is a Zulu culture related venereal disease. This disease is acquired when a man have sexual intercourse with a widow. The woman may actually have no sexually transmitted disease. Her bereavement is culturally considered a disease itself. The ancestors cause an illness which affects the man who have sexual intercourse with a woman who is bereaved due to the death of her husband. When the husband dies, his ancestors look after his wife, because she was, through an ancestral cultural ritual, introduced to them (ancestors). The gall bladder is used when such a ritual is performed. The kind of sexually transmitted disease caused by the ancestors is difficult to treat. It can only be treated by special people. People who suffer from such a disease usually die. Some of the culture related sexually transmitted diseases can be prevented through enemas. A woman who use to take enemas may not be severely affected by certain sexually transmitted diseases compared to those who don't use enemas. Women must now and again cleanse their blood to detoxify their bodies of blood borne toxins from any cause. This can be done through the use of izimbiza (curative mixtures). Condoms should also be used to prevent sexually transmitted illnesses. We can prevent inhlume, (an illness associated with genitals) and isilumo (dysmenorrhoea)."

b) Prevention of illnesses in children

Like in adults, indigenous healers prevent mainly supernaturally caused illnesses in children. It should also be noted that they do prevent the universal conditions. They also provide the preventive measures which may be similar to those employed in adults. For example, the respondents stated that:

> ***"Diseases that can be prevented from affecting children would include, for example, evil spirits, placement of dangerous medicines (imeqo).We protect them by making incisions for the insertion of curative mixtures. We also make incweba (a string put around a child's neck) which prevents or dispels evil spirits. We can protect children from measles. We provide protection by giving them enemas and specific remedies to drink. This is done prior to the onset of measles. We also protect children from a condition called ipuleti (plate).A child may be protected from a condition known as inyoni / ipuleti which is very dangerous. The child may be born weak. He /she cries frequently and may have sleepless nights. If inyoni remains untreated it may lead to the child's frequent illnesses. It involves delayed internal healing of a baby's umbilical cord. The cord sometimes become inflated like a ball. Inyoni may be caused by a pregnant woman's contaminated blood especially if she (pregnant woman) did not take herbal treatment called isihlambezo, which is usually taken during pregnancy. Inyoni can also be caused by ecological health hazard such as lightning especially if the pregnant woman walks across areas which have been struck by lightning. The baby may even have a sunken fontanelle. We protect the child from ipuleti***

by eliminating inyoni (green bowel content which is eliminated by a child after the administration of a specific enema). This speeds up the internal healing of the umbilical cord. We also make incisions and strengthen the child around his/her umbilical cord. The child may be born with some of the conditions like chest problem associated with coughing. We can also protect the child against such conditions by preparing some herbal mixtures for the child to drink. To prevent inyoni from affecting the baby we give the child some herbal remedies prior to or during its (inyoni) onset. These remedies cleanse the baby's blood. This prevents the severe effects of inyoni. These herbal mixtures are given to the baby as early as two weeks or one month after birth depending on the period of inyoni onset.

We prevent these conditions by performing the procedure called ukulahla. This procedure can be performed inside or outside the homestead. Sometimes you prepare a herbal remedy that the child can suck through the bottle. You can also give a child an enema, even if she/he is not sick. You are trying to rid the child of all the poisonous substances, she/he acquired from the mother during pregnancy.

We protect children from unhlangothi. If you, as a pregnant mother, have hypertension the new born may have unhlangothi. The unborn baby may end up being a stillbirth. Obviously hypertension may end up causing unhlangothi in the pregnant mother. Thereafter the baby may be born with some abnormalities. We protect children from the supernatural agent of the witch (isilwane) We also protect the child from

a supernatural agent which may accompany his/her mother. We chase the supernatural agent away from the mother's breast thus encouraging the child to suck and grow properly. We also protect the child from isilonda "sore" (a condition which constitute the wide opening of the child's anus on examination). This condition is associated with fever or flue. It is mainly caused by evil spirits. We prevent this condition by using herbal mixtures appropriate for the eradication of evil spirits.

We protect the child from having a sunken fontanelle. This condition is associated with green loose stools in young children. This may be due to the fact that the child together with his/her mother may have contact with places or people immediately associated with the use of very strong medicines. The child is protected by mixtures that prevent the fontanelle from sinking. He / she must be strengthened, have incisions for the insertion of curative mixtures, be in a house which is frequently fumigated with smoke of curative mixtures called izinyamazane. This prevents evil spirits from causing the child's restlessness. We protect children from eye infections which may be communicable. We administer herbal mixtures to prevent eye infections. The child is given such a mixture to drink. Another mixture is used as eye drops. The healer intervene in the eye problem the way she/he was instructed by his/her ancestors. If a person, despite good previous eye sight, tells you that he/she can't see anymore you can divine and identify the root cause of

his/her problem. Sometimes the eyes may be having something like mist. A person can use traditional healers remedies as well as the western treatment.

Certain types of retardation in children can be prevented. For example, the ancestors can retard the baby while in the uterus. For example, if the baby's biological father is Mr X but the pregnant mother states that her pregnancy is Mr B's responsibility. Mr B's ancestors will reject the baby during pregnancy. They (ancestors) may even cause some physical disability which may become apparent after delivery. What I am talking about actually happened in my family. We really see the effects of the ancestors. This problem occurs when a woman has two boyfriends. She gives the responsibility to the man she feels is better than the other, not to the real biological father. After delivery, the child become problematic. Sometimes he / she might become disabled because Mr B's ancestors can see that this child does not belong to them. This implies that the child may suffer from effects of conflict between the ancestors of two different surnames. The solution would be to take the child back to the responsible parent (father). This means giving the child his / her appropriate surname. This is done by performing specific cultural procedures acceptable to the ancestors."

c) Referral to hospital

Referral to hospital appears to be part of prevention at a tertiary level whereby indigenous healers may ensure that the

child functions within his /her disability, if any, to the best of his / her capabilities. For example, the respondents stated that:

> ***" We quickly refer babies with very critical conditions to hospital. At the hospital, incubators may be used. We refer because our knowledge is not the same. Another indigenous healer may know what to do in order to intervene. Babies who need incubators may be very small probably because of the things which may have been affecting them while in the uterus. However, there can be things that you can do, as an indigenous healer, to reverse a culture related problem if you discover that the child is healthy though small. Sometimes the child may be very weak. In this case you must rush him/her to the hospital so that doctors may assist with their machines. There is nothing we, as indigenous healers, can do if the baby is unable to eat or suck. Doctors can also insert a drip."***

d) Co-operation

Co-operation between indigenous healers and the western health workers, like the referral system, may function as a means of prevention. Through co-operation, illnesses may be prevented at both secondary and tertiary levels. This may become clear when the respondents mentioned that:

> ***"We can co-operate with the formal health professionals because life is important. If there is anything puzzling I come across, the western health professionals will intervene. What I can say is that the western health system***

is a powerful health system on its own. On the other hand, indigenous healing system is very powerful on its own. But what is common to both systems is that we need people to recover from their illnesses. At the hospital the doctor will treat an illness he/she knows better as a western trained practitioner. However, an illness that may be related to African culture will remain untreated if any. The latter illness may eventually become the cause of death of a patient. Similarly, we, as indigenous healers, may treat what is relevant to our system of healing. Illnesses relevant to the western system may be left untreated. Eventually we come to a point where indigenous healers on one hand and western medical professionals on the other, need to co-operate. But I do not believe that each system can bring up another system like a child. Both systems are racing. We need to meet somewhere because, at the end, we need people to be healthy."

e) Prevention of illnesses during pregnancy

Historically, African pregnant women used to take precautionary measures which led to their well being as well as that of the unborn child. This is well articulated by the respondents when they stated that:

"Immediately after marriage, the experienced women in marriage (amakhosikazi) would advice the novice (newly married woman) not to start wondering around when she is pregnant because this would be detrimental to the life of the unborn baby. We, as young married women, used not to attend marriage ceremonies because such events were

associated with very strong medicines called izitolumu which were burnt. We did not attend especially if we were pregnant. A pregnant woman is vulnerable. She is, traditionally, not allowed to attend social functions. She does not visit bereaved families because when she cries and become emotional, she may end up having pre-mature delivery. When a pregnant woman goes around visiting people in the neighbourhood, the unborn child may contract diseases quite easily. A woman should look after herself during pregnancy through constant use of herbal mixtures until delivery. We use herbal mixtures called izihlambezo. The woman drinks these herbal mixtures. They prevent or eliminate swelling (oedema). They cause the woman to pass more urine like the doctor's tablet. When a woman is pregnant she doesn't sleep well at night especially if she has high blood pressure."

In terms of pregnancy, indigenous healers claim to prevent culture specific illnesses which may affect women during pregnancy. Respondents interviewed pointed out that:

"Umeqo (a condition which arises due to the act of stepping over a harmful substance) may be due to visible or invisible tracks left behind by men, animals, birds, poisonous snakes and lightening causing an environmental health hazard. Sometimes sorcerers or jealous people may deliberately place harmful medicine in the pathway of a person they perceive as their "enemy". Pregnant women can step over dangerous tracks (umeqo). It (umeqo) may become localized in the uterus where it may subsequently lead to abortion. A pregnant woman may be vulnerable like a newborn child. Harmful medicines can even attack the foetus in the uterus. When time of delivery

comes, the pregnant woman may experience difficult labour especially if she did not take precautionary and preventive measures. When the pregnant woman contacts umeqo, her blood may be contaminated. The baby's blood may become contaminated by illnesses acquired by the mother who may have been in contact with many people who use strong medicines. This may affect her thus causing an illness. Umeqo also stays in the kidneys. It affects both kidneys and the uterus. The problem with kidney problem is that sometimes it becomes very difficult for a pregnant woman to realize that she may be suffering from such a condition. She may complain of losing energy. The western doctor might consequently diagnose high blood pressure. A woman with high blood pressure may experience difficulties during delivery of her baby. It should therefore be noted that the life of a human being heavily depends upon the proper functioning of kidneys. Everything you get, "stays" in the kidneys. Kidneys supply the whole body.

After delivery, the woman still remains vulnerable. As a result she is discouraged from going outside her house in the morning, especially before sunrise. She must stay inside the house until the sun is up the sky. We prevent these illnesses by giving pregnant women curative medicines to lower the high blood pressure. Herbal remedies decrease pregnant woman's blood volume which is positively related to contamination with umbhulelelo or (umeqo). We purify her blood using herbal remedies. These remedies encourages the pregnant woman to urinate excessively, thus lowering high blood pressure. She may then have successful delivery of

her baby. The unborn baby can be protected by giving the pregnant mother a special string which she wears around her waste. We strengthen her. We also give her some curative mixtures relevant to a pregnant woman. Herbal mixtures which prevent the foetus from becoming embedded (sticking in the uterus) are prescribed. Diseases which affect pregnant women also include bleeding per vagina and culture specific sexually transmitted diseases. These illnesses may be prevented by the use of herbal mixtures. Pregnant women may be troubled by isilwane (the supernatural agents of a witch). We protect the women against isilwane by providing her with some ointment to apply on her abdomen. Such an ointment will cause isilwane to run away from the woman."

f) Nutrition knowledge

Very few informants appeared to be aware of conditions related to malnutrition. For example, they pointed out that:

"Umzimba omubi is another common condition (Kwashiorkor and marasmus) that may be prevented. This condition may be associated with lack of breast-feeding. What seems to be a problem for children is the fact that they are not breast-fed by their parents. They eat everything. These children become more vulnerable to diseases. They grow faster. Now babies are deprived of breast-milk early in life. Babies eat "diseases". Today, the child's growth is accompanied by diseases. Breast-milk was treatment used to ensure proper growth of a child. The breast milk used to be the child's diet. When traditional food like izincumbe was the main diet children were growing very well. This kind of diet used to

strengthen them. However, the sick mother's breast may sometimes transmit an illness to the child through breast feeding."

g) Complications of pregnancy

It should also be noted that indigenous healers are also aware of the complications associate with pregnancy. Conversely though these complications may be similar to those encountered by the western medical practitioners, their causes, according to the respondents, may be culture related. For instance the respondents pointed out that:

"When a woman is pregnant her child/baby might be "sick" "embedded" in the uterus and may not be able to turn around. Sometimes during the period of delivery the baby may move towards the fundus (upper part of the uterus) instead of moving towards the cervix (mouth of the womb). Both mother and baby may die because of this situation or the woman may have caesarian section performed or have a still birth or abortion. Sometimes the situation can lead to foetal distress. Burning water prevents the baby from moving freely in the uterus. Sometimes the baby may not be embedded in the uterus but may be troubled by the foregoing water. He / she may be born with a sunken fontanelle. The child may be born with the disease acquired from the mother who could not restrict her movements during pregnancy. Such problems are prevented by prescribing imbiza (a prepared mixture called isihlambezo) for a pregnant woman so as to keep the baby healthy in the uterus. After strengthening her, we provide her with incweba to offer more protection. I give her

izihlambezo (prepared mixtures) to drink and to use as an enema. These mixtures will cleanse her. They clean her inside. A pregnant woman should also get izinyamazane (medicines used to fumigate the house with a smoke). Sometimes a pregnant woman may have burning urine and a vaginal discharge. We prepare izihlambezo (herbal mixtures) for such problems.

There is an illness that affect the blood system by contamination. It may be caused by the clashing of evil spirits in the pregnant woman's blood. Sometimes we discover that a woman's blood may be contaminated resulting in oedema (swelling). Sometimes her contaminated blood may need to be cleansed. There are things that can be used by a pregnant woman and those which may be contra indicated. The things that she may not suppose to use can eventually lead to unsuccessful pregnancy . These things would include smoking and drinking alcohol during pregnancy. She may be vulnerable to diseases caused by drinking and smoking. Alcohol and smoking directly affects the baby in a pregnant woman. The baby may, after birth, suffer from illnesses which may be related to alcohol and smoking, for example, chest problem. Pregnant women may suffer from high blood pressure as a result of smoking. Some women don't look after themselves during pregnancy. Women during pregnancy must use herbal mixtures to cleanse the baby so that it can stay freely in the uterus. These mixtures may lead to successful labour. A pregnant woman with high blood pressure is between life and death. HIV in the pregnant mother can affect the baby. A pregnant woman may not experience any problem while

being infected by such an illness. She may start experiencing problems during delivery. This may be the time when an illness reveals its presence. These are problems of a pregnant woman."

h) *Effects of complications of pregnancy upon the new born child.*

According to the respondents, some illnesses acquired by pregnant women during pregnancy may lead to congenital diseases. Children may also suffer from the effects of culture specific illnesses acquired by their mothers during pregnancy. It should however be noted that some respondents seem to have misconceptions regarding the conditions they do not well understand. For instance, the respondents stated that:

"The child may be born with difficulty in breathing through the nostrils. Sometimes the child may be born deaf. Sometimes one side of the baby's body may be paralysed. These illnesses may be congenital. A child may be born with sores due to venereal diseases. The child sucks contaminated blood from the mother. Sometimes the child may be born yellow or blue. We treat both mother and child. We give herbal mixtures to the mother to drink. Such curative mixtures protect the child inside the uterus. Sometimes the baby may be born dead (stillbirth). Sometimes the child may be born alive with deformity of a specific part of his/her body. The baby's condition at birth may be so poor that her/his response to various stimuli might be poor. For example, the baby may be unable to cry. The child may also be possessed by the evil spirits. Evil spirits are very

dangerous. They can deprive the child of oxygen. The child may be restless and run short of breath. This may be as a result of African culture-related illnesses acquired by the mother during pregnancy. After fumigation the child usually recovers. We also need to prevent jaundice. Some people say jaundice is caused by eating too much oranges and certain types of cool drink. I personally did not experience the foregoing problems. I never received any information from the health facility staff regarding taking precautions against eating too many oranges and drinking too much specific cool drink like fanta, for instance."

4.3 MAJOR THEMES BY FORMAL HEALTH PROFESSIONALS

4.3.1 Conditions which formal health professionals think indigenous healers can assist in terms of health promotion and illness prevention

The need for interventions by indigenous healers is expressed when one of the western medical practitioners made the following remarks:

"Actually I think in my own view that it depends on which community you come from. In my community, that is the African black community, I believe the traditional healer should be involved in all conditions when it comes to health promotion and illness prevention."

a) HIV and AIDS

The formal health professionals believe that African indigenous healers can make a substantial contribution in health care delivery system in terms of health promotion and illness prevention. For instance, registered nurses, similar to the western medical practitioners, seem to believe that indigenous healers also use their herbal remedies as symptomatic treatment for patients living with AIDS. This treatment seems to prolong patients' lives. A registered nurse working at Edendale hospital, for instance, maintained that:

> ***" Regarding indigenous healers and AIDS, I have had a very positive response. There was a girl that was HIV positive who came in with her baby. She had been to a traditional healer at Umlazi Township. She said the treatment she was given by the healer was much better than the hospital treatment. She said the healer's treatment was boosting her and she had been gaining weight. She looked much better than when I previously saw her. I have never encountered any negativism with traditional healers. I do not know whether it is because clients are afraid to talk about traditional healers."***

Another registered nurse at the hospital believed that the involvement of indigenous healers in terms of prevention and treatment may, to a certain extent, alleviate the great impact of HIV and AIDS. She further maintained that:

> ***"AIDS is a major condition. People are dying out there so something must be done both at the level of prevention and***

treatment because in the meantime there is no cure. May be traditional healers can come up with something to intervene at the level of treatment. At the moment I can say please people come up with something, cure for AIDS. We are dying. The youth is dying. So if there can be something that can help, may be the world will be a better place to live in."

Formal health professionals are of the opinion that HIV seems to be a major underlying cause for most of the conditions with which clients present. They believe that although many people consult with indigenous healers, the healers have not put a lot of effort in educating their clients about prevention of HIV infection. For example, a registered nurse working in a rural clinic maintained that:

"Regarding conditions of many patients, the basic thing is HIV. We really need traditional healers to come in there. Basically what happens is that we get patients coming in here to the clinic. They have been to the traditional healers but as far as prevention and promotion is concerned, they educate their clients on a very small basis. HIV is affecting the children and it is our major problem. What is happening we are seeing young stars like sixteen and fifteen year olds becoming infected. The reason is because most parents are too shy to talk about sex with their children. With regard to teenagers, healers can prevent STDs and HIV infection."

