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EXPERIENCES OF TRADITIONAL HEALTH PRACTITIONERS WORKING WITH THE DEPARTMENT OF HEALTH IN THE RURAL SUB-DISTRICT OF RATLOU

By

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirement for the degree of Master of Public Health (Rural Health).

October 2019

Supervisors: Ms Abigail Dreyer & Dr Motlatso Mlambo

DECLARATION

I, Nomvula Hazel Legobye, declare that this Research Report is my own, unaided work. It is being submitted for the Degree of Master of Public Health at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

_____

(Signature of candidate)

_____day of_____20_____

DEDICATION

This study is dedicated to my late father

Ncamile (Ncanywa, “Tatoskapa”) Cameron Mangena

1929 - 2010

ABSTRACT

Background

Traditional Health Practitioners (THPs), previously known as traditional healers, continue to be the first point of contact with health services for most African indigenous communities. This choice of health care provision is happening while the National Department of Health (NDoH) is making strides to work together with the THPs. While this process by the NDoH is ongoing, tensions still exist between THPs and Bio-medical Health Practitioners (BHPs). This study aimed to explore the experiences of THPs working with the North West Department of Health (NWDoH) in the rural sub-district of Ratlou, in the Ngaka Modiri Molema (NMM) District of the North West Province of South Africa.

Methods

A qualitative exploratory research design was used to conduct this study. In-depth interviews were conducted with 30 purposively selected THPs providing services in the district. A thematic analysis approach was used, which involved familiarising myself with the data, assigning preliminary codes to the data in order to describe the content, searching for similar patterns or themes from all the interviews, reviewing themes and then finally naming the extracted themes.

Results

Four themes emerged from this study: collaboration appreciation, collaboration challenges, collaboration gains and impact, and approaches to collaboration strengthening in the rural sub-district of Ratlou. Collaboration appreciation was due to acknowledging opportunities for knowledge enhancement, collaboration contentment, traditional versus western cultural harmony, patient referral harmony and reciprocal learning between THPs and BHPs. Collaboration challenges included health provider attitudes, non-acceptance by BHPs of traditional treatment methodologies, strained referral systems and communication breakdown. Collaboration gains and impact were experienced in terms of reduction of morbidity and mortality, the involvement of THPs in health-related programmes and activities and opportunities for inter-referral of patients. Recommendations for strengthening the collaboration in Ratlou sub-district included promoting a two-way referral system; effective communication platforms;

recognition of THPs as equal partners in health care service provision coupled with mutual respect and reciprocal learning; and community garden project initiation.

Conclusion

This study has revealed that the majority of THPs have embraced working together with the NWDoH. It is important to strengthen communication between THPs and BHPs through a structured patient referral organogram, recognition of THPs as equal partners in health service delivery, reciprocal learning, mutual respect and initiation of community garden projects at Primary Health Care (PHC) level.

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Table of Contents

DECLARATION ..... **ii**
DEDICATION ..... **iii**
ABSTRACT ..... **iv**
Background iv
Methods iv
Results iv
Conclusion v
ACKNOWLEDGEMENTS ..... **vi**
ABBREVIATIONS ..... **xi**
LIST OF FIGURES ..... **xii**
LIST OF TABLES ..... **xiii**
NOMENCLATURE ..... **xiv**
CHAPTER 1 ..... **1**
1.1. Introduction 1
1.2. Background 1
1.3. Problem statement 6
1.4. Justification of the study 7
1.5. The aim of the study 10
1.6. Central research questions 10
1.7. Study objectives 10
1.8. The significance of the study 11
1.9. Literature review 11
1.9.1 Global legislative framework for THPs 11
1.9.2 South African legislative framework for THPs 12
1.9.3 Models for integrating THPs into health departments 14
1.9.3.1 Option 1: Integrating THPs into the health system 14
1.9.3.2 Option 2: Co-operation and collaboration 14
1.9.3.3 Option 3: Complete integration 14
1.9.4 Integrating THPs into the national health system: global perspectives 15
1.9.5 SADC countries' perspective: willingness to collaborate with THPs 17
1.9.6 Culture Care Diversity and Universality 20
1.9.7 Conclusion 21
CHAPTER 2: RESEARCH METHODOLOGY **22**

2.1. Introduction 22
2.2. Study design 22
2.3. Study site 22
2.4. Study population 26
2.4.1 Inclusion criteria: 27
2.5. Study sample 27
2.6 Data collection 27
2.7 Data management and analysis plan 28
Phase 1: Familiarisation with data 29
Phase 2: Coding 29
Phase 3: Collection of memos 30
Phase 4: Searching for themes 30
Phase 5: Defining and naming themes 30
Phase 6: Defining the sub-topic 30
2.8 Ethical considerations 31
2.9 Trustworthiness 33
2.10 Reflexivity 34
2.11 Ensuring clear understanding by participants 35
2.12 Managing the environment 36
2.13 Data collection methods 36
2.14 Theoretical framework for inter-professional collaboration 36
2.15 Conclusion 38
CHAPTER 3: RESULTS 40
3.1 Introduction 40
3.2 Socio-demographic characteristics of the participants 40
3.3 Participants' socio-demographic characteristics 40
3.4 Major study themes 42
3.5 THPs' experiences of working in the Department of Health 43
3.5.1 Theme 1: Collaboration appreciation 43
3.5.1.1 Knowledge enhancement 43
3.5.1.2 Collaboration uncertainty and contentment (THPs' expressed feelings and emotions) 48
3.5.1.3 THPs' experiences of happiness (traditional versus western cultural harmony) 50
3.5.1.4 Patient referral harmony 52

3.5.1.5 Reciprocal learning 54
3.5.2 Theme 2: THPs' experiences of collaboration challenges 55
3.5.2.1 Healthcare providers' attitudes 56
3.5.2.2 Non-acceptance of traditional treatment methodologies 60
3.5.2.3 Strained referral pathways 62
3.5.2.4 Communication breakdown 65
3.5.3 Theme 3: THPs' experiences of collaboration gains and impact 68
3.5.3.1 Reduction of morbidity and mortality 69
3.5.3.2 Involvement of THPs in health-related programmes and activities 70
3.5.3.3 Patients' referral opportunities 72
3.5.4 Theme 4. Approaches to collaboration strengthening 75
3.5.4.1 Two-way referral systems 76
3.5.4.2 Effective communication platforms 77
3.5.4.3 Recognition of THPs 79
3.5.4.4 Mutual respect 84
3.5.4.5 Community garden project 85
3.6 Conclusion 87
CHAPTER 4: DISCUSSION OF RESULTS 88
4.1 Introduction 88
4.2 Participants' demographic characteristics 88
4.3 Key experiences of THPs working with the Department of Health 89
4.3.1 Collaboration Appreciation 89
4.3.2 Experiences of collaboration challenges 96
4.3.3 Experiences of collaboration gains and impact 101
4.3.4 Approaches to collaboration strengthening (recommendations) 103
4.3.5 Recognition of African THPs 109
4.3.6 Planting of community gardens 110
4.4 Conclusion 111
CHAPTER 5: CONCLUSION AND RECOMMENDATIONS 113
5.1 Introduction 113
5.2 Conclusion 113
5.3 Study recommendations 114
5.3.1 Strengthening communication between THPs and BHPs 114
5.3.2 Recognition of THPs as equal partners in health service delivery 114

5.3.3 Reciprocal learning 115
5.3.4 Stakeholders' involvement 115
5.3.5 Initiation of community garden project at PHC level 116
5.4 Recommendations for future research 116
5.5 Study limitations 117
REFERENCE LIST 118
ANNEXURES 127
Annexure A: Human Research Ethics Committee (Medical) Clearance Certificate No. M150204 127
Annexure B: Ngaka Modiri Molema Clearance Certificate 128
Annexure C: Letter of request to the North West Department of Health Ethics Committee 128
Annexure D: Study participants' consent form 130
Annexure E: Audio recording consent form 131
Annexure F: Information sheet 132
Annexure G: In-depth interview guide 133
Annexure H: Kaelo e e tseneletseng ya Dipotsolotso 134

