SIYEZWA NGABANTU:
LISTENING TO THE APPROACHES OF A GROUP OF TRADITIONAL HEALERS TOWARDS HEARING IMPAIRMENT

Victor Manuel de Andrade

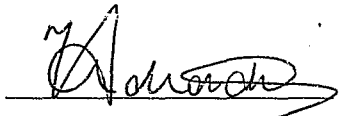
A research report presented to the Department of Speech Pathology and Audiology, Faculty of Arts, University of the Witwatersrand, Johannesburg, South Africa, in partial fulfilment of the requirements for the degree M. A. Audiology by Coursework.

February 2000

DECLARATION

I hereby declare that this research report is my own original work and that the assistance which I have received is detailed in the Acknowledgements of this report, and that I am responsible for the text of the study and the conclusions reached.

No part of this report has been submitted in the past, or is to be submitted, for a degree at any other university.



Victor Manuel de Andrade

14/2/2000

Date

ACKNOWLEDGEMENTS

The researcher wishes to extend his sincere thanks and appreciation to:

Dr. E. Ross, my research supervisor, whose contagious enthusiasm, encouragement and guidance I greatly admire.

My family whose uninterrupted encouragement and patience are sincerely appreciated.

The traditional healers who, by giving their time and sharing their knowledge, contributed immensely to this research project and to modern health care professionals' understanding of traditional medicine. *Ngiyabonga kakhulu!*

Phephsile Maseko, William Sekonya, and the rest of the staff at the Traditional Healers' Organisation for their active interest and tremendous assistance in collecting the data for this study.

My friends and colleagues for their support and ideas which contributed richly to this research report.

ABSTRACT

Many South Africans consult with traditional healers in order to receive treatment for a variety of problems. Traditional and modern medicine have different views on disease which may cause disagreement between the two approaches. After interviewing a group of traditional healers, information was acquired regarding their beliefs on the aetiology, diagnosis and treatment of hearing impairment as well as information on their training, the perceived reasons for patients consulting with them, and potential for collaboration with modern medical practitioners. Consequently, it was found that different belief systems and world-views from those held by modern health care practitioners tended to guide this group of traditional healers in addressing hearing problems. However, despite these differences, similarities between the two approaches were also identified. The results of this study have important implications for audiologists and other modern health care professionals, policy makers, and traditional healers in terms of: cross-cultural consultations; the possibility of sharing information regarding the effects of hearing impairment; the potential for collaboration with traditional healers; the potential use of traditional healers in primary health care; traditional healers as possible community educators; the potential use of traditional healers in identifying hearing impairment; the potential for the standardisation of traditional healers' methods; and, further research

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

CHAPTER ONE

LITERATURE REVIEW AND RATIONALE FOR THE STUDY

"Umuntu ngumuntu ngabantu"

Zulu proverb

("A person is only a person because of other people")

South Africa and the world are changing and modernising. Despite these changes, certain traditional practices and ideas that have been handed down from previous generations are meshing with modernity. In support of this viewpoint, it has been reported that approximately 80% of the Black population in South Africa consult with traditional healers (Gumede, 1992:9; Kale, 1995:1182; Gilbert, Selikow & Walker, 1997:79). The research conducted into traditional healing seems to concentrate on conditions such as Acquired Immune Deficiency Syndrome (AIDS) (Moolman, 1996:36), tuberculosis (TB) (Collins & Ntsele, 1996:527), pregnancy and childbirth (Harnett & Mnisi, 1996:9), and mental health (Thabede, 1991:11; Mojalefa & van Staden, 1999:152). Studies on traditional healers and communication impairment seem to have focused on the areas of stuttering (Platzky & Girson, 1993:43) and aphasia (Tungay, 1993:7). Yet, despite the apparently large number of people consulting with traditional healers, there appears to be a paucity of literature regarding their treatment of audiological problems[1].

Schneider (1992:57) found that approximately 45% of communicatively impaired people living in rural areas present with hearing problems such as otitis media, hearing loss, otitis externa, painful ears, impacted wax and tympanic membrane perforations. McPherson and Swart (1997:2) report that approximately 1.2 million children in sub-Saharan Africa present with audiological problems ranging from middle ear dysfunction to sensori-neural hearing loss due to maternal rubella and meningitis. Along the same

[1] In the text of this report, the terms "audiological problems", "hearing impairment", "hearing loss", "hearing dysfunction" and "hearing problems" are used interchangeably to refer to otological and audiological problems seen by traditional healers.

lines, Op't Hof (1991:32) estimates that more than one and half million people in South Africa present with a hearing loss. This estimation is consistent with the finding that approximately 4% of South Africans have a hearing disability (Hirschowitz & Taunyane, 1995:77). The percentage of hearing problems increases as a function of age as it is reported that about 20% of South Africans older than sixty-five years of age have a hearing impairment (Taunyane & Hirschowitz, 1995:121). Interestingly, it has been shown that the number of persons who consult with traditional healers also increases with age, probably reflecting this age group's belief in traditional methods (Hirschowitz & de Castro, 1995:63).

Research conducted by Tom (1992:27) found that persons with audiologically related problems made up some of the 9.5% of people who consult with traditional healers. Similarly, Pretorius, de Klerk and van Rensburg (1993:23) estimated that about 2.9% of people with ear-related problems consulted with traditional healers. However, the focus of these two afore-mentioned studies was on traditional healers in general and not particularly on hearing loss or its diagnosis and treatment by traditional healers.

The World Health Organisation 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" (Pretorius et. al., 1993:5). It is reported that there are in the region of 175 000 to 200 000 registered traditional healers in South Africa (Pretorius et. al., 1993:15; Kale, 1995:1182) although Erasmus (1992:105) estimates that there may be as many as 1 500 000 traditional healers in the country.

There are different categories of traditional healers in South Africa, including the *inyanga*, *isangoma*, and *umthandazi*. A hierarchy of superiority or importance does not seem to be in place among the different categories of traditional healers (Hammond-

Tooke, 1989:121). The first kind, the *inyanga* (traditional doctor), is usually a male who has an extensive knowledge of curative herbs and medicines made from animal extracts. He has usually served an apprenticeship under another *inyanga* for at least a year and pays his mentor in cash or in cows (Blackett-Sliep, 1989:43; Kale, 1995:1182). The *inyanga* is seen as a herbalist, priest and psychologist who diagnoses and treats the patient directly (Ngubane, 1992:366; Ellis, 1996:144). The second kind, of which 90% are female, the *isangoma* (diviner), uses the guidance of ancestral spirits through divination to diagnose an illness (Hammond-Tooke, 1989:114; Kale, 1995:1182). She is usually consulted by the patient's family and uses spiritual insights to interpret the causes and consequences of the disease without necessarily seeing the patient in person (Ngubane, 1992:366). The process of becoming an *isangoma* entails undergoing a spiritual possession when the ancestors call on the person to become a diviner. This possession or *thwasa* results in a spiritual transfer of knowledge to heal disease. The *isangoma* is then considered sacred and must abstain from sexual intercourse, certain foods and social contact (Blackett-Sliep, 1989:43; Hammond-Tooke, 1989:106). The *umthandazi* or faith healer usually belongs to one of the African independent churches and uses the power of prayer and laying on of hands to heal (Kale, 1995:1182; Ellis, 1996:144).

Health and illness issues are guided by people's social context and the social meaning attached to these concepts. Sociologically, a distinction is made between the concepts of disease, illness and sickness[2]. Disease refers to the objective, biological impairment of an organism whereas illness refers to the individual, subjective experience of the disease. Sickness is a social term applied to people who are deemed by others to be ill or diseased causing a shift in those person's social identity due to changes in their psycho-socio-economic environment (Gilbert, Selikow & Walker, 1997:8).

[2] Although cognisance is taken of the differences between the sociological concepts of disease, illness and sickness, these terms will be used interchangeably in the text of this report to refer to patients' ailments.

Culture is defined as "the values the members of a given group hold, the norms they follow, and the material goods they create" (Gilbert, Selikow & Walker, 1997:48) and largely influences the medical decisions taken by the members of a cultural group with regards to the need and choice of treatment. Since the experience of being sick is culturally learned, a person's culture will also determine which symptoms constitute a sickness, even if in another culture the same symptoms would not be considered as such (Battle, 1997:123; Gilbert, Selikow & Walker, 1997:49). The decision to opt for traditional or modern[3] treatment is therefore also culturally driven.

Different world-views shape people's perception of health matters. One's world-view is determined by the interaction of social institutions, structures, customs and conventions in society which impact on the perception of causality and treatment (Craffert, 1997:1). The modern view of disease focuses on biological malfunctioning (Ellis, 1996:129). Disease is viewed as the chemical, anatomical or physiological changes which manifest in ill-health while the socio-psychological and cultural reactions to illness are also explained in bio-medical terms (van Rensburg, Fourie & Pretorious, 1992:311; Craffert, 1997:1). Consequently, modern interventions seem to focus on the individual where the problem and solution are seen to lie within the person.

In contrast, within the traditional view, illness represents personal, interpersonal and cultural forces which are governed by familial, social and cultural factors, suggesting that illness is culturally constructed and socially created (Battle, 1997:123). Health, in the traditional approach, has its basis in the balance between cosmic life forces and the dynamic relationship with other people, spirits and nature (van Rensburg, Fourie & Pretorious, 1992:325). Moreover, traditional medicine appears to concentrate on interdependence and the fostering of harmony among groups (Battle, 1997:123). Illness in the traditional view cannot be situated in the mind or body alone, but rather within an integrated social pattern and for this reason, disease is attributed to social disharmony

[3] The term 'modern' in this report will refer to an intervention grounded within a biomedical, allopathic and scientific paradigm (Pretorius, de Klerk & van Rensburg, 1993:4), as well as to those members of the health care team who practise within this framework, including audiologists.

(Craffert, 1997:2). Traditionally, disease is perceived as a "supernatural phenomenon governed by a hierarchy of vital powers beginning with a most powerful deity followed by lesser spiritual plants and other objects ... (and) disharmony in these vital powers can cause illness" (Kale, 1995:1182). Diagnosis is based on the traditional healer's interpretation of the patient's social circumstances and through supernatural dynamics (Ngubane, 1992:368). Alleviation of the patient's symptoms is brought on by using plants, animals, other objects and calling on the ancestral spirits (Kale, 1995:1182). Curing refers to the physical reversing, limiting or preventing of disease while healing alludes to the personal, perceptual alleviation of illness (Ellis, 1996:129; Craffert, 1997:1).

A strong link seems to exist between religious beliefs and the alleviation of disease in the traditional view. It is, therefore, difficult to separate the deep rooted spiritual experience from physical reality (Mbigi & Maree, 1995:19). A great deal of importance is placed on the function of the ancestors in human functioning as it is believed that they care for their descendants, although, they can send misfortune and illness if angered. Sorcery and witchcraft can also account for the presence of disease as it is believed that evil spirits can cause illness due to envy and malice. In addition, disease can be brought on by pollution where people are ritually impure due to engaging in some activity believed to be unclean (Hammond-Tooke, 1989:46; Ellis, 1996:133).

According to modern medicine, health is viewed " as a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity" (Gilbert, Selikow & Walker, 1997:7), while traditional medicine sees health as the balance between opposing internal and external forces. The patient is a passive recipient of treatment in the modern approach while traditional medicine encourages the patient to participate actively in regaining health by strengthening constructive forces (van Rensburg, Fourie & Pretorious, 1992:315). The emphasis that modern medicine places on the scientific method, however, does not automatically ensure its acceptance by people with a different understanding of life and view of life (Conco, 1991:10). This

difference in world-views creates a distance between traditional and modern medicine, as characterised by the Zulu term *ukufa kwabantu* ("diseases of the black people"), which implies the need for a treatment based on these culturally specific beliefs (van Rensburg, Fourie & Pretorious, 1992:327). Although an illness may present with physical symptoms, the interpretation and evaluation of these symptoms suggests that the physical aspects are combining with the realm of human meaning and discourse to influence the benefits gained from healing (Craffert, 1997:3).

The benefits of traditional healing have been documented and include psychological relief from ailments and reduced anxiety through a shared, unquestioned belief in the powers of the healer, while modern medicine may be looked upon with doubt and uncertainty as it may be regarded as foreign (Buhrmann, 1980:332). The treatment given by traditional healers is seen as holistic as it targets the mind, body and soul of patients within their family, community and religious contexts (Blackett-Sliep, 1989:43; Hammond-Tooke, 1989:147). Traditional medicine is widely accepted by many since the values it propounds are congruent with those of the community and seem to conform with the notion of *ubuntu* which expounds the ideas of group solidarity, conformity, compassion, respect, human dignity and collective unity (Hammond-Tooke, 1989:121; Dheyongera, 1994:15; Mbigi & Maree, 1995:3).

Also, traditional healers may be more accessible to populations residing far from centres which dispense modern medicine and may be cheaper than medical practitioners resulting in people opting for the less costly, more accessible service (Blackett-Sliep, 1989:43; Dheyongera, 1994:15). However, even though it may be geographically more accessible, traditional medicine is not necessarily always cheaper as rare and expensive remedies may need to be procured (van Rensburg, Fourie & Pretorious, 1992:333). In addition, it is believed that the natural remedies provided by traditional healers may be easier to absorb than those prepared in a laboratory (Jacobs, 1993:73; Dheyongera, 1994:15). Blackett-Sliep (1989:43) also stresses how being directly accountable to the community may enhance the traditional healer's effectiveness. Hammond-Tooke

(1989:148) acknowledges that it is difficult to explain why traditional medicine seems to work, but speculates that healing may be promoted by the meaning the patient derives from the treatment.

Traditional medicine endeavours to comply with the aims of modern medicine which are to cure, to relieve and to comfort. The cure may not always be found but it is argued that a person will search for one and will try various means to reach this goal. Relief from pain, depression and despair may be provided through traditional medicine, even though a cure is not always found. Traditional healers are encouraged to bring comfort to the ill which correlates with the notion of healing (the personal, perceptual alleviation of illness) and is different to the concept of curing (the physical reversing, limiting or preventing of disease) (Conco, 1991:12; Ellis, 1996:129).

Hammond-Tooke (1989:120) maintains that the use of natural medicine in the treatment of disease is an old practice and has shown pharmacological benefits in the treatment of various diseases. However, the virtue of being natural does not mean that traditional medicine is always safe. Traditional medicine can be drunk, smoked, inhaled, used for washing, or smeared on the body. Emetics, enemas, and purgatives are regularly used to cleanse the body of disease (Kale, 1995:1185). Nevertheless, the non-standard and sometimes unhygienic provision of traditional medicine can result in problems such as shedding of the rectal mucosa, hepatic failure and even methemoglobinaemia (reduced transmission of oxygen in the blood stream due to toxicity) (Karlsson & Moloantoa, 1986:28; Blackett-Sliep, 1989:43; Dirkx, 1995:537; Ellis, 1996:146). Medication given by traditional healers has resulted in various complications such as hepatotoxicity and cancer (Jacobs, 1993:73). The medicine administered by traditional healers may have adverse effects on the mouth, tongue, stomach, duodenum and jejunum (Kale, 1995:1185). The application of ear-drops made from the juice and oil of the aloe plant can result in perforation of the tympanic membrane and subsequent middle ear dysfunction (Karlsson & Moloantoa, 1986:28). Ellis (1996:146) points out that the traditional healer may erroneously ascribe the cause of the disease to bewitchment by a

family member who may consequently be assaulted in revenge for the sorcery. Also, unqualified people may pose as traditional healers and exploit those who come to see them (Blackett-Sliep, 1989:44; van Rensburg, Fourie & Pretorious, 1992:333) as registration and regulation with professional bodies has been lax in the past (Ingle, 1994:605).

The National Health Plan published by the African National Congress in 1994 (Sidiropoulos, Mashabela, Mackay, Gordon-Brown, Frielinghaus, Musiker, Swanepoel, Gallocher & Forgey, 1995:281) sanctions consultation with traditional healers. The White Paper for the Transformation of the Health System in South Africa (1997:57) recognises that traditional healers form part of the broader primary health care team and suggests that an ethical code and standards of practice needs to be outlined for them so that they can be effective partners in the provision of health care in South Africa. This recognition seems to be in line with the proposal by the United Nations' Declaration of Alma-Ata (World Health Organisation, 1978:429) which expounds the need for the social and technical training of traditional healers for their subsequent involvement in the provision of primary health care in their respective communities. The Health Systems Trust (Pitt, 1997:14) proposes that communities become involved in the health system. This involvement entails the co-ordination of community health workers and the provision of centres for offering health services. Traditional healers are suggested participants in this community health model as they are highly regarded in their communities (Pitt, 1997:14).

Three types of recognition of traditional healers exist, namely (1) illegalisation (the direct and explicit prohibition of the activities of traditional healers); (2) legalisation (the explicit recognition and control over traditional healers); and (3) tacit recognition (a government acceptance of traditional medicine with no direct legal control over traditional healers) (Dauskardt, 1990:353). A tolerant system, as followed in South Africa and other countries with a colonial history, officially recognises modern medicine, yet tacitly acknowledges the presence of traditional medicine (van Rensburg, Fourie &

Pretorious, 1992:336). Already in the late 1800's, strategies were introduced in an attempt to regulate traditional healers in South Africa and in 1982, the Associated Health Service Professions Act 63 made provision for traditional healers in the health care system (van Rensburg, Fourie & Pretorious, 1992:336). However, it seems as though not all traditional healers are registered and therefore not subject to the regulations and legal provisions made for them (Ingle, 1994:605).

Collaboration between modern and traditional medicine has been recommended by Dauskardt (1990:352) as a viable option to health care provision in countries which have a traditional character. This author describes the Chinese system of barefoot doctors who are medical practitioners practising traditional and modern medicine. Kale (1995:1184) outlines the collaboration policies followed in some other countries and relates how certain universities offer courses in traditional healing such as in India, Uganda, Kenya and Zaire. In some of these countries, specific governmental ministries are in place to address the issue of traditional medicine, as in Tanzania and Zaire. Failure to collaborate in patient care may also result in dangerous consequences for patients as they may not inform the modern practitioners that they are consulting with traditional healers and vice versa. This failure to inform means that the patient may be taking double, and possibly harmful, doses of medication (Ngubane, 1992:368).

Partnership options with regard to traditional healing in South Africa are summarised by Freeman and Motsei (1990:2) and include incorporation, co-operation and total integration. The first option, that of incorporation, proposes that traditional healers become integrated within the primary health care system and provide preventive and promotive health care services to the community. The second option, namely the co-operation alternative, proffers that traditional and modern practitioners remain autonomous in their methods while recognising the possibility that they can work in collaboration to treat a patient who requests both types of intervention. Total integration, the third option, advocates the combination of traditional and modern medicine where the practitioner is proficient in both spheres and is able to dispense both types of

medicine. This option endorses the treatment of the disease with modern medicine while providing patients with a traditional explanation.

These various partnership options are particularly relevant to the field of hearing impairment. Hearing impairment, be it transient or permanent, has serious ramifications for those it affects. Jamieson (1994:596) points out that hearing loss has a pervasive impact on the communicative, cognitive, speech, linguistic and psycho-social functioning of children as well as the educational, occupational and social patterns of adults. Even the slightest hearing loss can have serious ramifications for the development of language, reading and writing in children. Speech development may also be affected as speech intelligibility and content are reduced due to poor reception of the speech stimulus (Op't Hof, 1991:31; Jamieson, 1994:610). Occupational barriers are imposed on adults with hearing loss as jobs open to them may be limited and they generally earn lower salaries than their hearing counterparts (Jamieson, 1994:610). Socially, hearing impaired persons may experience social isolation as they often encounter difficulty in communicating with others (Op't Hof, 1991:31; Jamieson, 1994:610). Because of these difficulties, it is imperative that the identification of hearing loss and subsequent intervention and rehabilitation occur promptly in order to reduce the negative consequences of hearing impairment (Op't Hof, 1991:31). Considering the far-reaching ramifications of hearing loss as well as the large number of people presenting with audiological problems and the equally large number consulting with traditional healers, it seemed important to investigate the treatment of hearing loss by traditional healers.

More specifically, it appeared necessary to study the role of the traditional healer in the management of hearing dysfunction so as to gain information related to their patient load, their diagnosis and treatment of hearing problems. Also, by acquiring this information, it was envisaged that audiologists could possibly learn from, as well as assist in the training of traditional healers, as suggested by the Declaration of Alma-Ata (World Health Organisation, 1978:429) and the White Paper for the Transformation of the Health System in South Africa (1997:57).

McKenzie (1992:50) states that the linguistic, cultural and socio-economic changes occurring in South Africa necessitate a deeper understanding of these factors in order to provide a more effective service. An important reason for conducting this research project was to estimate the secondary referrals that could be expected if the primary intervention by the traditional healer was unsuccessful. It was anticipated that this research might also reveal data that could be used to develop social policy regarding the registration and regulation of traditional healers. Finally, it was felt that the information obtained from this research would be useful for guiding professional collaboration with traditional healers and possibly fostering a stronger referral system for a well rounded intervention in respect of persons with a hearing problem.

