# TREATMENT RECEIVED BY CHILDREN WHO VISIT TRADITIONAL HEALERS

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**A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Science in Medicine in Paediatrics.**

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**ABSTRACT**

One hundred caregivers/parents were interviewed in the survey to find out treatments children who visited the traditional healers received and the outcome of such treatments, fees paid and motivation for soliciting the services of traditional healers. The mean age of respondents was 28.8 years and 22.4 months for children. Seventy five percent of respondents visited the traditional healer voluntarily while 25% were pressurised by family. The majority of respondents (70%) sent their children to the traditional healers for treatment for either inyoni (sunken anterior fontanel) or ibala (capillary naevus). Six-four percent of the children were given oral herbal preparations, 57% had scarification while others had talisman/amulet for protection. Seventy-five percent of the children recovered after visiting the traditional healers. Six-three percent of the caregivers/parents were satisfied with the treatment received and expressed their willingness to visit again. Recommendations have been offered to improve collaboration between western medical and traditional medical practices for the benefit of children.

**DECLARATION**

I, Prosper Kwame Ayibor declare that this research report is my own work. It is being submitted for the degree of Master of Science in Medicine in Paediatrics in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

……..

14 December 2008

Dedicated to the Almighty God and to all those who have contributed in diverse ways in making me who I am.

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## LITERATURE REVIEW

## INTRODUCTION

The World Health Organisation (WHO) classifies the traditional healer "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".[1]

Traditional medicine is widely used and of rapidly growing health system and economic importance. In Africa up to 80% of the population uses traditional medicine to help meet their health care needs.[2]

In Sub-Saharan Africa, the ratio of traditional healers to the population is approximately 1:500, while medical doctors have a 1:40 000 ratio to the rest of the population.[3]

The use of traditional medicine (TM) remains widespread in developing countries, while use of complementary and alternative medicine (CAM) is increasing rapidly in developed countries.[2] It is estimated that 40% of the adult American population use herbal remedies[4] with similar trends occurring in Canada, Europe, and Australia. There is a fallacious view that herbal medicines are harmless and free of side effects because they are "natural". In recent times, there have been several cases of hepatic injury and even death associated with their use.[5] For instance, in South Africa, the administration of the traditional Zulu remedy impila (Callilepis laureola) in high doses results in severe or fatal hepatotoxicity and, in some cases, nephrotoxicity. Patients

poisoned with impila characteristically show severe hypoglycaemia as a precursor to catastrophic hepatocellular necrosis.[6-9] In Asia and Latin America, populations continue to use traditional medicine as a result of historical circumstances and cultural beliefs. In China, traditional medicine accounts for around 40% of all health care delivered.[2]

In developing countries, the broad use of traditional medicine is often attributable to its easy accessibility and affordability. Other reasons why some prefer traditional healers include long distances they have to cover to get to health facilities, long queues and waiting periods to see doctors; morbid fear of surgical procedures; the desire to maintain privacy (traditional healers do not usually keep records) and the belief in an African explanation of illnesses.[10]

The traditional healers view illness as being influenced externally by spirits or ancestors, whilst western doctors regard illness as inherent within the patient e.g. in the case of neurotransmitters and brain function. This belief by traditional healers is generally shared by African populace.

Traditional healers are not officially recognised by most governments. They operate outside formal health structures. Exclusion of traditional healers from the formal health structures can have serious consequences. Some patients, preferring the healers, may disregard their doctor's advice or take herbal medicines that could have dangerous interactions with modern medical preparations. Parents who shuttle between traditional healers and modern health facilities may delay diagnosis and treatment and may also interfere with follow up care with disastrous consequences. Children are particularly at risk since they rely on their parents to consent to or take decisions regarding their health care. Knowledge of what these traditional healers administer to these children would assist practitioners of modern medicine with the management of some of life-threatening cases that are often brought to the hospitals by parents.

Though there have been extensive studies on traditional healers and the role they play in society,

there are limited or no specific references to the treatment that children who visit traditional healers receive and the outcome of the treatment. Literature shows that people of all ages visit traditional healers.[11-13] A study by Ahmed et al in Sudan aimed at assessing the characteristics of visitors attending traditional healers, the reasons for visits, the frequency of visits, satisfaction with visits and advantages and disadvantages of visits, showed that children under ten years did not take part in the visits; most of the visitors were between 21 and 40 years (61%). They believed this is because the age group 21-40 is more at risk of psychological problems; more mobile and can travel to the healers while children less than ten years are less prone to psychological stress.[14] However, a study in Taiwan showed that the age-group 0-9 years were most likely to visit the traditional healers.[15]

This study attempts to unveil some of the details regarding specific treatment that children who are sent to traditional healers receive, the outcome of this treatment and to explore how much it costs parents. Attempt will be made to find out why children under six years are sent to these practitioners even though treatment in the formal health system is free for this age-group.

**Traditional medical practice in South Africa**

Although Western medicine is generally accepted throughout South Africa, it is open secret that most parents/patients consult traditional healers before accessing modern medicine.
There is an estimated 250,000 to 300,000 healers in the country which by far outnumbers other health practitioners: there are about 30,000 doctors and 200,000 nurses in South Africa.[10]
Traditional healers are established health care workers within their communities. It has been estimated that between 60 and 80% of the South African population use the traditional medical sector as their first contact for advice and/or treatment of health concerns. Their treatment is

holistic, dealing with the physical as well as the psychosocial aspects of disease.[16]

Traditional healers occupy an esteemed position within South African culture as they assume the roles of medicinal healer, priest, psychiatrist, advisor, diviner, and herbalist. They are consulted for a variety of physical, social, and emotional problems.

There are different categories of traditional healers in South Africa, including inyangas (herbalists), sangomas (diviners), and umthandazi (faith healers). The services of prophets are also widely used.

The herbalist is usually a male who has extensive knowledge of curative herbs and medicines made from animal extracts (muti). The diviners are predominantly female and use the guidance of ancestral spirits through divination to diagnose an illness. Diviners are usually consulted by the patient's family and use spiritual insights to interpret the causes and consequences of the disease without necessarily seeing the patient in person. The faith healer usually belongs to one of the African independent Christian churches and uses the power of prayer and the laying on of hands as ways of healing. The duration of training for a traditional healer varies from a few weeks to up to 10 years and depends on the ability of the apprentice. The fee for training is not fixed.[17] Skills are usually acquired through apprenticeship to an older healer, experience of certain techniques or conditions, or by experiencing a calling from the spirits or ancestors.

**Reasons for visiting traditional healer.**

*"Degedege (convulsion) is caused by bad spirits. In this realization, spirits that cause convulsion must be removed first so that Western and other medication can work in treating the child. That is why we start at the traditional healer for treatment of a convulsed child and later we take him or her to hospital". ....*view of a mother in Tanzania.[18]

*"Children are normally attacked by spirits which cause uncoordinated movement of eyes and limbs. The disease is better understood traditionally and the spirits easily and quickly leaves the child when urinated on, fumigated with elephant dung smoke and with other herbs as well as washing the convulsed child with herbal water. Mothers know this very well and that is why they bring convulsed children to us for treatment"*…..view of a traditional healer in Tanzania regarding convulsion.[18]

*"I believe when there is witchcraft around, then the child feels it, she can feel something, like evil spirit"*...a parent in South Africa.[19]

*"So that he cannot inhale, we Blacks think that there's something wrong in the air that the child he can inhale and get sick, so the protection (Haarlemensis/Stiups/Doepa) is for that"*…. South African parent.[19]

The above accounts show that treatment seeking for children suffering from illness is a complex process, being a function of socio-cultural milieu in which people live. Generally, mothers would consult different healing resources at the same time starting with traditional healers and then modern care, back and forth.[18] Patients visit traditional healers for treatment of various illnesses including sexual transmitted diseases, psychotic diseases, divulgence of secrets, immunisation against witchcraft, prophecies of future events and annual check ups.[20] Children are often sent with acute diarrhoea, chronic skin rashes, fever, convulsions, loss of appetite and weight loss. The recipes used to prepare the herbal remedies are usually kept secret. Adverse effects and interactions of these herbal remedies are not usually known while dosages and frequency of daily doses do not conform to standard prescriptions in modern medical literature thereby resulting in patients being overdosed with disastrous consequences. The herbal medications can either be

taken orally, steamed, inhaled, and used for washing; smeared on the body, or given as enemas. Using enemas to treat children with diarrhoea and dehydration can be fatal. Fatal cases of enema colitis, meningitis and drug poisoning have been reported in various hospitals throughout the country.

**Recognition of Traditional Health Practitioners (THP) in South Africa**

South Africa has taken a number of initiatives to deal with the unique situation of African traditional Medicines. The National Department of Health developed the National Drug Policy (1996) which recognises the potential role of and benefits of available remedies of African Traditional Medicines in the National Health System. This is aimed at investigating the use of effective and safe traditional medicines at primary level; investigating traditional medicines for efficacy, safety and quality with the aim to incorporate their use in the national health care delivery system.[21]

Also in recognition of the important role traditional healers play in the society, the South African parliament passed the Traditional Health Practitioners Act, 2004, that comes into operation on a date to be determined by the President.[22]

The law seeks to regulate the traditional health practice and practitioners. An interim council is set up among others to:

1. Register all qualified traditional health practitioners. No person may practise as a traditional health practitioner within the Republic unless he or she is registered in terms of this Act.
2. Ensure provision of quality health services

3. Protect and serve the interest of the public the use their services
4. Promote and maintain appropriate ethical and professional standards
5. Promote and develop interest in traditional health practice by encouraging research, education and training of members.
6. Ensure that traditional health practice complies with universally accepted health care norms and values.
7. From time to time determine and publish the fees to be charged by traditional healers and only the amount so determined is payable by the patient.