ABBREVIATIONS

AIDS : Acquired Immunodeficiency Syndrome

ANC : Antenatal Care

BHP : Biomedical Health Practitioner

HIV : Human Immunodeficiency Virus

HRH : Human Resources for Health

IDP : Integrated Development Plan

KZN : Kwazulu-Natal

MOU : Memorandum of Understanding

MEC : Member of the Executive Council

NDoH : National Department of Health

NMM : Ngaka Modiri Molema District

NWDoH : North West Department of Health

PHC : Primary Health Care

TBA : Traditional Birth Attendant

TB : Tuberculosis

THP : Traditional Health Practitioner

WHO : World Health Organization

LIST OF FIGURES

Figure 1: Road Infrastructure in Ratlou Local Municipality 3

Figure 2: Northwest Province 23

Figure 3: Statistics South Africa. Census 2011 25

Figure 4: Theoretical framework for intra-professional collaboration. 38

Figure 5: THPs' experiences of collaborative challenges 56

Figure 6: THPs' experiences of collaboration gains and impact 69

Figure 7: Approaches to collaboration strengthening 76

Figure 8: Five traditional healers from RSA have been honoured in the USA 110

LIST OF TABLES

Table 1: Performance Indicators First Quarter 2016/17 9

Table 2: Population groups 24

Table 3: Total headcounts 25

Table 4: Participants' socio-demographic data. 41

Table 5: Major study themes 42

NOMENCLATURE

Traditional Health Practitioner (THP)

The World Health Organization (WHO) defines a Traditional Health Practitioner as a person who is recognised to provide health care, using vegetable, animal and mineral substances and certain other methods. THP practices are based on the social, cultural and religious background as well as on the knowledge, attitudes and beliefs that are relevant in the community, regarding physical, mental and social well-being and the causation of diseases and disability [1].

In the South African context, a THP is defined as any person who is registered under the Traditional Health Practitioners Act 22 of 2007 and practises in the Republic of South Africa. They fall under the following groups which usually have other culturally accepted names, such as diviners (Oracle/Sangoma/Iqgirha), traditional birth attendants (Umbelethisi), herbalists (Inyanga/Igedla/Ngaka e Tsotshậ) and traditional surgeons (Ingcibi/Rathipana/Ralebollo) [2]. In the context of this study, THPs refer to persons who utilise recognised and acceptable traditional health care practices or approaches and methods which focus on promotive, preventive, curative and rehabilitative health care services to clients and patients. They may be registered or not registered with the Interim Traditional Health Practitioners Council of South Africa [2].

These THPs are further classified according to their scope of work as follows:

Herbalists (Ngaka e tshotshậ)

This cadre of THPs are not trained and they do not possess occult powers; however they have learned skills through an apprenticeship with an expert and therefore possess extensive knowledge in the use of herbal medicine, both for preventive care and curative care, as medicinal mixtures. These THPs know where to dig roots and even how to prepare medicinal herbs [2].

Traditional Surgeons (Rrathipana)

Traditional surgeons refer to THPs who perform circumcisions as part of the African traditional ritual to manhood and are registered as such under the THP Act [2].

Traditional Birth Attendants (TBAs)

These are women only, either middle-aged or elderly, who acquired their skills through observation from their parents, without any formal training. They can also take pregnant women through antenatal care, education on diet, exercise, giving herbal medicines for pain and discomfort, abdominal massages and taking a pregnant woman through pregnancy until labour, and the actual delivery of the baby [2].

Diviners (Traditional Doctor/Ngaka ya ditaola/Sangoma)

These THPs cast bones or use any form of divination set for determination of causes of people's complaints. Their diagnostic tools are bones which they throw, and these bones then guide the diviner on the circumstances or the cause of the disease. As they cast the bones, they connect with the ancestors who are instrumental in giving them the diagnostic powers. They are said to have knowledge and skills to reveal to patients what ancestors dictate to them. The training of THPs varies from three months to a year, depending on the trainers [2].

Biomedical Health Practitioners (BHPs)

According to the WHO, Biomedical Healthcare Practitioners refer to nurses, doctors, psychologists, psychiatrists, pharmacists, dentists, environmental health practitioners and physiotherapists, who have undergone a period of training in institutions of higher learning and have acquired certain competencies on completion of their studies. These cadres are, therefore registered with their different professional bodies and are licensed to practice [1].

The biomedical health system

A biomedical health system is defined by the WHO, as the organisation of people, institutions and resources that deliver health care services to meet the needs of targeted populations. A successful health system is interdependent on the following building blocks for its efficiency: leadership and governance; medical technologies; health informatics; financing; human resources and organisation; and service delivery [1].

The traditional healing system

It is described as health practices, approaches, knowledge and skills; and is based on theories, beliefs and experiences indigenous to different cultural beliefs, communication

and guidance by the ancestors, incorporating the first nation's healing and wellness while using traditional ceremonies; plant, animal, or mineral-based medicines; energetic therapies; or physical hands-on techniques [1].

Ancestors

Ancestors are spirits of descendants or forefathers called upon to protect, lead and guide individuals in the path of harmony between the living and the dead, the creator and his/her creation [2].

Collaboration

The WHO defines collaboration as a process in which different parties work together in a climate involving acknowledgement, respect, and appreciation of each other's roles and provide mutual assistance to help attain a common goal. In this context, the common goal is to manage and heal patients presenting with different ailments/diseases. In this study, collaboration refers to the collaboration between THPs and BHPs [1].

Culture

Culture is a certain characteristic way of living, which guides the thinking and decision making and actions of a particular group, and where learned, shared and transmitted values, beliefs, norms and lifestyle are passed from one generation to the other [4].

Health care integration

Health care integration can be used interchangeably with collaboration, and it refers to a legal body passing a law that enhances and legalises its existence through a process of combining or bringing about two separate entities or bodies to function as one. This integration, from the perspective of the Human Resources for Health Strategy for the Health Sector, defines integration as necessary, as Traditional Health Practitioners play an important role in the health care system. Their integration requires them to work collaboratively with the Community Ward-based Outreach Teams (WBOT), facilitating good implementation of PHC Re-engineering in assisting health professionals to mitigate the shortage of health professionals in the country, and reducing disease burden in households [1].

Referral

A referral is defined as a process where patients move through the first point of entry seeking health services, to the next level of care, where there are better amenities and skilled human resources to offer the necessary desired health care provision. Therefore, referral could be from a community member to a clinic, or from a clinic to either a district or provincial or tertiary hospital depending on patients' health needs [1].

Primary Health Care (PHC)

The World Health Organization's Alma-Ata Declaration of 1978 defines Primary Health Care as:

> The essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and determination [5].

CHAPTER 1

1.1. Introduction

This chapter introduces the topic, which is being studied, by outlining the background, problem statement, justification of the study, aims of the study, and study objectives. It further puts into perspective the historical background and the origins of Traditional Health Practitioners (THPs) with a critical review of what is known on this topic, i.e. previous investigations, both old and current, across the globe.

1.2. Background

THPs have existed in parallel with western practitioners for many years. According to Wilkinson et al. [6], the concentration of THPs is mostly in rural areas, and with this nearness of THPs to communities, patients in rural areas are most likely to use the THPs' services for their health care needs. Ratlou sub-district is 100% rural and is situated in the North West Province (NWP). This sub-district is the smallest of the five sub-districts which form Ngaka Modiri Molema District. THP clinics (Ndombas) are seen all over the sub-district. This reinforces the belief that it is a common practice that, in rural areas, communities seek health services from THPs, mainly because of the closeness of THPs to communities, and because they are more trusted within communities.