Registered nurses working at the hospital pointed out that there is a high prevalence of children with HIV infection. Most of them are clinically identified and then confirmed after the

administration of HIV test. This is expressed when one of the registered nurses, for an example, related that:

> ***"We do have HIV cases but babies present with diarrhoea (gastro-enteritis). When we treat this diarrhoea we may discover that the baby does not respond immediately compared to other babies. As a result the doctor may decide to take some blood specimens and eventually discovers that the baby is HIV positive."***

b) Diarrhoea

Diarrhoea was considered by the western medical practitioners as one of the serious causes of high mortality and morbidity rates associated with infants and young children. This is noted, for instance, when one of the western medical practitioners said:

> ***"I think probably one of the biggest killers in children is diarrhoea."***

Although most western medical practitioners agreed that diarrhoea is the biggest cause of mortality in children, some of them however, pointed out that HIV, in which indigenous healers should play a very big role, is the major predisposing factor of children to the fatal effects of diarrhoea. This is reflected when one of them stated that:

> ***"For me HIV is quite a priority because what ever we do children come with diarrhoea and the next thing I find that the underlying cause is HIV. They come in with TB and I find that the underlying cause is HIV."***

Diarrhoea in children has been perceived by registered nurses as one of the major conditions in which indigenous healers could intervene in terms of prevention and treatment. Indigenous healers can make a big contribution by educating mothers about how to effectively manage diarrhoea in children at home. These ideas are reflected when nurses maintained that:

> ***"The first condition I think is most important for indigenous healers is diarrhoea which is common in our area in children. I suppose they could be of help in preventing diarrhoea. They also help a lot if the child has diarrhoea. They have got their indigenous medicines to cure diarrhea.***

C) Dehydration

Dehydration is considered by the registered nurses as one of the life threatening conditions in which indigenous healers could make a considerable contribution in terms of prevention. One of the registered nurses, for an example, made the following comment:

> ***"Most of the children we see in this clinic are children with dehydration. This is one of the five major conditions in which traditional healers could assist in terms of prevention of childhood illnesses especially prevention of complications. Dehydration could be caused by vomiting, diarrhoea or both."***

d) Hypertension

Registered nurses believe that hypertension is one of the conditions in which indigenous healers can make a considerable impact in terms of illness prevention and health promotion especially during pregnancy thus preventing complications. They proposed that:

> ***"Healers need to stress to the pregnant women that they need to come to the clinic so that they can be monitored since their bodies change when they are pregnant. You may not have blood pressure before you are pregnant but while you are pregnant because of the extra strain, the kidneys and so forth have changes which cause blood pressure which can be very dangerous not only to the mother but to the baby. The medical scientists discovered that as the baby is forming, there are certain folic acids which are needed by the baby to develop its brain and its neurological side properly. The mother needs to get those tablets from the clinic. Then of course blood pressure is stress related. This may be due to unemployment, perhaps the bread winner dying of AIDS. All goes back to a healthy lifestyle which traditional healers could promote fantastically."***

e) Tetanus

It should be noted, as one of the western medical practitioners pointed out, that tetanus still remains one of the serious conditions affecting the children where indigenous healers can play a major role.

f) Worms

Worms are also considered by western medical practitioners as the most prevalent condition where indigenous healers could assist in terms of health promotion and illness prevention. One of the western medical practitioners, for an example, stated that:

> ***"I think the other condition that needs to be prevented is worms in children . I think this is very common in most children and in most communities. And traditional healers should know."***

Registered nurses are of the opinion that indigenous healers can assist in the treatment of children with worm infestation. One of them made the following comment:

> ***"When it comes to worms, healers can play an important curative role. Healers seem to have an indigenous medicine to cure worms. Every second child that comes in with a cough and a cold or what ever, if you look at them, examine them with your eyes, you will find that they are infested with intestinal worms. If they are living with intestinal worms the worms are eating all the goodness that the mother is putting in. As a result, all these other illnesses come about."***

g) Malnutrition

Malnutrition, an intersectoral problem, is regarded by both western medical practitioners and registered nurses as a serious condition where indigenous healers should be involved. They

maintain that adequate nutrition should form the basis of all health care interventions. One of the medical practitioners remarked that:

> *"The number one problem is malnutrition. Nutrition is the pillar of all successes in health care system. You can have nutrition which is very expensive and that which you can get through average expenditure. Communities need to be motivated. We can get help from traditional healers for such a motivation. We can discuss with them issues like nutrition. For instance, we can explain that if a person starves the child, he / she (child) will have malnutrition. If the child has malnutrition he will not have resistant power. What we need to add is that, sometimes some patients will need starvation but not at the cost of health status because good health status is very important to resist or fight diseases."*

Some of the registered nurses interviewed regarded malnutrition as a priority condition in which indigenous healers can intervene in terms of prevention. This is noted when a registered nurse stated that:

> *" The first condition in which indigenous healers could assist is malnutrition which involves kwashiorkor. We know that there are many people who are poverty stricken who are battling to try and feed their children and so forth. They should get back to the simple things."*

h) Scabies

Another major problematic condition prevalent in children that has been identified by registered nurses is scabies. They believe that indigenous healers can play a significant role in the prevention of this condition which is quite frequently associated with serious complications. For instance, a registered nurse with an experience of working in a rural hospital maintained that:

> ***"Scabies is another major problem. Most of our children come in with scabies. If not treated it complicates into impetigo. Impetigo is big sores in the body. I have seen complications due to scabies. The complications of scabies would include cardiac failure and renal failure because of infection. I have been working in Appelsbosch hospital where babies would come already with heart failure. Healers can also prevent that. If the mother takes the baby to the healer, medication can be given. I have seen babies coming to hospital with serious conditions especially in the rural areas."***

Registered nurses also believed that scabies, which can be prevented at an early age, " can cause a lot of abscesses in the body and sometimes it can go deep into the scalp and cause brain abscesses."

i) Carcinoma

Carcinoma is one of the conditions which registered nurses felt indigenous healers can make a contribution in terms of prevention

and cure. For example, one of the registered nurses maintained that:

> ***"Traditional healers can assist in the prevention of cancer. In fact they do not only prevent but cure cancer. There are medicines they use most of the time. In most cases, when the patient with carcinoma had been admitted in the hospital, relatives would ask for a pass out. When we explain to them that we are taking the patient to Durban for radiotherapy, they would promise us to bring the patient back. They actually do not come back. They only come back when the wound has healed. When doctors take a specimen from the patient, the results from laboratory would become negative. When we ask the relatives what they did for the patient, they would tell us that he / she had been to a Zulu healer."***

j) Tuberculosis

Registered nurses are also concerned about the increasing number of people suffering from tuberculosis which includes both adults and children. They believe that indigenous healers can play a very crucial preventive and educational role. One of the registered nurses, for instance, stated that:

> ***"Traditional healers can assist in prevention of TB. Traditional healers can explain to the communities the causes of TB because most people think that if they have TB they have been bewitched. We get a lot of children with tuberculosis because of HIV. We had a 9 year old about two weeks ago. He looked as if he was two years old. I was***

certain that he had HIV. It was not picked up. He came with diarrhoea and dehydration and he was very emaciated. We referred him to hospital where he eventually died. Regarding tuberculosis, we have plenty of people coming in who have all the signs and symptoms of TB. But in fact the signs and symptoms of AIDS are very similar. So in many cases, those patients who come debilitated at the clinics are actually infected with the virus."

k) Chest Infections

Registered nurses also pointed out that other conditions where indigenous healers could assist include chest infections. These conditions are also associated with high mortality and morbidity rates. Regarding chest infections, a registered nurse said they have conditions like pneumonia.

l) Psychological problems

One of the western medical practitioners who has, over the last 20 years, conducted research in relation to culture and traditional practices, has identified some of the merits of African indigenous healing system. These would include, among other things, psychological interventions. This is reflected in his comments when he said:

"I certainly think that in illnesses where there is a psychogenic component, where problems are related to ubuthakathi (witchcraft), where the problems are related to psychosomatic diseases concerned, where I think a cultural explanation could be offered in terms of the ancestral

displeasure, a question of being 'thakathiwe' (bewitched), cultural therapist has a far superior role to play in that person's improvement than western medicine would do."

Registered nurses believe that indigenous healers can play a very important counselling role especially if patients are worried about African culture related issues. A clinic registered nurse, for instance, made the following remark:

"And if counselling can start from them I am sure we will go a long way. What we see here at the clinic are patients who are already infected with HIV. When they come here we do counselling. I think traditional healers will play a major role in that. A lot of AIDS people have got beliefs that they are outcast of our society and that the spirits are going to turn them away when they die. One lady who saw me her biggest fear was that when she died her ancestors were actually going to reject her. And I had to return her back to her people because I myself did n't know much to be able to help her. She went to speak to her headman. She had to go through certain rituals, like cleansing rituals. She knew that she would be accepted by her ancestors. If traditional healers could deal with that type of thing it would save people from trauma of not knowing. They need to be educated that in fact their ancestors were actually not going to reject them. They are already stressed because they have got an illness. They also get double stress because the ancestors and the various rituals which we have all got in our different cultures. Healers may be able to help in that area."

The western medical practitioners believe that indigenous healers can play a very important role especially when a patient's prognosis is very poor or when the patient is suffering from an incurable disease. They believe that they can send such a patient to an indigenous healer with a referral letter. An indigenous healer can in turn provide the patient with relevant counselling and psychological support.

m) African Culture Related Illnesses

One of the experienced African western medical practitioners interviewed, was of the opinion that indigenous healers have a crucial role to play in prevention of various illnesses in children especially African culture related illnesses. She expresses her experience of indigenous healing system when she said:

> ***"I think traditional doctors have a very big role to play in the prevention of several diseases especially psychological problems. I have seen this especially in psychiatric or emotional problems. It should be noted that I have locked patients in psychiatric wards and an inyanga (indigenous healer) would come and say, "hey you guys, (relatives) the patient is behaving this way because you haven't done this and this." As a result the relatives may request to take the patient for umsebenzi (cultural ritual) and we (doctors) may be reluctant to give them the patient because we do not believe a piece of skin (skin bangle) can solve a problem. But you find that the explanation to the causation of the disease might be better understood if given by someone with a customary backing and with a solution in view 'Hambani***

niyohlaba inkomo uzobangcono lona,' (go and slaughter a cow this one will be better) if the problem is spiritual. Once the cow has been slaughtered, this might do much better than anti depressants."

"On emotional and psychiatric conditions I think we should work very closely with the izinyanga (indigenous healers) because they will give the reason why I am sick. And if I believe that reason and the solution is given forth as just the performance of a cultural ritual, I might become healthy. And they can correct it up to the solution what ever the basis of my depression could have been. So rather than exclusively giving anti depressants you rather link very closely with the community and see how they look at causation of diseases, be that they are serious organic diseases or emotional and psychiatric problems. I have seen people taken out of psychiatric wards and going home and getting better. They were told how to solve the problem and they solved it."

Some registered nurses believe that indigenous healers can also assist in the prevention of conditions which are related to the African culture. This belief is expressed by one of the nurses when she stated that:

" there are many conditions in which traditional healers can assist in terms of healing or prevention of children's illnesses. The first condition is inyoni (gastro enteritis). Healers help a lot in curing and prevention of inyoni. Healers also assist a lot in African culture related

conditions such as isilonda. People believe that these culture related conditions are also deadly."

4.3.2 Indigenous healers' medication

Regarding the efficacy of indigenous healers' treatment, some formal health professionals seem to believe that certain herbal remedies used by indigenous healers are effective. For instance, a western medical practitioner interviewed said:

> *"I certainly believe that there are large range of culturally based pharmacological, mostly herbal based products which can have a beneficial effect to the patient. We are well aware that the medical management by way of portion, lotions, ointments bear some relevance because a lot of herbal remedies are currently being investigated for their active ingredients. But the pharmaco-dynamics of what these traditional healers are using are not clear. But I think there is a whole huge area there which needs investigation. I can tell you that from the point of view of the things used in opening the bowels such as laxatives, anti emetics etc, the traditional practitioner does quite a lot of measures of success. How many are in fact perhaps not helped by these medication is something difficult for me to say. There are some that are obviously very effective. They have got to be enumerated and investigated."*

When addressing the potential role indigenous healers could play in terms of health promotion and illness prevention, registered nurses seem to have gone beyond medical conditions to include orthopaedic conditions. Nurses believed that healers can

intervene with African traditional treatment at a tertiary level of prevention. This view was expressed by a registered nurse with more than 20 years experience of working in a surgical-orthopaedic ward when she made the following statement:

> ***"When it comes to fractures, traditional healers can contribute with umhlabelo (herbal preparation used for treatment of fractures). This medication helps prevent clots that may go to the heart. Traditional healers can assist even with ordinary wounds. They can come in with their indigenous medicines besides these ointments we are applying to the wounds to hasten the healing of wounds. I have observed so many wounds (more than ten cases) that were not healing despite application of ointments like betadine. When the relatives asked for a patient's pass out, sometimes they came after a month with a wound that has healed. If you find out from them what they had used, they would say "We have been to a traditional healer."***

4.3.3 Health education

In terms of health promotion and illness prevention, the western medical practitioners believe that indigenous practitioners, as compared to the western medical practitioners, are well situated because they are in touch with the community. They are confronted with diseases from the community where they live. They should know how to prevent diseases and then educate the community because most of the conditions can be prevented by just knowing what to do and what not to do. Preventive measures identified by the formal health practitioners would include oral rehydration,

prevention of infection, sex education, breastfeeding, immunization, personal hygiene, environmental hygiene, proper use of resources and good social values.

a) Oral rehydration

The formal health professionals pointed out that indigenous healers can make a major contribution by intervening in children with dehydration (loss of body fluids) which may be due to diarrhoea and vomiting. They can educate mothers about the importance of rehydration (fluid replacement). This is noted when one of the western medical practitioners said:

> ***"The traditional healers could put into good word about adequate fluids and plenty of fluids to be taken by mouth for children with diarrhoea and not to stop them and not to keep them nil per mouth and not to give those children enemas, and that I would put very high on my list. I don't think it is important whether you stop the diarrhoea or not but the important thing is to maintain the hydration of that child by adequate fluids. Those would be the two rules that I would make about the child with diarrhoea. Continue feeding and give adequate fluids."***

b) Prevention of infection

The western medical practitioners also believe that indigenous healers could, through health education, assist in the control of infection. They stated that:

"Anybody making scarification should make sure that they have got clean instruments. Indigenous healers could make a positive contribution by avoiding scarification methods where the likelihood of neonatal tetanus would occur. Indigenous healers should have the knowledge of how to avoid transferring infection. For an example, indigenous healers need to be careful with scarification practices."

c) Sex education

Regarding control of the spread of HIV infection, which not only affect adults and the young people but the unborn babies as well, formal health professionals strongly feel that indigenous healers could play a crucial role in promoting good moral standards.

This is also reflected when one of the western medical practitioners said:

"in terms of education indigenous healers should promote sex education."

Registered nurses, with a profound understanding of the young people, proposed that before indigenous healers could embark upon health education with regard to the prevention of HIV infection, they need to understand how the young people think about HIV and AIDS. In order for the healers to understand the nature of the young people, one of the registered nurses provided the following proposal:

" Education has to continue. Many young people, that is 12, 13, 14 years, are sexually active. Mentally they do not seem

to be able to comprehend what AIDS actually is doing to the world. Because of peer pressure at school, they are inclined to think that they must have a boy friend and they must do certain things with the boy friend because that's what the friends are doing. Education should start right from the base, young kids. Then we get the twenty to thirty year olds. Many of those women are very aware of what is going on. They want to change things. But the men in many instances are not interested in having safe sex and they will not use condoms. These young people often come in tears. I had a couple this morning both pregnant, both casual relationship both no condoms. They say "Sister if you insist in using condoms they hit you." I think that education by indigenous healers right from the young children could be a fantastic job. Many of the older women have realised that their husbands have many girl friends. They come to the clinic and take their own private precautions. But they will say "we just have to pray sister what else can we do." Indigenous healers can assist by giving health education. Regarding HIV, traditional healers can assist by educating the public about the mode of transmission. I suppose we would not be faced by such high rates of incidences of this condition."

Registered nurses also believe that there is an urgent need to mobilise various stakeholders including indigenous healers and communities to participate in teaching our youth about sex education which is associated with high moral standards as a means of combatting the spread of HIV infection. One of the registered nurses, for an example, made the following proposal:

"We need to influence the community, the teachers, parents about sex education because we get children coming from primary schools infected with HIV. Sometimes symptomatic treatment does n't work. We need to get some form of treatment to curb HIV. Probably indigenous healers need to come in and teach the communities and teach clients on a one to one basis about prevention and promotion. And most of the clients take the little ones (teenagers) to the traditional healers."

Some of the registered nurses were of the opinion that women specifically need to teach young people about good morals which appear to be disappearing in our communities. This is noted when a registered nurse made the following proposal:

"Get women trained to go out in your areas and work with these young people. The youth are wonderful people. They want to learn. They are keen to learn. Tell them that they are the chaps that can change things. Not the old men who had a lot of girl friends all his life. You guys that are finishing school that are coming out of school, its' your world you must teach the men to respect you and understand what they are doing and start uplifting your morals. You have got to do it. You girls have to do it. From that angle healers could do a wonderful work in the community."

A registered nurse with a European cultural background made a comment about virginity testing, a historical African cultural practice, that has been revived by some Zulu speaking people who

seem to believe that preserving historical African cultural values could be used as an instrument to combat the spread of HIV infection. She stated that:

> ***"Virginity testing had its place. It is a terrible practice. However, if people accept it, It is okay. May be if its being done in a proper way then I could accept it. As long as they are also being told that it is no good having virginity testing done and then running for a condom. Everybody is talking about condoms. Condoms have got their use. But if the young children are brought up to think that they can have sex all day long if they want to if they use a condom there is nothing moral in that at all. One has got to get back to moral issues. The bible lays out such clear foundations and examples of how we actually should live. And if we get back to uplifting our moral selves where sex is concerned."***

d) Nutrition

Formal health professionals believe that indigenous healers can play a major role in the prevention of illnesses through health education about the importance of child nutrition. The western medical practitioners also suggested that indigenous healers could make a considerable impact even during the early stages of child development. This is noted when one of them said:

> ***"I will start in the natal (from one's birth) period and say that it would be very important if cultural healers can involve themselves in positive acts of encouraging breast feeding They can advise mothers that breast feeding is the***

priority and that it is very difficult for babies to get illnesses if they are being breastfed right from the beginning. They can also teach communities about the importance of growing vegetables at home because to buy vegetables is so expensive. This may help in prevention and treatment of malnutrition at home. Indigenous healers should indicate to people the type of food that they can give their children. They can also teach the parents about the disadvantages of bottle feeding."

Registered nurses have also suggested that indigenous healers should also stress to the communities the importance of nutrition even to those people who are living with AIDS because it may, to a greater extent, improve their health status. For an example, one of the registered nurses made the following comments:

"I can speak of patients who have come to me over the years having been diagnosed with AIDS. Many of them came in debilitated. I counselled them and spoke to them about diet. I recommended that they should eat a simple healthy diet. They have so much improved and you can not believe it. Although they have been diagnosed HIV positive, they now know how to prepare a healthy diet. They avoid the expensive western fried food. You rather go and buy a bunch of spinach. And I have living proof of diet having sustained people living with AIDS for a long period of time. I think our traditional healers could start off by telling the people and teaching them from the start that to grow vegetables, eat them fresh and not throw all the vitamins down the sink when they cook them rather save the water and make soup out of it ."

e) Immunisation

Formal health professionals also feel that indigenous healers should be actively involved in immunisation programs where they could play a crucial educational role in the community. For instance, one of the western medical practitioners proposed that:

> ***"the cultural therapists should be strongly advised to encourage their patients at a neonatal level to take part in immunisation schedules."***

f) Personal hygiene

Formal health professionals are also of the opinion that indigenous healers could, through health education in the community, prevent a number of conditions associated with serious complications. One of the western medical practitioners, for an example, noted that:

> ***"the problem with scabies is that it can be transmitted from one person to another. However, it can be prevented very easily by hygienic means. If the kids are kept clean in the community, scabies can not occur."***

Registered nurses interviewed further remarked that:

> ***"due to the fact that the communities go to traditional healers for sores, the healers should assist with health education on personal hygiene. You will find the baby coming to the clinic three or four times within three months. Medication alone can not help. People need to be informed***

about the importance of personal hygiene. Many of the children come in with body sores which could have been prevented through cleanliness."

g) Environmental hygiene

A potential role of indigenous healers in prevention of infectious diseases through dissemination of health information in the communities, is being highlighted by western medical practitioners when they said:

"If indigenous healers know and are aware of diseases affecting our communities, then they will be able to advise community members and their clients. For an example, that if they don't boil drinking water properly such water may be contaminated with bacteria. Contaminated water will make members of the community sick."

h) Proper use of resources

The western medical practitioners express the feeling that, given the limited human resource in formal health facilities, indigenous healers have a potential to ensure, through health education, that the communities make a maximum and appropriate use of the already limited material resources. They illustrated that:

"Even if somebody gets treatment, if he / she does not take it properly, it does not work. There should be proper use of

medication and available health facilities. People may have resources but they may not have the knowledge of how to use them."

i) Change in life style.

One of the western medical practitioners interviewed was of the opinion that African indigenous healers can educate the communities about the importance of equity (equal distribution of available resources) which involves a change in social values. This may lead to improvement of the health status of the society. He suggested that:

"Emphasis should be on co-operation as opposed to competition. You know in our society some people have got little wealth. We can discuss among ourselves that neighbours must not starve when some of us have got millions. These are the important issues in our society. They include wealth, distribution of wealth, organizing and making people feel for each other."

j) Hypertension

Registered nurses also believed that indigenous healers can also, through health education, assist in the prevention of complications which may arise because of hypertension especially during the perinatal period. This is expressed, for instance, when one of them made the following comments.