The law prohibits unregistered healers from claiming cures or relief for cancer or HIV or AIDS. The passage of the law is expected to help minimise/eliminate charlatans. It is estimated that of the 80,000 persons practising traditional healing in Gauteng, only about 10% are bona fide healers, i.e. healers who abide by the strict ethical code of this vocation. The effect of these charlatans is shown by the finding that of the patients with poisonous intoxication admitted to a hospital near Pretoria, 15% were ascribed to traditional "medicines".[16]

At the moment, the Department of Health in collaboration with NGOs are involved in the training of traditional healers in childhood and communicable diseases especially in the management of HIV/AIDS and TB. As a result, traditional healers are now actively involved as DOT supervisors[23] and are becoming increasingly aware of hygiene and sanitation. Interestingly, some traditional healers having voluntarily tested for HIV now refer patients with TB and other ailments to health care services for treatment and HIV testing. The Department of Health now provides home-based care kits to healers including gloves, disinfectant, bandages, and bleach.[24] This close relationship between traditional healers and the Department of Health is expected to enhance acceptability as part of the formal health system.

**Positive role of Traditional health care**

Traditional health care is not necessarily a significant impediment or a delaying factor in the treatment of ailments brought to hospitals. There is a need to foster training on the management of certain cases, periodically involving both traditional health practitioners and health workers to identify modalities of better collaboration.[18]

In developing countries such as South African where traditional healers play very significant roles in the health care delivery some degree of cooperation with or integration into the formal health system, though it may attract resistance, will be beneficial if done tactfully and with sensitivity. This is particularly relevant in the face of the high prevalence of HIV/AIDS in the country and important role traditional healers can play in improving its management, reducing spread and impact on society.

**The Cuban example**

Even though Cuba is a poor, developing country, its health indicators (e.g. infant mortality rate of 6.2/100,000 in 2004 and projected life expectancy of 75.5) are similar to those of the United States. This is achieved partly because the Cuban health care system integrated CAM—or natural and traditional medicine (NTM), as it is known in Cuba—into conventional systems of medical care. Cuba incorporated NTM into clinical practice, medical education, pharmaceutical production, and medical research. As in most cultures, there is a substantial history of informal NTM and folk medicine in Cuba. However, the Cuban government established a national mandate for the integration of NTM into the health care system in 1992, and by 1995 the Ministry of Health had created a state commission for the development of NTM.[25] As of 2002, 86% of Cuban physicians practised some form of NTM, with 100% of Cuban hospitals offering acupuncture anaesthesia. Today, the teaching of both the theory and practice of many NTM

modalities is part of the core curriculum in all 23 of Cuba's medical schools. There are a few areas in which the Cuban approach to NTM does incorporate practitioners of other healing arts. In particular, *santeros*- the practitioners of Santeria, one of the indigenous religions of Cuba-are often consulted by patients before or in parallel with conventional physician. Santeros typically dispense spiritual advice and often use herbal remedies as well. *Yerberos*—herbalists, some of whom are santeros and others not-are granted a license to provide (and sell) herbs for medicinal and spiritual healing. However, before granting the license, the Ministry of Agriculture mandates a two-week course that addresses the benefits and potential dangers of certain herbs. Also, the Ministry of Health routinely enlists cooperation from the santeros and yerberos in coordinating major health education campaigns.[26]

**The way forward for South Africa**

Since traditional medicines constitute an integral part of South African heritage that cannot be ignored, and the role of traditional practitioners cannot be overemphasised in the South African community today. With the current era of high prevalence of HIV/AIDS with the concomitant high TB cases exerting so much pressure on the existing health facilities it may be an opportunity to evaluate the role of the traditional healers in the effort to integrate traditional and western (alternative) medicines. Research into traditional medicine should be made a priority with the objective of developing necessary expertise in the production of traditional medicines and improving their safety and efficacy. To achieve this, genuine collaboration between western medical practitioners and the traditional healers is vital. This requires a measure of respect for indigenous medicine and African culture. It also requires avoidance of stereotyping of African traditional healers and efforts must be made to search for a common ground between western

biomedicine and traditional healers. A supervisory body will have to be instituted to regulate the activities of the traditional health practitioners as in the case of western health practitioners whose activities are regulated by the Health Profession Council of South Africa (HPCSA). Department of Health which plays the overall supervisory role will have to be very instrumental in the regulatory process to weed out charlatans in order to protect the interest of those who may want to use the services of the traditional healers.

## METHODOLOGY

### Aim

The **aim** of this study was to determine some of the specific treatments that children who visit traditional healers received and the outcomes; how much it costs parents and why parents prefer services of traditional healers even though children below six years are entitled to free medical treatment in South Africa.

### Objectives:

1. To determine the types of treatment children who visit traditional healers receive and the outcome of this treatment where outcome refers to:
   a. child recovered and well,
   b. no change in condition
   c. recovered but with a sequela e.g. disability
   d. fatal (died)
2. To determine fees paid by parents for the services of the traditional healers.
3. To determine the motivation for soliciting the services of traditional healers before seeking the services of the formal health system.
4. To establish the percentage of OPD attenders who admit to using the services of a traditional healer.

## Definitions

**'Children'** refers to children below 14 years

**Formal health system** means public (state) health system.

## Study Design

The study was a cross-sectional, descriptive study of children who attended the out-patient department (OPD) of Coronation Hospital now Rahima Moosa Mother and Child Hospital, Johannesburg. The study was carried out from June to September 2008. Parents were interviewed using a structured questionnaire developed by the investigator.

## Study population

The study population consisted of all OPD attenders to the Coronation Hospital during the study period. This included patients from the Coronation Hospital traditional catchment areas, several informal settlements e.g. Diepsloot, Zamimpilo, Slovo Park, Kathrada Park and Matholesvile and other parts of Johannesburg.

The caregivers of children aged less than 14 years with new complaints to the Paediatric out-patient department (POPD) who admitted ever visiting traditional healers were included in the study. Only patients with new complaints were recruited because follow-up patients were mostly for collection of results etc and it was considered that they should not be inadvertently delayed. Caregiver consent was obtained.

## Study sample

A systematic random sample was done by choosing every third patient consulting the investigator who is one of the full time medical officers attending to daily sick children. The caregiver was asked if he/she had ever taken the child to a traditional healer. If he/she answered in the affirmative, he/she was duly taken through the patient information and consent form and if consented to take part, he/she was then recruited to take part in the survey.

One hundred (100) participants were purposefully interviewed using a structured questionnaire. The sample size of hundred was considered to reasonably reflect the population under study as this was mainly a descriptive study. A parent who only spoke a local language e.g. Zulu was interviewed using the services of a nurse interpreter.

## Measurements

The structured questionnaire was administered by the investigator. To ensure good response rate, the patients were given the option of giving only their first names if they so wished to maintain confidentiality.

## Data collection

Data was captured using a structured questionnaire. Interviews were conducted both in English and local languages but responses were recorded only in English. The socio-demographics of participants were captured but no names were recorded.

The questionnaire was divided into two sections:-

- Demographics details

- Type of treatment, consultation fees and motivation for visit

There were a total of 33 questions. Both closed and open-ended questions were used. The investigator asked the questions and filled in the response himself.

**Data analysis**

The information from the structured interview was captured on personal computer and coded. Data entry was done using Microsoft excel which was exported to Stata version 10 (Statistical software) for analysis. Data cleaning involved the checking of quality of the data in terms of missing values, internal consistencies and validity of responses. Data Analysis involved the use of frequency tables and graphical presentation of most of the key variables of the study e,g, frequency tables and graphical presentation were used to describe/ summarise the characteristics of respondents, types of traditional healers visited, reasons for making that choice, type of treatment received and outcomes, cost of treatment, willingness to visit again etc.

**Ethics**

The study did not raise any serious ethical issues. Voluntary signed informed consent and confidential agreement was obtained from respondents (caregivers) prior to commencing the study. Permission to perform the study was obtained from the University of the Witwatersrand Human Research Ethics Committee (Medical) for approval before commencement of the study- Protocol number M080204 dated 29 April 2008.

## RESULTS

### Response rate

A total of hundred respondents who visited traditional healers with their children were interviewed between June and September 2008. None of those who qualified to be recruited into the study refused to participate.

### Demographics

The important demographic details of the respondents are summarised in Tables 1, 2, 3 and Figure 1.

### Sex Distribution

The majority of respondents (caregivers) as expected were females (n=96), 96%. Of the 100 children brought by the caregivers (parents) 58% were males and 42% were females. Table 1.