In 1978, at the Alma Atta Conference, world leaders agreed that "governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures" [5]. Governments across the globe were targeting health for all by the year 2000, where through preventative strategies, communities will be informed and be self-reliant. World leaders also declared that Primary Health Care (PHC) services rely on effective systems of referrals of patients from local levels by community members, inclusive of THPs as well as Biomedical Health Professionals (BHPs) fostering teamwork, in response to the community's health needs [5].

The Traditional Medicine Strategy came into effect from 2002 to 2005, and set objectives in the four main focal areas, which are: a policy to integrate traditional medicine in the broader health system; promotion of safety, efficacy and quality of traditional practices by expanding knowledge based on traditional medicine; increased access through the availability and affordability for poor populations; and lastly to promote therapeutically sound use of appropriate traditional medicines by providers and consumers [7]. In all these objectives the expected outcome was to foster support and fast-track traditional

medicine recognition, by putting in place national policies to integrate traditional medicine into countries' national health systems and to increase knowledge and skills of THPs in PHC. This was also done to ensure recognition of traditional medicine through comprehensive national policies and integration into the national health care system, including basic training in PHC for THPs, and to increase access and extend the knowledge of traditional medicine through networking and exchange of accurate information [7].

Both the Alma-Ata Conference and the Traditional Medicine Strategy have influenced South Africa, so that in 1994 the democratic Constitution of the Republic of South Africa was crafted in such a way to accommodate the contents of the Alma-Ata Declaration [8]. Section 27(1) of the Constitution of South Africa states that everyone has the right to have access to health care services [8]. This section is understood to embrace all health care services, including traditional health care services. It is, therefore, the responsibility of the government to ensure that people have access to these facilities and that their safety and well-being are guaranteed [8]. People also have freedom of choice, which refers to the health care services they utilise and the right to choose where to receive health care services; this freedom of choice finds expression in the Patients' Rights Charter [9].

The study undertaken is localised to this rural sub-district, whose villages are under the leadership of local Chiefs called "Dikgosi", who still adhere to the cultural and traditional practices of the Batswana people [10]. In this sub-district, there is no hospital; and 14 health care facilities are scattered far apart across the largely forested area [10]. The nearest town, Mahikeng, is far from the sub-district, with the furthest village about 130 kilometres in a single trip to town [10]. The only big facility in this municipality is Ratlou Community Health Centre (CHC), which, when it was built, had 15 two-bedroomed nurses' homes, to ease the challenges of staff accommodation. The tarred roads are only connecting to the two nearby towns, which are Mahikeng and Delareyville, but internal roads which are connecting routes from one facility to the other are in a very bad state. The mode of transportation to both towns and clinics are buses and mainly donkey carts. Figure 1 below illustrates the road infrastructure in Ratlou sub-district.



Figure 1: Road Infrastructure in Ratlou Local Municipality

Source: Picture taken by the researcher

The community survey for 2016 revealed the following figures as social determinants of health: the unemployment rate was at 42.4%, households without sanitation stood at 2.3%, with the percentage of the population living below the poverty line of R283.00 per day standing at 42.3%, and illiteracy rate at 19.0% [11]. As a result, these social determinants of health in this municipality have a bearing on the disease burden, where there is a high prevalence of diseases such as Tuberculosis (TB), including a high prevalence of Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) coupled with a high defaulter rate of TB and Human Immunodeficiency Virus (HIV) treatment in the sub-district. This is the picture painted by the performance indicators of Ratlou sub-district [11].

There are currently 178 THPs who are registered in the sub-district database as being willing to work together with the North West Department of Health (NWDoH) in the NWP. This working-together has been in force for over ten years in the NWDoH and has sparked the interest of the researcher to explore the experiences of these THPs who have formed a partnership with the NWDoH [12].

It is common knowledge that African indigenous people in their rural settings have depended on Mother Nature for food production, enhancing their livelihoods, and usage of natural herbal mixtures as plants or roots from their natural habitats, for healing and survival since time immemorial. This occurred because health care facilities were either far from these communities, or they could not afford health care costs, both as hidden costs and calculated costs. Healing in those days differed according to the culture and religion of such communities.

The advantage to the communities of Ratlou Local Municipality, is accessibility of THPs in their vicinity who share the same norms and culture as they do [10]. In addition, THPs seldom charge a fee, but payments are usually made after completing a healing session,

mostly according to what patients can afford, either a goat, a sheep, or a cow. These are the most common payment methods that are affordable for communities who own livestock [10].

Davis et al. [13] believe that preservation and improvement of life of people living in rural communities should be a government priority. They further argue that rural communities have low-density settlements, sparsely populated, most often far from modern urban economic hubs which facilitate good livelihoods, coupled with distance from urban resources [13]. It is in rural areas where the poor and elderly populations live and where more concerted health care services are most needed [13].

In their further exploration of the problems of underserved areas, Davis et al. [13] said:

> Most medically underserved areas are underserved in other important aspects; Human resources development and community development are likely to be deficient as well; appropriately designed solutions to the under-serviced health problem may have important spillover benefits for human resources and community development.

In the NWDoH, the Annual Performance Plan for 2016/17 indicated an imbalance in the Human Resources for Health (HRH), as influenced by current financial pressures on health financing, leading to poor recruitment or slow recruitment processes, and changes in health policies, coupled with the ageing workforce [14]. Though the NWDoH has a retention strategy plan in place, the human resource succession plan is not in place to counter-offer the ageing workforce [14].

The NWP is 70% rural in nature. Most citizens in the province are living in rural areas, where HRH is becoming a scarce resource; therefore, fast-tracking the shifting of some health activities to THPs is seen by the NWDoH as an opportunity to complement the current health workforce. The social determinants of health impact negatively on the health status of communities, leading to reliance on social grants as a safety net for vulnerable groups [14]. These vulnerable groups are mainly the elderly, disabled, mentally ill patients and the orphans [14]. Inequality also remains high, coupled with high unemployment rates, leaving large numbers of the population still living in poverty-stricken areas [14].

Noticeable strides to incorporate THPs in the health system, have been made by the National Department of Health (NDoH), through commissioning a number of studies on

the possible approaches to integrate THPs in the NDoH, such as Mulaudzi's study [15]. This has been done by putting in place the following [2 & 15]:

- The Directorate: Traditional Medicine, which was established to manage the work related to Traditional Medicine within the NDoH; this has also been extended to Provincial Departments of Health across the country;
- The National Drug policy, which recognises the function and benefits of available remedies of African Traditional Medicine (ATM) in the national health system and the potential role of THPs in the formal health care sector; and
- The THPs Act, which was endorsed in January 2008: this Act provides for the legal recognition of traditional medicine in South Africa as part of the wider health care system.

Between the years 2007 and 2008, the NWDoH followed and used the available legislative frameworks as laid down by the NDoH and the THPs Act, in implementing the Alma-Ata declaration resolutions of integrating THPs into the broader National Health system. This was done by putting in place a Memorandum of Understanding (MoU) specific to NWDoH to give direction on how this working-together should unfold [16].

This MoU outlines the Terms of Reference (ToR) for integration. The MoU was entered into and signed on behalf of the THPs in the Province by Mr Pitso, in his capacity as the chairperson of the THPs in the Province, and Maj. Gen. (Dr) M. Radebe in his capacity as the then Head of the Department (HOD) for the NWDoH. The objectives of this agreement between NWDoH and the THPs in the Province were to build the capacity of all registered THPs and coordinate the organisation of all THPs in the province, through developing a database of all those THPs registered and willing to partner with the NWDoH [16].