"You know blood pressures are on the increase. This may be related to diet. Fats and salt are two main killers and we

all like them. Healers could offer health education on that line. If clients do have to go to hospital and are on treatment, they must not run out of their tablets. They have to take their tablets otherwise a stroke can be inevitable."

k) Psychological intervention

It is also pointed out by registered nurses that indigenous healers can play an important role by providing psychological intervention especially in psychological disturbances. Registered nurses think that indigenous healers, because of their status in the African black communities, can play a very important role in influencing people's attitudes positively toward health messages. They believe that this can be a reality only if indigenous healers are empowered with relevant information: These nurses made the following suggestions.

"We can be grateful if they can assist us because there are people who believe only in traditional healers and they take every word that they say if they can spread the word around about prevention. Most of our population have profound respect for traditional healers. If health education messages come from one of the indigenous healers, the community will understand more. Sometimes you will see people coming to the clinic and the next day they go to an indigenous healer. I think they can get proper education there. So traditional healers having been well equipped with knowledge, they would be of great help in the prevention of diseases because people have credibility in traditional healers and they have seen healers treating others."

4.4. CONCLUSION

Regarding current practice in terms of preventive and promotive health care, indigenous healers generally appeared not to be aware of the potential relationship between child malnutrition and specific child illnesses. Although no mention was made about the importance of a balanced diet in children, it should, however, be noted that indigenous healers are generally in favour of breast feeding.

Where pregnant women were concerned, indigenous healers did not highlight either the importance of encouraging their clients to attend antenatal clinic where routine assessment of a pregnant woman would be carried out or the importance of taking a balance diet for the well being of the baby thus preventing complications of pregnancy like pre-mature delivery which may be associated with anaemia during pregnancy, instead, they concentrated mainly on culture related illness and practices.

With regard to indigenous healers knowledge of environmental health, the respondents' knowledge appeared to be very shallow. For example, no mention was made of good sanitation. With increasing number of people suffering from HIV and AIDS which is associated with an increased number of people infected with tuberculosis, respondents did not highlight the importance of adequate houses which are well ventilated to prevent overcrowding and cross infection. However, in terms of their practices, healers did point out the importance of preventing the spread of HIV infection by using one razor blade for one client.

Concerning beliefs about health promotion, indigenous healers, unlike western medical practitioners, believed that it should

involve the role of the ancestors, without which lives of the African Black people become vulnerable. The role of *isangoma* (diviner) is to work with the ancestors who protect and defend their descendants against the forces of evil. Positive attitude toward African indigenous health care practices needs to be encouraged because African people who have abandoned such practices may become victims of witchcraft. It should also be noted that indigenous healers did believe in the prevention of illnesses particularly those illnesses which are related to African culture. Some of these illnesses may be due to witchcraft while others may be due to legitimate and moral anger of the ancestral spirits.

Regarding practices perceived by indigenous healers as preventive and promotive, it is important to point out that such practices were not only directed at the individual concerned, but also at the environment in which such an individual lives. These practices involved performance of cultural rituals, strengthening of an individual and the environment in which he/she lives.

Western health professionals indicated the priority areas/conditions in which indigenous healers' practices can be enhanced with regard to preventive and promotive health care. Indigenous healers can, through health education, disseminate information regarding specific conditions. Such areas/conditions would include, for example, nutrition, management of diarrhoeal conditions, immunization, prevention of infection, sexually transmitted diseases, HIV and AIDS, hypertension in pregnancy, diabetes mellitus personal hygiene and environmental health. Therefore it has been noted that indigenous healers practices are associated with strengths, weaknesses and points of congruence.

CHAPTER FIVE:

RESULTS PHASE TWO: TRAINING PROCESS

5.1. INTRODUCTION

After the description of the current practices of indigenous healers with regard to preventive and promotive health care and identification of specific areas in which their practices with regard to preventive and promotive health care could be enhanced, a training process was initiated. This chapter will include development of the training manual, training implementation, evaluation of training and major evaluation themes by indigenous healers.

5.2. DEVELOPMENT OF TRAINING MATERIAL

5.2.1 Introduction

Prior to developing training material, the researcher started by identifying people who were going to undergo training. In collaboration with registered nurse A who is based at Vryheid and currently working for the Primary Health Care project in Region D, the researcher decided to select indigenous healers who participated in the study during phase one. This implies that indigenous healers who were interviewed during data collection stage of the research were also encouraged to participate in the training workshop. This would make it easy for the evaluator to access the healers for evaluation purposes. To facilitate the process, registered nurse A suggested that nurses who were involved in the training of birth attendants be involved in

organizing healers who would participate in the short training course. Healers worked hand in hand with the clinic sisters during the organization process. A total number of twenty indigenous healers was arranged. Of eighteen izangoma (diviners), sixteen of them were females and two of them were males. The other two were male herbalists.

5.2.2. The training manual.

5.2.3. Choice of the course content

The course content was based on the training needs which emerged from indigenous healers and specific areas identified by the western health professionals in which indigenous healers' practices with regard to preventive and promotive health care could be enhanced. When negotiating the training needs with the researcher, indigenous healers expressed a concern that they needed to know more about the importance of breast feeding. Conversely though indigenous healers claimed to be able to treat different types of sexually transmitted diseases, diarrhoea, hypertension, diabetes mellitus and AIDS, they were, however, interested to know how such conditions could be prevented. Some of the issues like environmental health and personal hygiene were, to a certain extent, reflected in the description of the current practice of indigenous healers. However, this was very limited and this was therefore identified as a training need.

The training manual was also based on areas highlighted by doctors and nurses as priority areas where indigenous healers could make a tremendous impact in terms of health promotion and illness prevention by becoming involved in primary health care activities. Similar to conditions identified by indigenous

healers, areas identified by the western health professionals included environmental hygiene, conditions which may pose a serious threat to a pregnant woman like hypertension, diabetes mellitus, sexually transmitted diseases, HIV and AIDS, conditions affecting children like diarrhoea, health promotion like breast feeding, scabies and worms. Therefore the foregoing issues constitute the contents of the researcher's training manual. Putting together the topics from indigenous healers and western health professionals, three major topics were identified (see annexure D).

- Environmental hygiene (including tuberculosis)
- Pregnant women (including HIV/AIDS)
- Prevention of childhood illnesses

Visual Aids, and training material on these topics developed for rural women were utilised for the training process.
The visual aids covered all the topics that were going to be discussed in the training workshop. Pamphlets were also arranged for participants to take home after the completion of the workshop. Some transparencies were prepared to help supplement information healers gathered during the discussion period. Paper, flip chart, koki pens, prestik and overhead projector constituted material that were used during the training.

5.3 TRAINING IMPLEMENTATION

5.3.1 Introduction

The training workshop for indigenous healers was held at Natal Spa, Paulpietersburg where accommodation for twenty indigenous healers and the researcher who facilitated the workshop was

arranged. A three days workshop was conducted from the 24th to 26th October 2001. It was sponsored by the Primary Health Care for rural women project. Sitting was arranged in a circular form in order to allow free flow of communication and eliminate the number of barriers. A formal introduction among participants was initially conducted as part of getting acquainted exercise.

The workshop started at 10H00 in one of the seminar rooms. Healers decided to sing and then inform their ancestors that they had reached their destination which they considered to be a sacred place. They introduced their ancestors and explained the reason for attending the training workshop. This was done simply because *izangoma* do not have control over their lives. They are controlled by their ancestors (see annexure E).

5.3.2 Group expectations

Participants were requested to mention what they expected to gain from the training workshop. The following expectations and norms emerged.

A *Expectations*

- gain knowledge about communicable diseases
- gain knowledge regarding economic development

B. *Norms*

- There is neither wrong nor right answer
- All answers are acceptable

- Keep time
- Respect for one another
- Active participation from everybody
- Flexibility allowed
- Everybody responsible for own learning
- Only constructive criticism will be allowed

The trainer read the learning outcomes for the participants and introduced topics for discussion. Participants were then requested to form two groups in which they were given a few questions for discussion. Each group was requested to nominate a facilitator and a scribe who, on completion of discussions, would give a report back to the whole group. Participants in both groups were given paper and koki pens so that they could write down their responses. After a report back on each specific topic, the trainer would, using transparencies and based on his notes, give further clarification of various issues discussed by the groups. At the end of training participants were given a few evaluation questions so as to establish how they felt about the training workshop(see annexure F). The participants were then given pamphlets to take home.

5.4. EVALUATION OF TRAINING

Evaluation of the short indigenous healers' training course took place almost a month after the implementation of the training workshop. This evaluation intended to test indigenous healers'

awareness and their level of understanding of the conditions that were discussed during the training period. This is due to the fact that the way African indigenous healers conceptualize the aetiological factors of illnesses may be totally different from the one understood by the western trained health care providers. A one day evaluation interview was conducted. Eleven indigenous healers who participated in the training workshop were interviewed using an interview schedule (see annexure H). The major themes identified from the qualitative data was as follows:

5.4.1 Understanding the complex nature of HIV and AIDS

a) The need for self protection

Indigenous healers seem to admit that, due to lack of sufficient knowledge, they did not realise that it is crucial that they protect themselves against HIV infection especially during their practices. For an example, one of the healers who attended the training workshop stated that:

> ***"I did not know that I need to take necessary precautionary measures when dealing with people living with HIV and AIDS. For instance, I did not know that I need to protect myself with gloves when making scarifications on my patients. However, today I know that I need to wear gloves when making scarifications and discard razor blades that I have been using. When I do not have gloves, I can use ordinary plastic as an alternative."***

Indigenous healers have learned that they need to protect themselves against HIV infection mainly because clients who are HIV positive are not easily identifiable. For an example, one of the healers remarked that:

> ***"An individual can come to you for consultation purposes and you may not be aware of the fact that he/she might be infected with HIV."***

b) Prevention of cross infection

Indigenous healers expressed their concern that some of their procedures are potentially dangerous in terms of spread of HIV infection especially if precautionary measures are not taken. As an illustration, a healer who attended an evaluation interview made the following comments:

> ***" We should not use the same razor blade when performing a scarification procedure for more than one patient. I learned that each patient should have his/her own raiser blade for scarification purposes and it should be discarded after use. In fact, according to our normal practice, medicine mixture used for the acupuncture procedure is usually stored in one container (horn) and all porcupine quills are kept in the same mixture after use. However, because of HIV and AIDS, when I am going to perform the acupuncture procedure, I need to ensure that each patient has his/her medicine mixture and porcupine quill because using the same medicine mixture for all patients will easily spread HIV infection."***

c) The mode of HIV transmission

Indigenous healers seem to have learned that although HIV infection is mainly sexually transmitted, there are other ways through which HIV infection can occur. For an example, a healer who attended the training workshop remarked that:

> ***"I learned that a person who is not having HIV and AIDS can have HIV and AIDS if his/her blood comes into contact with the blood of a person living with HIV and AIDS. We as indigenous healers can contract HIV when we rub the patient's blood stained incisions with our bare fingers especially if our hands have some cuts or sores. I also learned that people who use drugs are predisposed to HIV infection. For instance, drug users who share needles when injecting themselves with drugs are more likely to become infected with HIV virus. HIV can be contracted if we carelessly use porcupine quills for acupuncture and razor blades for scarification of patients. This can happen when an indigenous healer uses one and the same porcupine quill for pricking more than one patient."***

Healers seem to have realised how the knowledge gained at the training workshop relates to their current therapeutic procedures. For an example, one of the healers pointed out that:

> ***"Regarding HIV and AIDS, I learned something I never thought of before. For instance, most of us never knew that, through the use of inungu (porcupine quill) when performing an acupuncture procedure, we were more likely to spread HIV infection from one patient to another. Now, we have***

discovered that when pricking an individual some droplets of blood may remain on the tips of the porcupine quills. When you prick another patient using the same porcupine, there is a potential danger of transmitting HIV infection from one patient to another. This is what we did not know."

Indigenous healers appear to understand that transmission of HIV infection through blood contact may occur even outside their areas of operation. They demonstrate open mindedness when they stated that:

"An individual can be infected with HIV if his/her blood get into contact with the blood of a person who is already infected with the virus especially where there is a road accident."

Generally, this implies that everybody needs to take precautionary measures where contamination with blood is more likely to happen.

Healers also demonstrated their understanding that precautionary measures should not be exclusively associated with unprotected sexual activities and direct blood contact, but also with any body fluids coming from the patient's body. They remarked that:

"People who wash corpses of people who might have died of HIV and AIDS should protect themselves with hand gloves to avoid the possibility of becoming infected with HIV virus especially if they have cuts on their hands."

d) Prevention of spread of HIV and AIDS

Healers seem to understand that there are many other alternative ways of prevention of the spread of HIV infection. They further suggested that:

> ***"Lovers should commit themselves to each other by going for HIV blood test prior to having sexual intercourse. If one partner is found to be already infected, the use of a condom should be considered as a preventive measure."***

They also seem to understand the need to intensify the struggle against the spread of HIV virus through HIV and AIDS awareness. For instance, one of the healers interviewed stated that:

> ***"It is important that I, through health education, inform all the people who are consulting with me about HIV and AIDS".***

e) Beliefs about HIV and AIDS

They were of the opinion that the training workshop has had positive impact upon their beliefs and attitudes toward an individual living with HIV and AIDS. This becomes illustrated, for instance, when they said:

> ***"We also believed that we needed to separate ourselves from people living with HIV and AIDS because we thought that by touching such people we would become infected. We also thought that kissing can also transmit HIV infection. It is, however, something new for us that there are so many things***

that we can do with somebody who is infected with HIV without actually becoming infected ourselves. It is also something new to learn that it is not only through unsafe sex that an individual can become infected with HIV virus. What I knew was that if you avoid unsafe sex you are protected. Now I have learned that by having a small cut on your hand you may not be safe especially if your cut becomes contaminated with blood from someone who is infected with HIV."

5.4.2 Understanding the complex nature of tuberculosis

a) Prevention of cross infection

Efforts by indigenous healers to prevent cross infection seemed to demonstrate that healers have understood how TB becomes an infectious disease. For an example, one of the healers made the following remark:

"I discovered something regarding people suffering from TB. I did not take any precautionary measures when handling patients suspected to be having TB and those suffering from other diseases. I mixed my patients. Now I clean properly the place where a patient with TB was accommodated before letting another patient suffering from a different condition to occupy it."

They further stated that:

" It is important that a person suffering from TB must not mix with patients suffering from other illnesses because

he/she might infect them. For an example, a patient who is coughing and suffering from TB can be treated for an African culture related condition using a steaming procedure. After the patient has finished his/her steaming procedure, another patient who may not be suffering from TB may use same blankets for steaming. This impies that he / she is more likely to get infected with TB."

b) Mode of spread of tuberculosis

According to indigenous healers who attended the evaluation interviews, their knowledge about the mode of spread of TB infection seemed to shed light about the nature of communicable diseases. For instance, this became reflected when one of the healers stated that:

"I gained knowledge about TB. I did not know how people get infected with TB. I learned that an individual can get TB infection through inhalation of small droplets from a coughing person with TB. The person who has inhaled the droplets, if not well nourished, can begin to suffer from TB. I did not know, however, that a well nourished person can become infected with TB without actually suffering from it."

Healers learned that there are many ways in which TB can be spread from one person to another. This appeared to have increased indigenous healers' efforts to prevent the spread of TB infection. For an example, one of the healers stated that:

"A patient can spread TB by coughing, spitting on the ground or by staying in an accommodation without fresh air where other people can easily become infected by inhaling such air. I mean that when people come together they should not infect one another with various communicable diseases. People should be treated separately depending on the nature of their illnesses from which they suffer."

c) Health education

Indigenous healers, due to the knowledge they achieved during the training workshop, seemed to be motivated to start disseminating health education messages about the ways through which the spread of TB infection can be prevented in the community . For instance, one of the healers who attended evaluation interviews made the following remarks:

"I will discourage people from coughing and spitting on the ground. They should spit their sputum into the sputum cups or containers. When coughing, people should cover their mouths with their hands otherwise they can easily infect other people with TB. I will also inform people that, for health reasons, the environment where they stay should be clean. Our houses should be big enough with windows and ventilators to allow fresh air. People need to know that TB can spread easily where there is overcrowding without adequate ventilation."

These indigenous healers further suggested that:

> *" People can prevent TB by eating a nutritious diet. They should be encouraged to grow vegetables to improve their resistance against infection. TB can also be prevented by sending to hospital someone suspected to be suffering from TB before he/she can infect others. We can prevent TB by improving environmental hygiene. For example, food should be always covered to prevent flies from spreading the disease. Children must be taken to the clinic where they can get immunisation against TB."*

d) Collaboration

Indigenous healers who attended the evaluation interviews seemed to have been inspired by the knowledge they gained during the training workshop and they seemed to be encouraged to participate in any proposed prevention programs. One of the interviewed healers stated that:

> *" Regarding the issues that were covered during the training workshop, I would like to stress the importance of co-operation in the prevention of many conditions like TB. When an individual suffering from a chest problem comes to you as an indigenous healer, you must, through divination, assess the condition of the patient. When culture related problems have been excluded and the patient is suspected to be suffering from TB, he/she should be referred to the clinic where he/she will be assessed by the formal health care facility staff using western methods so as to confirm the patient's diagnosis (TB) because there are African culture*

related procedures which the patient should not carry out if he/she is having TB. Prevention of TB can happen by early detection and prompt treatment especially because TB is an infectious disease. When an individual with TB is getting treatment, he/she can not infect other people"

5.4.3. Realising the fatality of diarrhoea in children.

a) Prevention of dehydration

Indigenous healers who attended evaluation interviews seemed to be aware of some of the limitations of their own system in terms of prevention of dehydration. One healer said:

"If the child has diarrhoea we use herbal remedies to stop diarrhoea. However, we did not know that by stopping diarrhoea we might be keeping germs inside the baby's tummy which may sometimes cause further problems. I found that when an individual has severe diarrhoea we should prepare water solution for him/her so as to prevent loss of water from the body. To prepare this water solution, you need to boil water, cool it down and pour it into a litre bottle. Add eight (8) teaspoons of sugar and one (1) teaspoon of salt and shake the bottle. Encourage the child with diarrhoea to drink this solution. After drinking this solution the baby should be able to regain energy. The baby should not be given any medication unless prescribed by the medical doctor. If diarrhoea becomes persistent, take the child to the clinic".

It is important to point out that healers who attended the evaluation interviews became aware of the importance of promoting breast feeding and its role in the prevention of ailments in children. This became clear when one of them stated that:

> *"Something that we have discovered in the training workshop is that breast milk is the child's full diet. I also learned that a baby must be breastfed immediately after birth. The child must be breastfed because breast milk is heathy. We believed that when the child has diarrhoea breast feeding should be discontinued immediately because we thought it would aggravate diarrhoea. This is where we made a mistake. We did not realize that by depriving the child breast milk we were depriving him/her the most important treatment. Babies must be breastfed even when they have diarrhoea."*

These healers further stated that:

> *"Diarrhoea can be prevented by avoiding the use of contaminated water from the river and by ensuring that the child stays in a clean environment and eats a balanced diet especially because some of the mothers are employed and their babies are being bottle fed. Poor environmental hygiene encourages flies which can easily contaminate the baby's bottle with germs thus causing the baby to have diarrhoea. As a result, a child's diet (including the bottle) should always be kept covered. We can prevent diarrhoea in children by encouraging breast feeding. Babies should be breastfed because breast milk protect the baby against any kind of infection including diarrhoea. Breast milk is nutritious. A child must be breastfed for at least*

two years or more. We need to discourage bottle feeding. The bottle is, in most cases, not healthy because the child can throw it on the ground or floor which may be dirty. Sucking of dirty bottle by the child can cause illnesses. Parents of bottle fed babies need to avoid using cold water when preparing the baby's feed and being inconsistent with the amount of powdered milk necessary for such preparation because this can cause diarrhoea. Therefore mothers should use breast milk because it stays the same and is always warm."