CHAPTER TWO

METHODOLOGY

2.1 AIMS OF THE STUDY

2.1.1 Main Aim

To examine the approaches of a group of traditional healers towards hearing impairment.

2.1.2 Sub-Aims

The following sub-aims were formulated in order to address the above aim:

1. To obtain information regarding the types of hearing problems seen by traditional healers.
2. To probe traditional healers' opinions on the cause of hearing problems.
3. To explore traditional healers' diagnostic methods with regards to hearing problems.
4. To elicit information on traditional healers' treatment of hearing problems.
5. To obtain data on traditional healers' training.
6. To ascertain traditional healers' perceptions regarding collaboration with other health care professionals.
7. To investigate traditional healers' views relating to the reasons why persons with hearing loss seek their services over or in addition to those offered by modern medical practitioners.

2.2 RESEARCH DESIGN

A descriptive, cross-sectional, survey research design, which utilised an in-depth interview format, was employed (Robson, 1995:49) to assess the responses of a group of traditional healers at a specific point in time regarding hearing impairment. The study was embedded within a qualitative research paradigm, defined as a context sensitive description of participants' responses so as to better understand dynamic processes and events (Sarantakos, 1998:46).

2.3 SUBJECTS

2.3.1 Subject selection procedure

A purposive sampling procedure was used as it allowed for building a sample which could provide useful information relating to the study being undertaken (Robson, 1995:141; Sarantakos, 1998:152). A purposive sample was selected to be representative of attributes of the broader population being studied (Berg, 1995:179).

It has been reported that the number of persons consulting with traditional healers is similar for both rural and urban areas (Hirschowitz & de Castro, 1995:75). As this study focused on the approach of traditional healers to hearing loss, subjects were recruited from the Traditional Healers' Organisation, a Johannesburg based organisation representing the traditional healers of the region and having a membership comprising different categories of traditional healers i.e. the *inyanga*, *isangoma* and *umthandazi*. Permission had been granted by a senior representative of the Traditional Healers' Organisation to recruit members from their organisation to serve as respondents in the study.

Originally, the researcher had intended to invite five members of each category of traditional healer to make up the sample size of fifteen. However, a senior representative from the Traditional Healers' Organisation maintained that the delineation of each category of traditional healer made in the literature was less distinct in reality and that a blending of practices might exist among the different categories. This blurring of roles was observed in the sample group as many of the respondents classified themselves as a particular type of healer but stated that they also fulfilled the role of other categories of traditional healer in their practices. Pretorius, de Klerk and van Rensburg (1993:5) similarly report on the overlapping of roles and explain that the same person may perform different functions such as divination and healing. Notwithstanding this blurring of categories, 15 members from the Traditional Healers' Organisation were invited to participate in this research project. This number was in accordance with the

recommendation that qualitative research employ smaller samples than quantitative research as the focus of the qualitative research is on obtaining descriptive information (Sarantakos, 1998:157). However, role overlap made it difficult to cross-tabulate category of traditional healer with attitudes towards hearing impairment in the subsequent analysis of data.

2.3.2 Description of Subjects

Fifteen respondents were contacted, all of whom agreed to participate in the study. Demographic information obtained from these 15 respondents is set out in Table 2.1.

2.4 RESEARCH INSTRUMENTATION

2.4.1 Motivation for the use of an interview schedule as a means of data collection

Berg (1995:35) proposes that interviews are useful tools for gaining an understanding of the perceptions of subjects and how they attach meaning to phenomena, that is, they include an affective element. The interview also allows for greater flexibility allowing the researcher to follow-up on interesting responses (Singleton, Straits & Straits, 1993:260; Robson, 1995:229). Moreover, the face-to-face interview enables the interviewer to seek clarification of responses through neutral probing (Singleton, Straits & Straits, 1993:261).

2.4.2 Construction of the interview schedule

A semi-structured, individual interview (Sarantakos, 1998:247) was utilised to obtain information on hearing loss from the subjects. This type of interview schedule enabled the researcher to ask a number of pre-determined questions and allowed for digression to further probe the subject responses (Berg, 1995:33). A survey of the existing literature did not reveal an interview schedule appropriate to the needs of this particular study. Therefore, through a review of the literature, the researcher developed an original research instrument to elicit the necessary information (Berg, 1995:22). From this literature search, the questionnaire set out in Appendix A was developed.

Table 2.1 Description of Subjects (N = 15)

Demographic Factor	Sub-Category	Number
Age	21 - 30	3
	31 - 40	4
	41 - 50	5
	51 - 60	1
	61 - 70	2
Gender	Male	6
	Female	9
Number of Years Practising as a Traditional Healer	1 - 10	7
	11 - 20	3
	21 - 30	4
	31 - 40	1
Category of Traditional Healer	Inyanga	3
	Isangoma	10
	Umthandazi	2
Ethnic Group	Shangaan	1
	Swazi	4
	Zulu	5
	Shona	1
	Ndebele	1
	Pedi	3
Current Place of Residence	Soweto	1
	Vosloorus	1
	Natalspruit	2
	Alexandra	4
	Thembisa	6
	Ivory Park	1

2.4.2.1 Guidelines considered in the development of the interview schedule

In order to ensure the effectiveness of the administration of the questionnaire, the questions were kept relevant to the study while ambiguous, double-barrelled, and leading questions were avoided (Sarantakos, 1998:238). Social desirability effects, where participants seek to give more socially acceptable responses, were considered and efforts were made to reduce them by using non-threatening, indirect question forms and by stressing the scientific importance of the research (Singleton, Straits & Straits, 1993:306; Baker, 1994:191). Also, the researcher endeavoured to convey a positive attitude to the respondents by adopting the stance of a colleague and demonstrating respect for their viewpoints (Sarantakos, 1998:237).

2.4.2.2 Types of questions

Open-ended questions were used in formulating the interview schedule as they granted the respondent the chance to volunteer descriptions, explanations or reminiscences which could be analysed by the researcher (True, 1989:210). Sarantakos (1998:231) proposes that open-ended questions allow the respondent to offer information in areas that might not have been foreseen by the researcher and are especially useful when studying complex issues.

2.4.3 Content of the interview schedule

2.4.3.1 Cover letter

The cover letter (enclosed in Appendix B) served to introduce the respondent to the researcher and research topic; to highlight the importance of the study; to reduce any doubt that respondents might have; to motivate them to participate in the study; to inform them of the potential benefits of the research; to point out their contribution to the field of knowledge; to assure participants that their responses would remain anonymous; and to promise a token reward in the form of providing the respondents with results of the study. The cover letter also included a consent form to obtain the traditional healers' permission to participate in the study, to tape record the interview,

and to use their responses in the write up of the study and any future publications or presentations (Singleton, Straits & Straits, 1993:270; Sarantakos, 1998:225).

2.4.3.2 Interview schedule

The interview schedule (outlined in Appendix A) was designed to provide information necessary to investigate the sub-aims of the study. Consideration was given regarding the flow and transition of the interview and for that reason questions were set out in a funnel format where items progressed from specific to non-specific, impersonal to personal and non-sensitive to sensitive (Sarantakos, 1998:226).

2.4.3.3 Section A: Biographical information

Singleton, Straits and Straits (1993:293) recommend that the first questions be easy to answer to encourage further participation in the interview. For this reason, questions relating to the participants' background were asked first as they tended to be of a less sensitive nature (Berg, 1995:42). This section aimed to elicit information regarding traditional healers' age, gender, number of years practising as a traditional healer, category of traditional healer, ethnicity, and current residence in order to assist in the understanding of the demographics of the participants.

2.4.3.4 Section B: Information relating to hearing loss

This section was drawn up to obtain information regarding traditional healers' approaches towards hearing loss. Questions were developed to address issues highlighted in the literature.

The first question explored the demographics of persons experiencing hearing problems who consult with traditional healers to provide biographical information relating to the types of audiological problems present in the population visiting traditional healers. In order to provide a service to persons with hearing dysfunction, it is necessary to know their demographic background so as to better cater for their needs (McKenzie, 1992:50). The research conducted by Tom (1992:27) and by Pretorius, de Klerk and van Rensburg

(1993:23) referred to in the introduction of this research report, did not look specifically at hearing dysfunction and traditional healers, suggesting a gap in the research literature.

It is accepted that traditional and modern medicine differ in their approaches to the cause, diagnosis and treatment of disease (Kale, 1995:1182; Ellis, 1996:129; Battle, 1997:123; Craffert, 1997:1). Questions 2, 3 and 4 were developed to gain information regarding the perceived cause, diagnosis and treatment of the hearing problems seen by traditional healers. The data gleaned from these questions were sought in order to aid in audiologists' understanding of the differences and possible similarities in approaches to hearing dysfunction.

As the training of traditional healers and modern medical practitioners is different (Blackett-Sliep, 1989:43; Hammond-Tooke, 1989:106; Kale, 1995:1182; Ellis, 1996:144) it was necessary to gain insight regarding the training of traditional healers and to analyse their areas of focus and study. The fifth question of the interview schedule addressed this aspect. It should be emphasised that this information was not intended to ascribe greater stature or importance to either traditional healing or modern medicine, but to provide audiologists with an understanding of traditional healers' backgrounds as well as the rationale for their work (Freeman & Motsei, 1990:9).

Historically, the main obstacle to collaboration between modern practitioners and traditional healers has been the incompatibility of the scientific versus the supernatural paradigms characteristic of the two approaches (Pretorius, de Klerk and van Rensburg, 1993:42). Kale (1995:1185) maintains that co-operation between modern and traditional medicine can result in better patient care as recommended by the Declaration of Alma-Ata (World Health Organisation, 1978:429). For this reason, Questions 6, 7 and 8 probed traditional healers' beliefs concerning the potential for collaboration between them and modern medical practitioners.

The accessibility, identification and acceptance of traditional methods have been cited as some of the reasons for people consulting with traditional healers (Blackett-Sliep, 1989:43; Dheyongera, 1994:15; Ellis, 1996:144). Question 9 of the interview schedule aimed to elicit traditional healers' perceptions as to why their patients consult with them. These data were elicited in order to establish an awareness of the traditional healers' perceived efficacy in treating audiological problems and their role in treating ear disease within the community.

Open-ended questions may reveal the thought processes and opinions of the participants (Singleton, Straits & Straits, 1993:283). For this reason, the tenth question in the interview schedule was included so as to allow respondents the freedom to provide unanticipated and unexpected information on the research topic (Robson, 1995:233; Sarantakos, 1998:231). As traditional and modern health care systems have different perspectives on the concepts, diagnosis and treatment of disease (Craffert, 1997:1), it was hoped that this open-ended question would grant traditional healers the opportunity to explain in more detail any other issues they considered important with regard to their approach to audiological dysfunction.

2.5 RESEARCH PROTOCOL

2.5.1 Pretesting the questionnaire

The items of the questionnaire were pretested on a representative of the Traditional Healers' Organisation before the administration of the questionnaire to the traditional healers who formed part of the study. This particular person was excluded from participation in the field study. The pre-test attempted to ensure the face validity of the instrument and to determine whether revisions to the questionnaire were necessary (Singleton, Straits & Straits, 1993:270) to reduce misinterpretation of the questions (True, 1989:209).

The representative from the Traditional Healers' Organisation felt that no amendments to the questionnaire were necessary, although she said that not all traditional healers separated themselves into discrete categories of either *inyanga*, *isangoma* or *umthandazi*. This observation corresponds with the comments mentioned earlier regarding the overlapping of traditional healers' roles. In light of this observation, the term traditional healer was used throughout the interview questionnaire instead of the terms *inyanga*, *isangoma* or *umthandazi*.

2.5.2 Submission of the interview schedule to the Ethics Committee for Research on Human Subjects

Application was made to the University of the Witwatersrand Ethics Committee for Research on Human Subjects for permission to conduct the research project. Respondents were required to sign a consent form prior to participating in the study. Through the cover letter, efforts were made to ensure that the physical, social and psychological welfare of the respondents as well as their anonymity and dignity were protected (Sarantakos, 1998:23). The interview schedule was accepted unconditionally by the Ethics Committee for Research on Human Subjects (Appendix C).

2.6 DATA COLLECTION

The programmes manager from the Traditional Healers' Organisation recommended that the interviews be conducted at the organisation's Johannesburg office as this location was central and known to the respondents. The researcher followed this advice and appointments were made at this location with the traditional healers who had accepted the invitation to participate in the study. These traditional healers were asked to set aside approximately an hour of their time for the interview. Also, permission from the participants was obtained to participate in the study and to have the interview tape-recorded for later transcription and analysis.

The researcher conducted face to face interviews with the respondents with the help of an interpreter who was fluent in various African languages. The services of an interpreter were used to assist in the conducting of the interviews for those subjects who were not proficient in English. In order to enhance the validity and reliability of the responses, the interpreter had been briefed regarding the content of the interview schedule, and the need for accurate translation of responses provided by subjects was stressed (Battle, 1997:134). The interpreter was also cautioned on the danger of oversimplification as well as over-elaboration of subject responses which might not reflect what was said (Battle, 1997:134).

As a semi-structured interview format was used, a certain flexibility was allowed in the order of questions asked (Sarantakos, 1998:247). This flexibility allowed the researcher to ask the all the respondents the same questions although the order may have been different for different respondents (True, 1989:206). Also, probes were to increase the richness of their answers, and to refine or complete responses (Patton, 1987:125; Sarantakos, 1998:263). Notwithstanding the fact that probing was employed to direct the discussion towards the objectives of the study, every effort was made to reduce the possibility of interviewer bias or distortion (Sarantakos, 1998:263).

2.7 DATA ANALYSIS

Content analysis, a systematic technique for analysing the symbolic content of any communication, was applied to the subjects' responses in order to highlight common themes articulated by respondents (Singleton, Straits & Straits, 1993:270). The analysis is conducted by identifying the same ideas, issues or concepts and combining them to address the research questions (Patton, 1987:149). Content analysis provides an effective tool with which to measure attitudes and to make inferences about a group's beliefs (Sarantakos, 1998:280). This form of analysis uses systematic and objective techniques with which to make valid inferences from communications in relation to their context (Weber, 1994:324). It was also anticipated that content analysis would be useful in

reflecting the cultural perspective of groups (Weber, 1994:252), which formed an integral part of this research study.

A basic tenet to content analysis is the classification of many words or sentences from the communications into meaningful and fewer content categories which have similar meanings or connotations and then relating these content categories to one another (Patton, 1987:150; Weber, 1994:254). This classification needs to be valid in that it must measure those variables it has set out to study, and it has to be reliable or consistent across time and across coders (Weber, 1994:259). The theme has been suggested as being a very useful basic recording unit for analysis of the data as it preserves important information, is more detailed and allows for long complex sentences to be broken down into shorter thematic units (Weber, 1994:264). It is recommended that both the manifest and latent content be analysed as it enhances validity and reliability. The manifest content refers to the visible, surface composition of the communication while the latent content relates to the underlying meaning of the data (Babbie, 1995:312). These aspects of content analysis were taken into consideration when analysing the responses elicited from participants in the present study.

Quantitative data were grouped and displayed via tables, pie diagrams and bar charts to display relationships between parts of the findings and to allow the reader to identify trends in the results (Sarantakos, 1998:345).

CHAPTER THREE

RESULTS AND DISCUSSION

3.1 INTRODUCTION

The main aim of the project was to investigate the approaches of a group of traditional healers towards hearing impairment. Fifteen traditional healers were interviewed to obtain this information. Results are presented and discussed in accordance with the sub-aims of the study. However, in order to link together similar ideas and themes, the discussion of the results does not necessarily follow the same order as the frequency information presented in the tables.

3.2 THE TYPES OF HEARING PROBLEMS SEEN BY TRADITIONAL HEALERS

The first sub-aim was to obtain information regarding the types of hearing problems seen by traditional healers.

It is accepted that there are many causes of hearing impairment, usually of a conductive or of a sensory-neural origin. Conductive hearing losses arise from "the mechanical attenuation of the sound waves in the outer or middle ear, preventing sound energy from reaching the cochlea" (Bull, 1992:6). Sensory-neural deafness "results from defective function of the cochlea or of the auditory nerve, and prevents neural impulses from being transmitted to the auditory cortex of the brain" (Bull, 1992:6) but can also include central lesions (Ginsburg & White, 1994.23).

The respondents in this study recounted that they were consulted by people with different types of ear and hearing problems. Table 3.1 outlines the kinds of audiological and/or otological problems with which patients present at the traditional healers surveyed in the

study. Although the research participants could not provide exact numbers in respect of patients they tended to see with hearing problems, it can be noted that various problems of an auditory nature were seen by this group of traditional healers. The traditional healers reported that they treated people of various ages, ranging from very young children to older persons. It was also reported that, especially in childhood and the aged population, the number of hearing problems increased in the colder months or when the weather was very windy. It can be surmised that this occurrence is probably due to the increased chances of developing upper respiratory tract infections, colds and flu which may occur concomitantly with a hearing dysfunction.

Table 3.1 Types of Audiological and/or Otological Problems seen by the Group of Traditional Healers (N = 15)

Type of Problem	Number	Percentage (%)
Hearing Loss/Deafness	12	80
Discharge from the Ears	11	73
Painful Ears	9	60
Tugging at Ears	4	27
Hearing Loss with Neck Ache and Headache	3	20
Ringing in the Ears	3	20
Sores in the Ear	2	13
Trauma to the Ear	1	7
Blocked Ears	1	7
Foreign Object in Ears	1	7
Hearing Loss with Venereal Disease	1	7
Wax	1	7

Note: Percentages do not add up to 100% as respondents mentioned more than one type of problem in their answers.

From Table 3.1 it is apparent that the traditional healers interviewed were treating a range of audiological problems. From the respondents' descriptions, it seems as though they were seeing patients with both conductive as well as sensory-neural hearing problems. A high proportion of respondents, i.e. 80%, who reported that they saw *hearing impaired/deaf patients* described their patients as hearing nothing (*"akezwa lutho"*); not being able to hear when spoken to; only being able to hear loud sounds; not hearing when persons did not face them; or not hearing when spoken to from a distance. One traditional healer noticed that some of her hearing impaired patients had poor oral speech and communicated via gestures. Another traditional healer mentioned that her hearing impaired patients tended to read the speakers' lips during verbal interactions. These symptoms are consistent with the accepted effects of hearing loss on a hearing impaired person's interaction with others, and are seen across all age groups (Alpiner, Kaufman & Hanavan, 1993:10; Northern & Downs, 1991:13).

Seventy-three percent of the traditional healers in this study reported observing cases of *aural discharge.* This discharge was described as either white and foul smelling or bloody. Northern and Downs (1991:63) describe three types of aural discharge, including clear fluid, cloudy fluid and blood. A cloudy fluid is often symptomatic of either an otitis externa or of an otitis media with a perforated tympanic membrane while a clear fluid may be the result of cerebro-spinal fluid leaking from a temporal bone fracture. A bloody discharge in the ear canal could result from excessive scratching in the ear canal in an attempt to remove wax or to relieve itchiness. However, this bloody discharge may also represent a temporal lobe fracture (Northern & Downs, 1991:63). All of these afore-mentioned aetiologies may cause a conductive hearing loss as the transmission of the sound energy through the middle ear to the fluid of the cochlea is compromised and it has been shown that this subsequent air to fluid mismatch may cause as much as a 30dB reduction in hearing ability (Hall & Mueller, 1997:27). An aural discharge can therefore be indicative of various pathologies and hence further investigation of the symptoms is needed in order to manage patients effectively.

It appears as though 60% of the sample treated patients for otalgia or *earache*, which is regularly associated with acute otitis media, otitis externa or acute mastoiditis although referred otalgia may also be present where a dysfunction elsewhere manifests with earache e.g. from tempero-mandibular dysfunction, impacted molar teeth, carious teeth or tonsillectomy, among others (Bull, 1992:53). The presence of foreign bodies in the external auditory meatus can also cause earache (Health Services Development Unit, 1988:12). The cause of the otalgia needs to be established in order to treat the underlying pathology and minimise the possibility of its re-occurrence in patient.

Just over a quarter, i.e. 27% of the group of traditional healers reported seeing patients *tugging at their ears* which is a typical symptom of otitis media, a inflammation of the middle ear usually accompanied by a middle ear effusion which attenuates the sound transmission through the middle ear cavity (Northern & Downs, 1991:66). McPherson and Swart (1997:6) report that the incidence of paediatric otitis media in Southern Africa differs from region to region and varies from about 2% to approximately 46% across regions. Northern and Downs (1991:65) suggest that otitis media is more prevalent in situations of poor socio-econonic status and in households with many family members. Research has shown that 32% of South Africans live in households with between five and seven members in that household while 15% share a home with eight or more family members (de Castro & Hirschowitz, 1995:15). At the same time approximately 57% of South Africans have less than 7 years of schooling, of which 21% have had no formal education (de Castro & Hirschowitz, 1995:12). In 1995, de Castro and Hirschowitz (1995:18) found that approximately 52% of South Africans had a monthly income of less than R1000-00. These socio-economic and educational factors may therefore place a large segment of the South African population at risk for developing an otitis media related hearing loss. These people may subsequently be consulting with traditional healers for treatment. Also, considering that the traditional healers in this sample were resident in areas of limited economic resources, it is postulated that they were probably servicing the very people prone to developing otitis media as a function of poor living conditions.