### Age Distribution

The mean age of caregivers (parents) was 28.8 years with the 20-29 year group being in the majority (53%) while 4% were below 20 years and 6% above 40 years.

For children (patients) the mean age was 22.4 months but most of them (45%) were below 1 year and 10% more than 5 years old. Table 1.

**Demographic details of respondents (Table 1)**

| **Sex of Caregiver** | **Number** | **Percent** |
|---|---|---|
| Male | 4 | 4 |
| Female | 96 | 96 |
| **Total** | 100 | 100 |
| **Sex of Child** | | |
| Male | 58 | 58 |
| Female | 42 | 42 |
| **Total** | 100 | 100 |
| **Age of Caregiver (years)** | | |
| <20 | 4 | 4 |
| 20-29 | 53 | 53 |
| 30-39 | 37 | 37 |
| 40+ | 6 | 6 |
| **Total** | 100 | 100 |
| **Age of Child (months)** | | |
| 1-11 | 45 | 45 |
| 12-23 | 14 | 14 |
| 24-25 | 17 | 17 |
| 36-59 | 14 | 17 |
| 60 and above | 10 | 10 |
| **Total** | 100 | 100 |
| **Occupation of caregivers** | | |
| Employed | 41 | 41 |
| Unemployed | 57 | 57 |
| Other | 2 | 2 |
| **Total** | 100 | 100 |
| **Level of education of Caregivers** | | |
| Illiterate | 1 | 1 |
| Primary | 8 | 8 |
| High school | 75 | 75 |
| Post-matric | 16 | 16 |
| **Total** | 100 | 100 |

**Occupation of Caregivers/Parents**

Fifty seven percent (57%) of respondents were unemployed, 41% employed in both skilled (electrical engineer, nurse) and unskilled jobs (domestic workers, cleaners); and 2% were students. Interestingly, one of the respondents was a female day-care worker and a sangoma. Table 1.

**Level of Education of Caregivers/Parents**

Seventy five percent (75%) of respondents reached high school (Grade 9-12) while 16% completed tertiary education (Admin assistant, receptionist, nursing). Eight percent had primary education (Grade 1-8) and 1 (1%) had no formal education. Table 1.

**Distribution of Caregivers/Parents by language**

Most of the respondents (36%) spoke isiZulu. Setswana came second (21%) then Sesotho (14%), isiXhosa (13%), and Shona, Afrikaans and SiSwati with one percent each. Table 2.

| **Language** | Freq. | Percent |
|---|---|---|
| IsiXhosa | 13 | 13 |
| Sepedi | 5 | 5 |
| Xitsonga | 3 | 3 |
| Sesotho | 14 | 14 |
| Shona | 1 | 1 |
| Setswana | 21 | 21 |
| Tshivenda | 5 | 5 |
| IsiZulu | 36 | 36 |
| Afrikaans | 1 | 1 |
| SiSwati | 1 | 1 |
| Total | 100 | 100 |

**Table 2. Distribution of respondents by language.**

**Distribution of respondents by residence**

Figure 5 shows the distribution of residence of respondents done according to the Johannesburg 11 regions map. Table 3, APPENDIX B. Coronation Hospital is based in Region 4 (Northcliff/Rosebank area). This area also includes Westbury, Westdene, Newclare, Newlands and Coronationville.

| Area | Johannesburg Regions |
|---|---|
| Diepsloot | **1** |
| Midrand/Ivory Park | **2** |
| Sandton | **3** |
| Northcliff/Rosebank | **4** |
| Roodeport | **5** |
| Doornkop/Soweto | **6** |
| Alexandria | **7** |
| Inner city | **8** |
| Johannesburg South | **9** |
| Diekloof/Meadowlands | **10** |
| Ennerdale/Orange farm | **11** |

**Table 3 Johannesburg Regions**

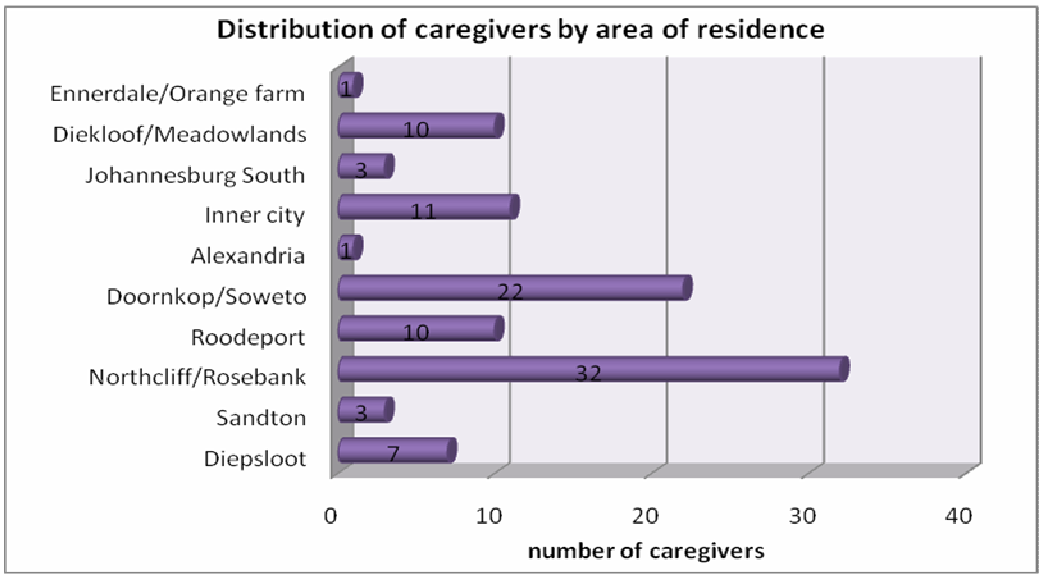



**Figure 1**

The majority of the respondents (32%) were from Northcliff/Rosebank (Region 4) area (Coronationville, Newclare, Newlands etc). Doornkop/Soweto area (Region 6) came second (22%); Inner City (Yeoville, Hillbrow, Jeppestown, Berea etc.) came third with 11% while Diepkloof/Meadowlands and Roodepoort areas followed with 10% each. Seven respondents came from Diepsloot area, three each from Sandton and Johannesburg areas and one each from Alexandria and Ennerdale areas. Figure 1, Appendix B.

**Frequency of visit**

Fifty-two percent of respondents had visited the traditional healer with their children at least once; 27% of respondents visited twice, while 11% visited 4 or more times in the preceding two and a half years. (Table 4)

| Frequency of visit to traditional healer | Number of respondents | Percent |
|---|---|---|
| | | |
| 1 | 52 | 52 |
| 2 | 27 | 27 |
| 3 | 10 | 10 |
| 4 | 4 | 4 |
| 5 | 3 | 3 |
| 6 | 1 | 1 |
| 9 | 1 | 1 |
| 10 | 2 | 2 |
| **Total** | 100 | 100 |

**Table 4: Frequency of visit to traditional healer**

**Willingness to visit**

When asked whether they visited the traditional healers at their own will or not, seventy five respondents (75%) responded in the affirmative while twenty five (25%) said they were pressurised. Of the 25 who said they did not go at their own will, 17 (68%) said they were pressurised by grandparents while 5 (20%) said child's father asked them to send their children to the traditional healers. Figure 2.

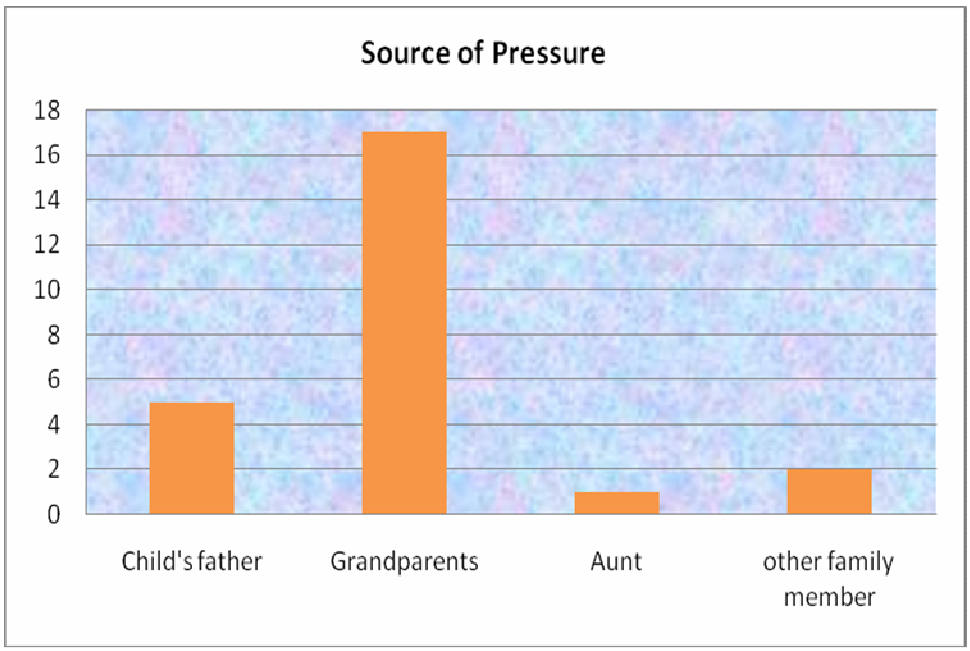



**Figure 2**

**Reasons for visiting traditional healers**

Of the hundred respondents 70% sent their children to the traditional healers for treatment for either inyoni (sunken anterior fontanel) or ibala (capillary naevus) or both. Twelve percent went because of gastrointestinal symptoms (diarrhoea and vomiting, loss of appetite, abdominal pains) while 5% went to secure some form of protection against evil forces for their children.