5.4.4. Understanding the importance antenatal care during pregnancy.

a) Prevention of illnesses during pregnancy

Indigenous healers who attended the evaluation interviews saw a need to refer pregnant women to the clinic so as to prevent ailments associated with pregnancy. This is reflected when one of the healers said:

"We need to work hand in hand with the clinic. When a woman falls pregnant she must be encouraged to attend antenatal clinic very early in pregnancy so that she can be monitored regularly by nurses. They will check her health status and that of her unborn baby. For example, she will have her weight measured and her nutritional status assessed. I learned that, when pregnant, a woman should eat a nutritious diet for the proper development of her unborn baby. She will also have her blood pressure monitored. Now I have realised

that a woman can have an onset of specific illnesses, especially during pregnancy, which may not have immediate effect. These illnesses may sometimes become problematic later and may become difficult to overcome. I also learned that a woman who is living with HIV virus should be discouraged from getting pregnant because pregnancy may compromise her poor health status and her baby may not live longer. Falling pregnant may increase both the infant and maternal morbidity and mortality rates".

b) Importance of ante natal care

Indigenous healers have realised the need to refer pregnant women to formal health care clinics so that potentially dangerous conditions associated with pregnancy could be excluded thus preventing complications. For instance, one of the healers stated that:

"I learned that when a woman is discovered to be pregnant, she should be encouraged to visit the clinic as soon as possible where her urine will be examined to confirm her pregnancy. Once her pregnancy has been confirmed, she will then be informed as to when to start her regular visits to the clinic. Before training I did not encourage pregnant women to go to the clinic. Now I have learned that pregnant women should not become infected with sexually transmitted diseases. It is therefore important for a pregnant woman to have her blood tested for any sexually transmitted disease."

Healers' role during pregnancy would be the one that will ensure that formal health services become accessible to the people

through their co-operation with the western health care practitioners. This became apparent when one of the indigenous healers remarked that:

> ***"We have a big role to play as indigenous healers because we see patients some of whom experience problems associated with infertility. We usually treat them until they conceive. After conception, is the time when the woman will need to visit the clinic where they will be examined and have their pregnancy confirmed. Blood will also be taken and examined. The woman will then be required to make regular clinic visits on one hand and also continue with African culture related therapy on the other. There will be a need for co-operation between healers and the clinic.***

c) Pregnancy related illnesses

Because of their knowledge of illnesses associated with pregnancy of which they were not aware, indigenous healers seem to realise a great need for them to encourage pregnant women to attend ane natal clinic as a preventive of the forgoing illnesses. One of the healers stated that:

> ***" We, as indigenous healers, never worried ourselves previously about the importance of encouraging a pregnant woman to visit the clinic. For pregnant women, for an example, we usually prescribe izihlambezo (herbal mixtures) especially when the woman does not feel well. When a pregnant woman appears to be healthy, we usually ignore her hoping that the baby grows well since the mother does not report any problem. Even the herbal mixtures are prescribed***

when the woman is just about to deliver. What I have now learned are these conditions which need the pregnant woman to visit the clinic. These conditions would include high blood pressure and many others. We can not assess high blood pressure. Sometimes we do assist in lowering it with our herbal remedies, but not to measure it. Ukuphaphatheka kwegazi (anaemia) which requires the pregnant woman to get some tablets is something we did not know as indigenous healers. What I knew about anaemia was that it could be one of the signals that would make me suspect that a woman might be pregnant. Now I have discovered that anaemia can also be associated with a specific ailment in pregnant women which requires them to visit the clinic."

d) Prevention of birth complications

Indigenous healers seem to be convinced that during delivery pregnant women should be delivered by the trained people so as to decrease the number of pregnant women experiencing problems. For an example, one of the healers made the following comment:

"During delivery, a pregnant woman should be attended by trained birth attendants. These would include nurses, doctors as well as women in the community. It is important that a pregnant woman delivers at the hospital or clinic."

5.4.5 Understanding the negative impact of children's illnesses.

a) Worms and the role of environment:

The healers seemed to have knowledge of the relationship between poor environmental hygiene and the spread of worms in the community. One of the healers, for instance, pointed out that:

> ***"A child can get worms in an area where people do not have toilets and where there is no proper disposal of excreta. Worms may lead to child malnutrition. They may cause internal irritation which can lead to the child's vomiting."***

b) The mode of spread of worms

Indigenous healers, through their adequate knowledge of environmental hygiene, demonstrated during evaluation interviews that they are in a better position to educate their patients and communities about the importance of environmental hygiene. This was reflected by the following statements:

> ***"I also learned about worms in children and that they can be prevented by ensuring good personal and environmental hygiene. We must have adequate toilets. Our drinking water should be far away from our excreta. People should not pass their stools all over the veld because flies will carry germs and spread them all over. Pigs must not be allowed to wander around in the community because they eat everything they come across even faeces contaminated with worm. As a result the pig's meat may be infested with worms' eggs. People eating such meat may end up having worms."***

"I have learned that worms may spread from a person to an animal through human excreta and from an animal to a person through meat. I have also learned that worms may enter the child's body through the anus. For instance, young children who like to play with soil are more likely to be penetrated by worms through their anuses especially where there are no toilet facilities."

"A child must eat a nutritious diet. A child must be breastfed. Mothers who bottle feed their babies should ensure high environmental hygienic standards because the baby's bottle may be dropped by a child all over. Where the environment is associated with dirt, babies may pick up contaminated bottles and put them straight into their mouths. For instance, the child may eat dirt which may contain a worm's eggs. I learned that it is crucial for the mother to clean her hands before preparing a baby's food especially when she has been to the toilet. The child should eat clean diet and continue with the mother's breast milk".

c) Worms and malnutrition

Because of their knowledge of the relationship between malnutrition and communicable diseases, indigenous healers seemed to be aware of the potential danger of worms in terms of spread of other diseases. For instance one healer remarked that:

"Worms are very dangerous because they eat the child's diet."

5.4.6 The role of environmental hygiene in causation of illnesses.

a) Prevention of diseases

It is important to note that indigenous healers seemed to be aware of the implications of low environmental hygienic standards in their communities. For instance, one of the respondents remarked that:

> ***"I learned about the importance of having toilets where we live and appropriate places for the proper disposal of refuse. For instance, in an environment where there are no toilets, all the human excreta becomes washed away into the streams and rivers from which people collect drinking water. This can lead to the outbreak of various diseases."***

b) Hygiene as an African value

It should be highlighted that although indigenous healers highly appreciated the new knowledge about environmental hygiene, they also claimed that hygiene was an old African practice. This was reflected when one of the respondents stated that:

> ***"I did learn something about environmental hygiene. However, I must point out that hygiene is something that was highly valued by the Zulu people. We do value cleanliness as indigenous healers. However, the topic appeared much more broader than what I expected. We have discovered that an individual might think that he/she is clean whereas there***

might be minor things that he/she may not notice, which might hinder his/her health status. We thought that hygiene is about having a bath and the sweeping of the floor. We never thought about the importance of sunlight and fresh air in the house. When building a house we frequently considered ensuring prevention of cold and rain from entering the house as our priority."

c) Causes of scabies

Indigenous healers were aware of the fact that scabies, an infectious condition, is related to low hygienic standards. For example, one of the respondents remarked that:

"Poor hygienic standards can lead to scabies in children. For example, when a child stays and plays in a dirty environment, he/she can suffer from scabies."

d) Prevention of scabies

Indigenous healers were in a good position to educate the communities in terms of prevention of scabies. For instance, one of the respondents said:

"Scabies can be prevented by ensuring good environmental hygiene. For an example, babies need to be kept clean in order to prevent scabies. We need to ensure that children do not play in a dirty environment."

e) Complications of scabies

Healers decided to take this condition quite seriously. A respondent who was surprised by the complications stated that:

> ***"Regarding children, what I new was that there are so many diseases we can treat as indigenous healers. However, I discovered during the training workshop that scabies has complications I did not know. For example, I have leaned that scabies can cause dysfunction of vital body organs in the child like kidneys."***

5.4.7 Indigenous healers' behaviour post training

a) Sharing of information

It is important to point out that indigenous healers, after attending the training workshop, started to impart the knowledge they gained to their patients, colleagues, and community members. This was reflected when one of the respondents stated that:

> ***"Yes, when I came back from training I told other healers that I have been to a training workshop where I gained a lot of knowledge which I did not have before. I told them how the training was conducted. As a result, a number of people now know about the preventive measures of specific illnesses. A lot of people got excited about the training and wished that this kind of work should prosper. I also educate youth about HIV AIDS and inform them about the precautionary measures they need to take. I explained to them about the mode of transmission of TB and HIV. When***

women come with children I impart knowledge I have gained. Because a number of people come to me, I am certain that many of them did not have adequate knowledge like myself. When preparing something for my patients, I simultaneously give them information about the new knowledge I have achieved. I also informed my patients and other healers about diarrhoea."

b) Environmental hygiene

Indigenous healers have decided to demonstrate the importance of environmental hygiene as one of the major strategy in the prevention of various illnesses in the community. Healers use this knowledge for their personal lives, the benefit of their clients and communities. This was noted when one of the respondents made the following remarks:

"As a traditional healer who make use of medicinal plants, I must ensure that all the resources I use are clean. Good hygiene brings about life. Now I ensure that my home environment is clean. I keep my consulting room clean so as to prevent communicable diseases. I encourage the building of toilets and proper disposal of refuse in the community. When people come for consultation I wash my hands before I help them. When an individual comes with an empty container for his/her medication to take home, I also wash it to ensure that it is clean."

c) Prevention of infection

It should be highlighted that prevention of cross infection is one practice that healers have accepted with enthusiasm. This is an indication that healers are prepared to help prevent the spread of communicable diseases during their practices. One of the respondents stated that:

> ***"Now I always clean my hands before handling medicine. I keep myself tidy so as to encourage cleanliness in my patients. I have started to ensure that a procedure directed to a specific patient is carried out properly without contaminating others. For instance, once the patient who has been steaming completes his/her steaming procedure, all the material he/she has been using will be discarded and the area where the procedure took place is properly cleansed before another patient carries out the same procedure. In another instance, I take precautions to prevent the spread of HIV virus which can also be transmitted from one person to another through blood contact. I tell my clients to come with their raiser blades for scarification procedure."***

The need to prevent infection was also reflected when indigenous healers prepare their medications. To illustrate this, one respondent remarked that:

> ***"When preparing my herbal remedies I boil them thoroughly so as to kill all the germs that might be present. Only the remedy will remain undestroyed. Heat does not kill the remedy."***

d) Health education

Indigenous healers also considered health education as one of their key strategy in terms of health promotion and prevention of illnesses. One of the respondents stated that:

> ***" When people come for consultation with a baby, I observe them and see whether they do take care of the baby's bottle especially if the mother is not breastfeeding. For example, one woman I observed in the bus picked up the baby's feeding bottle and put it straight into the baby's mouth after it had fallen down. I warned her about the potential danger of her actions. In terms of breastfeeding, I now advise lactating mothers about the importance of washing their hands and the breast before breastfeeding so as to prevent infection."***

e) Development of an informal referral system

Because of the awareness of the merits of western medicine in the management of specific conditions, indigenous healers started to informally refer pregnant mothers to the clinic to maximise health care delivery. This was noted when one respondent stated that:

> ***"When pregnant women come for consultation, I do not do much initially except referring them to the clinic. When they come back from the clinic they show me the clinic card so that I can see what the nurses have written. Some of the illnesses written on the card help me determine what I can do for the woman as well as what I can avoid."***

f) Sex education

Indigenous healers were concerned about the teenagers who seem not to be aware of what HIV infection is doing to the whole world. Consequently, they decided to go into the community and give sex education. For instance, one of the respondents made the following remark:

> ***"I also learned that we need to give sex education to teenagers from the age of 12 years. I have decided to educate my neighbours' children. Children must be discouraged from falling in love especially when they are still below the age of 21 because of the deadly diseases like HIV with which they can become infected. I was impressed by the flip charts and other teaching aids we discussed during the training workshop."***

5.4.8 Comparison before and after training

Some indigenous healers pointed out that they did not have any knowledge prior to the training workshop, particularly knowledge which is related to prevention of spread of infection and the importance of environmental hygiene. For instance, the respondent pointed out that:

> ***"After a scarification procedure I used to keep my raiser blade. When another patient came for treatment I would make use of the same razor blade. I never thought of protecting myself by wearing gloves or plastic when performing a scarification procedure. What I knew was that after a patient had completed his/her steaming or vomiting***

procedure, I could discard the vomitus or steaming medicine anywhere."

Another respondent who denied having any kind of knowledge prior to the training workshop made the following remark:

"What I new before training was that I am an indigenous healer and I treat people. I did not know many things. The training that was conducted opened my mind. I have knowledge now. I know that my home and especially my working area called isigodlo should be clean. I did not know all that."

However, It is important to note that some indigenous healers did have some knowledge prior to the training workshop. This was reflected when one respondent stated that:

"I knew that babies should be breastfed. However, the training workshop taught me that we need to put more emphasis that children should be breastfed."

Another respondent who had some information made the following remarks:

"Regarding HIV, I knew that HIV is a sexually transmitted disease especially through unsafe sex. I did not know anything more than that. Now I know what precautions to take when handling my patients."

Some indigenous healers pointed out that the amount and the nature of knowledge they had prior to the training workshop was

not enough to render them effective. For instance, one of the respondents made the following remarks:

> ***"What I knew was that diseases like diarrhoea and HIV do exist. But what I have gained in the workshop is how to actually prevent such illnesses. I did not have profound knowledge like the knowledge I achieved during the training workshop. Although I new that diarrhoea existed, but I did not know about its possible causes. I did not have adequate knowledge."***

Another healer who had some knowledge, stated that his knowledge was exclusively related to his cultural treatment. For an example, this respondent made the following remarks:

> ***"The knowledge I had before training was mainly related to treatment. I have been using herbal remedies. For scabies prescribe some herbal mixtures to be taken by mouth and some to be used for the bath. For pregnant women with specific complaints I would prepare herbal remedies for such ailments as headache and backache. I know herbal mixtures for sexually transmitted diseases. I have symptomatic treatment for AIDS."***

Another healer who did not have some knowledge before pointed out that:

> ***"I did not have any knowledge of the western ideas. All the knowledge I have I received from the training workshop."***

One respondent who had some information said she did know what to do if somebody was having diarrhoea and that diarrhoea can be prevented by drinking clean water.

Further, another respondent who had some knowledge made the following remark:

> ***"When a person has diarrhoea I know that I am not suppose to give him /her an enema. When a person is very ill I would refer him/her to the clinic. When a person is sick I discourage the use of old medication"***

Despite the fact that some indigenous healers had some knowledge prior to undergoing training, they felt that the workshop was of great benefit to them. This was reflected when one respondent stated that:

> ***"Before training I already had the knowledge about the importance of personal and environmental hygiene. I also knew that all the material we use as indigenous healers, including our medicines, should be clean. However, the training made a big difference because what I knew had been increased. Now I know the way forward. I know how to explain to my patients and the community the means by which they can promote their health status."***

Respondents seemed to understand, to a certain extent, how germs can cause various communicable diseases. For example, one respondent stated that:

> ***"I realised the importance of separating people when carrying the same or different procedures. I realised that***

diseases can be eliminated through prevention of infection by discarding contaminated raiser blades, changing linen and other materials before attending to the next patient. Infection can also be prevented through health education of the public about the building of toilets and proper disposal of refuse."

Another respondent with a similar insight stated that:

"In fact I did not take anything seriously before the training workshop. Now the training has opened my eyes. Now I become sensitive when my own children leave food uncovered. I give them advice about flies which carry germs that may be introduced in food."

The respondents have gained insight as to what strategies to utilise in order to positively influence attitudes of the youth. For an example, a respondent made the following remarks:

"I gained a lot of insight during the training workshop especially when it comes to HIV and AIDS. Before training I tried to educate our youth but I did not have enough information. The new knowledge and strategies I have started using are instilling fear in our youth and thus gradually changing their attitudes."

Some indigenous healers seem to have gained insight that human beings are complex beings and no single approach to health care can be able to address effectively all illness related problems. This was illustrated by a respondent when she stated that:

"The knowledge I gained about communicable diseases gave me insight as to how such diseases should be prevented. Many diseases I learned about gave me a lot of insight."

Some indigenous healers have gained insight by realising the limitations of their own system and the need for development. This was reflected, for instance when the respondent stated that:

" I gained a lot of insight as to how to prevent the spread of HIV infection by taking necessary precautions. I realised that we need to get more knowledge about other diseases usually treated by he western medical practitioners which are also found in our communities. This will give us capacity to help minimise such conditions in our communities."

Indigenous healers have also realised their potential to address some of the health related problems. This was illustrated by the respondent when she said:

"After the training workshop I realized that I need to recommit myself to my job and use the knowledge I gained during the training workshop. I need to ensure that the nation stays healthy by using the knowledge I have achieved. I have gained insight into the new role that I need to play as an indigenous healer."

Healers have developed insight into the need for the professionalisation of their own system. For an example, one of the respondents stated that:

"Having access to this kind of training caused me to develop insight into the possible solutions to the current problem of continuous stigmatisation of indigenous healing system by attributing all incidents whereby people are caught with human tissues to indigenous medicine instead of sorcery. I wish that everybody who is a traditional healer should be known by the government. The government should make sure that every indigenous healer has access to the knowledge we achieved during the training workshop. There must be a law that should encourage indigenous healers to know each other."

One indigenous healer gained insight into the importance understanding various aetiological factors. For instance, she stated that:

"I have been able to differentiate kinds of illnesses in terms of their causes. Because of lack of insight, I was afraid to attend to people with HIV and AIDS. I was even afraid to touch them fearing that I was going to become infected with HIV virus. I think I need to differentiate between AIDS and other African culture related diseases which have similar features. More work should be done in this direction."

Another indigenous healer gained insight into the need for the development of their own system. This was illustrated when she said:

"I developed insight by realising that by ensuring a high standard of personal and environmental hygiene, we can

increase the standard of our work. Generally speaking, there has been a tendency among some indigenous healers to overlook proper hygienic standards when serving their communities. I am also a trainer of indigenous healers. My students sometimes come back for further development. This training has been of good help because it will help me to proper develop my students. I will develop healers all over. Indigenous healers will know when they complete their indigenous training that personal and environmental hygiene is crucial for health reasons. As an indigenous healer who has trained a lot of healers all over South Africa, I think this training workshop should be continued."

5.5 CONCLUSION

The enthusiasm expressed by both clinic registered nurses and indigenous healers during the recruitment process of indigenous healers who were going to participate in the training workshop indicated that both formal health workers on the one hand and indigenous healers on the other, realised the importance of empowerment of indigenous healers through training. Healers showed a lot of interest in the content of the course they attended (see annexure G). They appeared to be open to new and unfamiliar western concepts of ill-health. They expressed their willingness to expand their knowledge so that they can help improve the health status of their communities through health promotion and prevention of illnesses.

After training, healers appeared to have developed a lot of insight into a number of conditions that were covered during training. Probably due to the communication skills used by the researcher, it appeared that healers did not perceive the

training course as having been imposed upon them. Instead, they felt that the course should involve a wide range of illnesses that can be prevented despite the fact that they might be falling within the framework of the formal health sector. This may also be due to the fact that during the interviews and focus group discussions, the researcher, as an outsider, started learning from the indigenous healers thus developing mutual trust and understanding.

CHAPTER SIX

DISCUSSION OF MAJOR FINDINGS

6.1 INTRODUCTION

Following an investigation into the preventive and promotive health care in the practice of indigenous healers, major findings were established. These would include the current practice of indigenous healers with regard to preventive and promotive health care, areas which can be enhanced, effects of training, limitations of the study and recommendations. Major findings are summarized in table 2 as the merits of indigenous healers, their limitations as well as the points of congruence between indigenous healers on the one hand and the western health professionals on the other.