Symptoms of meningitis include a *headache and stiff neck* (Werner, Thuman, Maxwell & Pearson, 1993:195). Meningitis is often a complication of otitis media or mastoiditis and may cause a sensory-neural hearing loss due to the destruction of the sensory receptors of the cochlea and eighth nerve (Northern & Downs, 1991:78). It is reported that bacterial meningitis is the most common cause of adventitious sensory-neural hearing loss (Silman & Silverman, 1991:60). It is possible that those respondents who described a combination of hearing loss, headache and neck ache, namely 20% of the sample, may have been describing cases of hearing impairment they had encountered subsequent to meningitis. Research has shown that South Africa has a rate of 34 cases of meningitis per 100 000 children, and is especially prevalent among those from impoverished backgrounds (Hussey, Schaaf, Hanslo, Hitchcock, Coetzee, Pitout, Malan & Donald, 1997:55). The probability of acquiring a hearing loss from meningitis is quite high as it has been shown that up to one-third of acquired sensory-neural losses in South Africa may be attributed to this disease (McPherson & Swart, 1997:9). Unfortunately, in treating this life-threatening condition, the audiological consequences may not be given a great deal of attention which suggests that a child may acquire a hearing loss of which adults are unaware which in turn has implications for the child's subsequent development (Fortnum & Davis, 1993:50).

Symptoms consistent with *tinnitus* were seen by 20% of the traditional healers interviewed. They stated that their patients reported a sound in the ears which was described by one of the traditional healers interviewed as "*a noise in the ear like the wind and then the person can't hear well*". Tinnitus, the perception of sound in the absence of an acoustic stimulus, may be present in otologically healthy people, although it is often seen in persons with hearing loss (Henderson, Salvi, Boettcher & Clock, 1994:37) or in persons with audiological diseases such as glomus tumours, arterio-ventricular malformations, Meniere's disease or acoustic tumours (Tyler, Stouffer & Schum, 1989:32). It is evident that tinnitus may be a symptom of an underlying harmful disease of which patients may be unaware. Because of the variability in the aetiology of tinnitus, it is difficult to ascertain the origin of the tinnitus the traditional healers came across in

the absence of audiological and otolaryngological information on these particular patients (Tyler, Stouffer & Schum, 1989:32). Traditional healers need to be aware of these aforementioned possible dangerous diseases which have tinnitus as one the symptoms so that the cause of the tinnitus can be further investigated through, for example, behavioural and electrophysiological audiometry (Zimmerman, 1994:25).

A small number of respondents, namely 13%, mentioned that they had been consulted by patients with *sores in their ears*. These observed sores may be due to an otitis externa (an inflammation of the skin lining the external auditory meatus) or to furunculosis (a painful infection of a hair follicle, usually in the lateral portion of the external auditory meatus) and tend to occlude the meatal passage which results in subsequent hearing impairment (Bull, 1992:28). People may be unaware that these diseases can result in hearing loss and the subsequent audiological impairment may be ignored which may have detrimental effects on communication (Jamieson, 1994:611).

Interestingly, mention was made of *hearing impairment subsequent to venereal disease*, which is not uncommon (Bull, 1992:14). Syphilis is a venereal disease which can cause a hearing impairment. Congenital syphilis may be caused by the disease reaching the foetus through the placenta and usually results in, among others, a bilateral sensory-neural hearing loss. Hearing-impairment due to adult-onset syphilis begins as a low frequency hearing loss which develops into a flat, asymmetrical, fluctuating, sensory-neural hearing loss. Vestibular symptoms may also be present (Silman & Silverman, 1991:56). Patients need to be aware of these seemingly unrelated complications of venereal disease so that they can be assessed for hearing problems. Children born of mothers with syphilis also need to be regularly monitored for hearing-impairment so that provision can be made for them in terms of treatment, amplification and education.

Similarly, it has been shown that patients who have developed the human immunodeficiency virus (HIV) or subsequent acquired immune deficiency syndrome (AIDS) are at risk for developing auditory dysfunction (Birchall, Wight, French,

Cockbain & Smith, 1992:117). Patients with either of these conditions may present with a sensory-neural hearing loss due to various infections (e.g. herpes simplex, cytomegalovirus, Zoster-varicella, meningitis, and encephalitis) and also due to the ototoxic medicines used in the treatment of the disease (Birchall, Wight, French, Cockbain & Smith, 1992:117). However, it has been reported that persons with the human immunodeficiency virus or acquired immune deficiency syndrome may also present with conductive hearing losses arising from opportunistic infections subsequent to the disease (Johnston & Ross, 1991:50). In very recent research, it has been estimated that 13% of South African adults have the human immunodeficiency virus or subsequent acquired immune deficiency syndrome and it is speculated that close on 14 000 000 people in Sub-Saharan Africa have been infected with either of these conditions (Bartholet, 2000:11). Therefore, it seems apparent that persons infected with as well as those involved in treating the disease need to be educated regards the audiological effects of the condition while audiologists need to monitor for changes in hearing status during the course of treatment with possibly ototoxic medicines. By providing assistance to persons whose hearing is affected by this disease, service providers could contribute towards improving the patient's quality of life.

3.2.1 Summary of findings in respect of sub-aim one

In summary, it appears that the traditional healers interviewed were consulted by persons presenting with a variety of audiological and/or otological problems. Of the participants, 80% reported seeing cases of hearing impairment which appeared to be both transient and permanent in nature, as well as conductive and sensory-neural in origin. From the symptoms described by the traditional healers interviewed, various pathologies were alluded to, including tinnitus, hearing loss subsequent to meningitis, noise induced hearing loss, hearing impairment resulting from venereal disease, and possible middle ear dysfunction, among others. These findings suggest the need to foster an awareness of the types of hearing problems, the possible effects of hearing loss, and the intervention strategies available to assist the person with a hearing impairment.

3.3 TRADITIONAL HEALERS' OPINIONS ON THE CAUSE OF HEARING PROBLEMS

The second aim was to probe traditional healers' opinions on the cause of hearing problems.

Modern perceptions on the cause of disease are based on the scientific understanding of the biology of the body (Ellis, 1996:130) and different classifications can be made of the cause. Firstly, hearing loss can be classified as either congenital or acquired i.e. a hearing impairment developed before birth or one caused after birth (Op't Hof, 1991:32). Furthermore, hearing loss can be caused by infectious and non-infectious diseases where infectious diseases are the result of the spread of micro-organisms from the carrier to the host while non-infectious diseases are caused by, among others, harmful agents, congenital factors, abnormal growths (Felhaber, 1997:23).

However, within the traditional paradigm, there are natural and unnatural causes of disease where natural causes may include germs, age-related diseases and accidents while unnatural causes include sorcery, spirits, ancestors and the failure to perform certain cultural rites (Felhaber, 1997:22). It is important to realise that modern medicine seems to look at *how* a disease is manifested while traditional medicine tries to explain *why* a particular person has been affected, and not another, at a particular point in time and not before, thereby introducing a cosmological aspect to the causation of disease (Karlsson & Moloantoa, 1986:26).

Table 3.2 outlines the traditional healers' beliefs regarding the cause of hearing problems. It appears as though the traditional healers in this study held both modern and traditional perspectives on the cause of disease which may be attributed to a transfer of modern methods through the media and continuing education programmes (Werner, Thuman, Maxwell & Pearson, 1993:21).

Table 3.2 Traditional Healers' Opinions Regarding the Cause of Hearing Problems (N = 15)

Perceived Cause of Hearing Problem	Number	Percentage (%)
Ancestors	10	67
Noise	6	40
Congenital Factors	6	40
Poor Aural Hygiene	5	33
Bewitchment	4	27
Blood Impurities	3	20
Sores in the Ear	3	20
Chest Infections and Colds	2	13
Insects in the Ear	2	13
Tinnitus	2	13
Advanced Age	1	7
Venereal Disease	1	7
Patient is in the Wrong Place	1	7
Poor Nutrition	1	7
Person's Inner Spirit is Disturbed	1	7
Trauma to the Ear	1	7

Note: Percentages do not add up to 100% as respondents could provide more than one cause in their answers.

A large percentage of the sample (67%) ascribed the cause of hearing loss to the *ancestors*. The ancestors or *amadlozi* are believed to be supernatural beings who reside in a different temporal dimension, although the living are still aware of their existence and they may occasionally appear to the living (van Rensburg, Fourie & Pretorius, 1992:322). These same ancestors are generally benevolent and look after the interests of their descendants but can also bring misfortune (Ellis, 1996:133). Hammond-Tooke (1989:47) describes how the ancestors can be angered if the living descendants do not perform the

necessary customary rituals, especially those related to birth, initiation, marriage and death, or if proper respect is not accorded to seniors.

The traditional healers interviewed for this research project seemed to have the same beliefs regarding the role of the ancestors in the causation of hearing problems. They also seemed to seek explanations for patients' symptoms as evidenced by their statements regarding the role of the ancestors in causing hearing loss. For example, one respondent stated: "*If they* (ancestors) *get cross, they can put a sharp noise in the ear and it can damage the eardrum*" and "*There is someone making a noise in the ear*". These statements seem to represent attempts to explain the cause of a hearing loss and the simultaneous presence of tinnitus. Of the respondents, 13% believed that this sound in the ears or *tinnitus* was a cause of hearing loss.

However, as respondents in this study also seemed to believe, disease may be a sign that the ancestors are calling someone to become a traditional healer (Ellis, 1996:141). It is believed that when traditional healers are called by the ancestors, the ancestors inflict an *inkathazo* or sickness on that person before the period of spirit possession or *thwasa* begins (Karlsson & Moloantoa, 1986:26). This physical ailment cannot be alleviated by modern medicine and a traditional healer has to be called in to diagnose the illness and to inform the afflicted person that this is a sign that the ancestors want this person to undergo *thwasa* in preparation to also becoming a traditional healer (Karlsson & Moloantoa, 1986:28; Ellis, 1996:141).

Statements made by the respondents with regard to the calling of the ancestors indicate that hearing impairment may be the way the ancestors are communicating their intention that the person undergo training so as to become a traditional healer. Such statements included, "*The ancestors are trying to tell you to become a traditional healer. The doctor can't see anything wrong, but you still experience problems*" and "*The ancestors will cause hearing problems if they want to give me my inheritance*".

Just over a quarter, i.e. 27% of respondents, thought that *bewitchment* could be the cause of hearing loss. These views reflected the traditional belief in supernatural powers. As discussed earlier in this section, the ancestors are generally viewed as benevolent beings who may occasionally be angered. For this reason, all diseases cannot be blamed on them and so the evil must be shared with certain people who have the ability to bring about evil. These witches or *abathakathi* have the ability to mobilise their powers and the forces of nature to harm other people (van Rensburg, Fourie & Pretorius, 1992:323). This harm can be inflicted by medicines or can be carried by mythical animals (Ellis, 1996:133). It is proposed that people may be harmed by witchcraft mainly because of the power of suggestion and the strong belief in the power of the witches (Werner, Thuman, Maxwell & Pearson, 1993:5).

Disturbance of one's *inner spirit* was cited by 7% of the sample as causing hearing impairment. It was reported that the person's spirit may be restless due to problems in that person's life, such as child abuse, and this spiritual disruption may cause a hearing loss. Hammond-Tooke (1989:54) likens this inner spirit to the concept of 'soul' or even 'personality'. Damage to this 'inner spirit' may result in a psychogenic hearing loss related to the trauma that the person has undergone. Martin (1994:553) maintains that it is plausible that a person may unconsciously present with a non-organic hearing loss after psychological trauma while Kaplan and Sadock (1991:417) list deafness as one of the possible somatoform disorders present after psychological distress. It is reported that auditory thresholds tend to improve after the psychological problem has been resolved (Silman & Silverman, 1991:137).

Noise exposure is a very real danger to aural health and this realisation seemed to be shared by 40% of respondents who identified it as a possible cause of hearing loss. Excessive noise levels damage the hair cells of the cochlea, more specifically those in the basal end first before spreading more apically (Ginsburgh & White, 1994:21). Comments such as "*You can become deaf if you work in a noisy place with machines*", "*If you work in a noisy place or you go to a noisy place, afterwards it feels like the noise is still in the*

ear even when you are in a quiet place" and "*When a mother is pregnant and she goes to a noisy place, like a shebeen, the child will hear a lot of noise and have a hearing problem*" seem to show their awareness of the damage noise can cause to a person's hearing. These comments on the effects of noise exposure were positive as they suggested consensus, rather than the usual disagreement, between the modern and traditional approaches and show the potential for finding common ground between the two practices.

Thirty-three percent of the sample ascribed hearing problems to *poor aural hygiene* as illustrated by these statements, among others: "*If people don't wash their ears, then dirt gets in the ear and blocks the ear*" and "*You can get dust in the ear*". The notion of aural hygiene appears related to the presence of foreign objects in the ear as reported by 13% of the sample who had encountered insects in their patients' ears. One traditional healer postulated that the presence of the insect in his patients' ear left a discharge in the ear canal which contributed to a hearing loss. Northern and Downs (1991:63) warn that the presence of a foreign object in the ear canal can obstruct the tympanic membrane and has the potential to damage this membrane which can result in hearing problems. Also, the presence of impacted wax can cause a hearing loss of between 20dB and 40dB (Schneider, 1992:59).

Within the traditional view, many diseases are believed to be caused by problems with a person's blood or *igazi* (Hammond-Tooke, 1989:54; Ellis, 1996:138). The *impure blood* referred to by 20% of respondents alludes to the state of ritual impurity that is caused by such things as sexual intercourse with a menstruating woman, handling corpses or handling faeces (Ellis, 1996:133,143). This pollution or *umnyama* (Ellis, 1996:140) "is a mystical force which reduces a person's resistance to illness" (van Rensburg, Fourie & Pretorius, 1992:327). Respondents could have been describing the biological malfunctioning of body fluids and their effect on hearing as seen in cases of Meniere's Disease, viral labyrinthitis or vascular abnormalities (Ginsburg & White, 1994:22).

Also, an allusion could have been made to the effect of ototoxic substances which adversely affect a person's hearing status. Of those who said that blood impurities could cause audiological dysfunction, one traditional healer mentioned that sniffing cocaine could "*dirty the blood*" and cause a hearing loss. Cocaine tends to increase the user's blood pressure and has the potential to cause an intracerebral haemorrhage (Leavitt, 1995:142). This bleeding can damage the central auditory system and lead to sudden hearing loss (Zimmerman, 1994:33), tinnitus, auditory hallucinations, difficulty understanding speech in noisy settings, and difficulty localising auditory stimuli (Silman & Silverman, 1991:62).

A place can also be polluted and 7% of the sample thought that *being in the wrong place* could be the cause of a hearing loss. The concept of *umeqo* refers to contracting a disease by stepping over dangerous tracks or being in a place that has been contaminated (Ellis, 1996:140). This notion could probably be equated to modern germ theory which proposes that the presence of bacteria within a certain area can cause the spread of disease. It has been shown that meningitis and otitis media, among others, are more prevalent in unsanitary environments and tend to spread to a greater extent in such areas (Northern & Downs, 1991:65; Hussey, Schaaf, Hanslo, Hitchcock, Coetzee, Pitout, Malan & Donald, 1997:55).

Congenital factors were believed by 40% of respondents to be the cause of hearing problems. It was reported that if a child was born deaf, it could have inherited the hearing loss from a dead family member while another respondent asserted that if a baby was named after a deceased hearing-impaired person, that baby would also be deaf. These descriptions could be referring to hereditary hearing loss running in families as Northern and Downs (1991:89) project that between 1 in 2000 and 1 in 6000 persons are born with a hereditary hearing loss. One of the traditional healers put forward another idea with regards to congenital causes of hearing impairment and proposed that "*deafness can be caused by parents fighting during the mother's pregnancy, and the baby hears the*

noise. The mother's heart starts pumping too much blood because she's scared and this is passed on to the baby".

3.3.1 Summary of findings in respect of sub-aim two

From the aforementioned discussion, it would seem that traditional medicine as practised by the group of traditional healers interviewed, seemed to place a large emphasis on mystical and magical causes of hearing impairment, although they also acknowledged that natural causes such as infection, organic deterioration, noise exposure and congenital factors can cause hearing impairment. However, the tendency was to personalise the cause of the disease and the reason for becoming ill was often sought in a supernatural realm. The implication from these findings is the potential use of traditional healers in educating the community regarding the prevention of hearing loss by improving environmental conditions and reducing the exposure to harmful agents.

3.4 METHODS USED BY TRADITIONAL HEALERS TO DIAGNOSE HEARING PROBLEMS

The third aim of this study was to explore the methods used by traditional healers to diagnose hearing problems.

As discussed in the introduction to this report, modern and traditional perspectives differ dramatically in their concepts and diagnosis of disease. The modern diagnosis is based upon the patient's history, an examination of the patient, and the carrying out of any special investigations or tests (Felhaber, 1997:29). In audiology, these evaluations are conducted using established methods of pure-tone, speech, immittance and evoked response audiometry (Bull, 1992:11).

In the traditional method, diagnosis not only seeks to establish the cause of the disease, but also to find out why the disease is manifesting itself and to find a deeper meaning or motivation behind the cause. The diagnostic methods include observation of the patient,

patient self-diagnosis, and divination (Felhaber, 1997:28). Table 3.3 summarises the methods used by the sampled group of traditional healers to diagnose hearing problems.

Table 3.3 Traditional Healers' Methods of Diagnosing Hearing Problems (N = 15)

Methods of Diagnosing Hearing Problems	Number	Percentage (%)
Throwing the Bones	13	87
Looking in the Ear	8	53
Feel the Patient's Pain and Know What is Wrong	8	53
Talking to the Patient's Relatives	6	40
Patient's Self Report of Hearing Problem	6	40
Talking to the Patient at Different Intensities	4	27
Asking the Ancestors	4	27
Prayer	4	27
Water	4	27
Sense that the Patient's Blood is Dirty	1	7
The Bible	1	7
Special Robe	1	7

Note: Percentages do not add up to 100% as respondents could give more than one method in their answers.

The majority of respondents, i.e. 87%, reported throwing the *bones* or *amathambo* (Ellis, 1996:144) to diagnose hearing problems. As Hammond-Tooke (1989:114) points out, the bones are seen as being very powerful and "can predict rain, the course of war, the position of lost or stolen objects and what medicine should be used". The *amathambo* are presented at the traditional healer's initiation ceremony and have at their core, four triangular bone or ivory tablets which have dots or lines inscribed on only one side so that the other side is clear. Each tablet represents a member of the family unit: an adult male, a young boy, an adult female and a young girl. Other items found in a traditional healer's divination kit include the bones of sheep, cattle, antelope, wild pig, baboon and

anteater as well as other objects such as sea shells and strangely shaped stones (Hammond-Tooke, 1989:114). When the bones are thrown, the coin tablets or dice can fall into sixteen different combinations, each with its own specific meaning (Hammond-Tooke, 1989:114; Felhaber, 1997:28). Comments made with regard to this diagnostic procedure included, "*The bones can tell you. We see the bones - we see how they lie, how they stand up, how they go like this* (lie diagonally). *So we know that you got something on your body*".

Other divination tools reportedly used by respondents included water, the Bible and a divination robe. *Water* was identified by 27% of respondents as a tool which can provide the traditional healer with useful diagnostic information. The respondents explained how they receive guidance from the ancestors by looking into water-filled vessels. Hammond-Tooke (1989:115) corroborates this belief as he describes how traditional healers use a specially decorated divination bowl filled with water on which certain shells and fruits are floated. Diagnostic information is then obtained by interpreting the position of these shells and fruits in the bowl. Moreover, 7% of respondents reported using the *Bible* as a diagnostic tool. It was explained that while praying over the patient, the traditional healer randomly opens the Bible and clues to the diagnosis can be found on the open page of the Bible. Another 7% of the sample recounted how a *special robe* was made from wool by members of the church which enables the traditional healer to diagnose a patient's audiological problem. One end of the robe is reported to put on the floor and another is put on the patient's ear after which the traditional healer listens to the robe to diagnose the cause of the patient's hearing problem.

Traditional healers are called upon to use their "second sight to see beyond what ordinary people perceive and so be able to know what the nature of the ailment is (and) what has caused it" (Ngubane, 1992:368). The clairvoyant and telepathic abilities described by Felhaber (1997:28) were mentioned by 53% of the traditional healers interviewed. They reported the ability to feel their patient's pain or disease before the patient's self-report of such, thereby using extra-sensory perceptual abilities to help make a diagnosis

(Hammond-Tooke, 1989:117). Just over a quarter, i.e. 27%, of respondents mentioned that they consulted with the *ancestors*. They explained that they needed to use similar powers of divination to diagnose patients' ailments. One traditional healer admitted that she needed ancestral assistance in making a diagnosis when she said, "*I can't do it by myself - I need help from the ancestors*".