Table 5

| Reason for visit | Percent | Cum. |
|---|---|---|
| Inyoni (sunken anterior fontanel)/ibala (capillary naevus at back of neck) | 70 | 70 |
| Gastrointestinal symptoms ( diarrhoea and vomiting, loss of appetite and abdominal pain) | 12 | 12 |
| Skin manifestations ( skin rash, nappy rash, ringworm) | 1 | 1 |
| Protection | 5 | 5 |
| Respiratory symptoms ( "Flu", lower/upper respiratory tract infection, shortness of breath, asthma) | 3 | 3 |
| CNS ( convulsion, meningitis) | 1 | 1 |
| Others (umbilical hernia, insomnia, ear/eye infections, injuries) | 8 | 8 |
| Total | 100 | 100 |

**Table 5. Reason for visit to Traditional healer**

**Type of traditional healer visited**

Sangomas were the most patronised (34%) followed by inyangas (28%), prophets (21%), and umthandazis least (17%) visited. (Figure 3)

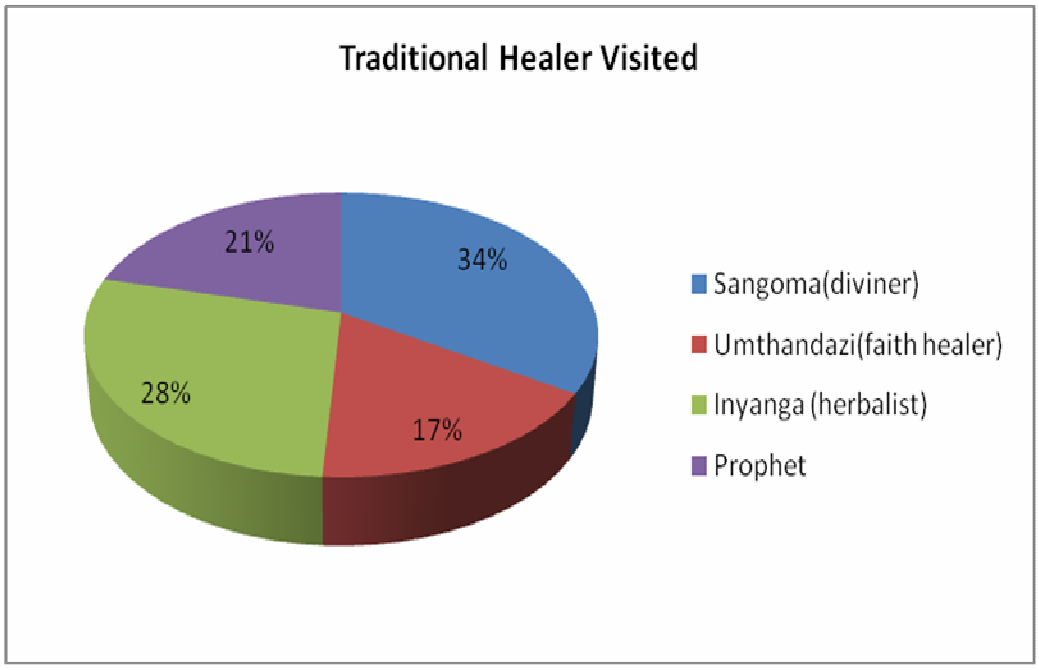



**Figure 3**

**What informed choice of type of traditional healer to visit**

When asked to give reasons for the choice of type traditional healer to visit, 71% said it was based on recommendation by relatives or friends. Twenty-one percent visited a particular traditional healer because of their personal previous experience while 8% went because the traditional healers were either relatives or, in the case of prophets, their church members. (Fig 4)

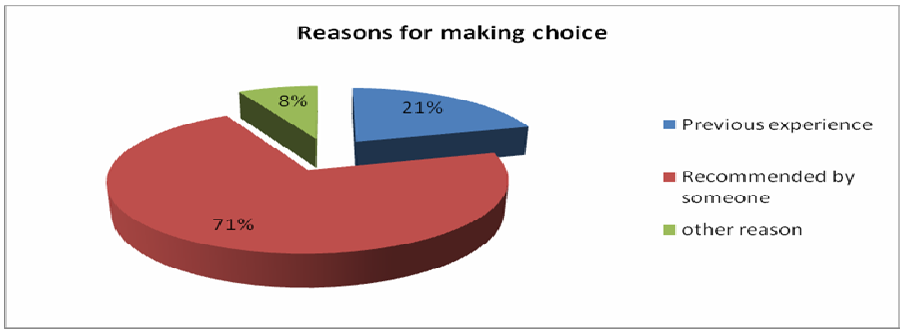



**Figure 4**

**Type of treatment received from the traditional healers**

Sixty four respondents (64%) had oral medications, 57% had scarification (cuts/ incisions) into which black burnt herbal preparations were rubbed; 36% had amulets/talisman to keep on their bodies as protection, 25% had enemas while 8% and 5% respectively had steaming and nasal inhalations. Nineteen respondents (19%) were given other forms of "medications" as shown in Table 6

**Other forms of treatments received. Table 6**

| Other forms of treatments | Number of respondents |
|---|---|
| Blessed water | 3 |
| Boiled water with garlic to drink/wash | 1 |
| Chloromycetin to eyes | 1 |
| Herbal prep to apply to anterior fontanel | 10 |
| Herbal prep to wash/ 'oil' as ear drops | 1 |
| Water and Sunlight soap to use as enema | 1 |
| Water+salt+honey to drink | 1 |
| water + salt as enema/Belt to rub child | 1 |
| Total | 19 |

**Treatment outcome**

Seventy-five percent of respondents said their children recovered well after visiting the traditional healers while twenty-five (25%) indicated that their children conditions did not change or got worse (Fig 5). Overwhelming 84% of those whose conditions got worse were sent to hospitals. Figure 6.

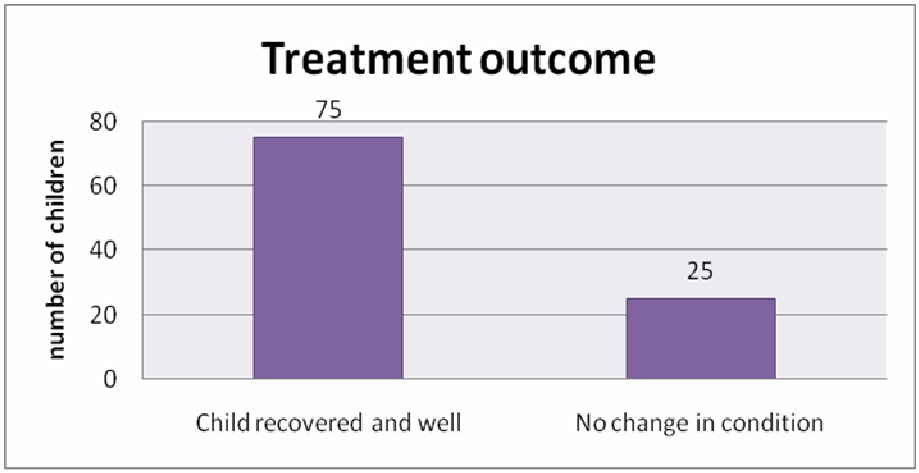



**Figure 5**

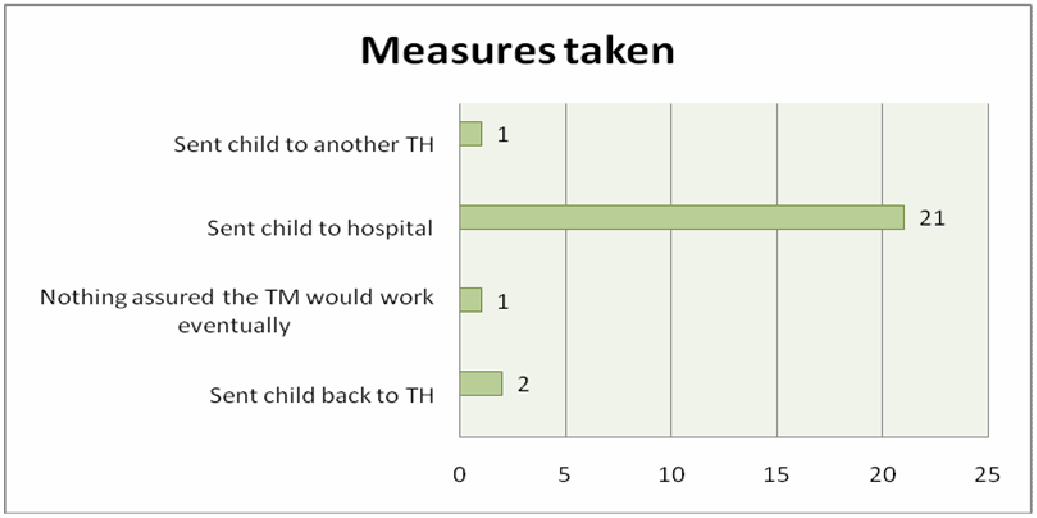



**Figure 6 (TH- Traditional healer, TM- traditional medicine)**

**Knowledge of contents/ name of herbal preparation**

Respondents were asked if the knew name or contents of some of the herbal medications given to their children. Overwhelming 88% answered in the negative while only 12% answered in the affirmative. Those who affirmed knowledge of name/contents mentioned products like Haarlemans, groen amaar, dintantanyane, diisha, mokhudi, mtlhabelo, nyamazane, tlhaka, garlic, salt and water.