6.2 CURRENT PRACTICE OF INDIGENOUS HEALERS WITH REGARD TO HEALTH PROMOTION AND PREVENTION OF ILLNESS

The current practice of indigenous healers revealed that they (indigenous healers) are characterised by attributes which not only enable them to deliver an effective health care service, but give them a potential ability to instil in the community a positive attitude necessary for the commitment and participation of community members in health related issues. This is where indigenous healers showed some strengths. However, weaknesses associated with indigenous healers' practices, which indicated that there is room for improvement, were identified from the outside by the western health professionals. Conversely though indigenous healers' practices are different from those of the western health practitioners, points of congruence were

identified. This is illustrated by table 2 below.

TABLE 2:Merits and Limitations of Healers & Points of Congruence

Strengths	Weaknesses	Points of congruence
1) Indigenous healers are opinion leaders in the society in which they operate. They have strong social links **2)** An indigenous healer understands the African language used by his/her clients. **3)** Indigenous healers understand the beliefs and value system of their clients **4)** Indigenous healers are effective in the treatment of illnesses related to African culture	**a)** Indigenous healers' dosages are not quite clear. Very strong dosages have a potentially negative effect. **b)** Some procedures of indigenous healers are potentially dangerous like scarifications. **c)** Because indigenous healers deal mostly with African culture related illnesses, they delay the diagnosis of conditions best treated by western medicine	**i)** Indigenous healers supported breast feeding as the best child's diet. **ii)** Indigenous healers claimed to treat asthma **iii)** Healers diagnosed and treated certain sexually transmitted diseases. **iv)** Indigenous healers treated children with green loose stools called *inyoni* (gastroenteritis) **v)** Indigenous healers identified hypertension in pregnant women as a problem

5) Indigenous healers are effective in diagnosis of illnesses related to African culture **6)** Indigenous healers have effective counselling & supportive role. They provide psychological support based on African culture. **7)** Indigenous healers can provide African culture related psychological support to patients with incurable diseases depending on patient's belief system. **8)** Some indigenous healers seem to be aware of some of the limitations of their	**d)** Inability by healers to refer patients who do not show any signs of improvement to the western health care practitioners may delay appropriate diagnosis and treatment. **e)** Some indigenous healers use corrosive substances for enemas. **f)** Indigenous healers never emphasized the importance of prevention of cross infection. **g)** Indigenous healers do not seem to have knowledge of conditions related to malnutrition.	**vi)** Indigenous healers identified diabetes mellitus as a problem vii)Healers also provided symptomatic treatment for patients living with AIDS. **viii)** Healers learned to prevent conditions like cholera. **ix)** Indigenous healers identified the need for co-operation between indigenous healing system and western medicine. **x)** Doctors have some knowledge of the practices and beliefs associated with indigenous healing system

9) Indigenous healers are open to new western ideas and concepts. **10)** Indigenous healers see the need for development and professionalization of their own system **11)** Indigenous healers take care of the spiritual aspect of health care.	**h)** Healers do not refer pregnant women to formal health facilities for ante natal care. **i)** Indigenous healers exclusively focus on spiritual aspect of care. This implies that they invariably view everything from a spiritual perspective. **j)** Indigenous healers may not be able to exclude conditions that may need surgical intervention like bowel obstruction especially if the child is unable to pass a stool	

6.2.1 Strengths of indigenous healers

The strengths of indigenous healers have the potential for the improvement of the health status of the majority of the South Africans. For instance, indigenous healers are opinion leaders in

the society in which they operate. This implies that, because of their credibility in the black communities, indigenous healers are frequently consulted by the people especially when they want to take major decisions about their lives. They have many social links. Thus, indigenous healers have a potential to positively influence the lives of the people particularly in terms of health promotion and prevention of illnesses (see table 2).

Indigenous healers have a language advantage. There seems to be a free flow of communication between Indigenous healers and their clients. The communication used by an indigenous healer does not seem to have many barriers because the healer, in most instances, does not need an interpreter.

It is also highlighted that the fact that indigenous healers understand the beliefs and value system of their clients increases the credibility of indigenous healing system. For example, indigenous healers' approach to their clients is, to a large extent, systematic. They do not treat their patients outside their family context. Treatment involves not only the patient's relatives, but even his/her ancestors. This seems to encourage social support for the client thus supporting behaviour change. This idea was supported by Kale (1995) who stated that indigenous healers treat their clients in a more holistic manner because they think about the client as an integral part of a family and a community.

As another strength, indigenous healers seem to be effective in the treatment of illnesses related to African culture. Such illnesses, as it would appear, may neither be understood nor treated by the western medical system. It is probably for this

reason that literature states that about 80% of Black South Africans consult with indigenous healers (Gumede, cited in Abdool Karim et al, 1994, p.3).

On the other hand, analysis of data has shown that health promotion within an African cultural perspective may not benefit African community members who have, perhaps discarded their historical cultural values and beliefs. Hilliard (1985) who supported this argument speculated that in any society where people have been severely oppressed, the oppressed are more likely to identify with the oppressors and consequently become prejudiced against their own culture. This implies that those patients who, for whatever reason, do not believe in indigenous healing system, may be predisposed to African culture related illnesses some of which may be fatal.

Similarly, indigenous healers are effective in the diagnosis of illnesses related to African Culture. For instance, the western medical practitioner may not be able to diagnose conditions which may be due to the displeasure of the ancestors or those which may be due to witchcraft. Reid (1982) supported this argument by pointing out that indigenous healers are trained so that they can be able to divine, diagnose and treat African culture related illnesses and problems of all causes.

Indigenous healers have an effective counselling and supportive role. They provide psychological support, based on the African culture. Their approach to their patients is characterized by profound respect and the willingness to listen to what their clients have to say. Clients do not seem to feel dehumanized after having consulted with an indigenous healer. Consultation with one client may take 30 minutes to an hour depending on the nature of the presenting problem. An indigenous healer has the

ability to create a more therapeutic atmosphere. Because of the foregoing strength, indigenous healers can provide psychological support to patients with incurable diseases depending on the patient's belief system. Another strength of indigenous healers is that they appear as if they belong to a system of healing which is relatively open. For instance, indigenous healers seem to be aware of some of the limitations of their own system.

6.2.2 Weaknesses of indigenous healers

Despite its merits, the indigenous healing system seems to be associated with some weaknesses. For instance, indigenous healers' dosages are not quite clear. It is speculated that there might be a number of factors influencing the nature of healers' dosages. Very strong dosages, according to the western health system respondents, have had a negative effect on some clients.

Some procedures of indigenous healers have been perceived by the health professionals as potentially dangerous. These procedures would, for instance, include scarifications. Indigenous healers are more likely to spread HIV infection especially if the scarification procedure is not modified.

Due to lack of co-operation and mutual understanding between indigenous healers and the western medical practitioners, indigenous healers who deal mostly with African Culture related illnesses, delay the diagnosis of conditions best treated by western medicine. For example, healers may delay conditions like tuberculosis if they cannot clinically diagnose such conditions. The patient may end up with complications. Lack of early diagnosis and prompt treatment of tuberculosis may increase the chances of spread of infection to other members of the family. The healer may be predisposed to tuberculosis infection.

Inability by indigenous healers to refer patients who do not show any signs of improvement to the western practitioners may delay appropriate diagnosis and treatment. This may be attributed to the Health Act of 1974 which prohibited any form of interaction between indigenous healers and the Western medical profession. According to this Act, registered medical practitioners were not allowed to communicate with non-registered practitioners.

Western health professionals have been sceptical about some of the remedies used by indigenous healers. For instance, some indigenous healers use corrosive substances for enemas. However, due to the absence of a registration system for indigenous healers, it is not clear whether indigenous healers who use corrosive substances are genuine healers or charlatans.

Indigenous healers never emphasized the importance of prevention of cross-infection. This might be due to the fact that indigenous healers mainly dealt with non-infectious diseases. Infectious diseases fell mainly within the framework of the nursing and medical professions. Due to the fact that indigenous healing system, within the historical and political context of oppression in South Africa, was discriminated against, opportunities for such a system to develop and become able to respond to unfamiliar conditions like infectious diseases, were very limited. This finding is illustrated by Natal Provincial Administration (1993) when they stated that many patients with tuberculosis infection arrived at hospitals with complication of tuberculosis and a lot of them were already disabled by the time they reached the hospital. This is probably due to the fact that communicable diseases are not familiar to indigenous healing system. The reason provided by Kris (1988) is that such illnesses like

tuberculosis, for instance, were traditionally introduced from the outside through contact with explorers, missionaries and colonial forces.

Indigenous healers do not appear to have knowledge of conditions related to malnutrition. This might be due to the fact that historically, malnutrition was not a problem for Black South Africans. Consequently, conditions which arise as a result of poverty did not exist within the South African community. This argument was supported by de Beer (1986) who clearly stated that, historically, tuberculosis never existed in the South African context. This author further notes that almost for one hundred and fifty years ago there was very little malnutrition. There are African languages that have no word for malnutrition which may be an indication that it did not exist. Starvation was only experienced in times of war as well as in times of drought, but there was not a kind of ongoing process of chronic malnutrition as exists at this point in time. The fact that poverty never existed in the South African context amongst Blacks was also supported by Wilson and Ramphele (1989) when they stated that for many people diet today is considerably worse than it was for their grandparents. They also maintained that the Zulu diet, for example, included meat from periodic feasts, quantities of *amasi* (sour milk) and a wide range of vegetables including sorghum, millet, pumpkins, yams, various nuts and indigenous beans. Ignorance regarding indigenous healers' knowledge of nutrition in pregnant women and children and its relationship with communicable diseases, implies that indigenous healers' practices remain inadequate and inappropriate in terms of health promotion and illness prevention of specific illnesses.

Another weakness associated with indigenous healers is the fact that they do not refer pregnant women to formal health facilities

for ante-natal care. This might be due to the fact that indigenous healers have been, for many years, marginalised by the formal health care delivery system. For instance, the formal health care facilities do not have policies or guidelines which encourage co-operation between indigenous healers and the formal health workers.

Indigenous healers focus exclusively on the spiritual aspect of care. This implies that they invariably manage conditions as though the causes are supernatural. For an example, with regard to environmental health, analysis reveals that indigenous healers appear to intervene mainly at spiritual level by enhancing the health of the people in an attempt to protect them against supernatural causes of ill health. Some supernatural causes may originate from the physical environment while others may be related to African culture. The latter causes of ill health were better explained by Ngubane (1977) when she stated that such causes may not be understood by non African people because they belong to a particular category called *ukufa kwabantu* ("diseases of the African people"). Protection against such causes of illness can be offered by indigenous healers. This author also stated that the former causes of ill health may be due to the fact that some wild animals and birds, are known to travel long distances and on their return may introduce something foreign. For an example, poisonous snakes leave dangerous tracks behind. When a pregnant woman contacts such tracks by touch or stepping over, the joints of the bone structure are said to be more vulnerable points trough which such evil elements enter the body. As a result, a pregnant woman or lactating mother can become contaminated and her baby becomes sick. She also added that the environment can also be made dangerous by what is discarded in healing as well as by the sorcerers.

However, exclusive focus by indigenous healers upon supernatural causes of illness may be attributed to their discrimination by the previous government, limited knowledge and limited perspective. This has been an ideological strategy to maintain the status quo. It implies sustaining the relations of domination over subordination between indigenous healers and the western health care system, thus leading to lack of development of indigenous healers. The foregoing argument was supported by Schweitzer (1983) who stated that the previous non democratic government in South Africa overemphasized the importance of the differences in culture among various ethnic groups so as to justify under development and inequalities. This argument was supported by Schweitzer (1983) who stated that the previous non democratic government in South African over emphasized the importance of the differences in culture among various ethnic groups so as to justify the existence of underdevelopment and inequalities.

Indigenous healers may not be able to exclude conditions that may need surgical intervention like bowel obstruction, especially if the child is unable to pass stool. This was perceived by the western medical practitioners as a potentially injurious kind of practice by indigenous healers. It has, however, been found that although indigenous healers do not focus mainly on environmental health which is associated with the formal health care system, they seem to have an understanding of the difference between illnesses which may arise due to African culture related factors (supernatural causes) and those that might arise as a result of natural factors. They believed that if there was something puzzling they came across, the western health professionals should intervene. They also believed that at the hospital the doctor will treat an illness he/she knows better as a western trained practitioner. An illness that may be related to African

culture may remain untreated by the western medical practitioners. This idea was supported by Shezi and Uys (1997) when they stated that some illnesses, especially psychiatric conditions, may be inextricably bound to specific cultures and may have features similar to those of the universal conditions. Analysis also shows that culture related illnesses may be further divided into two categories. For instance, there are those that may occur due to witchcraft on the one hand, and those that may occur due to the displeasure of the ancestors.

The implication is that African culture related illnesses may not be well handled by western medical practitioners, while indigenous healers may play a crucial role in the prevention of some of the natural illnesses like tuberculosis and diarrhoea which may arise as a result of poor environmental health.

6.2.3 Points of congruence

Despite the different conceptual frameworks used by indigenous healers and western medical practitioners, analysis revealed that there are points of congruence between the two health care delivery systems. Such points, which are more likely to form the basis upon which the two systems of healing can share ideas, include the fact that indigenous healers support breast feeding as the best diet for babies. Although indigenous healers did not seem to be aware of the relationship between diet and ill health, their support of breast feeding would form the point of departure in terms of filling the gap as far as their knowledge of nutrition is concerned.

Indigenous healers also claimed to treat asthma. This area can be further explored. Because asthma is closely associated with chest infections, indigenous healer's knowledge of chest infections

should be assessed and their role in prevention of such infections explored. Chest infections are responsible for high infant mortality rates (Buso, 1999, p.58). Indigenous healers, therefore, can play a very crucial promotive and preventive role.

Indigenous healers diagnosed and treated certain sexually transmitted diseases. Indigenous healers using herbal remedies, treated culture related illnesses, using herbal remedies, treated culture related sexually transmitted diseases. It is clear that indigenous healers played a very limited role, if any, in terms of prevention of sexually transmitted diseases. It was not clear whether indigenous healers were aware of sexually transmitted diseases that may require antibiotics. It is, therefore, crucial that indigenous healers focus on prevention of sexually transmitted diseases because they, in turn, could be preventing the spread of HIV infection.

Indigenous healers treated children with green loose stools *inyoni* which may be gastro enteritis. Indigenous healers considered *inyoni* as a culture specific condition. Analysis revealed that *inyoni* is a historical - culture related condition common in young children. Although *inyoni* may sometimes be associated with loose stools, it may require specific treatment in addition to the usual intervention measures taken in diarrhoeal conditions we see in children today which may be linked to socio-economic factors.

Analysis also reveals that indigenous healers identify hypertension and diabetes mellitus in pregnant women as a problem. They use herbal remedies not only to treat, but to prevent these conditions in pregnant women. They believed that these conditions may arise due to culture-related factors. It should, however, be noted that conditions like hypertension may

arise due to a variety of factors. It is not clear whether herbal remedies administered by indigenous healers to prevent pregnancy-induced hypertension and diabetes mellitus are effective or not.

Indigenous healers provide symptomatic treatment for patients living with AIDS. Analysis revealed that indigenous healers do not prevent HIV infection. Their main focus is on the curative aspect. Since HIV infection is incurable, it is important that indigenous healers shift their focus from the curative aspect and concentrate more on both prevention and care.

Indigenous healers have learned to prevent conditions like cholera. Cholera is a condition that arises as a result of poor environmental health. This implies that indigenous healers, to a certain extent, understand how poor environmental health contributes to the occurrence of certain environmental conditions. This knowledge probably encouraged them to learn about other conditions like TB diarrhoea, scabies and worms.

Indigenous healers identified the need for co-operation between indigenous healing system and western medicine. They appeared to be aware of the limitations of their own system and those of the medical profession. Indigenous healers pointed out that western medical practitioners may not be able to prevent and treat African culture related conditions. However, they also maintained that there were conditions in which the western medicine could provide immediate relief.

The knowledge of western doctors of the practices and beliefs associated with indigenous healing system seems to form part of the basis upon which mutual understanding between indigenous healers and the western medical practitioners could be established.

6.3. AREAS WHICH CAN BE ENHANCED

The training needs for indigenous healers were determined by responses from indigenous healers, doctors and nurses. These formal health workers identified areas and conditions in which indigenous healers practices could be enhanced in terms of health promotion and prevention of illnesses. The following conditions were considered as a priority:

diarrhoea, HIV and AIDS, worms, malnutrition, tuberculosis, scabies, cancer and hypertension. Health education was also recommended on the following: Oral rehydration, prevention of infection, sex education, breast feeding, immunization, personal hygiene, environmental hygiene, proper use of resources, change in life style, nutrition and importance of antenatal care.

It should be highlighted that most of the foregoing conditions are the main killers in South Africa despite the fact that they are preventable. They have led to very high morbidity and mortality rates in women and children. For example, malnutrition during pregnancy causes weakness and anaemia in the mother thus predisposing her to death during or after childbirth. Malnutrition can also cause miscarriage, or intrauterine growth leading to the baby being born too small, dead or abnormal (Felhaber and Mayeng, 1999,p.10).

Because of the prevailing boundaries between western health care system and indigenous healing system, indigenous healers might have not been aware of the fatality of the preventable and poverty related communicable diseases and their potential role in prevention of such diseases. Indigenous healers might have not been aware of the fact that malnutrition and lack of environmental health may lead to the spread of main killer

diseases like tuberculosis. This might be due to the fact that malnutrition, and chronic malnutrition in particular, never existed in the South African context except starvation during the times of war and drought (de Beer, 1986, p.14).

Enhancing indigenous healers' practices through training meant, first of all, bringing awareness to indigenous healers of how fatal communicable diseases are. Such awareness encouraged indigenous healers, after gaining insight into the nature of the problem, to fully commit themselves in health promotion and illness prevention strategies. For example, training on environmental health issues empowered indigenous healers in terms of how improved nutrition and environmental hygiene can lead to a decrease in diseases like diarrhoea. Sanders (1985) remarked that in the nineteenth century England and Wales, that is, before the discovery of antibiotics, improvements in nutrition and environmental conditions led to a sustained drop in mortality caused by communicable diseases (p.77).

Due to the fact that the western health practitioners seem to be making little impact in terms of health promotion and prevention of illnesses, the training of indigenous healers seems to be more likely to make health care services not only effective but accessible to the community members. For example, with regard to pregnant women, indigenous healers would give health education on issues related to nutrition, prevention of sexually transmitted diseases (including HIV infection), and importance of antenatal care. Patients with tuberculosis are regularly referred to the hospitals by the healers and are now being seen early, as are people with sexually transmitted diseases. Indigenous healers could, through health education, make a significant impact in the decrease of diseases associated with high morbidity and mortality rates in both children and pregnant women. Indigenous healers who

knew the relationship between poor personal hygiene and scabies, between diarrhoea and malnutrition, and between malnutrition and tuberculosis were more likely, because of their influential position in the community, to make a difference in health behaviour.

6.4. EFFECTS OF TRAINING

The response of indigenous healers to the training programme was positive. For example, regarding HIV and AIDS, indigenous healers saw the need to protect themselves during their practices. They have developed insight into the potential dangers of their procedures in terms of the spread of HIV infection and the need to take necessary precautionary measures. Analysis also revealed that healers not only gained knowledge during the training workshop, but applied or related such knowledge to their current practices. Healers also gained knowledge regarding the modes of spreads of HIV infection and different ways in which such infection would be prevented. They felt strongly about the need to impart to their clients and community the knowledge gained during the training workshop. They confessed that training positively influenced their beliefs and attitudes toward people living with HIV and AIDS. Indigenous healers gained insight in terms of tuberculosis as an infectious disease and how cross infection can be prevented. They learned about the role of nutrition in tuberculosis prevention. Indigenous healers believed that their understanding of the mode of tuberculosis infection and co-operation with the formal health workers would render them more effective in the prevention of tuberculosis.