The MoU had inclusion criteria which were not compulsory in nature. It accommodates only those THPs who were willing to work together with the department through a directorate in the NWDoH called Special Programmes. This directorate has been mandated to coordinate all the activities of THPs in the Province, and to assist in the realisation of a vision by the NWDoH to improve the health outcomes of the communities in the NWDoH [16].

In the sub-district of Ratlou, where this study was conducted, THPs are being recognised by the sub-district management team as partners in health service delivery as mandated by the NWDoH. They are also motivated to register with the body of THPs at the level of the sub-district. THPs in the database participate in different sub-district health forums and attend health-specific training as arranged by the department to keep them abreast of the latest developments in different disease presentations and management [12].

The Member of the Executive Council (MEC) for Health in the province has appointed, in writing, health forums to participate at different levels of care. The forum at province level is termed the Provincial Health Consultative Forum; at district level they are termed District Health Councils, and spiral down to institutions; at the hospital level they are called Hospital Boards; in the sub-district, they branch into three committees which are called Clinic Committees, Local Area Committees and Sub-District Governance Structures [14].

In all these appointed structures, the MEC has directed that at least one THP should be appointed as a member of that committee. Other than the THPs participating in the health appointed structures, there is a functional THPs' committee, drawn from THPs registered in the sub-district database, whose role it is to coordinate all the THPs' activities within the sub-district, and to foster linkages with the PHC services [12]. In addition, the MEC celebrates the THPs' special days and weeks, such as the THP medicine week, and these events are organised by the department and hosted by the MEC of the NWDoH [12].

1.3. Problem statement

Most African indigenous communities still use and will continue to use the health care services provided by the traditional healers and the community nurses either individually or concurrently. This could be associated with the fact that in rural areas health facilities, clinics and Community Health Centres (CHCs), are sparsely distributed, while within communities, THPs' clinics are within walking distances. THPs' healing practices continue to be regarded as outdated and a cause of mortalities in communities; however, patients continue to consult THPs for their health needs.

Non-collaboration between the BHPs and THPs due to such a negative view, is indirectly affecting access to health services and impacts adversely on the overall management of both acute and chronic ailments as health outcomes [14]. These poor health outcomes are seen with non-achievement of certain measured health indicators, where mothers still continue to die in the process of giving birth; TB continues to kill communities, yet it is a

curable disease; and HIV/AIDS in the era of antiretroviral (ARVs) medicines, continue to cause undesired fatalities [14]. The above scenario therefore calls for inter-professional collaboration between THPs and BHPs in providing PHC, and to address health problems faced by communities and reduce mortalities in communities. This collaborative effort between THPs and BHPs could have a positive impact on the current mortalities, as these two health providers' render health care services to the same population.

International and national studies have found that collaboration between THPs and BHPs is still faced with difficulties [17, 18 & 19]; this difficulty has prompted the South African government, through the NDoH, to come up with interventions towards the official recognition, institutionalisation and empowerment of THPs, through the following policies and legislation:

- The National Drug Policy (1996) that recognises the potential role and the benefits of available remedies of ATM;
- The Traditional Health Practitioners Act 22 of 2007 which was endorsed in January 2008. This Act provides for the legal recognition of traditional medicine in South Africa as part of the wider health care system; and
- The draft policy on ATM for South Africa, for the institutionalisation of ATM.

Though a major breakthrough has been made in South Africa towards the integration of THPs into the national health system, the researcher has observed that very little has changed at the level of health care service delivery. In the NWP there is limited empirical evidence about the experiences of THPs and the extent of collaboration between THPs and BHPs. In view of these observations, this study aims to explore the experiences of THPs who are working with the NWDoH in a rural sub-district of Ratlou.

1.4. Justification of the study

Ratlou Local Municipality (RLM), is a Category B municipality, situated in Ngaka Modiri Molema District Municipality in the NWP [10]. The municipality is 100% rural in nature and constitutes about 26 villages and commercial farms [10]. The size of the municipal area is about 4 618 km^2, with a population density of 24.37 per square kilometre, and it is divided into 14 municipal wards [10].

The Integrated Development plan (IDP) of this municipality indicates that the population of Ratlou Local Municipality stands at 107 340. Like elsewhere in the NWP, this

municipality is faced with challenges of unemployment, lack of employment opportunities, poor roads' infrastructure, scarcity of underground water and poverty [10]. The common disease burden includes high prevalence and incidence of HIV/AIDS, TB, non-communicable diseases, violence, and injuries, coupled with a high illiteracy rate [10]. Of the population, 28.90% have no formal schooling and the unemployment rate is at 54.40% amongst age groups 15 – 34; only 11.20% of the population have reached matric level [10]. These social determinants of health affect health outcomes in this municipality directly [10].

All 14 wards are underdeveloped. It is only in the past eight years that this municipality has seen some economic development, but in the past, it was considered untouched by modern development. The communities in this municipality still adhere to cultural norms and values of the traditional African lifestyle [11].

Traditional leaders, called Dikgosi in Setswana, are working in collaboration with ward councillors and traditional counsellors [11]. It is recognised as a fact that in Ratlou Local Municipality, clinics and health centres are scattered far apart from each other, and this is challenged by the presence of traditional clinics within the vicinity of communities, which predisposes communities to rely on THPs' services for their health needs.

Analysis of the annual performance for Ratlou sub-district for the end of quarter 1 of the 2016/17 financial year, paints a picture of poor performance by some of the priority programmes [12]. A major concern is the high defaulter rate of patients who are expected to be on lifelong ARV drugs and patients who are supposed to be on treatment for only 6 months for TB. These performance indicators are all below Provincial and National targets and are tabulated below:

Table 1: Performance Indicators First Quarter 2016/17

PERFORMANCE INDICATOR	ACTUAL PERFORMANCE	TARGET
1. Adults remaining on ART	6 167	8 900
2. TB defaulter rate	5.8%	<5%
3. Male medical circumcision	116	331
4. Infant 1st PCR test positive	<2%	3.1%
5. TB/HIV Co-infected Clients on ART	5 600	7 700
6. Death rates of co-infected clients	11%	<5%
7. ANC 1st Visit before 20 weeks rate	55%	60%

Source: District Health Information System (DHIS)

Despite the fact that all health facilities in the sub-district provide ARVs to HIV-positive patients, the death rate of clients co-infected with TB and HIV/AIDS is above target (high), and there is also evidence from statistics that patients co-infected with both TB and HIV continue to default on their treatment [12]. It is worrying to realise that the population who is expected to be on life-long ARV treatment is declining, with the possibility of defaulting on treatment or seeking alternative treatment elsewhere, where resistance to ARVs could lead to detrimental end results.

A thought-provoking question arises about why patients are not coming to health facilities and where do they access health care services from, as data paint a picture that these services are not accessed at health facilities.

To date, only a few studies have been conducted in the NWP examining this subject from the BHPs' perspective. The researcher deemed it necessary to examine this topic from the THPs' perspective, as the empirical evidence on this topic is limited. One study revealed that it is important to collaborate with THPs as both THPs and BHPs manage the same population and evidence from that study indicated that indigenous healers deal with the same health problems confronting formal health workers [20]. This study brought up new knowledge that THPs' services are not only confined to a specific group of people,

but that THPs treat all social classes in communities [20]. Interestingly, there seem to be health conditions that can be handled only by THPs due to their cultural nature [20].

These studies thus provide some light on why patients are defaulting on treatment from the health facilities, which eventually results in poor performance of the health indicators of the sub-district. However, in cases where the two disciplines work together, a different picture could be portrayed through data. The second study, also conducted in NWP, indicated to some extent that cultural practices, norms and values of rural communities influence their choice of healing therapies [21].

Literature reviewed has so far shown that there is limited empirical evidence about the nature and extent of how THPs view this working relationship with the NWDoH. Most researchers tend to explore this working-together from the perspective of the BHPs and not of the THPs. This study will, therefore, contribute to influencing policy directions in the NWDoH.