**Willingness to visit traditional healers again after last experience**

Sixty three percent of respondents would visit the traditional healer again after first visit while 37% would not for various reasons.

.**Satisfaction with services provided by the traditional healers.**

Sixty-nine percent of respondents were positive about their experiences with traditional healers. In other words, 40% were happy and 29% were very happy with services provided to their children by the traditional healers. Twenty-one (21%) had negative impressions about the services received i.e. 18% unhappy and 3% very unhappy with their services. Ten percent of the respondents were however neutral. Table 7

| How happy with service | Freq. | Percent |
|---|---|---|
| Very unhappy | 3 | 3 |
| Unhappy | 18 | 18 |
| Neutral | 10 | 10 |
| Happy | 40 | 40 |
| Very happy | 29 | 29 |
| Total | 100 | 100 |

**Table 7 Satisfaction with services of traditional healer**

**Fees paid by caregivers/parents to traditional healers.**

The traditional healers charged between R15 and R1200 per visit. The lowest amount paid respondents was R15 and the highest was R1200. The majority (62%) of the respondents paid between R1and R250 per visit. Eighteen caregivers (18%) paid between R251 and R500/visit, two percent paid between R501 and R1000/visit, one percent paid over R1000. Seventeen (17%) did not pay any fees for their treatments i.e. treatment was free. One respondent paid R1200 but did so by monthly instalments. Prophets were more likely to give free treatment (38.1% paid no fee) while Sangomas charged the highest fees. Three caregivers (8.8%) paid R500 or more to the sangomas. (Tables 8, 9, 10)

| Fees paid | Number of caregivers | Percent |
|---|---|---|
| No money | 17 | 17 |
| <R1-R250 | 62 | 62 |
| R251-R500 | 18 | 18 |
| R501-R750 | 1 | 1 |
| R751-R1000 | 1 | 1 |
| >R1000 | 1 | 1 |
| Total | 100 | 100 |

**Table 8. Fees charged by traditional healers**

| Fees paid | Number of caregivers | Percent |
|---|---|---|
| No money | 5 | 14.71 |
| <R1-R250 | 22 | 64.71 |
| R251-R500 | 4 | 11.76 |
| R501-R750 | 1 | 2.94 |
| R751-R1000 | 1 | 2.94 |
| >R1000 | 1 | 2.94 |
| Total | 34 | 100 |

**Table 9. Fees charged by sangomas (diviner)**

| Fees paid | Number of caregivers | Percent |
|---|---|---|
| No money | 8 | 38.1 |
| <R1-R250 | 12 | 57.14 |
| R251-R500 | 1 | 4.76 |
| Total | 21 | 100 |

**Table 10. Fees charged by prophets**

Ten respondents (58.8%) who visited the umthandazi paid R250 or less, 23.5% paid between R251 and R500 while 17.7% paid nothing. (Table 11)

| Fees paid | Number of caregivers | Percent |
|---|---|---|
| No money | 3 | 17.65 |
| <R1-R250 | 10 | 58.82 |
| R251-R500 | 4 | 23.53 |
| Total | 17 | 100 |

**Table 11. Fees charged by umthandazi (faith healer)**

Of the 28 respondents who visited the inyanga eighteen (64.3%) paid between R1 and R250, nine (32.1%) paid between R251 and R500 and only one (3.6%) was treated free of charge because respondent was a relative. Table 12

| Fees paid | Number of caregivers | Percent |
|---|---|---|
| No money | 1 | 3.57 |
| <R1-R250 | 18 | 64.29 |
| R251-R500 | 9 | 32.14 |
| Total | 28 | 100 |

**Table 12 Fees charged by inyanga (herbalist)**

**Opinion about effectiveness of traditional medicine**

Seventy-two percent of the respondents were of the view that traditional medicines given to their children were effective. Twenty-five percent indicated it failed because their children's condition did not improve or got worse and had to go to hospitals. Three percent had no opinion. (Table 13)

| Effectiveness of TM | Freq. | Percent |
|---|---|---|
| worked | 72 | 72 |
| failed | 25 | 25 |
| other | 3 | 3 |
| Total | 100 | 100 |

**Table 13. Effectiveness of traditional medicine.**

**Awareness of partners of visit to traditional healers**

When the respondents were asked if their partners were aware of or approved of their visit to the traditional healers, overwhelming 92 % said yes. Eight percent of partners of caregivers/ parents were not aware because either they were separated, divorced or partners did not believe in traditional medicines or they had travelled at the time of the visit. Table 14

| Partner aware of visit | Freq. | Percent |
|---|---|---|
| Yes | 92 | 92 |
| No | 8 | 8 |
| Total | 100 | 100 |

**Table 14 Awareness of partner of visit to traditional healer**

**Opinion of caregivers/parents about combining traditional medicine with western medicine**

The majority (61%) of respondents indicated that they were of the view that traditional medicine when combined with western medicine would not work better (Table 15). In other words they believed they must be used separately. Thirty-eight percent believed that combining traditional medicine with western medicine would work better. One respondent (1%) was not sure. (Table 15)

| CombineTM/WM | Freq. | Percent |
|---|---|---|
| Yes | 38 | 38 |
| No | 61 | 61 |
| Not sure | 1 | 1 |
| Total | 100 | 100 |

**Table 15 Caregiver opinion about combining traditional medicine (TM) with western medicine (WM)**

Of the 100 children seen 86% were treated and discharged for various complaints some of which included bronchiolitis, upper respiratory tract infection, uncomplicated pneumonia, ear infection, tonsillitis and eczema. Fourteen percent (14%) were admitted for gastroenteritis with moderate to severe dehydration.

## DISCUSSION

### Response rate

An average of 25 patients was seen on each working day by the researcher between June and September 2008. By interviewing one in three patients seen by the researcher it was projected that interviewing the hundred qualified respondents would be completed within 15 working days. However, it took about 55 working days to complete because only respondents who visited traditional healers with their children were qualified to be recruited into the study. None of those who qualified turned down the request to be part of the study. No interviews were done on very busy working days. An average of seven minutes was required for each session.

### Confidentiality and Limitations

The research was conducted in a hospital setting because of convenience. The ideal setting would have been the community where participants resided and where they would not feel threatened to say they had visited the traditional healers. Patients usually suspect that medical doctors disapprove of visits to traditional healers. Some of the caregivers were a bit sceptical about intentions of the research fearing it will have some political ramifications. However, they were assured of their confidentiality after going through the information sheets. I was reassured by the fact that no subjects refused to participate in the study.

The study population may not be representative of the general population as data of non-hospital attendees was not captured which may differ significantly from hospital attendees. These were likely to have a negative effect on the accuracy of the research result.

Because the Ethics Committee requested that the interview of caregivers should be purposeful

rather than random, the study objective four aimed to establish the percentage of OPD attenders who admit to using the services of a traditional healer, could not be realised.

**Sex distribution**

In most western countries, it is not unusual to see fathers accompanying their spouses to seek medical attention for their children but this rare in African setting. In the study, the ratio of female to male respondents was 24:1. The few male respondents who brought their children said they brought their sick children because according to them their mothers were working at the time. This is not surprising because in Africa, females are expected to take care of their families. With regards to the children more males than females in the ratio of 3:2 were seen. It is generally believed that most diseases show a male preponderance in young babies.

**Occupation of Caregivers/Parents**

The majority of respondents (57%) were unemployed. This high unemployment rate of respondents who patronised the Coronation Hospital could be attributed to the fact that Coronation Hospital being a public Level 2 referral hospital is a place where they could get very quality health care at very affordable cost hence its clients are mostly the poor who cannot afford to pay the high fees charged at private hospitals. The unemployment rate is probably a reflection of the current norm in these communities.