Indigenous healers have learned about the relationship between malnutrition and diarrhoea. This has led to their realization of the importance of breastfeeding even when the child is having

diarrhoea. Healers have learned about the importance of environmental health in the prevention of various childhood illnesses like scabies, diarrhoea, worms and tuberculosis.

Indigenous healers have learned about the prevention of childhood illnesses during pregnancy. They have learned about illnesses associated with pregnancy, and how such illnesses could be prevented. Analysis revealed that healers have realized the importance of antenatal care as well as their co-operation with the formal health workers in the prevention of childhood illnesses.

Analysis revealed that indigenous healers' knowledge was, to a large extent, determined by the culture in which they were raised. It was noted that although some indigenous healers did have some knowledge regarding environmental health, they highlighted that the training enabled them to develop a lot of insights regarding the nature of communicable diseases as compared to culture related conditions.

Positive effects of indigenous healers' training programme have been achieved in other countries. According to Good (1988,p.91), for example, indigenous healers who participated in a pilot project in Swaziland increased their understanding of dehydration and the use of oral rehydration fluids, importance of safe water, good sanitation, personal nutrition and immunization. Healers also referred their clients to the clinics for diarrhoea and gave them health education regarding good health practices.

As another illustration, Hoff and Maseko (cited in Good, 1988, p.91) stated that the outcome of the pilot study in Swaziland revealed that indigenous healers, with proper training and support, assisted in the development of more effective PHC at the

community level. Healers became actively involved and accepted responsibility for advocating and promoting good health practices and prevention of illness.

The fact that indigenous healers have a very positive response to the training programme might be attributed to a number of factors. For example, indigenous healers might have seen the training programme as an opportunity to gain respect and recognition (legal status)like other health workers. The training programme might lead to their interaction with the western health practitioners by attending seminars and conferences. Training might facilitate professionalization of their own system. Healers might have perceived the training as a means of paving the way toward achieving specific rights like issuing their clients with medical certificates and visiting their patients in formal health facilities. In the light of the very positive reactions of indigenous healers, it seems logical to involve them increasingly in health promotion.

Integration and collaboration of western biomedical and indigenous healing systems which is demanded by the realities of health care delivery may be based exclusively on the level of health promotion and illness prevention perspectives. In order to appreciate the need and nature of the proposed integration and collaboration model in South Africa, we need to conceptualize indigenous healing and western medicine as systems.

The two major systems of health care delivery in South Africa, that is, western medicine and indigenous healing system, should, to a certain extent, integrate and collaborate. As Berrien (1968, p.14) points out, a system can be defined as:

> "A set of components interacting with each other and a boundary which possesses the property of filtering both the kind and rate of flow of inputs and outputs to and from the system."

Both indigenous and biomedical systems are not static but dynamic with specific boundaries. It is important to note that all systems have semi-permeable boundaries. This implies that they permit and exclude certain information. This idea is further supported by Berrien (1968, p.16) when he states that:

> "circumstances compel us to conceptualize all real systems as open and noting at the same time that the degree of openness may vary from one system to another.
> Most boundaries involve rules that govern the systems. These rules control entry into the system and prescribe the processes of the system. They also regulate the stability of the system by governing the kind of information to be introduced in the system."

In order to function properly, systems need input of different kinds of resources and this will lead to system's production which may be in a form of a service being provided (Churchman, 1968, p.61). Input, as Berrien (1968) points out, are those things like information introduced into the system. He also remarks that new inputs are required to ensure the constant functioning of the system. It is therefore, apparent that boundaries have to be relatively permeable to allow continuation and growth. This implies that both indigenous healing and western medicine, though associated with different world views, need to grow in order to be able to face problems and challenges currently affecting South Africa.

Both systems are confronted by constraints in the form of great demand for the provision of health services of a good quality within a socio-political and economic context characterized by very limited resources. Another constraint is lack of appropriate knowledge necessary for handling or preventing unfamiliar biological as well as psychological illnesses. For instance, South Africa is associated with African culture-related diseases and those that were traditionally introduced to the African continent through contact with explorers, missionaries and colonial forces. Such illnesses present serious constraints to both indigenous and western medical systems in terms of rendering relevant health care services.

A serious problem would arise if both systems decide to function in parallel as closed systems and having to respond to physical and psychological illnesses that they are not familiar with. Closed systems, as Berrien (1968) states, are those which prefer to function within themselves. Evidence reveals that such systems with very limited inputs from their environments are more likely to deteriorate and eventually cease to function. For instance, Berrien, (1968, p.16) using his analogy, states that:

> "If viruses, germs, and seeds remain dormant beyond a given critical period, they die, which is evident in itself that some slow deterioration process is at work brought about by some minimal inputs from the environment."

Therefore, the apparent deterioration of the health services in the formal health sector in South Africa may be attributed to a lack of appropriate use of the readily available human resource like indigenous healers.

It is important to note that, unlike the environmental constraints which may involve the high demand for quality service that the government officials may not be able to control, the resource constraints, on the other hand, can be manipulated by the authorities. For an example, integration and collaboration between indigenous healers and western medical practitioners system should be established so as to be able to address the issue of accessibility of quality health services by the majority of the South Africans (Churchman, 1968 p.63). Many people, however, may argue that integration of both western medical practitioners and indigenous healers, due to the different world views, may be impossible. This problem is also demonstrated by Churchman(1968, P.76) when he says:

> "The larger the system becomes, the more the parts interact, the more difficult it is to understand environmental constraints, the more obscure becomes the problem of what resources should be made available, and the more difficult the problem of the legitimate values of the system."

However, the proposed integration and collaboration model does not envisage the integration of all of the components of both systems into a single large system because these two systems are totally different, especially at the secondary and tertiary levels of prevention. Integration is only possible exclusively at the level of primary prevention whereby each system can, for example, learn about the causes of ailments treated by the other system so as to be able to prevent such ailments by taking necessary measures. For an example, WHO (cited in Pretorius, de Klerk and van Rensburg,1993, p.19) describes effective integration as:

> "a synthesis of the merits of traditional and modern medicine by implementing modern scientific knowledge and techniques. The underlying assumption is that the characteristic skills of certain traditional healers can be adapted effectively in order that these healers receive appropriate training to be able to cope with certain modern practices and to transmit certain modern medical beliefs."

The need for collaboration has been suggested by various authors. For an example, Green and Makhubu (cited in Pretorius, de Klerk and van Rensburg, 1993, p.19) state that:

> "When the relation between traditional and modern medicine takes on this form, it means that the two systems co-exist but that they are independent of each other, each respecting the unique character of the other. Co-operation implies a better working relationship between the two sectors: appropriate referrals between the sectors occur regularly, certain skills of the traditional healer are upgraded, while the cultural sensitivity of modern health care practitioners is enhanced."

For meaningful collaboration to be achieved, it is imperative for each system of healing to learn more about the other. For an example, Felhaber and Mayeng (1997, p.1) state that:

> "Collaboration of the two healing systems could be greatly facilitated by better understanding on both sides of the other system's theories about the causes of disease."

This implies that it is at the level of primary prevention where both systems can share their experiences with each other in terms of health promotion and illness prevention. Indigenous healers

can learn about communicable diseases which are best treated by western medical practitioners. They can learn how to best prevent such illnesses by focussing on issues related to nutrition, environmental hygiene, infectious diseases like HIV and AIDS, sexually transmitted diseases and tuberculosis. On the other hand, western medical practitioners can learn about the realities of African culture-related illnesses and a serious threat that such conditions pose to the lives of the people. They can also learn how some knowledge of these illnesses, both medical and indigenous, may strengthen each of the two systems in terms of how each system should respond to illnesses which are not familiar to its world view or conceptual framework, thus improving the quality of the health service being rendered in South Africa.

It is noted that when dealing with issue of collaboration the focus should be on quality assurance. For an example, Yoder (cited in Pretorius, de Klerk and van Rensburg, 1993, p.19) points out that:

> "It is imperative that the ultimate goal of co-operation between modern and traditional medicine should be improvement in the quality of patient care and should not merely be undertaken to increase the understanding of practitioners of the 'alternatives' available or to serve as a stop-gap measure until biomedical care can be expanded."

6.5. LIMITATIONS OF THE STUDY

It should be noted that the evaluation of the short indigenous healers' training course was done a month after the implementation of the training workshop. The evaluation was, due to unforeseen circumstances, done by the researcher himself. It

is therefore not clear to what extent did the researcher's presence influenced the responses of the informants.

Due to the fact that the present study was highly subjective in nature, reliability as an important criteria for ensuring trustworthiness seems to be inappropriate and this was replaced by dependability which is more appropriate in qualitative studies.

6.6. RECOMMENDATIONS

Based on the findings of the present study, both collaborative and integrative approaches, as van Rensburg et al. 1992 & Abdool Karim et al. 1994 point out, appear to be more relevant in the South African context in order to render a comprehensive health care service accessible to the majority of the black South Africans. Integration of indigenous healers into a formal health care team would take place at the level of primary prevention of illnesses and health promotion. At this level each system can learn from the other thus developing mutual understanding and mutual trust. It is at this level that both systems have something in common. (Both systems have the responsibility to promote people's optimal health and prevent diseases before their occurrence). Collaboration which involves referral occur at the level of secondary prevention of illnesses. This implies, therefore, that for genuine collaboration to take place, there will be a need for prior active interaction between indigenous healers and the formal health care workers.

6.6.1 Recommendations for indigenous healers practices

a) Training of indigenous healers

This study has clearly identified the areas in which indigenous healers' practices with regard to preventive and promotive health care can be enhanced.

Orientation of indigenous healers to conditions best managed by Western medical Practitioners, but in which indigenous healers could play a very important preventive role.

This can happen through non formal education. Indigenous healers and Western medical practitioners can have meetings and seminars where they can discuss conditions affecting their clients. Indigenous healers can learn about obvious signs associated with such conditions. The study has also highlighted the need for the development of a referral system which will help eliminate the delay of appropriate diagnosis of clients. The study has also reflected the need for indigenous healers to learn about their practices which may be potentially injurious to the lives of young children and how such practices could be improved.

b) Health education

Indigenous healers need to be encouraged to incorporate health education strategy as part of their practice especially in health promotion and prevention of communicable diseases. Because of the effectiveness of the short training course rendered to indigenous healers at

Paulpietersburg, a need has been identified by healers themselves that training needs to be done in other areas of the province. There is a need that an agreement be reached at the level of policy makers in the Department of Health regarding the responsibility of the Department of Health with regard to health education for this important group of community leaders.

c) Recommendation for further research

This study presented a number of challenges with regard to collaboration and integration between indigenous healers (invariably considered as the informal sector) on the one hand and the western medical practitioners (invariably considered as the formal sector) on the other. The study has identified the need for both systems to complement each other. It is, however, not clear to what extent do western medical practitioners know about the illnesses best treated by indigenous healers. Since the study identified the need for the development of a referral system, it is not clear what conditions the western medical practitioners would refer to indigenous healers and vice versa.

6.7. CONCLUSION

The study has revealed that in order for the formal health care delivery system to respond effectively to the current health crisis associated with very limited financial and human resources, it would need to revisit its theoretical perspectives. Evidence reveals that there is no single system of health care delivery in South Africa that can adequately address all the health care challenges. Therefore it would appear that a team

approach using a multi disciplinary perspectives may be more relevant of which indigenous healers form a major component. Empowerment of indigenous healers through training seems to be one of the major steps toward the improvement of health care services in South Africa.

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ANNEXURE A

INTERVIEW SCHEDULE FOR WESTERN HEALTH PROFESSIONALS

Explanation to respondents.

This study is an investigation into the preventive and promotive health care in the practice of indigenous healers. Indigenous healers constitute an important potential component of the formal primary health care. There is a tremendous opportunity to address inadequacies by involving indigenous healers in primary health care and taking the pressure off the formal health care services. Before indigenous healers can be assisted and developed, the nature of their current practices needs to be assessed so as to identify those specific areas in which their practice, with regard to preventive and promotive health care, can be enhanced. This research is very important at the present time in South Africa because all South Africans should receive an adequate health care service. You do not have to write your name and your information will be treated "with the utmost" confidence. Please answer each question as carefully and as honestly as possible. Thank you for your participation.

1. Are there practices of indigenous healers that you see as detrimental to children and pregnant women's health? Please elaborate.

2. Are there specific areas in which you think indigenous healers could assist in prevention of children's illnesses and/or promoting child health? Elaborate by giving at least 5 conditions in which you think indigenous healers could assist.

ANNEXURE B

BIOGRAPHICAL INFORMATION FOR DOCTORS

May I ask you if you could please give me your personal details?

a) How old are you _____ ?

d) Have you ever received training as a paediatric doctor? Yes ____ No ____

If the answer is yes, for how long have you been a paediatric doctor _____?

c) Sex. male_____ ? female _____ ?

d) What language do you use at home _____?

e) Have you ever been to a meeting with indigenous healers?
Yes _____ No _____

If the answer is yes, what was the meeting all about?

f) Have you ever attended a workshop/course on matters related to indigenous healing system?

Yes _____ No _____

If the answer is yes, what was the workshop/course all about?

ANNEXURE C

BIOGRAPHICAL INFORMATION FOR NURSES

May I ask you if you could please give me your personal details?

a) How old are you _____ ?

b) Have you ever received training as a paediatric nurse? Yes ____ No ____

If the answer is yes, for how long have you been a paediatric nurse _____?

c) Sex. male_____ ? female _____ ?

d) What language do you use at home _____?

e) Have you ever been to a meeting with indigenous healers?

Yes _____ No _____

If the answer is yes, what was the meeting all about?

f) Have you ever attended a workshop/course on matters related to indigenous healing system?..

Yes _____ No _____

If the answer is yes, what was the workshop/course all about?

ANNEXURE D

TRAINING MANUAL

ORIENTATION TO THE PROJECT: AN INVESTIGATION INTO PREVENTIVE AND PROMOTIVE HEALTH CARE IN THE PRACTICE OF INDIGENOUS HEALERS IN KWAZULU NATAL, REGION D: PART OF THIS STUDY WAS CONDUCTED IN REGION B (INDLOVU DISTRICT)

MATERIAL AND EQUIPMENT REQUIRED:

- Paper
- Koki pens
- Prestik
- Pamphlets
- transparencies
- flip chart

GENERAL

THEME 1: ENVIRONMENTAL HYGIENE

LEARNING OUTCOMES

At the end of this section you will be able to:

- Have knowledge about communicable diseases.
- Identify health practices considered by the formal health practitioners as health promotion and illness preventive

measurers thus acquiring additional skills necessary for appropriate intervention in health promotion and prevention of many unfamiliar health problems that did not exist in South Africa prior to the arrival of the white people.

- Understand how environmental factors predispose children to communicable diseases like, for instance, diarrhoea, chest infections, tuberculosis (TB) etcetera.

- See the need to encourage people to wash their hands after having been to the loo.

- Identify the need for people to use toilets to prevent diseases.

- Identify the need to use clean water so as to prevent diseases.

- Identify the need to boil water obtained from any source other than taps (river water, for instance).

- Identify the need to keep food covered to prevent diseases.

- The need for proper disposal of refuse.

- Appreciate the importance of complementing African culture related health promotion and illness preventive measures with the western related health promotion and illness preventive measures, thus bridging the gap between indigenous healers and formal health workers.

ACTIVITY 1: TUBERCULOSIS

Participants to form two groups and then discuss openly the following questions:

1. What is Tuberculosis?
2. How does tuberculosis develop?
3. How does tuberculosis micro-organism spread?
4. How does the disease appear?

Trainer to clarify and finally summarise discussion on transparencies.

TRAINER'S NOTES

1. What is tuberculosis?

Tuberculosis is an infectious diseases caused by micro-organism (TB germ), a bacilli called mycobacterium tuberculosis which usually enters the body by inhalation through the lungs. These germs spread from the initial location in the lungs to other parts of the body via the blood stream, for instance.

- Pulmonary (lung) tuberculosis is the infectious and common form of the disease, occurring in over 80% of cases.
- Extra pulmonary tuberculosis is a result of the spread of tuberculosis to other organs, most commonly pleura, lymph nodes, spine joints, genito-urinary tract, nervous system or abdomen. Tuberculosis may affect any part of the body.

2. How does tuberculosis develop?

Tuberculosis develops in the human body in **two stages.** The **first stage** occurs when an individual breathes in TB germs and becomes infected but the immune system contains the infection. The **second stage** is when the infected individual develops the disease (tuberculosis)

3. How are tuberculosis micro-organisms spread?

The infectiousness of an individual with tuberculosis is determined by a concentration of micro-organisms within the lungs and their spread into the air surrounding the patient who has tuberculosis. When a TB patient with active pulmonary tuberculosis coughs or spits, he or she will produce small droplets that contain TB germs. Anyone who inhales this air with droplets can then be infected and may later develop TB disease.

4. How does the disease appear?

Among those who do become infected, most (90%) will never become ill with tuberculosis unless their immunity is seriously compromised, for example by malnutrition, stress, HIV, cancer and diabetes. The micro-organisms remain dormant within the body and their presence is indicated only by a significant size of induration in reaction to a tuberculin skin test. BCG immunisation gives up to 80% protection against the progression of TB infection to disease. The main benefit of BCG is the protection against the development of the serious form of TB (TB meningitis, miliary TB) in children.

ACTIVITY 2. RELATIONSHIP BETWEEN HEALTH AND ENVIRONMENT

Participants will form two groups and then openly discuss the following questions

1. How can the environment where people live predispose them to tuberculosis?

2. How can people promote health in the environment where they live?

   Trainer to clarify and finally summarise discussion on transparencies. Trainer concludes by showing and explaining **FS :HP 8.2**

TRAINER'S NOTES

2. **high standards of environmental hygiene can be promoted through:**

- adequate and nutritious diet
- the provision of suitable housing
- satisfactory ventilation
- prevention of overcrowding
- efficient disposal of refuse and excreta
- provision of safe water supplies
- control of rodents and insects including flies

TRAINER'S NOTES

ENVIRONMENTAL HYGIENE MESSAGES

- No one is supposed to fetch water from the source in which or next to which people urinate.
- People should not urinate next to the source of drinking or washing water.
- Animals should be kept far away from the sources of drinking water.
- Drinking water should be boiled or have chlorine put into it, kept in a clean container which must have a lid so as to prevent dust and flies.
- Contaminated water should be sifted and have chlorine introduced.

People should wash their hands using soap and water:

- after having been to the loo
- after handling sick people and children's stools.
- Before meals, baby feeding or meal preparation.

2. THEME TWO : PREGNANT WOMEN

At the end of this section you will be able to:

- know important health messages which are related to pregnancy and delivery.
- know most of the complications of hypertension, diabetes mellitus, sexually transmitted diseases in a pregnant woman so as to be able to see the need for prevention of such complications.
- understand the importance of screening pregnant women during the antenatal period to identify various conditions which may pose a serious threat to both their lives and those of their unborn babies.
- realize the importance of giving health education to young people and pregnant women .
- have more knowledge about HIV and AIDS.

ACTIVITY 1 : WOMEN'S HEALTH STATUS DURING PREGNANCY

Participants to form two groups and discuss openly the following questions:

- What is the importance of attending ante-natal clinic?
- What kind of a person should assist during delivery?

- How can families prevent dangers of pregnancy?
- Why diet and rest is important for a pregnant mother?
- What is the most appropriate period for a woman to fall pregnant and why?
- Why it is important for women to grow healthy?