Similarly, *prayer* served as an important diagnostic tool for 27% of the traditional healers interviewed as illustrated by the one respondent who said, "*We must pray to God to help us*". With colonialism came new beliefs, including one regarding a Supreme Being, God (Hammond-Tooke, 1989:47). God is seen as the creator of the human race and of the life force in the world and He has a protective and compassionate power over people which can be harnessed to help in the diagnosis and subsequent treatment of patients' ailments (van Rensburg, Fourie & Pretorius, 1992:331).

Part of the modern audiological evaluation includes a physical examination of the external ear and tympanic membrane to look for congenital deformations, patency, foreign bodies, infections or growths in the ear (Ginsburg & White, 1994:11). Fifty three percent of the respondents also reported *looking into the ear* as part of their diagnosis of hearing problems. They stated that they take their patients into the sunlight and look for sores in the ear, discharge in the ear canal and a swollen eardrum. One traditional healer recounted, "*I look for a white spot inside and if it's red, it's a problem*". Similarly, a pearly, opaque tympanic membrane is sought during a modern otological evaluation as is the light reflex of the concave portion of the membrane (Bull, 1992:1) while a reddening, thickening, retraction or bulging of the tympanic membrane may indicate the presence of a pathology (Silman & Silverman; 1991:43).

Twenty-seven percent of respondents reported trying to estimate their patients' hearing loss by *talking at different intensities* and from *different distances* so as to gauge the severity of the hearing loss. This method of hearing estimation has also been reported in the literature in modern medicine as a way of screening for hearing-impairment and

suggested methods for performing this procedure include recording patient responses to whispered voice and conversational voice at distances of 15cm and 150cm from the ear (Bull, 1992:6). These ideas also form some of the components of behavioural observation audiometry in infants (Northern & Downs, 1991:152) as well as older persons (Health Services Development Unit, 1988:34). Examples of statements made in relation to estimating hearing ability included: "*If I want to find out if he can't hear, maybe I'll call him a little bit higher* (louder) *and maybe he can understand me. I can give him a long distance, and if he can't hear, I bring him a little forward and call him again. If he can now hear, that little bit of a gap says he can only hear when you speak loudly*". Another traditional healer stated that if a patient does not respond when spoken to, she will communicate in gestures, and if the use of gesture elicits a response, she deduces that the person has a hearing loss.

In contrast to the modern approach, traditional medicine does not always require that the patient be physically present in order for the healer to diagnose the illness. As Figure 3.1 shows, 40% of the traditional healers interviewed reported that they were able to diagnose a hearing problem even if the patient was absent from the diagnostic session.

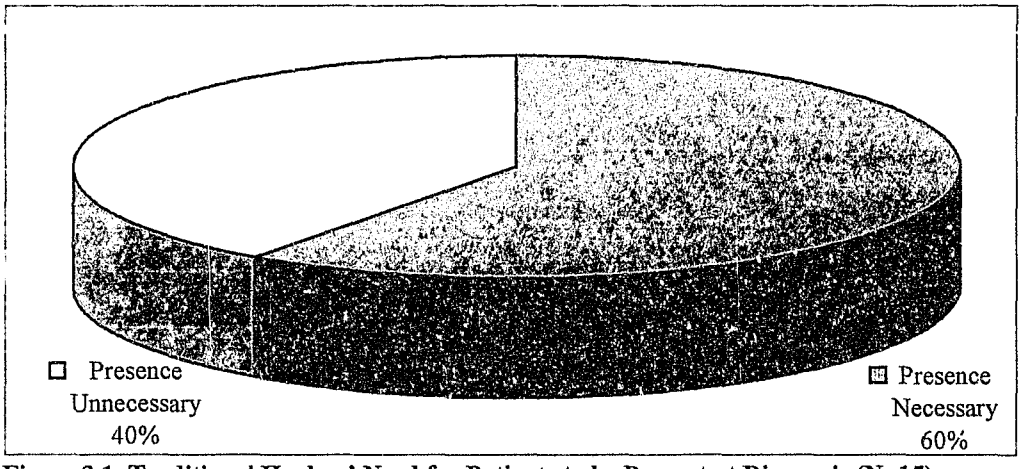


Figure 3.1 Traditional Healers' Need for Patients to be Present at Diagnosis (N=15)

Ngubane (1992:368) explains how the patient can remain at home while *relatives* consult with the traditional healer, a practice also reported by respondents in this study. During this process, the relatives do not recount any of the patient's history or symptoms as the traditional healers are expected to use their powers of divination to diagnose the ailment. The traditional healers usually sit opposite the family members and make statements concerning the patient. After each statement, the relatives clap their hands and shout, "*Siyavuma!*" (We agree) if that statement pertains to the patient or "*Asiva!*" (We do not hear) if the statement is not relevant. A diagnosis is then made by the traditional healer based on this procedure (Hammond-Tooke, 1989:113).

The traditional healers in this project who maintained that they were able to diagnose patients' problems in their physical absence, explained that a relative served as a representative of the patient. Other respondents stated that they found it useful if the relative brought with them an item belonging to the patient, such as a piece of clothing, to help in their diagnosis. They also affirmed their use of superior powers *to feel the patient's pain and illness* from which they could make their diagnosis. In modern audiology, the presence of the patient is essential for making a diagnosis of hearing dysfunction as the patient is expected to either participate in behavioural audiometry or be physically connected to the recording equipment during an electrophysiologic evaluation.

3.4.1 Summary of findings in respect of sub-aim three

It is apparent from the discussion on the diagnosis of hearing impairment, that the traditional healers interviewed used methods which are foreign to modern practitioners, e.g. throwing the bones, consulting with the relatives while the patient stays at home, asking the ancestors and prayer. However, some of their methods appear similar to modern techniques such as assessing the patient's response to different sound stimuli and otoscopic examinations. This finding suggests the need for disseminating information on the screening for hearing problems, and highlights the potential for the referral of patients for in-depth evaluations of their patient's hearing status.

3.5 INFORMATION CONCERNING THE TRADITIONAL HEALERS' TREATMENT OF HEARING PROBLEMS

Through this fourth sub-aim, information was sought on traditional healers' treatment of hearing problems.

As with diagnosis, the beliefs pertaining to the treatment of auditory dysfunction are different in the modern and traditional systems. Traditional medicine is described as "holistic because it cannot be reduced to a single dimension of treatment or remedy ... (and) is aimed not only at curing the disease, also at healing the patient" (Felhaber, 1997:34). Belief in the supernatural steers treatment options in the traditional approach (Gilbert, Selikow & Walker, 1997:50). Treatment is therefore given to restore the physical and cosmological harmony necessary for health through the use of culturally and historically supported rituals and medicines (van Rensburg, Fourie & Pretorius, 1992:325).

3.5.1. Plant based medicines used by traditional healers

In the traditional method, herbal remedies utilise a plant or combination of plants to treat illness (Felhaber, 1997:34). Usually, the leaves, roots or bark are used, although the fruit, seeds, gum or nectar can also be used (van Wyk, van Oudtshoorn & Gericke, 1997:12). Those who use herbal medicine believe that the plants are imbued with magical powers which contribute to their effectiveness (van Rensburg, Fourie & Pretorius, 1992:329). The traditional healers in this study placed a great deal of importance on the use of medicinal plants in the treatment of hearing problems, as illustrated by the statement by a respondent who said, "*I put water from plants in the ear. They think that water can cause infections. All the time they think what I will put will cause damage because your eardrum can burst or something. But I know my medicine will never make an eardrum to burst!*". Table 3.4 outlines the types of medicinal plants used by respondents in this study.

Table 3.4 Plants Used by Traditional Healers in Their Treatment of Hearing Problems (N = 15)

Vernacular Name	Scientific Name	Number	Percentage (%)
Unknown Name		7	47
Isikholokhoto (Zulu)	Sansevieria Hyacinthoides	2	13
Matokwane (Sotho)	Cannabis Sativa	1	7
Ugebelweni (Zulu)	Carpobrotus Edulis	1	7
Imphewula (Xhosa)	Cotyledon Orbiculata	1	7
Isihaqa (Zulu)	Tulbaghia violacea	1	7
Skanama (Sotho)	Drimia Robusta	1	7

Note: Percentages do not add up to 100% as respondents could name than one plant type in their answers.

Almost half of the traditional healers in this study did not know the names of some of the medicinal plants or *umuthi* they used, although they informed the researcher that they could recognise these plants visually. Almost half, i.e. 47%, of the sample reported that they were guided by the ancestors and spirits in dreams to identify the appropriate plants, as exemplified by the following statements: "*Maybe if the patient comes today, then we talk today. Then I go to sleep. If I concentrate on that one (patient) when I'm sleeping, someone will come explain if you can use this and this and this*" and "*I don't know all the names but amadlozi (ancestors) show me the plants in a dream and I get the plants from the mountains*". The guidance given in dreams is very plausible in the traditional method as the ancestors are believed to use them as a vehicle for communicating with the living (van Rensburg, Fourie & Pretorius, 1992:322) and for giving instructions to the traditional healer (Hammond-Tooke, 1989:107). Traditional healers place a great deal of reliance on these dreams as illustrated by one respondent who said, "*The ancestors show me what to use in a dream. I mix it all together as long as its not a poison. I only give something that is going to help*".

Nevertheless, some of the plants could be named, including *isikholokhoto*, a plant shown to contain sapogenins which have anti-inflammatory properties. This plant has been described as being beneficial in the treatment of ear infections and earache by squeezing the juice of a warm leaf into the ear (van Wyk, van Oudtshoorn & Gericke, 1997:224). The respondents in this study stated that they followed the same procedure for dispensing this medicine. One traditional healer even mentioned that she puts the juice in a special pot before pouring the drops into the patient's ear while another reported that she soaks a cloth in the plant juice and dispenses the ear drops from there.

In their classical work on the medicinal and poisonous plants of Africa, Watt and Breyer-Brandewyk (1962:6) identify *ugebelweni* as the *Carpobrotus edulis*. Juice from this plant is reported to have helpful antiseptic properties for treating wounds and ear infections (van Wyk, van Oudtshoorn & Gericke, 1997:70) which may be the reason traditional healers choose it to treat ear-related diseases. The *ugebelweni* leaves are used in conjunction with *isihaqa* leaves in the treatment of earache by mixing the leaves with hot water, letting this mixture stand for 15 minutes and then dropping small amounts of the infusion into the ear (Felhaber, 1997:178).

Either the juice or the whole leaf of the *imphewula* (commonly known as "pig's ear" in English) can be used in the treatment of earache. The warm juice can be dropped in the ear or a warm leaf can be applied to the painful area to ameliorate the pain (van Wyk, van Oudtshoorn & Gericke, 1997:92). Interestingly, the traditional healer who described using this plant, explained that, because the shape of the leaf resembles an ear, it can be used to treat ear problems. As van Rensburg, Fourie and Pretorius (1992:330) point out, "The general principle is that whichever characteristics plants, birds and animals may have, may be transmitted to man. Accordingly ingredients of these are often used as healing remedies". Hammond-Tooke (1989:120) echoes this hypothesis and cites a belief among the Mpondo people that "patients with mumps (should) address the *msenge* tree which has knobbly lumps on its trunk," in order to be healed.

The traditional healers in this study did not mention any circumstances when dispensing these drops into the ears was not recommended. However, the dispensing of medicine into the ear when the tympanic membrane is ruptured is contraindicated (Bull, 1992:31). This point is emphasised by the Health Services Development Unit (1988:41) which warns that those persons with a perforated eardrum should not get water in their ears while bathing or swimming nor should eardrops be administered as this procedure can lead to further middle ear complications. Even though Felhaber (1997:178) provides a text specifically designed for traditional healers' diagnosis and treatment of, among others, otological problems, he highlights the danger of dispensing medicine into a ruptured tympanic membrane and suggests that the patient should be referred to a hospital or clinic before such treatment is administered.

Skanama is regularly used as an emetic to purify dirty blood (van Wyk, van Oudtshoorn & Gericke, 1997:112). During the interviews, it was established that this plant can be drunk or can be eaten with soft porridge in order to clear the body's "dirty blood". It is believed that cleansing of the blood should be performed to remove toxins from the blood as well as to open the blood vessels for better blood circulation (Felhaber, 1997:35). However, this plant is believed to have toxic properties of which traditional healers and patients should be made aware (van Wyk, van Oudtshoorn & Gericke, 1997:112).

The use of *matokwane* or dagga (van Wyk, van Oudtshoorn & Gericke, 1997:66) is rather controversial due to the legal constraints placed on its use. However, smoking the leaves of the plant is reported to alleviate pain symptoms (Leavitt, 1995:143). The adverse effects from using the plant include, among others, an increased heart rate, memory problems, damage to the lungs from carcinogenic substances, cerebral atrophy and birth defects (Kaplan & Sadock, 1991:315). Because of its reported ability to reduce feelings of discomfort, it is probably recommended to ameliorate the pain in the ears rather than as a direct treatment of the otological problem.

3.5.2 Animal based products used in traditional healers' treatment

Research has shown that traditional healers use various animal products in their treatment of different pathologies although it is reported that animal based remedies are used less frequently than plant based treatments (Hammond-Tooke, 1989:120; van Rensburg, 1992:330; Kale, 1995:1182). Table 3.5 summarises the animal material used in the treatment of hearing problems by those traditional healers interviewed.

Table 3.5 Animal Products Used by Traditional Healers in Their Treatment of Hearing Problems (N = 15)

Type of Animal Product	Number	Percentage (%)
Chicken Fat	8	53
Snake Fat	5	33
Millipede	2	13
Lizard Fat	1	7
Waterbuffalo Fat	1	7
Sardine Fat	1	7
Powdered Tortoise	1	7
Powdered Owl	1	7
Powdered Monkey Brain	1	7

Note: Percentages do not add up to 100% as respondents could name more than one animal product in their answers.

Traditionally, it is believed that animal fat can serve as a protective layer against the spread of disease (Hammond-Tooke, 1989:120). From Table 3.5 it can be seen that animal fat was the most commonly used animal by-product in the treatment of audiological dysfunction. Those interviewed held the belief that *snake fat* was the most effective animal based audiological remedy, but that they often had to use *chicken fat* as a substitute as it is more readily available. The respondents explained how they melted the animal fat to then use as eardrops. Some traditional healers mentioned that they

usually combined the melted fat with the plant extracts previously mentioned to ensure better results. A respondent informed the researcher that the fat in the ear drops acted as "*moisturiser because the plants dry pus and the skin of the ear*". Some of the plants used in the treatment of hearing loss are highly astringent and may dry the skin (van Wyk, van Oudtshoorn & Gericke, 1997:70) and so it is plausible that traditional healers use the animal fat to counteract this excessive drying. However, as with the plant remedies, eardrops made from animal fat should not be used in instances of a ruptured tympanic membrane because of the potential damage to the middle ear (Health Services Development Unit, 1988:41; Bull, 1992:31; Felhaber, 1997:178).

A small proportion, i.e. 13%, of respondents, reported using the millipede or *shongololo* as a treatment for hearing problems, and explained that they bite off the arthropod's head, suck out the insides and spit them into the patient's ear. Research in entomology has shown that millipedes pose potential health risks to humans as their bodies contain toxic liquids which can burn, blister, and possibly infect the human skin. These effects can also be observed in the mouth if the liquid comes into contact with oral structures (Alexander, 1984:386). It, therefore, appears as though the practice of using the *shongololo* is potentially harmful to both traditional healers and patients. The implication of these findings is that both groups need to be educated regarding these effects so that harmful practices can be avoided.

The three types of powdered animals used in the treatment of hearing problems were proffered by the same traditional healer. She described how the animals are first dried and then ground into a fine powder. This powder is sprinkled over hot coals before the patient is asked to inhale the fumes. Smoke inhalation is reported to be a common means of ingesting traditional medicine due to the belief that it allows for the rapid entry of the medicine into the bloodstream and brain (Felhaber, 1997:38).

3.5.3 Other treatments used by traditional healers in their treatment

Traditional medicine does not only rely on plant and animal based treatments, but also uses a variety of rituals and other procedures to treat disease (Felhaber, 1997:34). Table 3.6 highlights these additional techniques used by the traditional healers interviewed.

Table 3.6 Other Methods Used by Traditional Healers in Their Treatment of Hearing Problems (N = 15)

Method	Number	Percentage (%)
Laying of Hands	9	60
Bones	4	27
Dreams	3	20
Breast Milk	1	7
Sewing Machine Oil	1	7
Glycerine	1	7
Peroxide	1	7
Special Robe	1	7

Note: Percentages do not add up to 100% as respondents could give more than one method in their answers.

The *laying of hands* was reported by 60% of respondents as a method of treating hearing impairment. These traditional healers described how they pray over the patient and invoke the healing powers of God or of the ancestors. There exists a strong belief that prayer is very helpful in treating disease as illustrated by the one traditional healer who exclaimed that prayer "*has the power to move mountains*" while another admitted, "*We must pray to God to help us. We can't just take the medicine and give it to them (the patients). I must put my hands over them and I ask Him to help me because everything God knows. I know how is the bones, but God knows better than me. If God doesn't want to help that child, then he won't get better. But, if you ask Him, that person will get better*".

Dreams and the *throwing of the bones* were again highlighted as a means of getting guidance from the ancestors, as was discussed earlier in this project. However, in the context of treatment, 20% of respondents used dreams and 27% reported throwing the bones (*amathambo*) for determining the optimal treatment for hearing-impairment. Those respondents who reported being guided by dreams, used them to obtain information about the types of plants needed for treating hearing dysfunction while the bones reportedly communicated the ancestors' intentions. The same traditional healer who had used the special divination robe for diagnosis, maintained that this robe also told her about the best plants and animal products to use in treating the hearing-impaired patient.

The suggested use of *glycerine* and *sewing machine oil* may provide a similar moisturising effect to the animal fat discussed earlier, while *peroxide* is probably a substitute for the astringent plants used for drying up aural discharge. However, doubt is expressed regarding the efficacy of these materials as they may cause further complications which need to be examined in future research. *Breast-milk* was proposed by 7% of respondents as a helpful remedy for getting rid of insects lodged in children's ears. It is speculated that because of the anti-bodies present in breast-milk (Werner, Thuman, Maxwell & Pearson, 1993:287), it is probably less dangerous to the ear than some of the other mentioned substances. However, it should again be pointed out that these substances should not be administered to the ear if the tympanic membrane is compromised (Health Services Development Unit, 1988:41; Bull, 1992:31; Felhaber, 1997:178).

Therefore, it can be seen that traditional healers use medicines which appear to have demonstrated benefits, although some of their treatments are less understood. However, it must be appreciated that "while disease has biological or psychological correlates, sickness becomes a human experience only as it is apprehended, interpreted, evaluated and communicated - that is, as it enters the world of human meaning and discourse"

(Craffert, 1997:3). Similarly, the medicines used by traditional healers may also undergo the same transformation which renders them beneficial to the patient.

However, the power of suggestion has a strong healing force, and, as a result, the faith in the treatment may result in feelings of health (Werner, Thuman, Maxwell & Pearson, 1993:4). Again, as discussed in the introduction to this report, health does not only imply the alleviation of the physical symptoms, but also the promotion of a feeling of well being which patients may be getting from traditional healers. It is also proposed that traditional methods may work because patients are placed at the centre of rituals, medicine, and social attention. Patients are made to feel important which improves their psychological state and fosters optimal conditions for the promotion of physical and psychological healing (Hammond-Tooke, 1989:123). Also, it is reported that many patients may attribute their recovery to the traditional healer's intervention, even though they may have recovered spontaneously from their disease (van Rensburg, Fourie & Pretorius, 1992:330).

3.5.4. The amalgamation of traditional healers' roles

In the past, distinct categories of traditional healers were recognised and each seemed to have their own domain. Recently, however, these categories have become less distinct and healers seem to be performing various practices (van Wyk, van Oudtshoorn, Gericke, 1997:11). The traditional healer is expected to take on different roles and act as a psychiatrist, advisor, diviner, and herbalist (Erasmus, 1992:105). A similar trend was also observed in the present research project. This variation in treatment methods used by the different traditional healers is summarised in Figure 3.2 which shows that the traditional healers interviewed may have been combining their skills and were not restricting themselves to only performing the conventional tasks associated with each category.

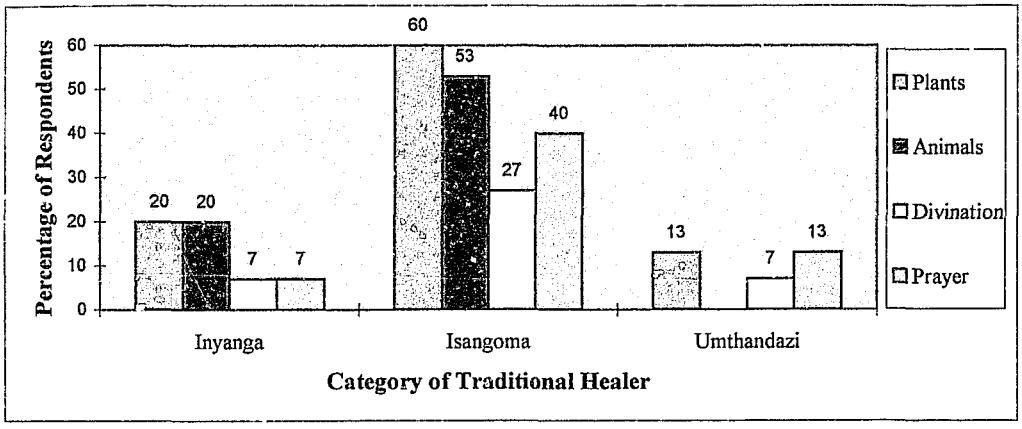


Figure 3.2 Variation in Treatments by Category of Traditional Healer (N = 15)

Note: Percentages do not add up to 100% as respondents could name more than one type of treatment in their answers.