1.5. The aim of the study

This study aims to explore the experiences of those THPs who are working together with the NWDoH in the rural sub-district of Ratlou.

1.6. Central research questions

1.6.1 What are the experiences of THPs who work together with the Department of Health in Ratlou sub-district?

1.6.2. How can THPs and BHPs improve the health outcomes of populations in their areas of operation?

1.7. Study objectives

- To explore the experiences of THPs who work with the Department of Health in Ratlou sub-district;
- To explore the THPs' expectations that might enhance a cordial working relationship with the Department of Health in Ratlou sub-district;
- To document experiences of THPs working with the Department of Health in Ratlou sub-district; and
- To table the recommendations coming from the study to the NWDoH for strengthening working relationships with the THPs.

1.8. The significance of the study

It is desired that this study should assist in developing strategies or models towards strengthening working-together between the THPs and the BHPs in PHC. Furthermore, the outcome of this study will be beneficial in different ways to different stakeholders as follows:

- Policymakers: It is envisaged that the findings will be used in guiding the Department of Health and other partners in the development of guidelines and management of collaboration between THPs and BHPs.
- Improvement in health care practice: Integration and health care practice may be improved in terms of reduction in morbidity and mortality rates; thereby lowering the burden of diseases that impact on life expectancy through treatment compliance and inter-referrals of patients between the two disciplines.
- Presentation on the outcome of this study: It is envisaged that during the departmental research day, the outcome of this study will be shared with research delegates, and this might assist in the reduction of prejudice and stereotypes existing between BHPs and THPs.

1.9. Literature review

The literature review seeks to explore from the past literature of scholarly articles, surveys and studies, the existing knowledge framework relating to the experiences of THPs across the globe, who have ventured into working closely with national departments of health. The literature review further seeks to establish how THPs contribute to the reduction of disease burden, and what their experiences are. It is also intended to provide a summary of the discussion by various authors on the study topic.

1.9.1 Global legislative framework for THPs

Almost 40 years ago, the Alma-Ata Conference, one of the world's biggest international conferences, declared an urgent need by world leaders to approach health care service delivery differently [5]. World leaders were urged to turn away from the hospicentric approach and focus mainly on strengthening PHC Services [5]. The conference also acknowledged and declared that PHC is a vehicle to be used to reach far-to-reach areas and bring health services closer to communities [5].

Years later, it became evident through a slow implementation of this call by the WHO, that countries needed guidance on how to initiate the inclusion of THPs in their respective

health systems [1]. The response by the WHO was to give countries direction through spearheading initiatives which were aimed at improving the collaboration with THPs in health systems and to examine traditional medicines' usefulness. [1].

Around the beginning of the 21st century, following the direction given by the WHO, country leaders started to implement the WHO resolutions [1]. Emphasis was put on ensuring that the local traditional healing traditions and practices were integrated within the broader health system in countries across the globe [1]. This came as a result of realising that these traditions appear to address some of the many shortcomings of biomedical modern medicine and health care needs in many communities [1].

The implementation process, however, started very slowly in the legislatures of African countries despite the directive from the WHO [1]. Realising the slow implementation process by countries, the WHO further urged countries to craft realistic and implementable traditional medicine polices and furthermore translate the proposed strategy and cascade them further down to provinces for implementation of these policies [1]. The expectation from national departments was to ensure that, when that exercise is carried out, there would be active collaboration with all partners [1].

1.9.2 South African legislative framework for THPs

Coming back from the Alma-Ata Conference, South Africa realised that THPs were a very rich health resource, which could be utilised to synergise patient care and management of diseases, and also to assist in task shifting, as at that time, South Africa was experiencing a high attrition rate of HRH [22]. This acknowledgement was followed by a number of provincial roadshows, which finally produced a THP bill. Parliament enacted that bill in 2004 as a THPs Act. Four years later in 2008 a Draft Policy on African Traditional Medicine for South Africa was released for public comment [23].

The South African Government, as a member state which participated in the Alma-Ata Conference, then moved at a faster pace, with the production of the Traditional Health Practitioners Act 22 of 2007 [2]. This Act can be seen as the yardstick in implementing resolutions and as a significant breakthrough in attempting to legalise and legislate traditional healing in South Africa [2].

In South Africa, THPs, who are registered under this Act, include categories such as herbalists (izinyanga), diviners (isangoma or amagqirha), traditional surgeons (ingcibi)

who mainly do circumcisions and traditional birth attendants (ababelethisi or abazalisi) [2]. It is estimated that in South Africa, there were about 190 000 such practitioners in 2007 [2]. For reasons not yet explored, the Act has, however, excluded one category of THPs called Faith Healers, who in South Africa also fall under the categories of THPs [2].

The THPs Act was formulated on the basis of addressing one focal area in the Traditional Medicine Strategy, which was to ensure that patients using THPs' medicines are being prescribed safe, correct and efficient medicines. The Act came at the right time, when South Africa was challenged by a quadruple burden of disease, with HIV/AIDS as the major contributor to morbidity and mortality in the country [22]. This epidemic made the NDoH realise a greater need for working together with THPs, as patients were consulting both THPS and BHPs [22]. In accordance with WHO prescripts, PHC was regarded as the entry point of health care service delivery; therefore the WHO felt education, orientation and training should take place, and community involvement should be directed by decision-makers to the professional staff, the general community and community leaders [24].

The NDoH's call on several THP organisations, which were present in 2007, to work together, in particular to reduce the AIDS scourge in the country showed a positive response; and furthermore, those THP organisations initiated a discussion with the NDoH [22]. These THP organisations indicated their willingness to work with Government to assist in the care and support of affected families and infected patients, even though the healing systems in the country at that time were still pluralistic [22].

Though the Alma-Ata Conference has made a declaration that health departments should work together with THPs, it was only during the era of the epidemic of HIV/AIDS, that health departments realised the importance of bringing THPs on board as it was evident that some HIV/AIDS patients were seeking healing from THPs [22].

At that time, morbidity and mortality due to AIDS were on the rise, and sick patients were consulting both disciplines of health care [22]. These efforts, however, were met with various obstacles, including insufficient knowledge by THPs about the disease itself, and disunity amongst THPs. Despite those obstacles, THPs continued to render health care to those patients who opted to seek health care from them [22].

1.9.3 Models for integrating THPs into health departments

In the period before 1990, there was no formal structured approach on how key stakeholders in the society would work together with the new democratic government of South Africa. The health sector was to re-arrange and re-position itself to accommodate all these key stakeholders in the provision of health care services to attain better health outcomes.

THPs were seen to be amongst the key stakeholders who the national department felt that, in accordance with the Alma-Ata Declaration, should find a place in the national health system [1]. In pursuit of the implementation of the Alma-Ata declaration, two researchers in South Africa recommended to government that THPs had a role to play in the national health system and furthermore came up with three models of collaboration. The heated arguments and results are summarised here as options [25].

1.9.3.1 Option 1: Integrating THPs into the health system

Under this option, the researchers advised the government to totally integrate THPs into the health care system. This option would be to see THPs as health practitioners in PHC settings working together with nurses and doctors. Their role would be mainly to offer preventative, promotive and rehabilitative health services, as deliberated in the Alma-Ata Conference, to strengthen PHC, particularly at the level of clinics and community health centres [25].

1.9.3.2 Option 2: Co-operation and collaboration

Here, both the THPs and the BHPs remain essentially independent practitioners, who would work together, but each cadre in their own space of work, having mutual respect. This option emphasises that these two disciplines should be willing to co-operate with one another and should value one another as contributors towards healthy communities. The two cadres, in this option, should furthermore agree on which conditions should be treated by THPs and which ones should be referred to BHPs [25].