**Level of Education of Caregivers/Parents**

Significant number of respondents (91%) was educated beyond Grade 9. Eight percent had primary education (Grade 1-8) and only one respondent (1%) had no formal education. Those who completed tertiary education (16%) included administration assistants, receptionists, nurses,

and electrical engineers. They said the main reason for visiting traditional healers was because it was part of their family tradition/culture. This confirms the deep-seated belief in the traditional healers by black South Africans in particular and Africans in general hence the level of education attained did not constitute a barrier to accessing their services. According to Kale traditional healers are enshrined in the minds of the people and are highly respected in their community and are often seen as its opinion leaders[17] and the level of education is only one of the many factors that may influence the choice between traditional healers and modern medicine.[27]

**Distribution of Caregivers/Parents by language**

The majority of respondents spoke isiZulu (36%) followed by setswana (21%) and isiXhosa (13%). In a study into health seeking behaviour for childhood illnesses in urban South Africa in Johannesburg/Soweto, Spark-du Preez et al observed that place of birth gives an idea of cultural influence. They observed that there is a strong link with traditional medicine in KwaZulu Natal (mainly Zulu speaking) and Eastern Cape (Xhosa speaking) because of cultural influence. In the study caregivers from KwaZulu Natal and Eastern Cape grouped together had slightly higher (81%) proportions using traditional medicine than those from other provinces (71%).[19]

Because of the open-door policy of the Coronation Hospital, it is patronised by many foreigners especially those from Zimbabwe. Since most Ndebele Zimbabweans speak Zulu this could add to the percentage of Zulu respondents.

Even though Coronation hospital is situated in mainly "coloured" community who speak predominantly Afrikaans, it accounted for only one percent. This reflects the low usage of traditional healers by the "coloured" but it is possible that some tried to hide the truth about their visits to the traditional healers.

**Distribution of respondents by residence**

As expected, the majority of the respondents (32%) were from Region 4 which includes Coronationville, Newclare, Newlands, Westbury and Westdene. Surprisingly, Doornkop/Soweto area (Region 6) which is supposed to be served by Baragwanath Hospital came second (22%) while Inner City (Yeoville, Hillbrow, Jeppestown, Berea etc.) came third with 11%. Diepkloof/Meadowlands and Roodepoort areas followed with 10% each. Most of respondents said they preferred Coronation to Baragwanath hospital because it is a children's hospital and that they were happy with the services provided. There is no active disincentive in place to dissuade patients from coming to Coronation Hospital.

**Willingness to visit traditional healer**

An overwhelming 75% of respondents visited the traditional healers at their own free will. This compares favourably with the estimated 60- 80% of the South African population who use the traditional medical sector as their first contact for advice and/or treatment of health concerns[16]. It also compares with a study in Soweto which found that 80% of the population had visited the traditional healer.[28] Twenty five percent said they were pressurised by close relations- 17 (68%) by the grandparent, 5 (20%) by child's father and the rest by aunts and friends. Other studies have shown higher figures with regards to the roles played by families/close friends in influencing patients' visits to traditional healers. A study by Ernest showed that 50% of patients who went to traditional healers did so because of pressure from the family or friends[29] and that by Odejide et al revealed that close relatives influenced the choice in 31.2% of cases[12]. This emphasises the complexities involved in the health seeking process. Socioeconomic status, family ties, ones beliefs and cultural practices, emotional support and accessibility of health

facilities in times of ill-health of loved ones may influence decisions that one makes in terms of when and where to seek health care. A study by Tabi et al in Ghana showed that the use of traditional healers and modern medicine was influenced by level of education, family, friends and spiritual/religious beliefs.[27] It is important to note that a lot of factors come into play when caregivers are making decisions concerning their child's health and these should be considered in health education programmes and in making policy decisions.

**Reasons for visiting traditional healers**

The most commonly given reason for consulting the traditional healer was treatment for inyoni and ibala (n= 70/100, 70%) Parents sent their children to the traditional healers for treatment for either inyoni or ibala or both. Ibala is the Zulu word for capillary naevus (red mark) found at the back of the neck in infants. The common belief according to the respondents was that the ibala would move up the head and would become fatal if it met at the anterior fontanelle. Inyoni literally means "bird" in Zulu and is associated with evil spirits that may enter through the fontanelle and is often blamed for severe diarrheoa and dehydration which may lead to sunken fontanelle. The caregivers believed that inyoni and ibala made the child vulnerable to evil spirits and only the traditional healers have the capability to treat it and that it was beyond conventional (western) medical practice. Since these conditions are generally "normal" and non-pathological, it may worthwhile for healthcare workers to stress the normality of these conditions to reassure parents. Treatments include the use of enema (spuits) and cuts and incisions on parts of the body into which shoe polish-like mixture known as mohlabelo is rubbed.[19] A study by Bland et al found that 52% of mothers consulted the traditional healer for the treatment of ibala and sought advice for inkaba (an imaginary internal wound believed to be caused by the severance of the

umbilical cord), abdominal pains and inyoni.[30] Twelve percent of the children brought by the respondents to the traditional healers were treated for abdominal pains, diarrhoea and vomiting. Five went to seek protection for their children, 3% for the common cold or "flu" and one each for fits and nappy rash while 8% went for various reasons including uncomplicated umbilical hernia, insomnia, ear/eye infections and injuries. Black South Africans or for that matter black Africans, believe that children's health are threatened by natural and supernatural forces which need to be prevented[19] by using supernatural power and the most common reason for taking a child to traditional medical practitioner according to Spark-du Preez et al contrary to finding of this study was for protection and "African illnesses which western medicine couldn't treat.[19] In Tanzania, 75% of mothers considered degedege (convulsion) to be caused by evil spirits and these spirits causing the convulsion must be removed first so that Western and other medication can work in treating the child.[18] This view was shared by most of the respondents in the study.

**Type of traditional healer visited and what informed choice**

The type of traditional healer visited according to the respondents depended in part on specific problem the child had or the perceived experience/ specialty of the healer. Other factors considered when choosing a healer were previous personal experience or those of their friends and relatives. Seventy one respondents (71%) visited a particular type of traditional healer because of recommendations by relatives or friends. Twenty-one percent made their choice based on their personal previous experience while 8% went because the traditional healers were either relatives or church members. Most of those who visited prophets did so because they were church members. Sangomas were the most patronised (34%) followed by inyangas (28%), prophets (21%), and umthandazis the least (17%) visited.

**Type of treatment received from the traditional healers**

The use of traditional medicine is influenced by symptoms and by having positive beliefs about traditional medicine and traditional healers[31] and as many as three quarters of caregivers would give traditional medicines to their children if the need arose.[19] The caregivers interviewed were unanimous in their confidence and beliefs in the effectiveness of the traditional medicines.

Of the hundred respondents interviewed 64% said their children were given oral herbal preparations as medications. Fifty-seven (57%) had scarification at back of neck or on the forehead or elsewhere on the body into which black burnt herbal preparations were rubbed. This was reported by the caregivers and confirmed by scars observed on the children's body. With the advent of HIV/AIDS, the traditional healer requires education on the need for sterile procedures and the use of disposable blades to prevent the spread of the infection. A programme for education of traditional healers is in place in KwaZulu Natal and other provinces but is inadequate[32].

Thirty-six (36%) were given talismans/amulets by the traditional healers to wear for protection against magical/evil powers. Twenty-five (25%) of the children were given enemas containing different ingredients like sunlight soap, water and salt. Eight (8%) and five (5%) of the children in the study had steaming and nasal inhalation respectively as a form of treatment. Additionally, 19 respondents (especially those with diarrhoea who visited prophets), were given "medications" like blessed water, boiled water with garlic to drink and wash. They were also given herbal preparations to apply to the anterior fontanelle while two patients were given chloromycetin by a sangoma to treat eye infection and oil as ear drops. Bland et al found that enemas containing Zulu medicine (herbs and animal extracts), water and sunlight soap were very popular (89%, 98/110) for cleansing out the infant's systems and oral only (58%, 64/110)[30] compared to 25%

who had enemas and 64% (64/100) who received medications orally in this study.

**Treatment outcome and measures taken**

Seventy-five percent of respondents said their children recovered well after visiting the traditional healers with 63% saying they would use their services again. Twenty-five (25%) indicated that their children conditions did not change or got worse. This group expressed their reservations about the efficacy of traditional medicine vowing never to visit again. Of this twenty-five whose condition did not change or even got worse, 21 (84%) were sent to hospital by their parents, two (8%) were sent back to the same traditional healer for review, one (4%) was sent to another traditional healer while one (4%) took no other actions because of reassurance from the traditional healer that child will be well. What was remarkable was the fact that the traditional healers in some cases instructed respondents to go to hospital if their children's conditions did not improve. Some of them who were literate even gave referral notes to their clients to clinics/hospitals. This was confirmed by the day-care worker/ sangoma who also brought the child to the hospital and was recruited by this researcher. This assertion gives credence to the fact that when given the right training, orientation, information and knowledge these traditional healers would cooperate with efforts to incorporate them into the existing health systems in countries where resources are limited.

**Satisfaction with services provided by the traditional healers and willingness to visit again**

When the respondents were asked if they were willing to send their children to the traditional healers again after the previous experience, 63% said they would because they were satisfied with the services provided. This figure almost agreed with the percentage of respondents (69%)

who said they were satisfied with the services rendered them by the traditional healers. They also revealed that it was part of their tradition and culture to send their children to the traditional healers. Thirty-seven percent of respondents would not go back because either their first visit was only meant for once-off protection for their children, or they did not see any improvements after repeated visits or it was too expensive. This brings into sharp focus the need for a regulatory body for the traditional medical practitioners to protect the interest of very poor who patronise their services.