Trainer to clarify and finally summarise discussion on transparencies. Trainer to conclude by showing and explaining **FC:AHC2**

TRAINER'S NOTES

1. **Many dangers of pregnancy and delivery can be prevented when women are encouraged to go to the clinic on suspicion that they might be pregnant.**

a professional midwife will:

- help save both mother and baby's lives
- continuously monitor the health status of a pregnant woman and immediately refer her to hospital if she encounters some problems
- screen the pregnant mother for diabetes mellitus which may predispose her to serious birth complications.
- monitor high blood pressure which may be dangerous to both mother and child if highly elevated
- give the pregnant woman iron tablets to prevent anaemia which may lead to pre-mature delivery and consequently increased infant **mortality** and **morbidity** rates.
- administer an injection to prevent tetanus
- monitor the child's progress in terms of growth
- provide pregnant woman with relevant information regarding delivery, breast feeding and baby care
- provide pregnant woman with advise about child spacing
- take the pregnant woman's blood specimen to diagnose sexually transmitted diseases if any

2. When a woman gives birth, she needs assistance of a trained birth attendant.

A trained birth attendant knows:

- that a woman with prolonged uterine contractions (for more than twelve hours) needs to be referred to hospital
- that delivery under sterile conditions help prevent diseases
- how to cut an umbilical cord in a more safe and sterile manner
- what to do if the baby is not presenting normally during delivery
- what to do if woman is bleeding profusely
- when to seek medical assistance
- what to do if the baby does not breathe immediately after delivery
- how to advise the woman about breast feeding immediately after delivery
- how to properly dry and keep the newly born baby warm immediately after delivery
- how to advise the woman about proper child spacing

3. During pregnancy it is important that a woman be well equipped with relevant information received from the clinic in terms of who will be assisting her during delivery. If the family members suspect that the woman's delivery might be associated with dangers, they might decide that the woman delivers at the clinic or hospital or be near the place where it would be easy for her to get assistance.

- It is important that all pregnant women, fathers and family members have knowledge of important signs that would help them determine whether the woman should be taken to the clinic or not.

The following should be noted in a pregnant woman.

- conception that takes place before a two years interval after the previous conception

- a conceiving woman should not be less than 21 years old or more than 35 years old to avoid complications associated with pregnancy.

- a pregnant woman with four babies or more
- a pregnant woman who had a previous difficult labour or caesarian section
- a pregnant woman who had previous pre-term babies
- a pregnant woman who had a miscarriage or still birth
- a pregnant woman with a weight less than 38 kilograms
- a pregnant woman whose height is less than 145 cm

The following sings should be noted in pregnant women

- lack of increase in weight (at least by 6 kilograms)
- anaemia (observed in the eyes)
- unusual swelling of legs, arms and face

4. The father and the family should ensure that the pregnant woman gets enough food and rest, particularly during the last three months before delivery.

A pregnant woman needs nutritious diet like, for example, milk, fruit, vegetables, meat, fish, eggs etcetera.

- a pregnant woman's weight should be monitored right from the outset

- it is important that a pregnant woman's weight shows some increase on monthly basis till time of delivery. It should increase at least by ten to twelve kilograms before delivery.

- a pregnant woman may predispose an unborn baby to serious dangers when she smokes, drinks alcohol and uses drugs. Women should avoid taking any medication unless it is prescribed by a trained birth attendant.

5. **The more appropriate period for a woman to fall pregnant is between 21 and 35 years. This decreases dangers which might arise during time of delivery. It is best to conceive after a two years interval.**

- Family planning is the best and safe way to **eliminate** dangers associated with pregnancy and delivery.
- Dangers associated with delivery increase a lot when the pregnant woman is less than 18 years old or more than 35 years old or when a woman has delivered a lot of babies.
- To avoid child birth by aborting a child is extremely dangerous. Illegal abortion has led to increased maternal mortality rate.

6. **A woman who grows healthy and well nourished experiences very little problems during pregnancy and delivery.**

- a safe an successful pregnancy seems to be more associated with a pregnant woman's good health status. Women should, therefore, take care of their lives, eat adequate and nutritious diet and be equipped with adequate knowledge.

ACTIVITY 2. :HIV AND AIDS

Participants to form two groups and discuss openly the following questions regarding HIV and AIDS:

1. What is HIV and AIDS?

2. What do we mean by safe sex?

3. What can predispose an individual to HIV infection?

4. Should a person living with HIV get pregnant?

5. What role can be played by parents in protecting young people from getting HIV infection?

Trainer to clarify and finally summarise discussion on newsprint.
Conclude by showing and explaining **FC : AHC5**
show and explain **FC : AHC12, FC :AHC7**

TRAINER'S NOTES

1 **AIDS is a preventable and communicable disease which can be spread mainly through having sexual intercourse with someone infected with HIV virus. HIV infection can also be transmitted from pregnant mothers to unborn babies before delivery or immediately after delivery.**

- **AIDS** is caused by the virus which destroys immune necessary for the protection of our bodies against diseases. People with AIDS die because their can not protect themselves

- There are no apparent signs indicating that an individual is having HIV infection. Many people with HIV infection look healthy and normal.

- When someone suspects that he/she has HIV infection, he/she should consult people with knowledge of HIV testing. It is crucial that people with HIV infection get counselling so that they can learn about the methods of preventing the spread of HIV infection.

HIV infection can be spread through the following

- blood, semen or sexual secretions from the female. This means that this virus can be spread through sexual intercourse between a man and a woman, male and a male.
- exchanging of infected needles by drug users.
- Blood transfusion with contaminated blood
- Mother to child transmission

Important information

- One is unlikely to contract HIV infection through the use of someone's toothbrush.
- It is not safe to pierce earlobes, make drawings upon the skin using unsterile instruments. Immerse them in boiling water before after use.
- A woman infected with HIV may breastfeed exclusively for six months. HIV virus is not easy to spread through breastfeeding. The mother should not bottle feed because this may be dangerous in poverty stricken societies.
- It is not possible to get the AIDS virus from being near to or touching those who have the AIDS virus. Hugging, kissing, shaking hands, coughing and sneezing will not spread the disease.
- The AIDS virus cannot be transmitted by toilet seats, telephones, plates, glasses, spoons, towels, bed linen, swimming pools or public baths.
- National child immunization programmes use needles which are sterilized between each use and are therefore safe. All infants should be taken for a full course of immunizations in the first year of life.
- Other injections are often unnecessary as many useful medicines can be taken by mouth. Where injections are necessary, they should be given only by a trained person using a sterilized needle and syringe.

2. **Safe sex means being sure that neither partner is infected, remaining mutually faithful, and, and using a condom if in doubt.**

A guide to safer sex

- The best way to avoid AIDS is to stay in a mutually faithful relationship with an uninfected partner.
- The more sex partners you have, the greater the risk of having sex with someone who is infected.
- The more partners your partner has, the greater the risk that you will be infected.
- Unless you and your partner have sex only with each other, and are sure you are both uninfected, you should protect yourselves by using a condom (a sheath or rubber).
- The following kinds of sex are much more risky than others:-

- Anal intercourse (in which the penis enters the rectum or back passage)
- Any sexual practice which causes even slight bleeding
- Sex with male or female prostitutes
- Sex with any persons who inject themselves with drugs

3. Any injection with an unsterilized needle or syringe is dangerous.

- Drug abuse, involving the sharing of unsterilized needles or syringes by two or more persons, is one of the main ways in which the AIDS virus is spread in the industrialized countries.

- A needle or syringe can pick up small amounts of blood from the person being injected. If that person's blood contains the AIDS virus, and if the same needle or syringe is used for injecting another person without being sterilized first, then the AIDS virus can be injected.

- Self-injection with drugs is in itself dangerous. But because of the additional risk of AIDS, those who do inject drugs should never use another person's needle or syringe or allow their own needle or syringe to be used by anyone else.

- Those who inject drugs are therefore particularly at risk from AIDS. So are those who have sex with those who inject drugs.

4. Women with the AIDS virus should avoid becoming pregnant.

- Women with the AIDS virus have about a 50% chance of giving birth to a baby who will also have the AIDS virus. Most babies with the virus will a baby who will also have the AIDS virus. Most babies with the virus will die before they are three years old.

- Women who know or suspect that they have the AIDS virus should therefore avoid becoming pregnant.

- In some countries, tests are available to people who are concerned that they might have the AIDS virus. A woman who wants to have a baby, but suspects that she may have the AIDS virus, should try to have the test first. This is especially important if she lives in an area where many people have AIDS.

5 **All parents should tell their children how to avoid getting AIDS.**

- Apart from protecting yourself and your partner, you can also help to protect your children against AIDS by making sure they know the facts about how to avoid getting and spreading the disease.

- In this way, everyone can help in the world-wide effort to stop the AIDS virus from spreading to the new generation.

TRAINER'S NOTES

EDUCATION OF YOUTH BY THE FAMILY

Every child should be planned and wanted and be given parental love relationships of care / love / discipline that ensures growth to that child's optimum physical, emotional, intellectual , environmental and spiritual health and maturity.

- No teenage coitus up to 21 years, because of relationship development, immaturity, education, abuse, cancer of the cervix, obstetric complications, poor motherhood and fatherhood skills, financial dependency, STDs and the legal constraints up to 16 years.
- Sexual intercourse should commence **after the final commitment** to each other before the community at marriage.
- This encourages the trust and emotional satisfaction of the woman, enhancing her self concept and status, and enabling her to offer respect and devotion to her husband. Such a relationship between the two people is the method to prevent AIDS spreading and threatening the community.
- The first child should be conceived when the mother is in the optimum reproductive period between 22 and 30 years
- The last child is conceived before the mother is 36 years old, to avoid the increasing health risks to the mother and the conceptus of the perimenopausal period.

THEME 3: INDIGENOUS HEALERS AND PREVENTION OF CHILDHOOD ILLNESSES

At the end of this section you will be able to:

- know how breastfeeding contributes in health promotion and prevention of illnesses in children.

- identify the major killer diseases in children and understand the preventive measures for such diseases

ACTIVITY 1: DIARRHOEA

Participants to form two groups and then openly discuss the following questions:

1. Why diarrhoea is considered to be dangerous in children?
2. Why it is considered necessary to breastfeed a child with diarrhoea?
3. Can we feed a baby with diarrhoea?
4. What measures should be taken if diarrhoea does n't stop?
5. What can you give to a child whose diarrhoea has stopped?
6. Should we give medication to a baby with diarrhoea?
7. How can we prevent diarrhoea?

Trainer to clarify and finally summarise discussion on transparencies. Conclude by showing and explaining:

FS : HP 8.2, FS : HP 8.1, FS :HP 6

TRAINER'S NOTES

1. DIARRHOEA CAN KILL CHILDREN BY DRAINING TOO MUCH LIQUID FROM THE BODY. SO IT IS ESSENTIAL TO GIVE A CHILD WITH DIARRHOEA PLENTY OF LIQUIDS TO DRINK.

- Diarrhoea is dangerous. Roughly one in every two hundred children who get diarrhoea will die from it.
- Most often, diarrhoea kills by dehydration, which means that too much liquid has been drained out of the child's body. So as soon as diarrhoea starts, it is essential to give the child extra drinks to replace the liquid being lost.
- Suitable drinks to prevent a child from losing too much liquid during diarrhoea are:-
  Breast milk, Gruels (diluted mixtures of cooked cereals and water),Soups, Rice water
- In almost all countries, special drinks for children with diarrhoea are available in pharmacies, shops, or health centres. Usually, these come in the form of sachets of oral rehydration salts (ORS) to be mixed with the recommended amount of clean water (see box). Although these 'salts' are specially made for the treatment of dehydration, they can also be used to prevent dehydration.
- Do not add ORS to liquids such as milk, soup, fruit juice or soft drinks.

- An effective drink for diarrhoea can also be made by using eight level teaspoons of sugar and one of salt dissolved in one litre of clean water.
- If none of these drinks is available, other alternatives are:- Fresh fruit juice, Weak tea and Green coconut water
- If nothing else is available, give water from the cleanest possible source (if possible brought to the boil and then cooled).
- To prevent too much liquid being lost from the child's body, one of these drinks should be given to the child every time a watery stool is passed:-
- Between a quarter and a half of a large cup for a child under the age of two
- Between a half and a whole large cup for older children
- The drink should be given from a cup (feeding bottles are difficult to clean properly). If the child vomits, wait for ten minutes and then begin again, giving the drink to the child slowly, small sips at a time.
- Extra liquids should be given until the diarrhoea has stopped. This will usually take between three and five days.

ORS - a special drink

A special drink for diarrhoea can be made by using a packet of oral rehydration salts (ORS).

- This drink is used by doctors and health workers to treat dehydrated children. But it can also be used in the home to prevent dehydration. To make the drink:
- Dissolve the contents of the packet in the amount of water indicated on the packet. If you use too little water, the drink could make the diarrhoea worse. If you use too much water, the drink will be less effective.

2. WHEN A BREASTFED CHILD HAS DIARRHOEA, IT IS IMPORTANT TO CONTINUE BREASTFEEDING.

- When a breastfed child has diarrhoea, breastfeeding should continue, and if possible increase. If the child cannot suck, it is best to squeeze out the breast milk and feed it to the child with a clean cup.
- If the child is being fed on milk powder solutions or cow's milk, more liquid should be given by adding twice the usual amount of clean water to the child's normal feed.

3. A CHILD WITH DIARRHOEA NEEDS FOOD.

- It is often said that a child with diarrhoea should not be given any food or drink while the diarrhoea lasts. This advice is wrong. Food can help to stop the diarrhoea. Also, diarrhoea can lead to serious malnutrition unless parents make a special effort to keep feeding the child during and after the illness.

- A child with diarrhoea usually has less appetite, so feeding may be difficult at first. But the child should be tempted to eat frequently, by offering small amounts of his or her favourite foods.

- Children who eat solids should be given soft, well-mashed mixes of cereal and beans, or cereal and well-cooked meat or fish. Add one or two teaspoonfuls of oil to cereal and vegetable mixes if possible. Also good for the child are yoghurt and fruits (especially brightly coloured fruits such as bananas, mangoes and pineapples). Foods should be freshly prepared and given to the child five of six times a day.

4. TRAINED HELP IS NEEDED IF DIARRHOEA IS MORE SERIOUS THAN USUAL

- Parents should seek help from a health worker without delay if the child:-

- Becomes dehydrated. Some signs of dehydration are:-
  Sunken eyes
  Extreme thirst
  No tears when the child cries
  Has a fever

- Will not eat or drink normally and vomits frequently

- Passes several watery stools in one or two hours

- Passes blood in the stool (a sign of dysentery)

- If a child has any of these signs, qualified medical help is needed quickly.

- The doctor or health worker will give the child a drink made with special oral rehydration salts (see box). In the meantime, keep trying to make the child drink liquids.

5. **A CHILD WHO IS RECOVERING FROM DIARRHOEA NEEDS AN EXTRA MEAL EVERY DAY FOR AT LEAST A WEEK.**

- Extra feeding after the diarrhoea stops is vital for a full recovery. At this time, the child has more appetite and eat an extra meal a day for at least a week. This will help the child to catch up on the food 'lost' while the child was ill and the appetite was low. A child is not fully recovered from diarrhoea until he or she is at least the same weight as when the illness began.

- Breastfeeding more frequently than usual also helps to speed up recovery.

6. **MEDICINES SHOULD NOT BE USED EXCEPT ON MEDICAL ADVICE.**

- Most medicines for diarrhoea are either useless or harmful. The diarrhoea will usually cure itself in a few days. The real danger is usually not the diarrhoea but the loss of liquids from the child's body.
- Do not give a child tablets or other medicines for diarrhoea unless these have been prescribed by a trained health worker. TOUCHING FOOD.
- Diarrhoea is caused by germs from faeces entering the mouth. These germs can be spread in water, in food, on hands, on eating and drinking utensils, by flies, and by dirt under fingernails. To prevent diarrhoea, the germs must be stopped from entering the child's mouth.

- Poverty and lack of basic services such as clean drinking water mean that many families find it difficult to prevent diarrhoea. But the most effective ways are:-
- Give breast milk alone for the first four-to-six months of a baby's life (breast milk helps to protect babies against diarrhoea and other illnesses).
- At the age of four-to-six months, introduce clean, nutritious, well-mashed, semi-solid foods and continue to breastfeed.
- If milk-powder solution or cow's milk has to be used, give it to the child from a cup rather than a bottle.
- Use the cleanest water available for drinking (water from wells, springs or rivers should be brought to the boil and cooled before use).
- Always use latrines to dispose of faeces, and be sure to put children's faeces in a latrine, or bury them, immediately (children's faeces are even more dangerous than those of adults).
- Wash hands with soap and water immediately after using the latrine and before preparing or eating food.

7. DIARRHOEA CAN BE PREVENTED BY BREASTFEEDING, BY IMMUNIZING ALL CHILDREN AGAINST MEASLES, BY USING LATRINES, BY KEEPING FOOD AND WATER CLEAN, AND BY WASHING HANDS BEFORE

- If possible, food should be thoroughly cooked, and prepared just before eating. It should not be left standing, or it will collect germs.
- Bury or burn all refuse to stop flies spreading disease.
- Measles frequently results in serious diarrhoea. **Immunization against measles** therefore also protects a child against this cause of diarrhoea.
- There is no vaccine to prevent ordinary diarrhoea.

ACTIVITY 2: BREAST FEEDING

Participants to form two groups and then openly discuss the following questions:

1. Why is breast milk so important?
2. When does a child begin to breastfeed?
3. How can we encourage breast milk production?
4. Why is bottle feeding considered to be dangerous?
5. why it is important to breastfeed a child for two years or more?

Trainer to clarify and finally summarise discussion on transparencies. Conclude by showing and explaining **FS :HP 10**

TRAINER'S NOTES

1. BREAST MILK ALONE IS THE BEST POSSIBLE FOOD AND DRINK FOR A BABY IN THE FIRST FOUR-TO-SIX MONTHS OF LIFE.

- From the moment of birth up to the age of four-to-six months, breast milk is all the food and drink a baby needs. It is the best food a child will ever have. All substitutes, including cow's milk, milk-powder solutions, and cereal gruels, are inferior.

- Even in hot, dry climates, breast milk contains sufficient water for a young baby's needs. Additional water or sugary drinks are not needed to quench the baby's thirst.

- Breast milk helps to protect the baby against diarrhoea, coughs and colds, and other common illnesses. The protection is greatest when breast milk alone is given to the baby during the first four-to-six months.

- Other foods and drinks are necessary when a baby reaches the age of four-to-six months. Until the age of nine or ten months, the baby should be breastfed before other foods are given. Breastfeeding should continue well into the second year of life - and for longer if possible.

- Frequent breastfeeding, both day and night, helps to delay the return of menstruation and so helps to postpone the next pregnancy. But breastfeeding, on its own, is not a reliable method of family planning.

2. BABIES SHOULD START TO BREASTFEED AS SOON AS POSSIBLE AFTER BIRTH. VIRTUALLY EVERY MOTHER CAN BREASTFEED HER BABY.

- Starting to breastfeed immediately after birth stimulates the production of breast milk. If possible, breastfeeding should begin not later than one hour after the delivery of the baby.

- In some countries, mothers are advised not to feed their babies on the thick yellowish breast milk (called colostrum) which is produced in the first few days after the birth. This advice is wrong. Colostrum is good for babies and helps to protect them against common infections. The baby does not need any other foods or drinks while waiting for the mother's milk to 'come in'.

- Many mothers need help when they first start to breastfeed, especially if the baby is their first. An experienced and sympathetic adviser, such as a woman who has successfully breastfed, can help a mother avoid or solve many common problems.

- Almost all mothers can produce enough milk if:-

- The baby takes the breast into his or her mouth in a good position.

- The baby sucks as often as he or she wants, including during the night.
- The position of the baby on the breast is very important.