1.9.3.3 Option 3: Complete integration

In this option, both the THPs and the BHPs join hands and work together, combining the healing methodologies of the THPs and those of the BHPs. Here it means patients will simultaneously be treated by THPs and BHPs and take those medicines as prescribed by both [25]. An example of such integration is where a THP is based in the vicinity of the

patients of a BHP and has access to them. This THP would render services as a care giver to patients who need counselling support and supervision at home [25].

The robust discussions on advocating for inclusion have led to the advancement of the following reasons:

- Insufficient Human Resources for Health particularly in rural areas;
- Traditionally and culturally THPs have been healing patients since time immemorial; and
- Respect for THPs as health professionals.

Those who were advancing their arguments against inclusion of THPs in the Department of Health said [25]:

- THPs have no formal controlling body;
- THPs lack a standardised training model to enforce skills and competency;
- THPs' medications are not scientifically tested for efficacy;
- THPs are not yet registered with any professional body, and therefore, they lack accountability for their practice; and
- THPs' medications are not tested for their potency.

Having a deeper understanding of how this working-together was to be implemented from the three options above, the NWDoH opted to adopt the second option of cooperation and collaboration by virtue of the current Memorandum of Understanding (MoU) [14]. This MoU was clear in its terms of reference, by organising all THPs in the province, through developing a database for all those registered and willing to work in partnership with the department [14]. The chosen option by the NWDoH also has some noted limitations in terms of the scope of operations of THPs, as autonomy is retained by each of the two disciplines, and the option only seeks to strengthen inter-referrals of patients between the two disciplines, coupled with mutual respect.

1.9.4 Integrating THPs into the national health system: global perspectives

It is estimated by the WHO, that around 80% of the population in Africa are still using traditional medicines and seek health care from THPs [1]. In Sub-Saharan Africa, it is estimated that for every 500 people there is one THP, while for every 40 000 people, there is only one medical doctor [15]. These figures not only are an indication that THPs are

acessible to patients, but also highlight shortages of BHPs in the provision of health care services to health care users.

The literature provides a handful of concrete findings that support the integration of THPs into national health systems worldwide to assist the health sector in different programmes. In Europe, there is public endorsement to integrate complementary and alternative medicine into the national health sector; however, opposition is observed from some BHPs [26]. This is displayed by the negative attitude of some members of government as policy-makers [26]. Actually, the study by Grace [26] indicated that, the support of working together with THPs, is geared at alleviating work force shortages.

In India, the findings of Piper [27] indicating that the contribution of THPs as Traditional Midwives (TM) led to overall improvements in maternal health outcomes is well documented. One study [28] in Pakistan corroborated the results of Piper [27], revealing a more educative extended role of trained Traditional Midwives (TM), by successfully training refugee women.

Interestingly, in Southern Thailand both THPs and BHPs have raised concerns about integrating and working together, even though the Thai Health System was advocating for integration [29]. This uncertainity comes mainly from BHPs, who cite reasons that THPs do not possess the necessary knowledge and skills, and that they are not licensed to practice [29].

The Joint United Nations Programme on HIV/AIDS (UNAIDS) argues that the call to work together with THPs in the health sectors of different countries, came as a result of the responses to the HIV/AIDS pandemic [30]. In their study, which was seen as “The best collection”, UNAIDS shared the lessons learned, including that THPs are not resistant to working together with BHPs [30]. The study findings further indicated that despite the experiences from THPs, BHPs are not willing to work with them; however, THPs remain willing to share their unique knowledge and skills in fighting the scourge of the HIV/AIDS pandemic [30]. The conclusion of the study was that UNAIDS is in support of this collaboration by virtue of the nearness of THPs to patients, coupled with the usage of culturally accepted healing methodologies [30].

1.9.5 SADC countries' perspective: willingness to collaborate with THPs

From the South African context, several studies have similar findings, and these depict a mixture of experiences from both THPs and BHPs. In fact, literature from two studies conducted indicated that most BHPs are either not supporting the integration or supporting it conditionally, while from the THPs' side, eagerness to work as a team with health professionals has been documented [31 & 32]. The THPs in these studies also highlight an important issue: that they are trained and capacitated on health-related conditions, and should be treated with respect, so as to better facilitate inter-referrals of patients between the two disciplines [31 & 32].

Policy makers in South Africa share the same sentiments as UNAIDS and are positive and supportive of this collaboration with the THPs in the health sector. However, they too, have reservations and advocate for targeted training and some form of regulation. Furthermore they feel that post-training assessments should be done to evaluate THPs' competency levels [33].

According to the mid-year population estimates from Statistics South Africa (Stats SA) of 2018, KwaZulu-Natal has the second largest population in South Africa (11.4 million), and this province has endured the devastating effects of HIV/AIDS [34]. This was during the time when treatment for HIV/AIDS was not yet easily available in health institutions [34]. In this province Years of Life Lost (YLLs) has been mainly as a result of HIV/AIDS [34]. By then the provincial prevalence rates rose from 38.7% to 39.5% in 2009 and stabilised in 2010 at 39.5% [34]. One study conducted on the role of THPs in HIV and AIDS prevention, concluded that THPs are a health resource, which needs to be utilised in the fight against HIV/AIDS [34].

The researchers further argued that, as the country shifted from a short-term HIV response of counselling and testing and providing treatment, to a test and treat approach, this new move on its own had created a demand for more Human Resources for Health [34]. BHPs were needed not only to ensure high uptakes of testing, but also to offer ARV treatment to those who tested positive for HIV/AIDS [34]. Putting more patients on ARVs was the aim of the NDoH, so as to reduce the devastating effects of HIV/AIDS, and enhance a productive life for HIV patients, thereby assisting to improve the life expectancy at birth and ensuring that viral loads of patients on lifelong ARVs are suppressed. THPs were viewed as an extension of health services to communities [34].

Still, looking at the role of THPs after the rollout of ART medication to HIV patients in Lesotho, Furin [35] concluded that the THPs were embracing the rollout of ARVs as a measure to reduce mortality attributed to HIV/AIDS. In her study, findings showed THPs participating in HIV/AIDS preventative programmes, assisting with counselling clients, and attending joint educational sessions with BHPs [35]. The other interesting finding from Furin's study [35] is that THPs also subjected themselves to testing for HIV, and some THPs made it known that their results were positive, and that they were complying with taking lifelong treatment (ARVs).

Contrary to policy makers' views and opinions of embracing collaboration with THPs in the NDoH, one study strongly opposes collaboration with THPs, on the basis of findings that seeking medical treatment from THPs were seen to have caused treatment delays, poor performance status and high mortalities in TB patients, as TB patients were delayed by THPs from accessing treatment [36]. In the same breath, a study by Colvin et al. [37] had different findings, concluding that THPs' contribution to the TB programme in Hlabisa District in KZN had led to better performance of indicators in those patients attached to THPs as Directly Observed Therapy Short Course (DOTS) supporters, against poor achievements of TB outcomes in patients attached to BHPs as DOTS supporters.

In the Nelson R. Mandela School of Medicine, Dr Naidoo, the head of Family Medicine, had an audience of 60 THPs, most of them older women in their beaded plaits and regal head dresses of their trade. This doctor usually teaches new first-year doctors, but that day was different, as he was conscious of the fact that South Africa was a country with few doctors and nurses for every 100 000 people, and at the same time, THPs are the people's choice in times of sickness and disease, more especially in that province [38].

Dr Naidoo was teaching the THPs about HIV/AIDS and how it was managed. It was not long afterwards that the school had a workshop, finding ways to bring together the world of traditional medicine with that of western health care provision [38]. His argument was that nurses were offering powerful lifesaving ARVs, but they lacked the implicit trust of their patients, which THPs possessed, together with an understanding of the psychology of their patients coupled with wide respect by villagers [38]. He also noted in his practice that THPs picked up the failures of hospitals; and vice versa, hospitals picked up THP's failures. In conclusion, he was supporting that this gap ought to be bridged, as these two disciplines needed each other [38].