Patients seem to want the traditional healer to provide a meaningful explanation of illness while responding to personal, family and community issues surrounding the illness. Moreover, the term 'traditional healer' implies a generic term for the practice of traditional medicine (Ellis, 1996:144). As they are expected to provide their patients with a holistic form of treatment, it appears as though the traditional healers interviewed were combining their procedures and therefore adapting to their patients' needs. This finding has important implications for traditional healers' ability to accept a new role in collaborative medicine, for example, dispensing primary health care.

3.5.5 Summary of findings in respect of sub-aim four

The traditional healers interviewed seemed to use a variety of treatment regimens, including plant and animal extracts, as well as rituals and other substances. From the discussion it appears that some of the plants have been shown to have healing properties while some of the other methods may not be as effective and may possess harmful properties. The traditional healers in this study project had strong beliefs regarding the effectiveness of their medicine and so it appeared as though the power of suggestion may be a core component of the traditional healer's healing capacity. Also, the traditional

healers showed an amalgamation of roles and did not seem to restrict themselves to the defined roles of each category of healer as described earlier in this research project. These findings imply that traditional healers and their patients need to be educated about the potential harm some of these medicines pose as well as encouraging safe administration of those medicines which may be helpful.

3.6 DATA PERTAINING TO THE TRAINING OF TRADITIONAL HEALERS

In accordance with the fifth aim of this research project, data were sought on the traditional healers' training.

Within the modern position, training is a structured and regulated procedure. Audiologists are expected to complete university accredited study programmes where, among others, subjects in auditory physiology; acoustics; and the identification, testing and rehabilitation of hearing impairment are taught (Katz, 1994:4). In South Africa, the legal requirement necessary to practice as an audiologist is the minimum of a four year degree or recognised equivalent in Speech-Language Pathology and/or Audiology from a registered South African university or overseas equivalent (Ethics and Standards Committee, 1996:1; Ethics and Standards Committee, 1998:2).

In contrast, the training of traditional healers appears to begin with a calling to the profession by the ancestors, usually in the form of a sickness or *inkathazo*, which is followed by a period of training under a mentor (Karlsson & Moloantoa, 1986:27; Kale, 1995:1182)). Data obtained pertaining to the training undergone by respondents in this research project are presented in Figure 3.3.

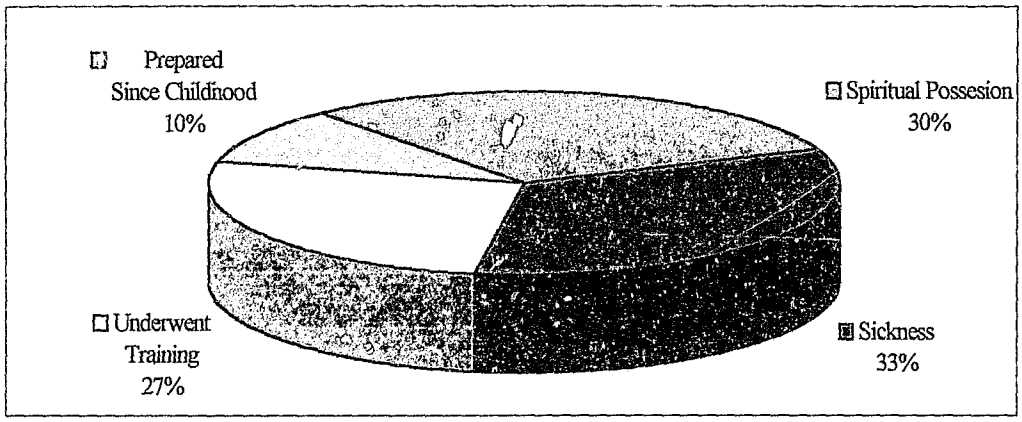


Figure 3.3 Training Undergone by Respondents (N = 15)

In his account of traditional healers' training, Hammond-Tooke (1989:105) lists various illnesses experienced by those who have been called to undergo training, including stomach-ache, nervousness, back-pain, uncontrolled hiccuping, excessive yawning, unconsciousness, and disturbing dreams. Approximately one-third, i.e. 33%, of participants reported having become ill during their calling, including experiencing cases of stomach-ache, headache, dizziness, fainting, difficulty walking, speech problems, disturbing dreams and chronic sleepiness which did not respond to treatment with modern medicine. These symptoms often had secondary effects as explained by one traditional healer who described how she had experienced scholastic difficulties due to her fatigue. With regard to those who had become unconscious, one respondent stated that when she woke up, she found herself transported to the home of the traditional healer chosen to be her mentor. Another respondent stated that she had become ill and subsequently died, before being resurrected three days later by the traditional healer who had been chosen to teach her. All participants confirmed that their symptoms resolved as soon as they had accepted the ancestors' calling and submitted to formal initiation.

During this period of illness (*ukuthazo*) prior to spiritual possession (*thwasa*), traditional healers may have strange dreams in which they see the ancestors or items used by traditional healers in their practice of healing (Karlsson & Moloantoa, 1986:28;

Hammond-Tooke, 1989:106). While conducting the interviews for this project, dreams again seemed to feature as an important trans-dimensional vehicle as traditional healers maintained that, during their sickness, they were told to answer their calling in strange dreams. A particularly interesting and symbolic dream was recounted by a respondent who said, "*I dreamed I was carrying a mudundo (basket) on my head. I didn't know where to go but the ancestors showed me*". She went on to explain that the *mudundo* symbolised a vessel for carrying medicinal plants and knowledge of traditional medicine.

Thwasa, the spiritual calling to become a traditional healer, alludes to a period during which initiates undergo possession by the ancestors and learn to communicate with the them (Hammond-Tooke, 1989:107). The dancing or *xhentsa* component of the initiation serves to transport the initiate traditional healer to the trance-like states necessary for communicating with the ancestors and allows the noviciate an opportunity to confess those things seen in dreams (Hammond-Tooke, 1989:108). As part of their training, 30% of respondents reported having undergone a spiritual possession, illustrated by one participant's response: "*I danced to the beat of the drums and the person inside, the spirit inside, spoke and he said that I must not work for a white man - I must become a sangoma*". Respondents explained that they received vast amounts of knowledge when the ancestors possessed them and transferred essential information needed for healing. From these accounts, it appears as though the spiritual possession may complement the knowledge gained from training under another traditional healer although it may also be sufficient on its own to allow the person to function as a traditional healer.

Mentors aim to teach novice traditional healers about the types of medicinal plants, their usage, interpreting the bones and communicating with the ancestors (Karlsson & Mojoantoa, 1986:28; Hammond-Tooke, 1989:107). Just over a quarter, i.e. 27%, reported that they had trained under another traditional healer, and described how they had been taught to dispense traditional medicine and to interpret the ancestors' intentions. They also explained that they learnt how to gain control of bodily functions

during spiritual divination as it was reported that inexperienced traditional healers may experience bodily harm if they do not know how to exercise the necessary control.

Ten percent of respondents in this study mentioned that they had been selected as children to become traditional healers in adulthood. This selection is reportedly not unusual as remedies can be passed on from one generation to another and children can almost be said to 'inherit' this knowledge (van Rensburg, Fourie & Pretorius, 1992:330). Of those participants who had recounted their preparation since childhood, one said that his grandfather, also a traditional healer, had always involved him in plant selection and gathering ever since he was a child. When his grandfather passed away, he assumed the role of traditional healer. Another respondent related how she had been called to become a traditional healer when she became very ill at the age of seven years. This illness did not improve and she was taken to see another traditional healer who insisted that the child would have to answer the ancestors' calling. However, her parents felt she was too young to go for formal training but allowed her to accompany the older traditional healer on her outings. Her illness did not resolve until she went into formal training upon entering into adulthood.

3.6.1 Summary of findings in respect of sub-aim five

Even though some commonalties in the diagnostic and treatment procedures between the traditional and modern approaches were identified earlier in this discussion, the differences in training appeared more pronounced. As was reported earlier, traditional healers in this study relied heavily on divination to diagnose and treat disease which is in conflict with the scientific basis of modern interventions. It was reported that training under another traditional healer might be undertaken but it was believed that the supernatural abilities of the novice were of greater importance in the learning process. These differences have important implications for the training of traditional healers in primary health care because of their potential to combine modern techniques with their knowledge of the supernatural.

3.7. TRADITIONAL HEALERS' PERCEPTIONS WITH REGARDS TO THE COLLABORATION WITH OTHER HEALTH CARE PROFESSIONALS

The sixth aim was to ascertain traditional healers' perceptions regarding collaboration with other health care professionals.

There appear to be "deep divisions, fuelled by mutual suspicion and lack of communication" (Hopa, Simabayi and du Toit, 1998:8) between traditional and modern interventions. Modernists maintain that their treatment is more effective and that traditional healing is primitive, based on superstition, and non-scientific (Freeman & Motsei, 1990:7). On the other hand, traditionalists argue that their treatment is holistic and believe that "modern medical science, with its biochemistry, X-rays, and biopsies, is a marvellous triumph of our technological prowess, yet it is representative of a world-view that has fragmented mind and body, the individual and society, spirit and landscape" (Featherstone & Forsythe, 1997:18).

The issue surrounding collaboration is a contentious one as it appears that the different world-views may hinder the potential for partnership. However, notwithstanding the differences in ideas, both parties seem to share a common interest in their patients' well-being. Earlier sections of this research project have highlighted some of these differences and the question arises whether collaboration is therefore possible.

3.7.1 Respondents' opinions regarding traditional healers' current collaboration with other health care professionals

When respondents were asked whether traditional healers were currently collaborating with modern practitioners, the majority answered in the affirmative, as depicted in Figure 3.4.

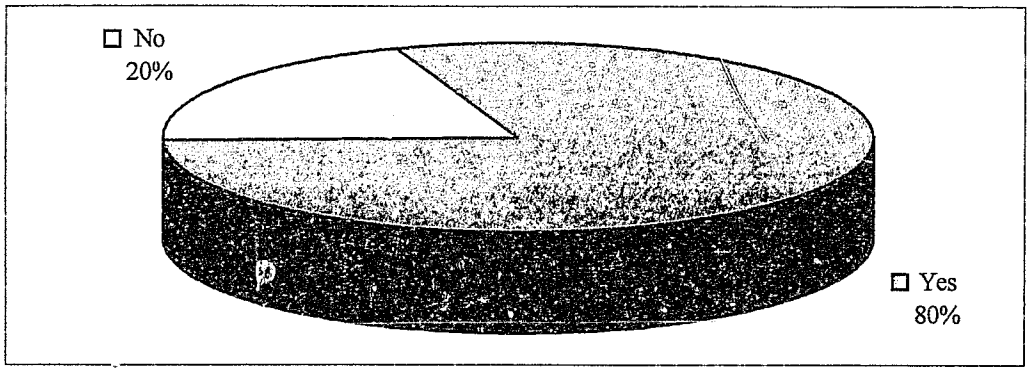


Figure 3.4 Respondents' Opinions on Whether Traditional Healers were Currently Collaborating with Modern Health Care Practitioners (N = 15)

Their responses seemed to indicate that they attempted traditional methods as a first line of treatment before referring to modern health care personnel. Also, they expressed their limitations in providing certain types of treatment. Responses pertaining to this question included: "*I throw the bones and they tell me if I can help this person. If I can't, I send him* (the patient) *to the modern doctor*[4]", "*Maybe he needs blood or the* (intravenous) *drip, then I say he must go to the clinic to get it first*", and "*I will see the patient for a while. If he doesn't get better, I send him to the modern doctor*".

However, although many of them stated that they were collaborating with modern health care practitioners, they felt that this collaboration was not reciprocated on the part of the modern sector, as depicted in Figure 3.5, a feeling shared by Freeman and Motsei (1990:9) and Pretorius, de Klerk & van Rensburg (1991:48). Respondents in this study expressed the view that modern health personnel harboured feelings of mistrust towards traditional healers as articulated by a participant who said, "*Modern doctors see traditional healers as dirty witches - they don't know if we are doing the right thing*".

[4] Respondents in this research project used the umbrella term 'modern doctor' to refer to any member of the modern health care team.

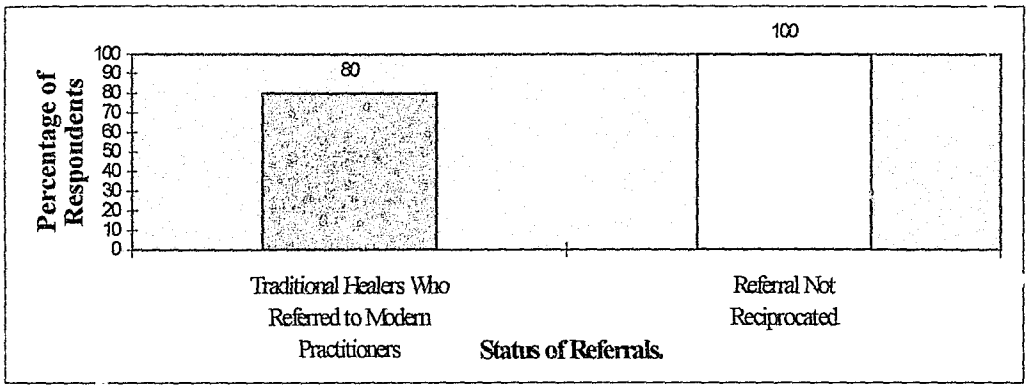


Figure 3.5 Respondents' Perceptions on the Status of Referrals to Modern Health Care Practitioners (N = 15)

In the past, the term 'witchdoctor' was used in popular literature to portray traditional healers as "the epitome of evil, primeval cunning and the dark forces of barbarism." (Hammond-Tooke, 1989:103). However, there has been a move to replace the term "witchdoctor" with "traditional healer" or "traditional medical practitioner" as these terms invoke less negative associations (van Rensburg, Fourie & Pretorius, 1992:328). Notwithstanding this trend, feelings of distrust may still persist among the modern fraternity.

One respondent bemoaned the fact that because some traditional healers may be engaged in dishonest practices, modern practitioners tended to generalise this attribute to all traditional healers. A few years ago there was already an increasing wariness of those persons posing as traditional healers since it was believed that they posed a great danger to patients because of their lack of even basic training and the benefit of learning from experienced healers (Ingle, 1994:604). Also, it was reported that modern health care staff often experience difficulty distinguishing bonafide traditional healers from those who are only posing as such, since even some training is considered better than no training at all (Kale, 1995:1184). Even though some medicines used by qualified traditional healers have been shown to have adverse effects. the danger is only multiplied if they are used by untrained persons who may target poor and uneducated families and

dispense medicine purely for financial gain (Blackett-Sliep, 1989:44; Freeman & Motsei, 1990:12; Ingle, 1994:605).

Another reason cited for this mistrust was the respondents' belief that modern practitioners viewed traditional healers as being uneducated. Again, this feeling may arise from the differences in training cited earlier. However, Featherstone and Forsythe (1997:50) argue that in the same way that modern practitioners may not fully understand traditional healers' methods, they cannot expect traditional healers to have knowledge of their modern methods. This misunderstanding seems to arise from a lack of communication between groups which contributes to the misgivings each group has of the other. Because of the differences inherent in each approach, a system of mutual referral is recommended by van Rensburg, Fourie and Pretorius (1992:340) where both types of practitioners undergo basic training regarding the leading concepts of each kind of medicine so that they can refer for cases which they feel would benefit from the other intervention.

3.7.2 Respondents' perceptions regarding the potential for traditional medicine to complement modern medical practices

In reply to the question whether traditional medicine could be used to complement modern medicine, all of the respondents believed that it was possible, as depicted in Figure 3.6. Also, participants asserted that it would give even greater benefit to the patient if the two types of medicine were used in a complementary way.

As the calling to become a traditional healer is believed to be spiritually guided, respondents felt that modern interventionists are not necessarily equipped with the supernatural skills necessary to treat such cases and felt that the latter should invite them to attend to those spiritually affected patients. Traditional healers in this study emphasised that modern practitioners can not see if a patient has been bewitched or if there is a meta-physical basis for the illness. For that reason, the traditional healers interviewed were of the opinion that modern medicine would not cure the disease

because the modern interventionists were focusing purely on the physical manifestations of the disease and were not considering the spiritual sphere, as vividly portrayed by this example: "*One girl had something moving behind her ear. You could see it moving like a worm behind her ear* (while respondent was pointing at her mastoid). *She went to Bara but they couldn't help her. She went to a traditional healer from Zimbabwe who took it out with magic because she was bewitched*". Another respondent accepted that her profession was different to the modern practitioners', but stressed, "*We help as much as the modern doctors do, so it would be nice if we could work together. We can't do the operations and we don't have the machines to make the tablets and the X-rays, but we know how to dig plants and speak to the ancestors*".

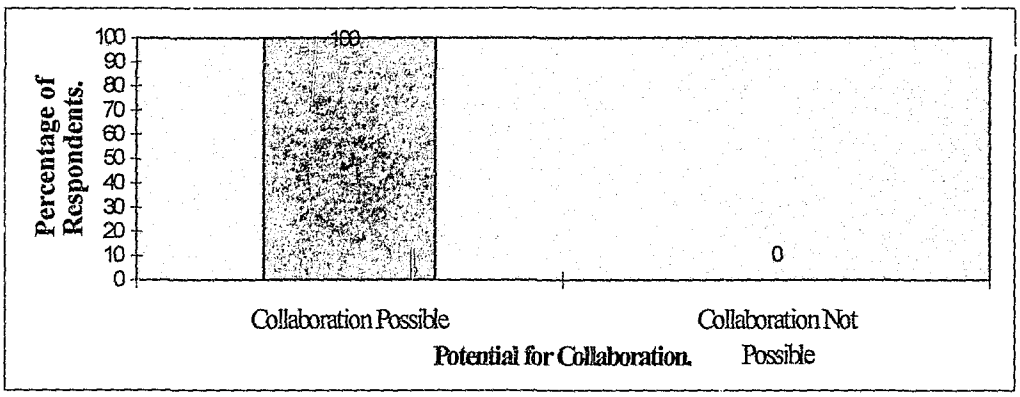


Figure 3.6 Respondents' Opinions on the Potential for Traditional Medicine to Complement Modern Medicine (N = 15)

The White Paper for the Transformation of the Health System in South Africa (1997:15) calls for health care facilities that are accessible to members of a community. However, research has shown that approximately 56% of South Africans visit public health care centres where patients can wait between 2 to 5 hours, or more, before being seen by a health care professional (Hirschowitz & de Castro, 1995:67). Getting to a health-care centre can also be extremely time-consuming as up to 46% of South Africans take between half-an-hour to an hour to reach such a centre (Hirschowitz & de Castro, 1995:68). Patients' travelling time alludes to the far distances that must often be

travelled before being seen by a modern health care professional. Respondents in this study verbalised similar concerns regarding the accessibility of health care settings and they felt that they could contribute towards improving patient access to health care, as illustrated by this statement: "*There are a lot of traditional healers who can help the hospital. The hospital is a small place and we are a lot, especially in the location. There is one hospital and maybe seven-hundred traditional healers in a place, so they (modern health care personnel) can send patients to the traditional healers so they can help*".

Although traditional healers may be more geographically accessible, Pretorius, de Klerk and van Rensburg (1993:15) postulate that this physical proximity is not always taken into consideration when seeking these services since the healer is often expected to diagnose the problem through divination and without the patient disclosing information about the illness. Also, the possibility exists that the healer may also be consulted by the person who has wished the disease on the patient. For these reasons, a patient may choose a traditional healer who resides elsewhere (van Rensburg, Fourie & Pretorius, 1992:332; Pretorius, de Klerk and van Rensburg, 1993:15).

3.7.3 Respondents' suggestions for mutual education

In order to enhance the potential co-operation between the different health systems, respondents were asked to give suggestions on aspects that traditional healers can teach modern practitioners and vice versa. The data gleaned from this question is summarised in Table 3.7 and Table 3.8.

Respondents' comments clearly seemed to reinforce earlier topics. The first comment related to the avoidance of pollution by traditional healers so as to enhance their healing powers. This pollution or *umlaza* has the potential to nullify the treatments given by traditional healers (Hammond-Tooke, 1989:106; Ellis, 1996:143). This sort of pollution may seem extreme, but it is probably only highlighting a similar cornerstone of modern medicine with regards to hygienic patient contact for the prevention of transmittable diseases.