**Fees paid by caregivers/parents to traditional healers.**

Presently there is no law regulating fees to be charged by traditional healers in the country. This has resulted in the practitioners charging as they will with some charging very exorbitant fees far beyond the means of their clients. One of the objectives of this study is to find out how much visitors to traditional practitioners are charged with a view of helping policy makers and other stakeholders have an insight into cost of treatment by traditional healers as compared to what pertains in public health facilities.

In the study it was noted that the traditional healers charged fees ranging between R15 and R1200 per visit. Sangomas charged the highest fees while prophets charged the lowest. Seventeen respondents did not pay any fees for their treatment and most of those who had these "free" treatment consulted with prophets who also happened to be their church members. Inyangas were next to sangomas in charging high fees followed by umthandazis. These differences in fees charged could reflect the varying roles, fields of expertise, and techniques of these healers[19]. According to Leonard, many of these healers are paid an outcome-contingent fee whereby the bulk of their payment is only received if their patient is cured[33]. In the local

situation most clients pay up front at the time of consultation but in this study the one who paid the highest fee (R1200) did so by monthly instalments. These expenses by the caregivers did not include transport and other hidden costs. Fortunately most of these traditional healers live within the communities and are not difficult to find. The majority of children (>90%) who were sent to the traditional healers in this study were under 6 and were entitled to free public health care for all children under 6 introduced by the South African government after 1994. However, caregivers were of the view that it did not matter how much they spent to visit these traditional healers since they believed that the supernatural causes of their children's illnesses would be better sorted out by the traditional healers. They believed that it was only after this was dealt with that they would go to the western doctors to take care of the natural causes.

**Opinion about effectiveness of traditional medicine**

Seventy two respondents (72%) were of the view that the traditional treatment was effective. This compared favourably with the number of respondents who said their children recovered after visiting the traditional healers (75%). As with the finding of treatment outcome above, 25% thought the traditional medicine had failed because their children did not recover while 3% did not have any opinion. This again demonstrates the strong confidence the black African population has in the traditional medical practitioners.

**Awareness of partners of visit to traditional healers**

Ninety-two out of the hundred respondents said their partners were aware of the visit to the traditional healers. Most of them said they were accompanied by their partners. The decision according to them was taken collectively. This demonstrates that the primary decision making

with regards to where to seek health for children remains the preserve of the immediate family. Eight of the respondents said their partners were not aware. When asked why they did not inform their partners, four of the eight said they were separated/divorced so did not see the need to inform their partners; three said their partners did not believe in traditional medicine and one said the partner had travelled at the time of the visit but would not have had any objections.

**Opinion of caregivers/parents about combining traditional medicine with western medicine**

When the respondents were asked if they thought traditional medicine worked better when combined with western medicine, 61% said they did not think so. They gave different reasons why they felt combining the two would not work better.

Some of their reasons were that:

1. Combining them would be harmful because they believed they have different effects.
2. Western medicine could not treat certain types of ailments
3. They indicated that certain ailments were due to supernatural/evil causes hence the need to see the traditional healers for protection against these forces.
4. Some said they would prefer using them separately to determine which would work better.

Thirty-eight percent of the respondents were of the view that traditional medicine would be more effective when combined with western medicine. They said they would benefit from the "synergistic" effect of combining the two types of medicines and that they felt it was harmless when combined.

The children of eighty-six percent of the caregivers/respondents were treated at the out-patient department and discharged while 14% were admitted for moderate and severe dehydration. There was no conclusive proof that the severity of their conditions was related to the tradition medicines. It, however, could be attributed to the delay in seeking care at the formal health care facility.

## CONCLUSION

This study has highlighted a number of important issues with regards to the type of treatment children received, why they visited traditional healers and addressed some of the reasons why parents would visit traditional healer no matter how much it cost parents. The majority of respondents were black South Africans who visited the traditional healers at their own will and were satisfied with the services rendered them and expressed their willingness to visit again. Zulus and Xhosas were more likely to visited traditional healer because of their inherent traditional and cultural beliefs. This confirms the assertion that majority of black Africans visit and will continue to visit the traditional healer in spite of availability and affordability of care at the formal health facility. There seems to be wide acceptance of the role for traditional healers in the management and prevention of childhood illness.

Most of the people who visited the traditional healer believed that there was a supernatural component of illness which would be best managed by the traditional healer. They would go to the clinics and hospitals only after this had been sorted out. Parents sent their children to traditional healers for different reasons of which ibala and inyoni and protection against evil forces were the commonest. Even though ibala and inyoni are considered entirely harmless conditions by western medical practitioners, the mythical beliefs associated with them make parents seek treatment from traditional healers regardless of how much it cost them. Parents need lots of reassurance regarding these benign conditions in order to avoid subjecting their children to unnecessary treatments.

Although the decision on where or when to seek medical care for children rests solely with parents, oftentimes they are influenced by a range of factors. These include traditional and cultural beliefs of the individuals, family pressures especially those from grandparents and

friends. Traditional healers offer a wide range of treatment options to children that are sent to them. Some of these include oral herbal medication, scarification or incisions into which herbal preparations are rubbed, talisman/amulets to wear on specified parts of the body for protection against malicious forces. The majority of respondents did not know the names or ingredients of the herbal preparations which the healers usually keep as a secret. The few who claimed they knew names/contents of these preparations mentioned non-traditional products like Haarlemans, sunlight soap, garlic, salt and water. It was interesting and encouraging to note that some traditional healers gave their clients western medical preparations e.g. chloromycetin for eye infection and that some even referred them to clinics and hospitals. This was welcoming revelation as it would enhance any efforts to incorporate them into the formal health system and promote collaboration with western medical practitioners. The use of over-the-counter (OTC) pharmaceuticals should be remembered if toxicity occurs.

A minority of respondents were not satisfied with the treatment received because their children's conditions did not improve or even got worse and sought further help at hospital. Surprisingly, some of them said they would visit the traditional healers again if there was no improvement after treatment in the hospital. Parents therefore, find themselves running between western medical facilities and traditional practitioners to ensure their children remain healthy. In spite of the free health care for children under six in the formal health system, the majority of respondents were prepared to pay high fees to traditional healers for treatment because they believed the ailments sent to them could not be treated by western medicine. Perhaps the free services may have devalued orthodox services.

Respondents held diverse views with regards to combining traditional and western medicines. While some believed that this was harmful and hence must be used separately, other thought it

was harmless and they would benefit from the “synergistic” effects of combining the two types of medicines. Efforts must therefore be made to ensure that parents are well educated on the problem of drug interaction and not to delay sending their children to clinics and hospitals and not to disregard for follow up visits to hospitals when requested. Traditional healers will continue to play a vital role in child care and as a matter of urgency must be incorporated into the formal health system so that their activities could be streamlined to the benefit of the public who use their services especially children who are sent to them.

## RECOMMENDATIONS

This study should also be repeated in the community where respondents reside since it is believed that they will not feel threatened to say they had visited the traditional healers. In this case it is expected that the negative effect of the hospital environment will be eliminated. Interview of the traditional healers with regards to this topic will also be useful.

Since traditional healers are widely consulted their practice cannot be ignored hence western medical practitioners instead of condemning parents for visiting them should find ways of collaborating with the traditional healers to create a safe and appropriate child care practices. Instead of ostracising the traditional healers it will be more productive to train them in hygiene and the need for sterile procedures especially in the prevention of HIV/AIDS and how to recognise danger signs in conditions such as diarrhoea and pneumonia. At the moment some traditional healers are involved in HIV/AIDS and TB prevention programmes. It is an open secret that some nurses and doctors practise traditional medicine in South Africa. It will be valuable to use them to train other traditional healers in the Integrated Management of Childhood illness (IMCI).

The traditional healers should be encouraged to avoid delays and refer cases that are beyond them to clinics and hospitals to reduce complications.

Although parents/caregivers have inalienable right to seek health care where and when they deem fit, they must be educated on benign conditions such ibala and inyoni that are by and large harmless. This will help them save money spent on these conditions to be used for other equally important family needs. The education must also focus on danger sign of common childhood

illnesses so that they can send such children to nearest clinics and hospitals to minimise delays.

The government must expedite the process of incorporating the traditional medical practice into the mainstream formal health systems in order to regulate their practice to serve the interest of those who use their services.

Existing research institutions such as the Medical Research Council (MRC) and the Council for Scientific and Industrial Research (CSIR) should be adequately resourced to research into traditional medicines.

Schools of medicine, nurses, and pharmacy should incorporate sufficient information about traditional medicine and complementary and alternate medicine obtained from the above research into the standard curriculum at the undergraduate, graduate and postgraduate levels to enable licensed professionals to competently advise their patients.