A bad sucking position is the cause of problems such as:

- Sore or cracked nipples. No enough milk. Refusal to feed
- Signs that the baby is in a good position for breastfeeding are:-
- The baby's whole body is turned towards the mother
- The baby takes long, deep sucks
- The baby is relaxed and happy
- The mother does not feel nipple pain
- Crying is not a sign that a baby needs artificial feeds. It normally means that the baby needs to be held and cuddled more. Some babies need to suck the breast simply for comfort. If the baby is hungry, more sucking will produce more breast milk,
- Mothers who are not confident that they have enough breast milk often give their babies other foods or drinks in the first few months of life. But this means that the baby sucks at the breast less often. So less breast milk is produced. To stop this happening, mothers need to be reassured that need the encouragement and practical support of their families, the child's father, neighbours, friends, health workers and women's organizations.
- Mothers employed outside the home need adequate maternity leave, breastfeeding breaks during the working day, and creches where their babies can be looked after at the workplace. So employers and trades unions also have a part to play in supporting breastfeeding.

3. FREQUENT SUCKING IS NEEDED TO PRODUCE ENOUGH BREAST MILK FOR THE BABY'S NEEDS.

- From birth, the baby should breastfeed whenever he or she wants to usually indicated by crying. Demand feeding is best for baby and mother, and frequent sucking at the breast is necessary to stimulate the production of more breast milk.

- Frequent sucking helps to stop the breasts from becoming swollen and painful.

- 'Topping up' breast milk feeds with milk-powder solutions, cow's milk, water, or other drinks, reduces the amount of milk the baby takes from the breast. This leads to less breast milk being produced.

- The use of a bottle to give other drinks can cause the baby to stop breastfeeding completely. The sucking action of bottle-feeding is different from that of sucking the breast, and the baby will usually prefer the bottle because less sucking is required.

4. BOTTLE FEEDING CAN LEAD TO SERIOUS ILLNESS AND DEATH.

- Cow's milk, milk-powder solutions, maize gruel and other infant foods given by bottle do not give babies any special protection against diarrhoea, coughs and colds and other diseases.

- Bottle feeding can cause illnesses such as diarrhoea unless the water is boiled and the bottle and teat are sterilized in boiling water before each feed. The more often a child is ill, the more likely it is that he or she will become malnourished. That is why, in a community without clean drinking water, a bottle fed baby is 25 times more likely to die of diarrhoea than a baby fed exclusively on breast milk for the first four-to-six months.

- The best food for a baby who, for whatever reason, cannot be breastfed, is milk squeezed from the mother's breast. It should be given in a cup that has been sterilized in boiling water. Cups are safer than bottles and teats because they are easier to keep clean.

- The best food for any baby whose own mother's milk is not available in the breast milk of another mother.

- If non-human milk has to be used, it should be given from a clean cup rather than a bottle. Milk-powder solutions should be prepared using water that has been brought to the boil and then cooled.

- Cow's milk or milk-powder solution can cause poor growth if too much water is added in order to make it go further.

- Cow's milk or milk-powder solution go bad if left to stand at room temperature for a few hours. Breast milk can be stored for at least 8 hours at room temperature without going bad.

- In low-income communities, the cost of cow's milk or powdered milk plus bottles, teats and the fuel for boiling water, can be 25-50% of family's income.

5 **BREASTFEEDING SHOULD CONTINUE WELL INTO THE SECOND YEAR OF A CHILD'S LIFE AND FOR LONGER IF POSSIBLE.**

- Breast milk is an important source of energy and protein, and helps to protect against disease during the child's second year of life.

- Babies get ill frequently as they learn to crawl, walk and play. A child who is ill needs breast milk. It provides a nutritious, easily digestible food when the child loses appetite for other foods.

ACTIVITY 3 :WORMS

Participants to form two groups and openly discuss the following questions:

1. In which way do you think worms are dangerous to the lives of children?
2. How can you prevent worm infestation.
3. How can you intervene where the child has worm infestation.

Trainer to clarify and finally summarise discussion on transparencies. Conclude by showing and explaining **FS: HP 17, FS : HP 18 & FS: HP 19**

TRAINER'S NOTES

Small worms enter the lungs

- A child coughs them out and swallow them.
- A child may eat food and drink fluids containing eggs of the worms.
- Eggs of the worms stay in the **intestines** and **eat the child's food.**
- Eggs of the worms come from the body and faeces.
- Eggs from the faeces may enter food and drinks.

TYPES OF WORMS

- Roundworm
- Hookworm
- Threadworm
- Whipworm

Worms may contribute to **under-nutrition** and **anaemia** in children making them **vulnerable to infection** and some worms e.g. roundworm affect the lungs and make them more likely to become infected. Regular deworming is recommended and may be done 6 monthly in the child who is 1 year and older.

ACTIVITY 4 : CHILDREN WITH SCABIES

Participants to form two groups and openly discuss the following questions:

1. Why scabies is considered a dangerous condition if not treated?
2. How can you prevent scabies?

Trainer to clarify and finally summarise discussion on transparencies. Conclude by showing and explaining **FS : HP 21**

TRAINER'S NOTES

SCABIES : A FAMILY DISEASE:

Look for scabies when the child start scratching him/herself. The child may scratch even the sores.

- Babies may have sores in the palms of the hands and feet.
- Older children may have unusual sores on the face, neck and head.
- They may have pimples, small boils which are characterized by itchiness.
- Child my have sores in the armpit, ankles, buttocks, fingers, wrists and elbows.

ACTIVITY 5 : IMMUNIZATION

Participants to form two groups and discuss openly the following questions:

1. Why is immunization important?

2 When should immunization of children start?

3. Should a sick child be immunized?

4 Have you ever seen a child or adult suffering from tetanus?

5. Why should all the women from 15 - 44 years be immunized against tetanus?

Trainer to clarify and finally summarise discussion on transparencies. Conclude by showing **FS: HP 16**

TRAINER'S NOTES

- Per 100 live births of children who were not immunized, three of them die of measles, two die of diphtheria and one dies of tetanus.

- Per two hundred live births of children who were not immunized, one off them will be disabled by polio.

- Children can be protected against these diseases through immunization.

- Despite the availability of immunization centres, a lot of children do not complete their immunization schedules.

- It is therefore important for parents to know why, where, when, how and how often should the babies be immunized.

- If no immunization programs in the community, parents should encourage community organizations to demand such programs.

ANNEXURE E

TRAINING PROGRAM

DAY 1

08H00 - 08H30 : A getting acquainted exercise
Expectations
Norms
Time schedule

08H30 - 10H00 :The trainer read learning outcomes for the participants. Participants were requested to form two groups and then discuss the following questions?

1. What is tuberculosis?

6. How does tuberculosis develop?

3. How are TB germs spread?

4. How does the disease (TB) appear?

10H00 - 10H30 : Tea

10H30 - I3H00 : The relationship between health and environment.

Participants will form two groups and then openly discuss the following

questions

1 How can the environment where people live predispose them to tuberculosis?

2 How can people promote health in the environment where they live?

Trainer to clarify and finally summarise discussion on transparencies. Trainer concludes by showing and explaining **FS :HP 8.2**

13H00 - 14H00 : Lunch

14H00 - 16H00 : Women's health status during pregnancy.

Participants will form two groups and discuss openly the following questions:

1. What is the importance of attending ante-natal clinic?

2. What kind of a person should assist during delivery?

3. How can families prevent dangers of pregnancy?

4. Why diet and rest is important for a pregnant mother?

5. What is the most appropriate period

for a woman to fall pregnant and why?

6. Why it is important for women to grow healthy?

Trainer to clarify and finally summarise discussion on transparencies. Trainer to conclude by showing and explaining FC:AHC2

16H00 : Tea

DAY TWO

08H00 - 08H15 : Singing and dance by indigenous healers in order to create a more relaxed atmosphere

08H15 - 10H00 : Prevention of HIV infection

Participants to form two groups and discuss openly the following questions regarding prevention of HIV infection

1. What is HIV and AIDS?

2. What do we mean by safe sex?

3. What can predispose an individual to HIV infection?

4. Should a person living with HIV get pregnant?

5. What role can be played by parents in protecting young people from getting HIV infection?

Trainer to clarify and finally summarise discussion on newsprint. Conclude by showing and explaining **FC : AHC5**
show and explain **FC : AHC12, FC :AHC7**

10H00 - 1030 : Tea

10H30 - 13H00 : Prevention of diarrhoea and its complications.

Participants to form two groups and then openly discuss the following questions:

1. Why diarrhoea is considered to be dangerous in children?

2. Why it is considered necessary to breastfeed a child with diarrhoea?

3. Can we feed a baby with diarrhoea?

4. What measures should be taken if diarrhoea does n't stop?

5. **What** can you give to a child whose diarrhoea has stopped?

6. Should we give medication to a baby with diarrhoea?

7. How can we prevent diarrhoea?

Trainer to clarify and finally summarise discussion on transparencies. Conclude by showing and explaining: **FS : HP 8.2, FS : HP 8.1, FS :HP 6**

13H00 - 14H00 :Lunch

14H00 - 16H00 Health promotion through breast feeding: Participants to form two groups and then openly discuss the following questions:

1. Why is breast milk so important?

2. When does a child begin to breastfeed?

3. How can we encourage breast milk production?

4. Why is bottle feeding considered to be dangerous?

5. why it is important to breastfeed a child for two years or more?

Trainer to clarify and finally summarise discussion on transparencies. Conclude by showing and explaining **FS :HP 10**

DAY THREE

08H00 - 08H15 :Singing and dancing by indigenous healers.

08H15 - 09H15 :Prevention of worms infestation in children.

Participants will form two groups and openly discuss the following questions:

1. In which way do you think worms are dangerous to the lives of children?

2. How can you prevent worm infestation.

3. How can you intervene where the child has worm infestation.

Trainer to clarify and finally summarise discussion on transparencies. Conclude by showing and explaining **FS: HP 17,FS : HP 18 & FS: HP 19**

09H15 - 10H00 : Prevention of scabies in children.

Participants to form two groups and openly discuss the following questions:

1. Why scabies is considered a dangerous condition if not treated?

2. How can you prevent scabies?

Trainer to clarify and finally summarise discussion on transparencies. Conclude by showing and explaining **FS : HP 21**

10H00 - 15H15 : Tea and departure

ANNEXURE F.

END OF TRAINING EVALUATION SCHEDULE

1. What is it that you liked most about the workshop?

2. What is it that you did not like about the workshop?

3. Were the workshop objectives clearly defined to you? Please explain your response.

4. Would you be able to implement this project / training within the next two (2) weeks? If no why?

5 How would you rate this workshop? Poor good Excellent.

6. Any additional comments on group discussion, materials, etc?

7. what did you learn from this workshop?

8. Would you have liked to have more information? If so, what kind of information?

9. Any other comments.

ANNEXURE G.

POST TRAINING FEEDBACK

GROUP ONE

QUESTION 1

- The warning about HIV and AIDS
- The warning about children's illnesses
- Environmental hygiene at home
- Health promotion

Question 2

- We liked everything because of the warnings and information we found
- We found information where we stay . We will use this information to warn our communities about diseases and hygiene.

Question 3.

- Everything was well explained to us
- We received knowledge about hygiene
- We received information about dangerous communicable diseases found in the community
- child care
- Reducing the impact of diseases in the community

Question 4.

- Yes, we will be able to do so.

Question 5

- Excellent

Question 6

- During group discussion we share our different views.

Question 7.

- Health of a pregnant woman
- The spread of HIV and AIDS
- Spread of scabies in children
- The spread of communicable diseases

Question 8

- Yes, We would like to know about other diseases associated with western medicine.

Question 9.

- We have no other comments

GROUP TWO

Question 1

- I was motivated by hygiene
- Getting information about how to prevent diseases
- increased knowledge for the protection of the community

Question 2

- Nothing

Question 3

- Everything was well explained
- We found profound knowledge about the western health care approach
- We learned about hygiene as the first intervention measures
- We learned about the desirable conditions under which we must live.
- Families should have adequate housing with enough space

Question 4

- Yes, because I have been trained

Question 5.

- Excellent

Question 6

- Group discussion is good because we share different ideas. We give answers without being ashamed.

Question 7.

- We learned that we need to impart knowledge to the community

Question 8

- We need more information about other diseases which we have not yet covered

Question 9

- We think that it is a good idea to be trained.
- We request that training be continued and should be opened to everybody who is a traditional healer.
- An announcement which will reach all the healers must be made. A mechanism to make training compulsory must be established.

We need further training regarding the following illnesses:

- Heart problems
- pneumonia
- Diseases affecting uterus
- bones
- kidneys
- Asthma
- eye problems etc

GROUP THREE

Question 1

- HIV and AIDS
- Prevention of childhood illnesses
- Knowledge about pregnant women

Question 2

- Nothing
- Everything led to our intellectual development

Question 3

- yes
- because where we did not understand we asked questions and issues were clarified

Question 4

- Yes
- We understood very well what we have learned

Question 5

- Excellent

Question 6

- It helps us to learn while discussing
- We easily accept one another
- We learn about important things we encounter in the community

Question 7.

- We learned that western knowledge is sometimes related with indigenous knowledge, in other instances

Question 8

- Yes
- Knowledge about delivery and other conditions we did not cover in the training

Question 9

- We need more information if available
- we need teaching aids, like Flip charts on STD, playing cards with HIV / AIDS information etc.

ANNEXURE H

INDIGENOUS HEALERS POST TRAINING EVALUATION SCHEDULE

1 What was new in terms of your knowledge, beliefs and practice?

2 In terms of your practice as an indigenous healer, are you doing anything differently?

3 What health related knowledge did you have before the training workshop?

4 What insight did you gain after the training workshop?

ANNEXURE I

INTERVIEW SCHEDULE FOR INDIGENOUS HEALERS

1. What is a healthy home?

2. How can you ensure a healthy environment?

3. Are there illnesses that you can prevent from occurring ? If the answer is yes, how can you prevent such illnesses?

4. Which illnesses can you prevent from occurring in adults?

5. Are there illnesses you can prevent from occurring in children? If the answer is yes, how can you prevent such illnesses?

6. Are there illnesses that affect a pregnant woman? If the answer is yes, how do you prevent such illnesses?

7. Are such illnesses dangerous to an unborn baby?

8. Is there anything that you may wish to ask or comment on?

ANNEXURE J

BIOGRAPHICAL INFORMATION FOR INDIGENOUS HEALERS

May I ask you if you could please give me your personal details?

a) How old are you _____ ?

n) Have you ever received training as an indigenous healer?
Yes ____ No ____

If the answer is yes, for how long have you been an indigenous healer _____?

c) Sex. male_____ ? female _____ ?

d) What language do you use at home _____?

e) Have you ever been to a meeting with doctors and nurses?

Yes _____ No _____

If the answer is yes, what was the meeting all about?

f) Have you ever attended a workshop / course on matters related to the formal health care sector
Yes _____ No _____

If the answer is yes, what was the workshop / course all about?

ANNEXURE K

PROVINCE OF KWAZULU-NATAL | **ISIFUNDAZWE SAKWAZULU-NATAL** | **PROVINSIE KWAZULU-NATAL**

HEALTH SERVICES | **EZEMPILO** | **GESONDHEIDSDIENSTE**

OFFICE OF:- THE CHIEF MEDICAL SUPERINTENDENT, EDENDALE HOSPITAL

Ikheli leposi	: Private Bag x 509	Fax	:	Ucingo	:
Postal Address	: Plessislaer	Fax No	: 033-3954031	Tel. No.	: 033-3954133
Pos adres	: 3216	Faks No:		Tel. No.	:
Imibuzo	:	Usuku	:	Inkomba	:
Enquiries	: DR L RAMIAH	Date	: 15.03.2001	Reference	: Makhathini ME
Navrae	:	Date	:	Verwysing	:

Mr M E Makhathini
Matron's Control Office
EDENDALE HOSPITAL

PERMISSION TO CONDUCT RESEARCH

Your request to conduct a research at Edendale Hospital is approved provided that the conditions stipulated in the letter dated 30/11/2001 from the Secretary of Health – Department of Health – KZN are met.

Best wishes with your project.

DR L RAMIAH
CHIEF MEDICAL SUPERINTENDENT

HNNEXURE K.

DEPARTMENT OF HEALTH
PRIVATE BAG X9124
PIETERMARITZBURG

TEL. : 033-3426675
FAX : 033-3943235
E-MAIL: h993804@dohho.kzntl.gov.z

OFFICE OF THE REGIONAL DIRECTOR
INDLOVU HEALTH REGION - B

Mr M Makhathini

RESEARCH INTERVIEWS

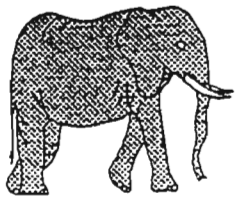
This office grants you permission to conduct the research in some of our Clinics as specified in your proposal.

Please take note of the conditions set by Head Office on this matter.

2001/05/07.

Dr M L Mhlongo
REGIONAL DIRECTOR:
INDLOVU HEALTH REGION

ANNEXURE K



PIETERMARITZBURG/LIONS RIVER/MOOI RIVER
VULINDLELA DISTRICT HEALTH SERVICE

P O Box 89, Pietermaritzburg, 3200

ENQ. : Dr J Dyer

TEL : 033-3951350

FAX : 033-3951505

25 April 2001

Mr E M Makhathini
Matrons' Control Office
Edendale Hospital
Private Bag X509
Pietermaritzburg
3200

Dear Mr Makhathini

RESEARCH STUDY

Your letter of 24 April 2001 to Mrs MacDonald, forwarded to me, refers.

Permission is granted to conduct your research at clinics in the Lions River Sub-District - please liaise with Mrs MacDonald regarding the timing of your visits to the clinics in order to choose times which are mutually convenient.

Yours sincerely

J J DYER
DISTRICT HEALTH COORDINATOR

c.c. Mrs M MacDonald

ANNEXURE K.

PROVINCE OF
WAZULU-NATAL
HEALTH SERVICES

ISIFUNDAZWE
SEKWAZULU-NATALI
EZEMPILO

PROVINSIE
KWAZULU-NATAL
DEPARTEMENT VAN GESONDHEID

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Private Bag :X9051
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Privaatsak : 3200

Enquiries: Prof. R.W. Green-Thompson
Extension: 3176
Reference: 9/2/3/R – Vol.3

Ir M.E. Makhathini
.O. Box 1279
IETERMARITZBURG
200

2000 -11- 30

ear Mr Makhathini

EQUEST FOR PERMISSION TO CONDUCT RESEARCH

our research proposal dated 16 November 2000 and Research Ethics Committee approval dated 17 ovember 2000, refer.

lease be advised that authority is granted to conduct research provided that :-

(a) Prior approval is obtained from the Head of each Institution involved (e.g. Chief Medical Superintendent);

(b) Confidentiality is maintained;

(c) The Department is acknowledged; and

(d) The Department receives a copy of the report on completion.

ours sincerely

ECRETARY: DEPARTMENT OF HEALTH
WAZULU-NATAL
Gmakhathini

Dr M.L. Mhlongo
Regional Director: Region B
Department of Health : KwaZulu-Natal
Private Bag X9124
PIETERMARITZBURG
3200

ANNEXURE K

PIETERMARITZBURG-MSUNDUZI TRANSITIONAL LOCAL COUNCIL
CITY HEALTH DIVISION, Nursing Services

FORM OF INDEMNIFICATION FOR STUDENTS

I, the undersigned ELLIOT M. MAKHATHINI having been granted permission by the City Council of Pietermaritzburg to serve (without remuneration) as a student in its City Health Division. I hereby acknowledge that I undertake this period of student training entirely at my own risk and I hereby agree to indemnify the said City Council and its employees against any claims for damage or injury occurring to myself or my property or to other person (including employees of the City Council) or their property arising from or attributable to such service.

I undertake also to make good any damage caused to the property of the City Council or its employees through my fault or negligence during such service.

Signed by E.M. Makhathini on 19 JUNE 2001
at Pietermaritzburg in the presence of the undersigned witnesses.

Please tick the appropriate block :-

Are you married in Community of Property	YES	X
	NO	
If yes please get your husband/wife to sign this form.		

Husband's / Wife Signature : _____ **Date :** _____

Are you under 18 years old	YES	
	NO	
If yes please get your parents to sign this form.		

Parent's Signature : _____ **Date :** _____

As Witnesses :-

1. _____ Date : 19-06-01

2. _____ Date : 19-06-01