Table 3.7 Areas in which Traditional Healers Feel They Ca: Teach Modern Health Care Personnel

Area of Teaching	Sample Comments
Importance of ritual purity in the healer	• *"If you are going to treat a patient, you can't have sex before th t".*
Use of traditional medicines	• *"I can show wh : plants to use and how to make the medicir .* . • *"They can lear to use fat to fix the ear problems".*
Showing interest in the holistic nature of the patient	• *"They must try listen and to have patience, it is the most imp rtant thing. Don't be impatient with that persc : who cannot hear. They want you to listen to hem".* • *"We have time to sit down with the patient and listen. The m dern doctors don't. They have a lot of people waiting for them so they must hurry".* • *"The modern doctor can know that they also need to look t the spirits to really heal the patient."*

The participants in this study did not seem to have major reservations with regards to sharing their informanon. This finding is interesting since here has been a tendency in the past for healers to guard their medicinal secrets as the e are no legal or copyright regulations in the customary oral tradition. This secrecy may serve as a guarantee that traditional healers will not lose their patients to other hea ers who might discover the secrets and use them in their own practices (Hammon -Tooke, 1989:147; Kale, 1995:1185). Therefore, it is recommended that healer protec ion and rights of ownership be promoted so as to ensure true reciprocity and open inform ation sharing among health

providers (Airihenbuwa, 1995:59). This openness possibly reflected a change in attitude towards co-operation with modern medicine which was also noted with regard to the referral to modern medical staff discussed earlier.

Modern practitioners tend to be portrayed as separating the disease from the person and being disinterested in their patients' spiritual needs (Freeman & Motsei, 1990:5; Gumede, 1990:9; Hirschowitz & de Castro, 1995:72; Gilbert, Selikow, Walker, 1997:50). Similarly, audiologists have been blamed for being technocratic and focusing exclusively on machines, tests and devices, rather than persons (Hodgeson, 1994:616). Some of the respondents in this study seemed to subscribe to this belief and expressed the view that modern health care professionals do not have enough time and/or patience for dealing with patients' complaints. It is postulated that older and more experienced health professionals may have more time constraints against them (Erdman, 1994:393) which patients, and the traditional healers in this study, may perceive as a lack of interest, concern or understanding.

From these statements made by the traditional healers in this study, it appeared as though they wished to teach modern practitioners a more holistic approach to patient care. According to Featherstone and Forsythe (1997:24), holistic care responds to a person as a whole, including body, mind and spirit, within the context of that person's environment. Also, this approach supports an openness to using a wide range of interventions, from the physical to meta-physical. Featherstone and Forsythe (1997:25) feel that "a combination of approaches on different levels increases the effect of the intervention dramatically; giving some immediate relief and improving the general life quality of the patient, as well as helping with the presenting problem".

Table 3.8 highlights the areas in which traditional healers felt they could learn from modern health care professionals.

Table 3.8 Aspects which the Group of Traditional Healers Felt Modern Health Care Personnel Can Teach Them

Area of Teaching	Sample Comments
How to use modern instruments	• *"They can teach me how to use that torch* (otoscope) *to look in the ears. Then I can know what I must look for".*
Use of modern medicines	• *"If they can show me how to make pills".*

The respondents in this study seemed to indicate a desire to combine modern techniques with their established ones so as to better treat their patients. Specific topics that participants mentioned with regard to learning from modern health care practitioners included the accurate measurement and dosage of medicine; the hygienic storage of remedies; and how to mix medicines. However, their focus appeared to be on the physical health of the ear and no mention was made of modern audiometric testing techniques to evaluate hearing acuity.

Dual consultations are apparently very common in that the traditional healer is consulted for supernatural causes and explanation, whereas the modern practitioner is consulted for symptom relief and examination (Ellis, 1996:145). In light of this duality, traditional healers may want to show their patients that they can also perform similar procedures to those performed by modern health care professionals. Van Rensburg, Fourie and Pretorius (1992:333) report that traditional healers are attempting to appear more modern by adopting strategies such as wearing white overcoats, using patient visiting cards, and creating more hygienic environments. Traditional healers may be worried that in the scientific era, patients may be expecting them to use formal health care structures in conjunction with their traditional methods.

In the literature, there is a tendency to focus on the differences between the traditional and modern approaches. Surprisingly, traditional healers and modern health care practitioners may share more in common than previously believed as evidenced by

traditional healers' attempts at combining modern techniques with their traditional ways. However, it is argued that this similarity extends also to the relationship between patient and health care provider. It has already been established that in the modern approach, patients hand over the responsibility for healing to the health practitioner (Lupton, 1994:106). In the same way, traditional healers' effectiveness is rooted in the authority they exercise over patients due to their perceived expertise in medicine and close association with the supernatural domain (Hammond-Tooke, 1989:147).

3.7.4 Summary of findings in respect of sub-aim six

The results of this section seem to suggest that traditional healers in this project were referring patients to modern practitioners but they believed that modern health care personnel were not reciprocating this referral. Traditional healers interviewed were of the opinion that that modern practitioners are distrustful of their traditional methods. However, even though the differences between the traditional and modern approaches have been elaborated on, there also appeared to be similarities regarding the intention to do good for the patient. Also, the group of traditional healers felt that they could teach modern practitioners regarding the holistic care of patients. Respondents expressed a wish to add modern techniques such as otoscopy to their repertoire of traditional methods.

3.8. TRADITIONAL HEALERS' VIEWS REGARDING THE REASONS WHY PERSONS WITH HEARING LOSS SEEK THEIR SERVICES

The seventh aim was to investigate traditional healers' views relating to the reasons why persons with hearing loss seek their services over or in addition to those offered by modern medical practitioners.

Research conducted in the area of traditional healing seems to have focused on patients' reasons for consulting with traditional healers (Tom, 1992:27; Pretorius, de Klerk and van Rensburg, 1993:23). This research project, therefore, also looked at the traditional

healers' perceptions as to why they thought their clients seek their services. Table 3.9 summarises the traditional healers' perceptions about their patients' reasons for consulting with them.

Table 3.9 Traditional Healers' Views Regarding the Reasons why Persons with Hearing Loss Seek Their Services

Reasons Given By Traditional Healers	Number	Percentage (%)
They Can Treat Supernatural Causes	10	53
Good Reputation	5	33
Not Getting Desired Treatment at Modern Practitioners	4	27
Cultural Reasons	3	20
Patients are Seen Sooner	2	13
Ancestors Guide Patients to Them	2	13
Privacy	1	7

Note: Percentages do not add up to 100% as respondents could give more than one reason in their answers.

Once again the traditional healers' supernatural abilities seemed to be highlighted as a reason for patients consulting with them since 67% of respondents stated that they could perform the rites and rituals necessary to treat diseases of an otherworldly nature. As discussed at length in a preceding section of this research report, it is believed that there needs to be a balance between the physical and cosmological aspects of being human. Therefore, rituals are carried out in order to bring about that harmony by satisfying the ancestors or repelling the evil of the witchcraft (van Rensburg, Fourie & Pretorius, 1992:325; Gilbert, Selikow & Walker, 1997:50).

Participants in the study contended that their ability to cure cases of bewitchment and to appease the ancestors made them sought after by persons afflicted with diseases of such an origin. Earlier in this report, it was mentioned that 67% of respondents believed that hearing impairment could be caused by the ancestors while 27% ascribed this condition

to witchcraft. Similarly, 60%, 27% and 20% reported using laying of hands, throwing the bones, and dreams respectively as part of their treatment regimens. Similarly, those 27% of respondents who felt that their patients did not get the desired treatment at modern practitioners stated, "*The modern doctor can't cure the patient, he can just stop it for a few months because he can't see the ancestors*" and "*They want me to throw the bones*" suggesting an inability of modern practitioners to provide this type of assistance.

Throughout this research project, culture and help-seeking behaviour seemed to be a recurrent theme mentioned by respondents. It would seem as if patients seek a treatment which is culturally congruent with their own and one that is believed by the community to be effective. Cultural factors were cited by 20% of respondents as a reason for their patients consulting with them. Responses in relation to this theme included "*Patients will follow the traditional way because the elders did it that way*" and "*It is part of our history, where we come from*". However, one participant's answer was surprising when he said, "*People believe in culture and they want the same culture to help them. But they must remember that traditional medicine will work on White people the same way that their pills work on Black people*". This statement highlights the belief that modern medicine is 'White medicine' as entrenched by South Africa's previous history of forced segregation (Freeman & Motsei, 1992:6; Ellis, 1996:125) although it also hints at a cross-cultural effect of traditional medicine.

Karlsson & Moloantoa (1986:27) describe *ukufa kwabantu* as "the disease of the people" which refers to a disease that is based on cosmology and tradition which people from other cultures may find difficult to understand. Due to the belief in these culturally specific diseases, patients are more likely to consult with a health care provider who is sympathetic to their needs and has an understanding of patients' experiences. Such cultural ailments may be driven by the ancestors, spirits or witches and present with specific symptoms peculiar to that group. Modern health care personnel may casually ascribe these culturally specific conditions to unscientific and superstitious beliefs. However, even in the modern domain there are distinct conditions for which treatment is

sought more often than in traditional cultures, such as post-traumatic stress disorder, pre-menstrual syndrome, menopause, mid-life crisis, burnout, anorexia nervosa and chronic fatigue syndrome (Ellis, 1996:131).

Approximately one-third, i.e. 33% of traditional healers in this study seemed to depend quite heavily on their reputation as a way of attracting patients, which is not dissimilar to modern health care professionals' reliance on maintaining a good professional standing. Examples of respondents' statements included: *"If I do a good job, other patients will come see me"* and *"I provide a good service so, people come see me"*. In the same vein, 13% explained that the ancestors tell patients to come see them, as illustrated by this response: *"My inner spirit and the patient's inner spirit meet in another world and my inner spirit tells the patient's spirit to come see me"*. This response suggests that the reason for visiting the traditional healer also appeared to be spiritually mediated, as were the cause, diagnosis, and treatment of hearing problems.

Elsewhere in this report, conditions in public health care facilities were discussed in relation to, among others, time spent waiting for treatment. This sentiment was repeated in the responses furnished by 13% of the traditional healers who believed that they offered a speedier intervention than that provided by the modern practitioners. A respondent made his views clear when he complained about the delays in seeing patients at some modern health care centres and explained that he followed a different system at his practice: *"If I have many patients, I don't just take patient number two, number three if I see patient number six is seriously ill. I maybe talk to those who are next in the queue, number two, number three and say, 'I know you also need my help, but what if we can help that one because he is a little more serious"*.

3.8.1 Summary of findings in respect of sub-aim seven

Therefore, it appeared as though the traditional healers interviewed considered themselves an important health resource as they provide spiritual, culturally appropriate, timeous, and beneficial intervention and they believed that their patients had the same

opinion of them and their intervention. One of the major reasons cited for patients seeking their assistance was that traditional healers are skilled in supernatural healing which patients may be wanting. Also, cultural reasons were given as a factor in patients' help seeking behaviour.

3.9 ADDITIONAL COMMENTS MADE BY THE TRADITIONAL HEALERS REGARDING THEIR APPROACH TO HEARING IMPAIRMENT

Respondents were given the opportunity to volunteer any additional information regarding their approach to hearing impairment and hearing impaired persons.

Open-ended questions are described as being useful in allowing respondents the chance to offer information on areas not included in the questionnaire as well as to furnish additional ideas to responses already given (True, 1989:210; Sarantakos, 1998:231). Participants were encouraged to share any additional comments or concerns that they might have had regarding the role of traditional healers in dealing with ear or hearing problems. Examples of these comments are summarised in Table 3.10.

The additional comments furnished by the traditional healers echoed many of the themes articulated throughout this study with regard to their belief in their medicine, the need for referrals and modern medicine's disapproval of traditional medicine. However, the comments regarding belonging to an organisation and the importance of identifying and addressing hearing problems were significant as they indicated an awareness of these needs.

Table 3.10 Additional Comments Regarding Traditional Healers and Their Approach to Hearing Impairment

Theme	Sample Comments
The Importance of Identifying and Addressing Hearing Problems	• *"It is important that we treat patients with hearing problems, otherwise they will become dull and need to go to a special school to learn to talk with their hands".* • *"If they can't hear properly, they will fail at school".*
Importance of Belonging to an Organisation	• *"Traditional healers used to heal people, but they are a little more civilised now because they have already been taught about using clean medicines, about putting the stuff in nice, good order. The organisation can teach us these things".* • *"Before joining the organisation, we used to just do it anyhow, but now it has improved".* • *"We say government must help us, but if we are not registered, they won't know where to find us".* • *"The organisation helps to speak for us and what we think. Also, we can help each other in the organisation and teach each other the medicines".* • *"Those people who don't belong to the organisation don't want to share their knowledge and want to keep it secret".*
Strong Belief in Traditional Medicine	• *"I will go to the hospital and give the patient some medicine. The doctors will discharge them thinking that their medicine helped, but it is mine".*
Need for Mutual Referral	• *"Bewitched patients must be referred".* • *"To get a good treatment, patients should see us* (traditional healers) *and modern doctors".* • *"We go to workshops and training and they give us certificates. But we don't get a chance to see the patients because there is no referral from the modern doctor to the traditional healer".* • *"Modern doctors sometimes do not have time for all the patients, so they can refer to us".*
Modern Health Practitioners' Disapproval of Traditional Medicine	• *"It is a problem in hospitals because the traditional healers and modern doctors do not understand each other because they learn different things. Modern doctors don't like it when patients see the traditional healer".*

The respondents in this study all belonged to the Traditional Healers' Organisation. Participants in this study recognised the value of belonging to an organisation as they explained that this affiliation can provide members with continuing education, a platform for expressing their views, and a system of referrals within the organisation. Other bodies are also in existence, including the South African Traditional Healers' Council, the African National Healers' Association, the African Dingaka Association, and the Traditional Healers' and Herbalist Association (Pretorius, de Klerk & van Rensburg; Jacobs, 1993:73; Ingle, 1994:602). However, as it has been reported earlier, not all practising traditional healers seem to be registered with such organisations. Some reasons have been put forward as possible reasons to why traditional healers do not register, including a scepticism of modern medicine's hidden motives of trying to "colonise" traditional medicine (Freeman & Motsei, 1990:8); a desire to keep their methods secret to ensure that they retain their patients (Hammond-Tooke, 1989:147; Kale, 1995:1185); and the desire on the part of impostors to prevent being discovered (Ingle, 1994:606).

The importance of identifying and addressing hearing problems was articulated by respondents as being of vital importance for communicative, cognitive and scholastic development. Research has shown that failure to intervene timeously after the identification of hearing loss can have a huge impact on the hearing-impaired person's life (Jamieson, 1994:596). The use of the term "*dull*" by a respondent in the study suggests that the traditional healers interviewed were already aware of the cognitive effects of the failure to stimulate the person with a hearing loss. By suggesting placement of hearing-impaired learners into special education settings, respondents may have been recognising the need for a modified system of teaching for hearing-impaired learners that uses a different communication modality. However, by stating that hearing impaired learners may "*fail at school*", traditional healers may also have been appreciating the possible need to adapt the existing schools to cater for these learners.

3.9.1 Summary of additional comments made regarding traditional healers and their approach to hearing impairment

Traditional healers interviewed reiterated their opinion on topics relating to: their belief in traditional medicine, the need for mutual referral, and modern health practitioners' disapproval of their methods. However, their comments relating to the importance of belonging to an organisation and the early identification of hearing problems possibly showed that they shared similar ideas with modern practitioners regarding these issues. The findings of this section have important implications for the possible registration of traditional healers as well as their potential use in the provision of audiologically related services.

CHAPTER FOUR

CONCLUSIONS AND IMPLICATIONS OF THE STUDY

4.1 SUMMARY OF THE MAIN FINDINGS OF THE STUDY

This research project set out to obtain information regarding the approach of a group of traditional healers towards hearing impairment. Data pertaining to the types, cause, diagnosis and treatment of hearing loss were gathered. Also, information on traditional healers' training, perceptions regarding their collaboration with other health care personnel and their beliefs regarding the reasons why persons with hearing loss seek their services.

The traditional healers interviewed reported being consulted for a variety of audiological and/or otological problems which appeared to be both transient and permanent in nature, as well as conductive and sensory-neural in origin. Allusions to various pathologies were made, including tinnitus, hearing loss subsequent to meningitis, noise induced hearing loss, hearing impairment resulting from venereal disease, and possible middle ear dysfunction, among others.

Information relating to the causes of hearing impairment showed that a considerable emphasis was placed on mystical and magical elements. However, the respondents also mentioned other factors such as infection, organic deterioration, noise exposure and congenital aspects which were thought to contribute towards hearing loss. The traditional healers interviewed tended to personalise the cause of the disease and the reason for becoming ill was often sought in a supernatural realm.

It became clear that the traditional healers interviewed used techniques for diagnosing hearing loss with which modern practitioners are unaccustomed, e.g. throwing the bones, consulting with the relatives while the patient stays at home, asking the ancestors and prayer. Despite these differences, some of their methods appeared similar to modern

techniques such as assessing the patient's response to different sound stimuli and otoscopic examinations.

Various treatments for hearing problems were described by the traditional healers interviewed in this study. These treatments included plant remedies, which may have demonstrated healing properties, as well as some animal extracts. Other substances and specific rituals were also mentioned. It is possible that some of these other methods may not be as effective and may in fact be harmful to patients e.g. the insides of the millipede and sewing machine oil. An important contributor to health appeared to be the belief in the medicine's ability to heal and so the power of suggestion may be a core component of the traditional healer's healing capacity. The traditional healers interviewed also seemed to be amalgamating their skills and adopting a variety of tasks relating to patient care e.g. divining, making medicines, and praying over patients.

Despite the occasional similarities noted between traditional and modern techniques, a considerable difference with regards to training was observed. Traditional healers in this project seemed to place greater reliance on a spiritual calling and supernatural guidance in the training process. They reported that they may train under another traditional healer but that this training also focused primarily on communicating with the meta-physical realm.

Issues revolving around collaboration showed that the traditional healers interviewed were referring patients to modern practitioners but they believed that this referral was not being reciprocated by modern health care personnel and they were of the opinion that that modern practitioners were distrustful of their traditional methods. However, even though the differences between the traditional and modern approaches were identified, there also appeared to be similarities with regards the intention to do good and be of benefit to the patient. Also, traditional healers felt that they could teach modern practitioners regarding the holistic care of patients while they expressed a desire to include modern techniques such as otoscopy in their traditional approaches.

The traditional healers interviewed considered themselves important contributors to the health system as they believed that they provide spiritual, culturally appropriate, timeous, and beneficial intervention and they felt that their patients had the same opinion of them and their intervention. Cultural reasons, communication with the ancestors, and the traditional healers' abilities to perform spiritual healing were among the reasons cited for patients seeking assistance from traditional healers.

4.2 LIMITATIONS OF THE STUDY

A critical evaluation of this study revealed several limitations which need to be acknowledged.

Despite efforts to gather respondents from various areas, it is acknowledged that traditional healers in different provinces may have other approaches to hearing impairment which makes it difficult to generalise the results of this particular study to all traditional healers in different parts of the country.

Exact numbers of persons visiting traditional healers for audiological or otological problems were not obtained in this particular research project. Tom (1992:27) and Pretorius, de Klerk and van Rensburg (1993:23) estimated that about 9.5% 2.9% of people, respectively, consult with traditional healers with regard to hearing related problems. However, this study was not able to ascertain the exact number of patients seen by the traditional healers interviewed.

Notwithstanding the overt cultural differences between Blacks and Whites in South Africa, cultural differences in the conceptualisation of disease exist between the different Black cultural groups too (Ellis, 1996:126). Due to the disproportionate number of representatives from different cultural groups, the approaches of traditional healers from different cultural groups were not analysed separately. Instead, this study focused on the approaches of traditional healers as a whole towards hearing loss.

Despite efforts to reduce the social desirability effects of participants seeking to give more socially acceptable responses, there is a possibility that there are other traditional methods which were not reported by participants in this study, thereby confining the results of this research project to the information respondents were willing to divulge. Also, since 47% of the sample could not name the medicinal plants used in their treatments, the discussion on the traditional healers' herbal treatment of hearing loss was restricted to those plants that could be named.

Another limitation of this study was that it did not probe the respondents' awareness of the potential difficulties posed by hearing impairment. Research has shown that hearing impairment may have a significant impact on emotional, cognitive, communicative and social functioning (Ross, 1988:149; Op't Hof, 1991:31; Jamieson, 1994:598). Even though some mention was made of the need for special education and communication difficulties encountered by hearing impaired persons, traditional healers' awareness of the effects on vocational and social functioning, among others, was not investigated.

Respondents were asked to give information on their traditional diagnostic methods with regard to hearing impairment. This research project showed that traditional healers in this study used both physical and meta-physical methods in their diagnosis. However, their knowledge of modern audiometric techniques was not directly explored in this particular study.

4.3 IMPLICATIONS OF THE STUDY

Despite these methodological limitations, the findings from the study have important implications for audiologists and other modern health care professionals, policy makers, and traditional healers in terms of: the potential for cross-cultural consultations; the sharing of information regarding the effects of hearing impairment; collaboration with traditional healers; the use of traditional healers in primary health care; the role of traditional healers as community educators; the potential use of traditional healers in

identifying hearing impairment; the potential for the standardisation of traditional healers' methods; and further research.