Healthcare workers should do their best to stress the normality of certain features e.g. anterior fontanelles and storkbites to parents in order to reassure them.

| | | |
|---|---|---|
| **Section 1: Demographics** | | |
| 1. | Gender (Sex) of caregiver | 1. Male 2. Female |
| 2. | Gender of child | 1. Male 2. Female |
| 3. | Age of caregiver | |
| 4. | Age of Child | |
| 5. | Occupation of caregiver | |
| 6. | Level of education | |
| 7. | Home language | |
| 8. | Residence | |
| **Section 2: Type of treatment, consultation fees and motivation for visit** | | |
| 9. | Have you ever visited a traditional healer with your child? | Yes☐ No☐ |
| 10. | If yes, when? | 1. Less than one month ago.<br>2. Three months ago.<br>3. Six months ago.<br>4. One year ago |
| 11. | How often do you visit the Traditional healer in year? | |
| 12. | For this illness, did you visit the traditional healer? | |
| 13. | If yes, when? | 1. Less than one week.<br>2. one month ago.<br>3. More than one month. |
| 14. | Did you send your child to the traditional healer at your own free will? | Yes☐ No☐ |
| 15. | If no, were you under any form of pressure/compulsion to send your | Yes☐ No☐ |

| | | |
|---|---|---|
| | child to the traditional healer? | |
| 16. | If yes, by whom? | 1. Child's father.<br>2. Grandparents.<br>3. Aunt.<br>4. Other family members |
| 17. | For what conditions did you visit the traditional healer? | |
| 18. | What type of traditional healer did you visit? | 1. Sangoma (diviner)<br>2. Umthandazi (faith healer)<br>3. inyanga (herbalist)<br>4. Prophet<br>5. Others, state |
| 19. | What was the reason for making your choice? | 1. Previous experience<br>2. Recommended by someone.<br>3. Other reasons, state |
| 20. | What treatment was given to your child? ( Choose one or more) | 1. Oral herbal preparation<br>2. Nasal inhalation<br>3. Steaming<br>4. Talisman for protection<br>5. Scarification (cuts with insertion of herbs/ black herbal preparations)<br>6. enema |
| 21. | What was the outcome of the treatment? | 1. Child recovered and well,<br>2. No change in condition (still ill)<br>3. Recovered but with a disability. |
| 22. | If the condition was worse what did you do? | 1. Sent child back to traditional healer<br>2. Nothing - assured the traditional |

| | | |
|---|---|---|
| | | medicine would work eventually<br>3. Sent child to hospital |
| 23. | Do you by any chance know the name of the herbal preparation given to your child? | 1. Yes☐<br>2. No☐ |
| 24. | If yes, give name. | |
| 25. | With what you experienced will you ever send your child to the traditional healer? | 1. Yes ☐<br>2. No☐<br>3. Give reason in each case. |
| 26. | How much did you pay/spend? | |
| 27. | How happy are you with the service provided by the traditional healer? | 1. Very unhappy<br>2. Unhappy<br>3.Neutral<br>4. Happy<br>5. Very happy |
| 28. | In your opinion did the traditional medicine fail? | 1. Yes☐<br>2. No☐ |
| 29. | Was your partner aware of the visit to the traditional healer? | 1. Yes☐<br>2. No☐ |
| 30. | If no, why? | |
| 31. | Do you think traditional treatment works better when combined with western medicine? | 1. Yes☐<br>2. No☐<br>3. Give reason in each case. |
| 32. | Why have you brought your child to this hospital today? | |
| 33. | What is the main complaint? | |

**PARTICIPANT INFORMATION SHEET AND INFORMED CONSENT FORM**

Part A

STUDY NUMBER:

STUDY TITLE: Treatment received by children who visit traditional healers.

INVESTIGATOR: Dr PK Ayibor

INSTITUTION: University of the Witwatersrand, Department of Paediatrics and Child Health, Division of Community Paediatrics.

TELEPHONE NUMBER: 0733390110

Part B

1. Introduction

Good day.

My name is Dr PK Ayibor, student from University of the Witwatersrand, Department of Paediatrics and Child Health, Division of Community Paediatrics. I am conducting a study to evaluate the type of services traditional healers render to children that parents bring to them. The findings may help practitioners of western medicine (medical doctors) in the management of very sick children that are brought to the hospitals after visits to the traditional healers. The finding may also help influence health policy decisions at governmental levels.

You are therefore invited to consider participating in this study. Your participation in this study is entirely voluntary. Before agreeing to participate, it is important that you read and understand the explanation of the purpose of the study. This information sheet is to help you decide if you would like to participate.

If you have any questions, do not hesitate to ask me. You should not agree to unless you are satisfied with the procedures. If you do agree to participate in the interview, you are still free to withdraw from the study at any stage and this will not be held against you. If you decide to take part in this study, you will be asked to sign this document to confirm that you understand the study and agree to take part. You will be given a copy to keep.

All information obtained during the course of this study will be kept strictly confidential. Data that may be reported in scientific journals will not include any information that identifies you as a participant in this study.

Part C

**Informed consent for parents/ Caregivers:**

Dr PK Ayibor has provided me with a copy of the Participant Information Sheet regarding the study, "Treatment received by children who visit traditional healers." and has fully explained to me the nature and conduct of the study.

The study doctor has given me the opportunity to ask any questions concerning the study.

It has been explained to me that l will be free to withdraw my child from the study at any time, without any disadvantage to future care.

I have understood everything that has been explained to me and consent for my child to participate in this study.

**PARENT/CAREGIVER:**

_____

Printed Name Signature/ Mark or Thumbprint Date and Time

I, Dr PK Ayibor, herewith confirm that the above participant has been fully informed about the nature and conduct of the above study.

**STUDY INVESTIGATOR**

_____

Printed Name Signature Date and Time

**TRANSLATOR / NURSE EXPLAINING INFORMED CONSENT**

_____

Printed Name Signature Date and Time

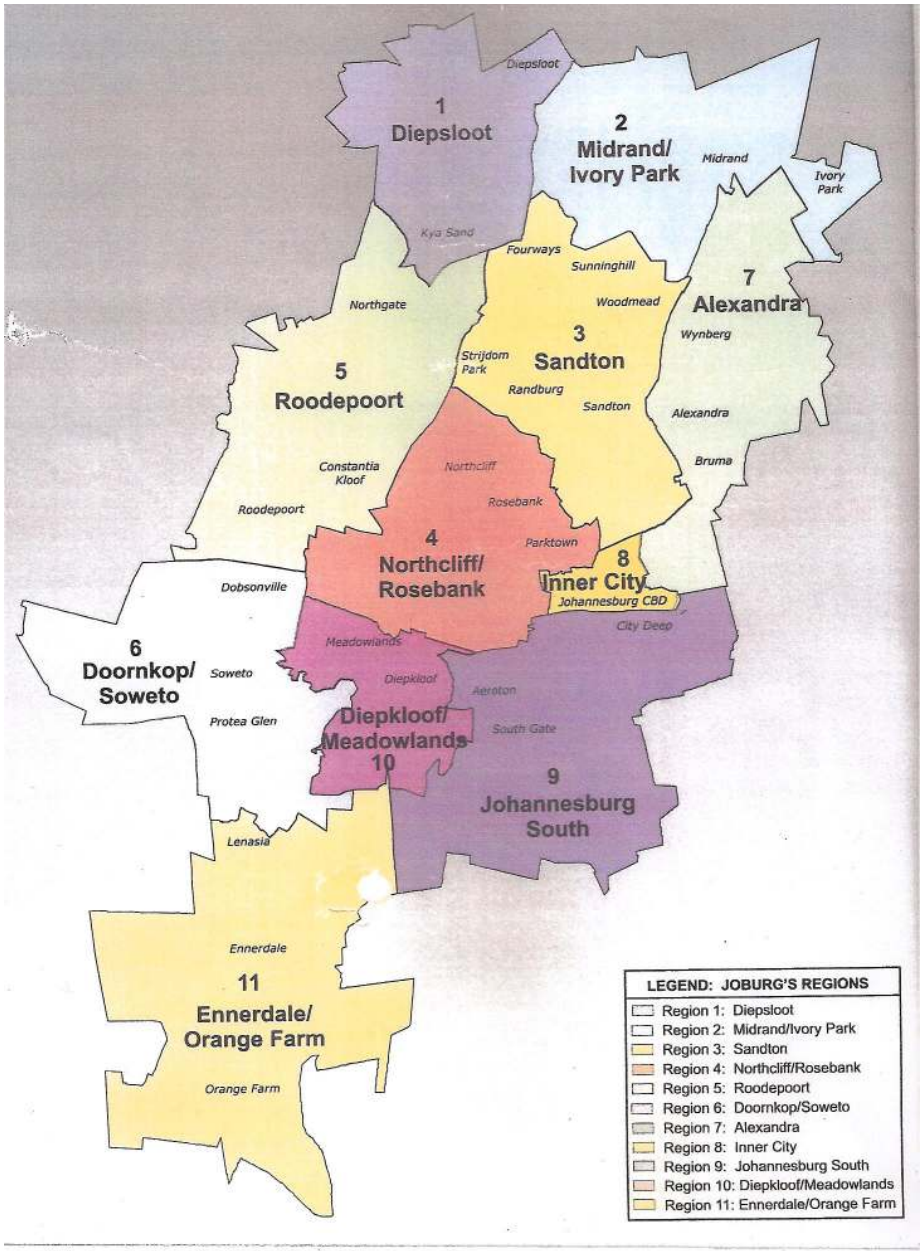
**Thank you for your participation. For further information contact:**

**Wits Human Research Ethics Committee (Medical)**

**Tel: (011) 717-1234**

**Fax: (011) 339-5708**

**APPENDIX B: Johannesburg City Map**



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