Heinzerling [39] shares positive results from THPs who indicated that they had been referring their patients to BHPs for many years; however, these THPs showed optimism of working closer to BHPs at the district primary health care level, and further indicated that when that happened, BHPs should be sensitive to their level of training, when implementing any training platform for THPs. In Botswana and Ethiopia, researchers had synergistic findings, which described mixed opinions of BHPs about working together with Health Departments, while THPs' views were often not well explored, or were totally left out [40-41]. A significant number of THPs also acknowledged that they needed training from BHPs, which would promote harmony and mutual respect between THPs and BHPs [40-41].

In Zambia, studies by Kaboru et al. [42] and Burnett et al. [43] showed a slight difference in findings: nurses from the private sector were positive and showed a willingness to work with THPs. In both studies, BHPs were able to identify roles of THPs coupled with potential risk, which they mentioned as unavailability of policy guidelines to give direction on how to implement this collaboration [42-43].

In Sierra Leone, one study looked at how mothers experienced the labour process conducted by THPs as Traditional Birth Attendants (TBAs) versus delivering in health facilities [44]. Emerging major themes from participants cited that the choice was for THPs because they were trusted by the community due to cultural affiliations and their familiarity with the community [44]. THPs were viewed as relating well with pregnant mothers' spouses [44]. Participants further appreciated that their follow-up care during pregnancy and their fees were within reach of the communities and affordable, as they accepted any form of payment, be it cash, goods or services, unlike health care professionals, who required standardised up-front payments; for THPs, the service was rendered first, then after the service was completed, payment followed [44].

There was a small percentage (14%) of participants from that study who blamed THPs for the rising infant mortality rates in that country, and their findings were supported by health professionals who attributed these death rates to the incompetence of THPs as TBAs [44]. Though insignificant as 14% may seem, one physician was of the opinion that this matter of infant deaths called for a deeper look at the underlying problem, as he was citing other causative factors, for example, that even when THPs had referred the mother who was in labour, lack of adequate transportation to the nearest health centre or hospital

was still a major challenge. Though BHPs seemed to embrace collaboration with THPs, the studies above indicated an element of reservation about collaboration with THPs [44].

The latest approach in the management of HIV/AIDS in South Africa, is the rollout of the home test and treat campaign. As indicated by USAID, the HIV/ADS pandemic was the reason to call for collaborative efforts with THPs. In KZN, a recent study released the findings on the experiences of THPs in this campaign [45]. Experiences shared by THPs indicated their willingness to collaborate and work with BHPs in ensuring that patients were retained in care, and to refer those who needed BHP follow up visits [45].

One THP shared how she explored the campaign by calling upon a passing BHP to come into her house, so that she could be tested for HIV. She continued to share that experience as fulfilling living knowing your status and disclosed that she was fortunately HIV negative [45].

Most THPs from this study indicated that nurses working in HIV clinics were treating THPs badly, and they became even more frustrated when they tried to help BHPs by referring patients, and those patients did not go to the clinics. This study indicated the willingness of THPs to join hands and work with the BHPs, but this collaboration was made difficult by non-receptive attitudes of nurses and BHPs [45].

The Regional Committee for Africa has set out clear objectives to support the integration of THPs into the health sector [46]. In its meeting this committee has put in place a regional strategy for Africa to support collaboration with THPs [46]. This committee has indicated that health ministries should recognise the treatment methodologies employed by THPs in healing their patients and should take a lead in creating enabling environments for THPs, ensuring that there is resource allocation for this course, and institutionalisation of traditional medicine [46].

1.9.6 Culture Care Diversity and Universality

Leininger's Theory of Culture Care Diversity and Universality explains how an individual's world view is tailored by a person's culture in terms of how the individual thinks, and how certain things are done in a certain way, inclusive of how the individual views the phenomenon of health [47]. Most of the current challenges affecting the health of individuals should be seen in a context of diversity in terms of cultural practices and views [47].

It is for this reason that BHPs should be culturally sensitive when dealing with patients, and take patients' cultural beliefs and cultural norms into consideration when providing health servises to individual patients [47]. However, often nurses' behaviour and insensitive conduct regarding people's beliefs and culture are contrary to the contents of this important nursing theory [47].

It is therefore imperative that BHPs understand that patients' cultures differ, including their beliefs regarding illness and health, and that they are cognisant of the fact that there are cultural differences regarding beliefs and practices related to health, illness and care. They should understand that THPs are uniquely positioned as they are incorporating clients' cultural beliefs into health care.

This understanding will assist nurses in learning about the worldview of a group or an individual. From their worldview, cultural groups derive their cultural and social structural dimensions that define their existence. This is seen in communities like Ratlou, where culture is embedded in their roots and is religiously practised; changing communities' mindsets should be done gradually to influence lifestyles which negatively affect health.

1.9.7 Conclusion

The working-together between departments of health and THPs, as advocated by Geneva, is aimed at strengthening PHC, which is the vehicle of rendering health care services to communities. It is evident in the literature above that the engagement of THPs with the health sector takes place in clinics and health centres, where doctors only visit, and where the concept of PHC is executed. It is therefore sensible to observe that, most of the time, THPs base their experiences mostly on their working together with nurses, and not doctors. There is also enough global evidence from the literature that this collaboration is initiated with difficulty and is skewed towards the side of the THPs, while BHPs have little interest in collaborating with THPs. There is therefore a need to demystify and legitimise THPs' practices, so as to separate it from those harmful practices which tarnish the image of traditional healing practice.

CHAPTER 2: RESEARCH METHODOLOGY

2.1. Introduction

In this chapter, the research methodology followed in conducting the study is explained. This chapter further outlines the rationale for choosing the specific design, and outlines the type of sampling strategy, data collection and data analysis approaches which were followed. The chapter further addresses ethical considerations of the study including measures taken to ensure the trustworthiness of the data. Finally, the chapter is concluded by a description of the theoretical framework.

2.2. Study design

This study utilised a qualitative explorative design to explore THPs' experiences of working with the Department of Health in a rural sub-district called Ratlou. Exploratory research does not intend to offer final and conclusive evidence and is used by researchers as an attempt to connect ideas in helping them to understand the problem at hand [48]. A qualitative research methodology was recommended so that tacit assumptions could be unpacked as relevant variables have not been identified and there has been little research done in the past on the topic [48].

Because of its flexible nature, qualitative research methods allow researchers to immerse themselves in the data enabling them to reflect on the data collection process and on the development of new ideas [49]. Creswell [49] further indicates that qualitative studies allow researchers to verify data for a better understanding of the meaning drawn from excerpts.

Exploratory design is well suited to assist the researcher in addressing all the study objectives and to answer the research question while exploring the experiences of THPs who are working together with the Department of Health. According to Pope et al. [50], exploratory design is characterised by continuous change, evolving or taking a new direction as new data emerge and give new insights to the researcher.

2.3. Study site

The study took place in one rural sub-district called Ratlou, which is the fifth smallest sub-district of Ngaka Modiri Molema District in the North West Province (NWP) [14]. NWP has four district municipalities, namely Bojanala Platinum District, Dr Ruth Segomotsi

Mompati District, Ngaka Modiri Molema District and Dr Kenneth Kaunda District [14]. The figure below shows the location of Ngaka Modiri Molema in the North West province.