4.3.1 Implications for audiologists and other health care professionals

4.3.1.1 Cross-cultural consultation issues

It is accepted that South African society was historically divided in political and cultural domains on the basis of race. Some of the effects of this segregation are apparently still present today where certain interactions between Black patients and White modern medical professionals may evoke feelings of discomfort. *Uyamehlisa* is a term which means that patients may be lowering the modern practitioner's dignity and status by asking questions or seeking a further explanation, even if they have not fully understood what has been said. Also, the patient could believe that by asking questions it could be perceived as if the patient was not listening, which would be interpreted as disrespectful (Ellis, 1996:135). Because of *inhlonipha* or respect for the modern medical professional, patients may avoid describing all their problems so as not to appear presumptuous (Ellis, 1996:135). Furthermore, because traditional healers are believed to have divining powers, patients trust their abilities to diagnose the problem and they do not necessarily fear *uyamehlisa* and can therefore maintain *inhlonipha.*

In the past, the main cultural distinctions in South Africa used to be in terms of Black and White, mostly due to socio-political factors. Class and gender differences have also always been present, although South Africa appeared to be primarily divided by colour which then perpetuated other types of social strata (Webster, Alfred, Bethlehem, Joffe & Selikow, 1994:10). Due to this colour classification, many of South Africa's ethnic cultural identities were disregarded and there was the assumption that all black cultures were the same. However, as Ellis (1996:126) points out, cultural differences exist in the concepts of disease between groups such as the Zulu, Xhosa, Pedi, and Sotho. These diseases are unique to those people in terms of aetiology, diagnosis and treatment and are driven by that group's particular world-view. For this reason, it is crucial that modern health care practitioners do not just simply categorise all people as the same, but that

they rather familiarise themselves with the cultural beliefs common to the area where they are working.

It is recommended that those involved in cross-cultural consultations realise that, although they have their own culturally bound beliefs and values, there are other valid procedures that are not necessarily better or worse, but different. Also, it is suggested that in cross-cultural consultations, practitioners need to be aware of their own values and biases, and how they affect the interaction, as well as being comfortable with the possible differences that may exist between themselves and their patients (Sikhitha, 1996:63).

Because of these cultural variations, it is recommended that modern health care practitioners be encouraged to be sensitive to patients' backgrounds and beliefs within cross-cultural consultations. Generally, modern practitioners are advised to understand the patients' perspective and keep explanations within that frame of reference; use non-verbal communication; ask whether a traditional healer has already been consulted and what recommendations were made; ascertain what the patient is expecting from the consultation; confirm that the patient has understood everything that has been explained; consider the involvement of the family; and discuss the involvement and desired outcome of simultaneous traditional healing (Ellis, 1996:148).

4.3.1.2 The possibility of sharing information regarding the effects of hearing impairment

From the results of this study project, it appeared that the group of traditional healers interviewed were being consulted by patients with various otological problems. Consequently, traditional healers need to be taught about the potential audiological difficulties that can arise as a result of the otological problems already outlined. By giving traditional healers information relating to the possible audiological consequences of otological problems, better provision can be made for rehabilitative services necessary for the persons concerned.

Also, if traditional healers become aware of the importance of early identification of hearing problems, more severe complications and adverse effects of hearing loss can be minimised. By being able to properly identify those at risk for hearing impairment based on the their patients' symptoms, speedy intervention can be implemented to reduce the impact of the hearing impairment (Op't Hof, 1991:33).

The information given to traditional healers needs to be disseminated effectively and concisely while simultaneously engendering feelings of mutual respect between modern and traditional practitioners. This mutual respect is likely to go a long way to encourage the appropriate referrals to the relevant health care personnel (van Rensburg, Fourie & Pretorius, 1992:342). Also, if patients observe that there is a mutual respect between the modern and traditional spheres, they may also change their own long-standing negative attitudes to modern practitioners to more positive ones (van Rensburg, Fourie & Pretorius, 1992:342) which could result in more effective identification and consequent rehabilitation of audiological problems.

4.3.2 Implications for policy makers

4.3.2.1 The potential for collaboration with traditional healers

Craffert (1997:4) contends that integration should not necessarily be the goal, but rather that the two systems try to co-exist and understand each other's role in patient care. It is maintained that the collaboration between traditional and modern practitioners does not mean that the one must assume the role of the other or that the one can be put in place of the other (Airhihenbuwa, 1995:58). Instead, the two groups need to foster an understanding of the other's potential contribution in treating the patient physically and spiritually. For this reason, Airhihenbuwa (1995:58) suggests that traditional healers and modern health care practitioners should meet in a forum where they can be both trainers and trainees since both have a contribution to give and to gain. It is further recommended that the afore-mentioned practitioners be encouraged to respect each other's contribution to health care, communicate openly, educate and support each other, thereby acting in the best interests of the patient (Featherstone & Forsythe, 1997:20).

By encouraging a multidisciplinary co-operation consisting of open communication and respect, the patient can be protected from harmful interventions (Featherstone & Forsythe, 1997:20). Through mutual education, traditional healers can learn about the possible negative side-effects of some of their medicines and modern practitioners can understand the danger of neglecting the patient's spiritual well-being. This knowledge is likely to go a long way to preventing harm being done to patients. Already within the modern medical profession, there exists cross-discipline communication, which suggests the need for an attempt at cross-system communication.

However, it is argued that through patients' help-seeking behaviour, they are effectively handing over their health concerns to health care professionals, which implies a power differential driven by patients' handing over of responsibility for their health and by their acknowledgement of the health care staff's expertise (Lupton, 1994:105). Therefore, the perceived indifference from the modern health care staff may serve as a tool for maintaining a social distance between modern practitioners and their patients, thereby allowing them to successfully take control of the situation and, in so doing, provide what they consider to be best for the patients' health. Because of the traditional healers' tendency to include spiritual, environmental and historical aspects in their approach, they may perceive modern practitioners as being impatient and disinterested because they tend to focus primarily on the physical and biological manifestations of the disease.

Notwithstanding the perceived distance between modern practitioners and their patients, practitioners are encouraged to "support the sick person, affirming his or her worth and maintaining a considerate attitude" (Lupton, 1994:106). Audiologists, in particular, are encouraged to explore patients' emotions around auditory dysfunction, reflect on patients' feelings regarding their hearing impairment, and ascertain the impact of their hearing loss (Hodgeson, 1994:616). They are also requested to attend to the person and not to treat the audiogram, by communicating care and concern while trying to gain a better understanding of hearing impairment and its effects in a given person (Erdman, 1993:393). Therefore, it would seem as though modern health care professionals have in

fact been given information relating to the affective treatment of patients, although traditional healers in this study felt that they might not necessarily possess such knowledge.

4.3.2.2 The potential use of traditional healers in the provision of primary health care

Until the 1950's, primary health care referred to the extension of basic medical curative services into rural or understaffed areas. Thereafter, in the 1980's, a distinction was made between the terms 'medical care' and 'health care', where the first type treats disease and the latter endeavours to prevent disease and promote health (Abbat & McMahon, 1985:2). From this distinction, it can be seen that medical care does not address the conditions which may perpetuate disease but only treats the manifest symptoms. On the other hand, health care attempts to treat the disease while removing those elements that first caused the disease so as to reduce further transmission. Abbat and McMahon (1985:4) contend that the improvements in sanitation, clean water supplies and community education contributed to reducing the incidence of diseases such as typhoid, tuberculosis, measles, and whooping cough, and infant mortality rates were dramatically reduced

The desire expressed by traditional healers in the present study to complement their traditional ways with more modern techniques may warrant their involvement in the provision of primary health care. The United Nations' Declaration of Alma-Ata (World Health Organisation, 1978:429) suggests that traditional healers be included in the provision of primary health care. Although the White Paper for the Transformation of the Health System in South Africa (1997:57) does not include traditional healers as members of the public health service at this time, it does recognise their contribution to primary health care in South Africa.

It is posited that traditional healers can be useful contributors to the primary health care system due to their cultural, social and psychological proximity with the members of

their community (Pretorius, de Klerk & van Rensburg, 1993:15). Dheyongera (1994:16) submits that traditional healers can contribute towards primary health care since they can fill the vacuum in the health care delivery system due to the shortage of staff; they can provide symptomatic relief through the administration of safe and hygienic herbal remedies; they are knowledgeable regarding aspects of psychosomatic medicine; they possess skills in counselling; they are members of the communities in which they practice; and, due to the respect afforded them by their communities, they can implement primary health care services related to the treatment and prevention of disease.

Dennil (1995:3) states that there may be a notion that primary health care is cheap, simple and second-class care, although its premises are actually based on scientific research. The increase in financial expenditure on primary health care from R5,3 billion in 1996/97 to a projected R7.3 billion in 2000/01 (Sidiropoulos, Jeffery, Mackay, Forgey, Chipps & Corrigan, 1997:488) appears to signal a push for the development of primary health care in South Africa and refutes the misconception that primary health care is cheap. It is reported that the Department of Health envisages a primary health care system that comprises personal and non-personal health services so as to provide comprehensive care. Personal services include, "curative, promotive and preventive services such as basic optometry, basic rehabilitation services, counselling, family planning, health education, HIV/AIDS education, immunisation, maternal and child care, mental health, nutrition, oral health, the provision of essential drugs, and screening for common diseases" while non-personal services comprise "communicable and non-communicable disease control, health-related water and sanitation services, school and nutritional health services, and other environmental health services" (Sidiropoulos, Jeffery, Mackay, Forgey, Chipps & Corrigan, 1997:488).

Even though optometry is included in this afore-mentioned list of services, audiology appears to have inadvertently been excluded. Notwithstanding this exclusion, the tenets of primary health care can be extended to audiological concerns too and traditional

healers can be involved in providing the personal and non-personal services advocated earlier by, for example: learning basic audiometric screening; educating members of their communities regarding the dangers of noise pollution and encouraging the use of ear-protection; promoting hygienic living conditions so as to reduce the risks of, among others, meningitis or otitis media; advocating for improved immunisation against disease; identifying hearing impairment in the population; establishing an at-risk register to help provide for those with hearing impairment; teaching communication strategies for assisting hearing impaired persons; providing educational and rehabilitative options for children with hearing loss; warning communities of the possible ototoxicity of certain substances (e.g. large doses of aspirin); referring persons with hearing loss for affordable assistive listening devices; procuring funding for assistive listening devices; campaigning for the rights and privileges of hearing impaired people; catering for hearing impaired children's schooling needs; fostering community understanding of the impact of hearing loss; and teaching good aural hygiene.

According to the Health Professions Council of South Africa's current database, there are 1804 registered speech-language-hearing therapists in South Africa (Hoffman, 2000, personal communication). Broomberg and Shisana (1995:27) estimate that South Africa will need to employ the services of 192 speech-language-hearing therapists per 50 000 people for the year 2000/2001. If these figures are taken into account, it appears as though audiologists will need assistance in their provision of services to the South African population. Pitt (1997:14) reports on the successful use of traditional healers as community health workers in providing primary health care. These community health workers function within a primary health care model where they focus on preventive and promotive work. Schneider (1992:55) similarly reports on the use of community health workers in the provision of speech-language-hearing services.

However, it must be remembered that in trying to include traditional healers in primary health care, modern medicine should not assume a superior role and apply a "donor-deficit" approach by focusing and teaching only what the traditional healers do not know.

Instead, it is suggested that modern practitioners build on the traditional healers' existing knowledge of treating disease and extend it to include modern methods (Airhihenbuwa, 1995:57). Modern practitioners are, nevertheless, warned that in an attempt to include aspects of modern medicine in traditional healing, there is a danger that traditional healers may also adopt some of the characteristics for which they criticise the modern practitioners (van Rensburg, Fourie & Pretorius, 1992:340).

The inclusion of participants' ideas and opinions in service provision leads to the development of knowledge, skills and confidence which are then transferred to the community (Barnes & Walker, 1998:199). Empowerment of traditional healers can occur if modern practitioners identify and build on existing strengths so as to consolidate the new information with the existing ideas and to bring about change within the community (Ross, 1991:196). By applying Ross (1991:196) and Barnes and Walkers' (1998:200) general principles of community inclusion and respect for participants' input, traditional healers can become empowered to provide better services. At the same time, those traditional healers will in turn be empowering community members with the necessary collective influence to bring about necessary changes to those conditions found to be contributing to ill health.

In an effort to achieve good aural health, audiologists seeking to include traditional healers in primary health care need to remember, therefore, that the services they offer should be available, accessible, and appropriate to the community. Hence, audiologists should not only attempt to extend their services into under-served communities, but rather, in addition, ought to empower traditional healers and the community to promote the prevention of hearing impairment through the training and inclusion of participants providing audiological services.

4.3.3 Implications for traditional healers

4.3.3.1 Traditional healers as possible community educators

Given the knowledge that traditional healers in this study seemed to have of the detrimental effects of noise on a person's hearing, they could serve as advocates for hearing conservation in their community, especially as they are generally highly regarded and respected by members of the community (Dheyongera, 1994:15). They also tend to share the same cultural experiences as their communities (Gilbert, Selikow & Walker, 1997:50) and can therefore implement culturally appropriate hearing conservation programmes, especially with regard to those working on the mines and in industry.

In addition, traditional healers can serve as the primary interventionists with regards to teaching people how to maintain good aural health while discouraging possibly harmful practices such as scratching in the ear with sharp instruments to remove foreign objects or impacted wax (Northern & Downs, 1991:63; Bull, 1992:24). They could also promote the need for environmental hygiene as a pre-requisite for optimal health since it has been shown that meningitis and otitis media, among other conditions, are more prevalent in unsanitary environments and tend to spread to a greater extent in such areas (Northern & Downs, 1991:65; Hussey, Schaaf, Hanslo, Hitchcock, Coetzee, Pitout, Malan & Donald, 1997:55).

Traditional healers in this study alluded to the danger of ototoxic substances to hearing. The effects of these ototoxic substances have been documented and they are reported to enter the inner ear through the blood stream and usually damage the stria vascularis, spiral ligament, sensory hair cells and supporting cells of the cochlea while the cristae of the ampullae in the semicircular canals may also be affected (Northern & Downs, 1991:74; Silman & Silverman, 1991:58). Armed with knowledge of the types of ototoxic substances that could be potentially harmful (e.g. excessive amounts of aspirin in persons for whom it is not prescribed), traditional healers are in the position to advise people on safer use of these substances. Also, traditional healers could warn people regarding the use of apparently audiologically innocuous substances such as alcohol.

Foetal alcohol syndrome has the potential to cause central nervous system, cognitive and hearing impairments (Northern & Downs, 1991:363; Leavitt, 1995:160). Traditional healers could therefore become involved in educating the community regarding these dangers.

Through their involvement and social standing in their communities, traditional healers could serve to educate people regarding hereditary deafness and counselling those couples at risk for having hearing-impaired children. Also, by identifying those families at risk, an at-risk-register could be established so as to make better educational, social and communicative provision for those children born with a hearing loss (Northern & Downs, 1991:239).

Research has shown that hearing-impaired learners require a multi-disciplinary approach and community involvement in order to better adjust within an inclusion programme (de Andrade, 1999:337). Traditional healers with a knowledge of hearing impairment and surrounding management issues could possibly help to accomplish this goal by serving on multi-disciplinary teams. They could facilitate or advocate for amplification, the use of sign language, the teaching of communication skills, and the modification of existing teaching methods to accommodate hearing-impaired learners (de Andrade, 1999:337).

Vocational issues also need to be considered with regard to hearing-impaired persons as their employment opportunities tend to be limited (Jamieson, 1994:510). Traditional healers could advocate for the establishment of community employment opportunities for persons with hearing-loss. This ability to work may then reduce the negative effects on the person's socio-economic status and self-esteem usually associated with unemployment (Ross, 1988:149).

4.3.3.2 The potential use of traditional healers in identifying hearing impairment

If traditional healers are able to recognise these signs of auditory dysfunction, an appropriate referral can potentially be made for the further evaluation and management

of these symptoms. It is vitally important to identify these hearing problems in order to provide rehabilitative services for those persons with hearing impairments. As discussed earlier, hearing losses, be they acute (e.g. due to otitis media or tympanic membrane perforation) or chronic (e.g. sensory-neural deafness due to congenital or acquired factors), have serious communicative, scholastic, social and occupational ramifications for both the hearing impaired person and those within the person's social network.

The large proportion of traditional healers interviewed who reported coming across persons with hearing loss, suggests a need for the training of traditional healers regarding the identification of potential audiological problems in their communities. Even though traditional healers may not have the same training with regard to the methods of audiological assessment as audiologists, guidelines have been provided to help identify the presence of a hearing loss. For example, Loveday (1990:151) and the Health Services Development Unit (1988:35) provide suggested protocols for the identification of paediatric hearing losses, although these same principles can also be used for older persons. Some of the principles of behavioural observation audiometry and visual reinforcement audiometry (Northern & Downs, 1991:145) are included in these suggested protocols. These suggestions include looking for: reactions such as blinking or showing surprise reactions to sounds; localisation to sounds from a noise maker e.g. a rattle; smiling in response to familiar voices or sounds; and asking the older patient to repeat words or numbers. It is also suggested that children should be saying a few words by the age of 18 months and many words by the age of 3 or 4, and, therefore, a delay in speech-language development can be also be indicative of the presence of a hearing loss (Health Services Development Unit, 1988:35; Loveday, 1990:151). Even though these afore-mentioned tools may not seem very accurate or specific, they can serve as screening tools for the referral of the patient for further audiometric testing. Also, McPherson and Knox (1992:139) report on the successful use of the hand-held Liverpool Screening Audiometer in developing countries in identifying hearing loss which could be added to identification protocols.

4.3.3.3 The potential for the standardisation of traditional healers' methods

One of the arguments against the use of herbal remedies is the perceived non-standard dosages and vague formulae that may be employed by traditional healers in making their medicines (Karlsson & Moloantoa, 1986:29). As Ellis (1996:146) points out, a common practice among traditional healers is to use "a handful (*isandla*)" of herbs notwithstanding the fact that hand sizes may vary between practitioners. It is felt that traditional healers may require more information about the origins, contra-indications, side effects, toxicity, and dosage of preparations (Ingle, 1994:604). Publications by the Health Services Development Unit (1988:iii), Werner, Thuman, Maxwell and Pearson (1993:iii) and Felhaber (1997:vii) have attempted to provide standard guidelines that could be followed by traditional healers in their treatment of patients. In these publications, the authors seem to be providing a modern influence to traditional medicine while still respecting its traditional character. Similarly, there appears to be a need to distribute information regarding the possible contra-indications and side effects of some traditional medicines and for the provision of safer alternatives and procedures so as to ensure optimal patient health.

Traditional healers in this study indicated the potential benefits of belonging to an organisation. Membership of such an organisation can serve to protect both patients and traditional healers (Hopa, Simbayi & du Toit, 1998:13). It can also go a long way towards improving quality control of the methods used by traditional healers so as to remove potentially harmful ones; to obtain recognition from the government and modern medicine; to set standards of registration; to negotiate with employers regarding the writing of sick-notes by traditional healers; and to improve the efficiency of consultation, diagnosis and treatment of patients (Ingle, 1994:605). Also, registration is likely to provide modern practitioners with a referral base of traditional healers who have passed the regulations set by the organisation to which they belong.

However, various authors have suggested that registration may be difficult due to the perceived aspiration of modern practitioners to exercise an authoritative control over

traditional healers and their medicine, as well as the traditional healers' desire to keep their methods secret (Hammond-Tooke, 1989:147; Freeman & Motsei, 1990:8; Kale, 1995:1185). Also, those traditional healers who may be practising unethically are likely to resist registration in the hope of not being discovered (Ingle, 1994:606). It is also suggested that the standards of regulation applicable to modern medicine would be inappropriate to traditional healing due to differences in beliefs, training and methods. Instead, traditional healers are encouraged to establish ethical codes and disciplinary bodies that reflect an understanding of the founding principles of traditional medicine (Hopa, Simbayi & du Toit, 1998:12). These traditional registration bodies could be set up along the lines of other para-medical associations that are geared to address the specific needs of their members.

4.3.4 Implications for future research

- The difficulty in generalising the results of this particular study to all traditional healers in different provinces in South Africa implies that similar studies be replicated using larger samples in different areas across the country. Also, similar research could be conducted in other countries in which traditional healers are consulted so as to ascertain information regarding the traditional methods employed in those countries.

- Even though efforts were made in previous studies to estimate the number of persons visiting traditional healers for audiological or otological problems, more accurate numbers need to be established so as to better cater for these persons.

- Also, the disproportionate number of representatives from different ethnic groups in this study suggests that it would be useful to investigate possible ethnic differences in the approach to hearing impairment.

- Further analysis is needed of the pharmacological effects of the medicinal plants that could not be named by 47% of the sample so as to acquire knowledge regarding their suitability for treating hearing impairment.

- A study of traditional healers' awareness of the potential difficulties posed by hearing impairment is needed so as to gain insight into their understanding of the emotional, cognitive, communicative, vocational and social functioning of these persons.

- As traditional healers' knowledge of modern audiometric techniques was not directly explored in this particular study, it would be interesting to investigate this area so as to establish a baseline of knowledge on which to build.

- It is suggested that a programme for the training of traditional healers with regard hearing impairment be implemented, after which a study of the effectiveness of such a programme could be carried out.

In conclusion, this research report has highlighted the differences and similarities in the traditional and modern approaches to hearing impairment. It showed that different belief systems and world-views guide traditional healers in addressing hearing problems. However, these differences also serve as a possible source of division between the two groups. The results of this study imply a potential for collaboration based on mutual respect and understanding of each approach. However, more importantly, it became clear that traditional healers in this study emphasised the need to consider the patient holistically, without separating the patient from the disease. Herman von Helmhotz, one of the founding fathers of audiology, seemed to share a similar sentiment and pointed out that science alone may not provide all the answers when he declared (Hall & Mueller, 1997:3):

"Whoever, in the pursuit of science,
seeks after immediate practical utility,
may generally rest assured that he will seek in vain.
All that science can achieve
is a perfect knowledge and a perfect understanding
of the action of natural and moral forces".

REFERENCES

Abbat, F. & McMahon, R. (1985). ***Teaching Health-Care Workers.*** London, UK: Macmillan Education Ltd.

Airhihenbuwa, C. O. (1995). ***Health and Culture: Beyond the Western Paradigm.*** Thousand Oaks, CA, USA: Sage Publications.

Alpiner, J. G; Kaufman, K. J; & Hanavan, P. C. (1993). Overview of Rehabilitative Audiology. In Alpiner, J. G. & McArthy, P. A. (eds.). ***Rehabilitative Audiology in Children and Adults.*** (2nd ed.). Baltimore, MD, USA: Williams and Wilkins.

Baker, T. L. (1994). ***Doing Social Research.*** (2nd ed.). Singapore: McGraw-Hill Inc.

Babbie, E. (1995). ***The Practice of Social Research.*** (7th ed.). Belmont, CA, USA: Wadsworth Publishing Co.

Barnes, M. & Walker, A. (1998). Principles of Empowerment. In Allot, M. & Robb, M. (eds.). ***Understanding Health and Social Care.*** London, UK: Sage Publications Ltd.

Bartholet, J. (2000). The Plague Years. ***Newsweek.*** 135:6-11.

Battle, D. E. (1997). Multicultural Considerations in Counselling Communicatively Disordered Persons and their Families. In Crow, T. A. (ed.). ***Applications of Counselling in Speech-Language Pathology and Audiology.*** Baltimore, MD, USA: Williams and Wilkins.

Berg, B. L. (1995). ***Qualitative Research Methods for the Social Sciences.*** (2nd ed.). Boston, Mass, USA: Allyn & Bacon.

Birchall, M. A; Wight, R. G; French, P. D; Cockbain, Z; & Smith, S. J. M. (1992). Auditory Function in Patients with the Human Immunodeficiency Virus. ***Clinical Otolaryngology.*** 17:117-121.

Blackett-Sliep, Y. (1989). Traditional healers and the primary health care nurse. ***Nursing RSA.*** 4:42-44.

Broomberg, J. & Shisana, O. (1995). ***Restructuring the National Health System for Universal Primary Health Care.*** Pretoria: Department of Health.

Buhrmann, V. (1980). Why are certain procedures of the indigenous healer effective? In Wilson, F. & Westcott, G. (eds.). ***Economics of Health in South Africa: Volume II.*** Johannesburg, RSA: Ravan Press.

Bull, P. D. (1992). ***Lecture Notes on Diseases of the Ear, Nose and Throat.*** (7th ed.). Oxford, London, UK: Blackwell Scientific Publications.

Collins, T. F. B. & Ntsele, M. (1996). The role of the South African National Tuberculosis Association, family practitioners and others in the fight against tuberculosis. ***South African Family Practice.*** 17:527-530.

Conco, W. Z. (1991). Zulu Traditional Medicine: its role in modern society. ***Community Health.*** 6:8-13.

Craffert, P. F. (1997). Opposing world-views: The border guards between traditional and biomedical health care practices. ***South African Journal of Ethnology.*** 20:1-9.

Dauskardt, R. P. A. (1990). Traditional medicine: Perspectives and policies in health care development. ***Development Southern Africa.*** 7:351-357.

de Andrade, V. M. (1999). Attitudes of a Group of Deaf Adolescents Towards Educational Inclusion. ***South African Journal of Education.*** 19:327-340.

de Castro, J. & Hirschowitz, R. (1995). Household Description. In Sinclair, M. & Tyson, J. (eds.). ***The Community Agency for Social Enquiry (CASE) - A National Household Survey of Health Inequalities in South Africa.*** Washington, DC, USA: The Henry J. Kaiser Foundation.

Dennil, K. (1995). International views on primary health care. In Dennil, K; King, L; Lock, M; . & Swanepoel, T. ***Aspects of Primary Health Care.*** Halfway House, RSA: Southern Book Publishers.

Dirkx, J. (1995). ***Stedman's Medical and Allied Health Dictionary.*** (26th ed.). Baltimore, MD, USA: Williams and Wilkins.

Dheyongera, J. P. (1994). Prospects and scope for traditional medicine in the health care system of developing countries. ***Journal of Comprehensive Health.*** 5:15-16.

Ellis, C. (1996). Ukufa Ukwaba. ***S.A. Family Practice.*** 17:124-148.

Erasmus, P. C. (1992). More about complementary medicine: Traditional healing. ***Continuing Medical Education.*** 10:105-106.

Erdman, S. A. (1993). Counseling Hearing-Impaired Adults. In Alpiner, J. G. & McArthy, P. A. (eds.). ***Rehabilitative Audiology in Children and Adults.*** (2nd ed.). Baltimore, MD, USA: Williams and Wilkins.

Ethics and Standards Committee. (1996). ***Medico Legal Guidelines for Speech-Language Therapists and Audiologists.*** Johannesburg, RSA: South African Speech-Language and Hearing Association.

Ethics and Standards Committee. (1998). ***Standards for Speech-Language Therapists in Private Practice.*** Johannesburg, RSA: South African Speech-Language and Hearing Association.

Featherstone, C. & Forsythe, L. (1997). ***Medical Marriage.*** Findhorn, Scotland: Findhorn Press.

Felhaber, T. (1997). ***South African Traditional Healers' Primary Health Care Handbook.*** Cape Town, RSA: Kagiso Publishers.

Fortnum, H. & Davis, A. (1993). Hearing Impairment in Children After Bacterial Meningitis. ***British Journal of Audiology.*** 27:43-52.

Freeman, M. & Motsei, M. (1990). Is there a role for traditional healers in health care in South Africa? ***The Centre for the Study of Health Policy.*** University of the Witwatersrand, Johannesburg, RSA.

Gilbert, L; Selikow, T. A; & Walker, L. (1997). ***Society, Health and Disease.*** Randburg, RSA: Ravan Press.

Ginsburg, I. A. & White, T. P. (1994). Otologic Disorders and Examination. In Katz, J. (ed.). ***Handbook of Clinical Audiology.*** Baltimore, MD, USA: Williams and Wilkins.

Gumede, M. N. (1992). Interview. ***S.A. Practice Management.*** 13(2):9-10.

Hall, J. W. & Mueller, H. G. ***Audiologists' Desk Reference: diagnostic audiology principles and procedures.*** San Diego, CA, USA: Singular Publishing.

Harnett, L. & Mnisi, P. (1996). Pregnancy and childbirth: tradition confronts medical practice. ***Health Systems Trust.*** 16:9-10.

Hammond-Tooke, D. (1989). ***Rituals and Medicines: Indigenous Healing in South Africa.*** Johannesburg, RSA: AD. Donker Pty. Ltd.

Health Services Development Unit. (1988). ***Primary Clinical Care: conditions of the ear, nose and throat.*** University of the Witwatersrand Medical School, Johannesburg, RSA.

Henderson, D; Salvi, R. J; Boettcher, F. A; & Clock, A. E. (1994). Neurophysiologic Correlates of Sensory-Neural Hearing Loss. In Katz, J. (ed.). ***Handbook of Clinical Audiology.*** Baltimore, MD, USA: Williams and Wilkins.

Hirschowitz, R. & Taunyane, L. (1995). Chronic illnesses and disabilities: adults aged 16 to 64 years. In Sinclair, M. & Tyson, J. (eds.). ***The Community Agency for Social Enquiry (CASE) - A National Household Survey of Health Inequalities in South Africa.*** Washington, DC, USA: The Henry J. Kaiser Foundation.

Hirschowitz, R. & de Castro, J. (1995). Access to health care: adults aged 16 to 64 years. In Sinclair, M. & Tyson, J. (eds.). ***The Community Agency for Social Enquiry (CASE) - A National Household Survey of Health Inequalities in South Africa.*** Washington, DC, USA: The Henry J. Kaiser Foundation.

Hodgeson, W. R. (1994). Audiologic Counselling. In Katz, J. (ed.). ***Handbook of Clinical Audiology.*** Baltimore, MD, USA: Williams and Wilkins.

Hoffman, Y. (2000). ***Personal Communication.*** Health Professions Council of South Africa.

Hopa, M; Simabayi, L. C; & du Toit, C. D. (1998). Perceptions on integration of traditional and western healing in the new South Africa. ***South African Journal of Psychology.*** 28:8-14.

Hussey, G; Schaaf, J; Hanslo, D; Hitchcock, J; Coetzee, G; Pitout, J; Malan, H & Donald, P. (1997). Epidemiology of Post-Neonatal Bacterial Meningitis in Cape Town Children. ***South African Medical Journal.*** 87:51-56.

Ingle, R. (1994). No healer is an island. ***S.A. Family Practice.*** 15:602-606.

Jamieson, J. R. (1994). The impact of hearing impairment. In Katz, J. (ed.). ***Handbook of Clinical Audiology.*** Baltimore, MD, USA: Williams and Wilkins.

Jacobs, M. (1993). The role of traditional medicine in a changing South Africa. ***Critical Health.*** 43:73-76.

Johnston, E. & Ross, E. (1991). Attitudes of a Group of South African Speech and Hearing Therapists Towards Patients with Acquired Immunodeficiency Syndrome. ***The South African Journal of Communication Disorders.*** 38:49-57.

Kale, R. (1995). Traditional healers in South Africa: a parallel health care system. ***British Medical Journal.*** 310:1182-1185.

Karlsson, E. L. & Moloantoa, K. E. M. (1986). The traditional healer in primary health care. ***Nursing RSA.*** 1:26-29.

Kaplan, H. I. & Sadock, M. D. (1991). ***Synopsis of Psychiatry.*** (6th ed.). Baltimore, MD, USA: Williams and Wilkins.

Katz, J. (1994). Clinical Audiology. In Katz, J. (ed.). ***Handbook of Clinical Audiology.*** Baltimore, MD, USA: Williams and Wilkins.

Leavitt, F. (1995). ***Drugs and Behaviour.*** (3rd ed.). Thousand Oaks, CA, USA: Sage Publications.

Loveday, M. (1990). ***Community Based Rehabilitation Workers: a South African training manual.*** Cape Town, SA: SACLA Health Project.

Lupton, D. (1994). ***Medicine as Culture: Illness, Disease and the Body in Western Societies.*** London, UK: Sage Publications.

Martin, F. N. (1994). Pseudohypoacusis. In Katz, J. (ed.). ***Handbook of Clinical Audiology.*** Baltimore, MD, USA: Williams and Wilkins.

Mbigi, L. & Maree, J. (1995). ***Ubuntu: the spirit of African transformation management.*** Randburg, RSA: Knowledge Resources (Pty) Ltd.

McKenzie, J. A. (1992). The Provision of Speech, Language and Hearing Services in a Rural District of South Africa. ***The South African Journal of Communication Disorders.*** 39:50-54.

McPherson, B. & Knox, E. (1992). Test-retest variability using the Liverpool screening audiometer in a field environment. ***British Journal of Audiology.*** 26:139-141.

McPherson, B. & Swart, S. M. (1997). Childhood hearing loss in sub-Saharan Africa. ***International Journal of Pediatric Otorhinolaryngology.*** 40:1-18.

Mojalefa, S. R. & van Staden, S. M. (1999). Perception of mental illness amongst black communities. ***Social Work/Maatskaplike Werk.*** 35:152-160.

Moolman, J. (1996). Empowering traditional healers to help care for HIV and AIDS infected persons. ***Health Systems Trust.*** 13:36-37.

Ngubane, H. (1992). Clinical Practice and Organisation of Indigenous Healers in South Africa. In Feierman, S. and Janzen, J. M. (eds.). ***The Social Basis of Health and Healing in Africa.*** Los Angeles, CA, USA: University of California Press.

Northern, J. L. & Downs, M. P. (1991). ***Hearing in Children.*** (4th ed.). Baltimore, MD, USA: Williams and Wilkins.

Op't Hof, J. (1991). A strategy of the S.A. National Council for the Deaf for the prevention of hearing-impairment. ***Rehabilitation in RSA.*** 35:30-35.

Patton, M. Q. (1987). ***How to Use Qualitative Methods in Evaluation.*** London, UK: Sage Publications.

Pitt, L. (1997). Community Participation in a Model District Health System. ***Health Systems Trust.*** 26:14.

Platzky, R. & Girson, J. (1993). Indigenous Healers and Stuttering. ***The South African Journal of Communication Disorders.*** 40:43-48.

Pretorius, E; de Klerk, G. W; & van Rensburg, H. C. J. (1993). ***The Traditional Healer in South African Health Care.*** Pretoria: HSRC.

Robson, C. (1995). ***Real World Research.*** Oxford, UK: Blackwell.

Ross, E. (1988). An ecological approach to social work with Deaf communities. ***Social Work/Maatskaplike Werk.*** 24:146-152.

Ross, E. (1991). Empowerment of Persons with Acquired Hearing Loss. ***Social Work/Maatskaplike Werk.*** 27:191-197.

Sarantakos, S. (1998). ***Social Research.*** (2nd ed.). London, UK: MacMillan Press Ltd.

Schneider, M. (1992). The Nature and Management of Communication Disorders in a Rural Area. ***The South African Journal of Communication Disorders.*** 39:55-61.

Sidiropoulos, E; Mashabela, H; Mackay, S; Gordon-Brown, C; Frielinghaus, J; Musiker, C; Swanepoel, H; Gallocher, R; & Forgey, H. (1995). ***Race Relations Survey 1994/1995.*** Johannesburg, RSA: South African Institute of Race Relations.

Sikhitha, T. M. (1996). Social Work Practice in Cross-Cultural Situations: Som Guidelines for Practice. ***Social Work/Maatskaplike Werk.*** 32:61-66.

Silman, S. & Silverman, C. A. (1991). ***Auditory Diagnosis: Principles and Applications.*** San Diego, CA, USA: Academic Press.

Singleton, R. A; Straits, B. C; Straits, M. M. (1993). ***Approaches to Social Research.*** New York, NY, USA: Oxford University Press.

Taunyane, L. & Hirschowitz, R. (1995). Research Findings: adults aged 65 years or more. In Sinclair, M. & Tyson, J. (eds.). ***The Community Agency for Social Enquiry (CASE) - A National Household Survey of Health Inequalities in South Africa.*** Washington, DC, USA: The Henry J. Kaiser Foundation.

Thabede, D. G. (1991). The relevance of traditional healers in the provision of mental health services. ***Social Work Practice.*** 2:11-14.

Tom, M. E. (1992). ***The Reasons Given by Patients for Visiting Traditional Healers.*** Unpublished MA Dissertation. The University of the Witwatersrand, Johannesburg, RSA.

True, J. A. (1989). ***Finding Out: Conducting and Evaluating Social Research.*** (ed.). Belmont, CA, USA: Wadsworth Publishing Co.

Tungay, C. (1993). ***Bridging the Gap: Tsonga Traditional Healers and Speech Therapist's Beliefs Concerning Stroke.*** Unpublished BA Speech and Hearing Therapy research report. The University of the Witwatersrand, Johannesburg, RSA.

Tyler, R; Stouffer, J. L; & Schum, R. (1989). Audiological Rehabilitation of the Tinnitus Client. ***J.A.R.A.*** 12:30-42.

van Rensburg, H. C. J; Fourie, A; & Pretorious, E. (1992). ***Health Care in South Africa: Structure and Dynamics.*** Pretoria, RSA: Academica.

van Wyk, B. E; van Oudtshoorn, B, & Gericke, N. (1997). ***Medicinal Plants of South Africa.*** Pretoria, RSA: Briza Publications.

Weber, R. P. (1994). Basic Content Analysis. In Lewis-Beck, M. S. (ed.). ***Research Practice: Volume 6.*** London, UK: Sage Publications Ltd

Webster, E; Alfred, L; Bethlehem, L; Joffe, A; & Selikow, T. A. (1994). ***Work and Industrialisation in South Africa.*** Randburg, RSA: Ravan Press.

Werner, D; Thuman, C; Maxwell, J; & Pearson, A. (1993). ***Where There is no Doctor.*** London, UK: Macmillan Press Ltd.

White Paper for the Transformation of the Health System in South Africa. (1997). Government Gazette. 382(17910). Pretoria, RSA: Government Printing Works.

World Health Organisation. (1978). The Alma-Ata conference on primary health care. ***WHO Chronicle.*** 32:409-430.

Zimmerman, R. L. (1994). Neurologic Disorders and Examination. In Katz, J. (ed.). ***Handbook of Clinical Audiology.*** Baltimore, MD, USA: Williams and Wilkins.

APPENDIX A

INTERVIEW SCHEDULE FOR TRADITIONAL HEALERS

Section A: Biographical information.

1. Age.
2. Gender.
3. Number of years practising as a traditional healer.
4. Ethnicity.
5. Category of traditional healer.
6. Current Residence.

Section B: Information relating to hearing loss.

1. What kind of hearing problems do people who come see you present with?
2. What do you see as the cause of hearing problems?
3. How do you diagnose these hearing problems?
4. How do you treat these problems?
5. What training have you received as a traditional healer?
6. Are traditional healers working in collaboration with other professionals e.g. doctors, nurses, pharmacists etc.?
7. Do you think traditional medicine can be used to complement modern medicine? If so, how?
8. What can traditional healers teach other professionals such as audiologists regarding the appropriate management of ear or hearing problems and vice versa?
9. Why do you think people with hearing problems come to see you instead of a modern medical practitioner?
10. Are there any other comments you would like to make which can help us to understand the role of traditional healers in dealing with ear or hearing problems?

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Private Bag 3, WITS 2050, South Africa • Telegrams 'Uniwits' • Telex 4-27125SA • Telephone (011) 716-1111

Department of Speech Pathology and Audiology
Speech and Hearing Clinic
Telephone (011) 716-2374
Fax (011) 716-2405

APPENDIX B
COVER LETTER AND CONSENT FORM FOR PARTICIPATION IN THE STUDY

Dear Participant.

My name is Victor de Andrade and I am a post-graduate student in the Department of Speech Pathology and Audiology at the University of the Witwatersrand. As part of my research work, I am studying how traditional healers identify and treat hearing loss and hearing problems. I am also looking at the collaboration between traditional and modern medicine in relation to hearing-impairment.

I would like to invite you to participate in this study. Should you agree to participate in this study, I will need to meet with you once at a time and place that is convenient for you. This meeting will take approximately one hour, during which time I will ask you some questions. You will be required to provide answers to various questions relating to traditional healers and hearing loss/hearing problems. Please feel free to give your own opinions as your responses will remain anonymous. If you are agreeable, I would like to tape record the interview.

By taking part in this study you will help researchers understand how traditional healers approach hearing loss/hearing problems and you will provide useful information on how to better help people with a hearing-impairment.

Your participation in this study is voluntary and you may withdraw from the study at any time without it being held against you in any way. If you are interested in the results of the study, I will be only too willing to share the findings with you. Should you require any further information, please do not hesitate to contact me on 716-2374.

Thank-you.

Yours sincerely,

Victor de Andrade
Researcher

Dr. Eleanor Ross
Supervisor

CONSENT FORM

I hereby consent to participation in this research project and to have the interview tape recorded. Furthermore, I give Victor de Andrade permission to use my responses in the write up of the study, and any future publications or presentations.

Date: _____
Signature: _____

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

APPENDIX C

COMMITTEE FOR RESEARCH ON HUMAN SUBJECTS (HUMANITIES)
Ref: R14/49 (Registry)

CLEARANCE CERTIFICATE

PROTOCOL NUMBER 991002

PROJECT	Siyezwa NgobantuL Listening To The Approaches Of A Group Of Traditional Healers Towards Hearing Impaired
INVESTIGATORS	Mr Victor M de Andrade
DEPARTMENT	Speech Pathology & Audiology Department
DATE CONSIDERED	14 October 1999

RECOMMENDATION OF THE COMMITTEE Approved unconditionally

DATE APPROVED 25 October 1999

CHAIRMAN..... .....Prof B W McKendrick

DECLARATION OF INVESTIGATOR(S)
To be completed in duplicate and **ONE COPY** returned to
Ms Anisa Keshav at Room 10-005, 10th Floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

DATE 3/2/2000 SIGNATURE