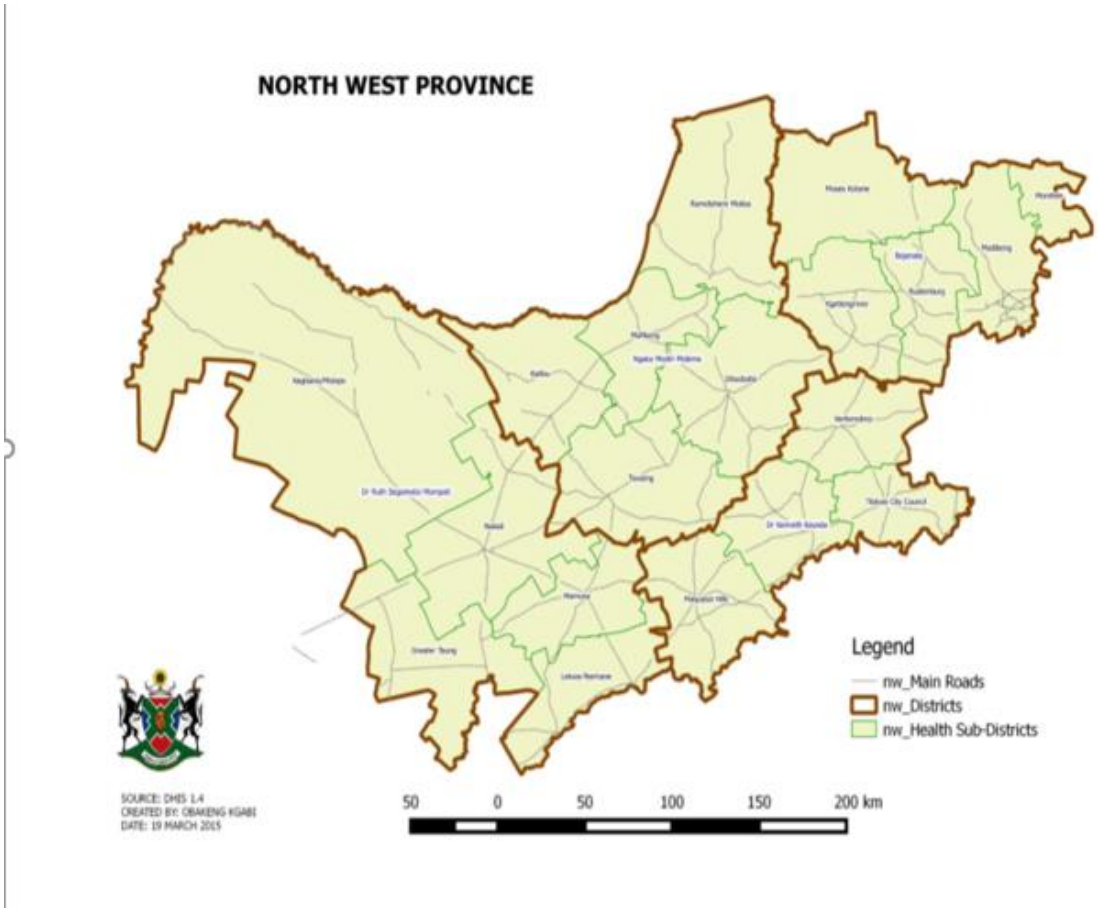


Figure 2: Northwest Province

Source: Municipal fact sheet. Report No.03-01-58. Pretoria: Statistics SA; 2012

Ngaka Modiri Molema District as one of the districts in the NWP comprises of five sub-districts, namely Ditsobotla, Mahikeng, Ramotshere Moiloa, Tswaing and Ratlou. The district borders Botswana to the north. The language most spoken at home is Setswana at 87%, Afrikaans at 3%, with Sesotho and IsiXhosa both at 2% [11].

Ratlou sub-district, where this study was conducted, comprises of 14 wards and is made up of 28 rural villages scattered over a forested area, covering 4 555 km^2 [12]. In this sub-district, health service delivery takes place from four health posts, twelve clinics, three mobile clinics and two community health centres [12]. According to the Ratlou Local Municipality's 2016/17 draft Integrated Development Plan, the population size has

increased significantly from 97 665 in 1996 to 106 165 in 2001 and then to 107 339 in 2011 [10]. Amongst the five sub-districts, Ratlou is the smallest in terms of population size and does not have a full-service hospital. As a result, patients are referred to Gelukspan District Hospital and Mafikeng Provincial Hospital respectively, which are about 80 kms and 95 kms away [10].

The site is chosen because of its demographic nature, vast distances between health facilities, and the fact that there is no hospital within the local municipality; and, because communities are known to have access to THPs' services [10]. The Community Survey of 2016 indicated that the population for NMM was 889 108 [11]. The table below indicates the population groups in Ngaka Modiri Molema District:

Table 2: Population groups

DISTRICT	POPULATION GROUPS				TOTAL
DC38 Ngaka Modiri Molema	Indian/Asian	African	Coloured	White	
	4 968	791 251	13 801	30 950	889 108

Source: Stats SA. 2016 Community Survey.

Below is a map indicating the five sub-districts which constitute Ngaka Modiri Molema District which in principle shows both their location and size.



Figure 3: Statistics South Africa. Census 2011

Source: Municipal fact sheet. Report No.03-01-58. Pretoria: Statistics SA; 2012

The statistics of patients seen in the health facilities within Ratlou Local Municipality for both under-five-years and above-five-years combined from April 2017 to March 2018 as extracted from the District Health Information System (DHIS) is presented as Table 3 below.

The statistics below are for patients that have been seen by the following Human Resources for Health who are allocated across all the above-indicated health facilities. The figures indicate that to be serviced by the few health professionals below, these health professionals are probably overworked due to staff shortages.

Table 3: Total headcounts

North West : Ratlou Local Municipality		
Apr 2017 to Mar 2018	PHC headcount under 5 years	51 106
Apr 2017 to Mar 2018	PHC headcount total	288 956
Apr 2017 to Mar 2018	PHC headcount 5-9 years	9 361

Apr 2017 to Mar 2018	PHC headcount 10-19 years	19 329
Apr 2017 to Mar 2018	PHC headcount 20 years and older	209 160

Source: DHIS

As at March 2018, the report drawn from PERSAL gave the figures below as warm bodies appointed in Ratlou sub-district:

- Professional Nurses: 76
- Staff nurses: 80
- Assistant Nurses: 50

It is worth noting that there are only two appointed medical doctors allocated to this sub-district, and they render clinic support visits once a week, while the only two appointed pharmacists support the clinics by performing outreach services, which rarely cover all facilities. The two pharmacists are placed in the two district hospitals, which supply pharmaceuticals to all health facilities in the sub-district.

2.4. Study population

Polit et al. [51] define a population as an “an entire aggregation or eligible group from which a sample can be drawn”. In this study, the target population was drawn from the Traditional Health Practitioners’ database for the Ratlou sub-district [12]. By January 2017, there were 178 THPs in the database who have agreed to work with the Department of Health [12]. These are all THPs who have dual roles, working as independent healers in their THP clinics called “Ndombas,” and having agreed to work with the Department of Health. All the THPs in the database were meeting the definition of THPs, according to the THPs Act 22 of 2007 [2].

2.4.1 Inclusion criteria:

- THPs of all ages and genders registered only in Ratlou sub-district database.
- THPs whose names also appear in the provincial THP database.
- THPs who are active in health service delivery, either as members of clinic committees or as members of Ratlou sub-district governance structures, and who are actively participating in patients' referrals to the clinics.
- THPs who meet the required eligibility criteria of the various categories of THPs as defined in the Traditional Health Practitioners Act 22 of 2007, namely Traditional Doctors, Diviners (Sangomas), Traditional Surgeons, Traditional Birth Attendants (TBAs) and Herbalists [2].

2.5. Study sample

A sample refers to a subset of a population selected to participate in a study [52]. Participants were purposefully sampled on the basis of their experiences in working with the NWDoH. Purposive sampling is non-probability sampling where selection is based on the characteristics of a population and the objectives of the study, and is also known as judgemental, selective or subjective sampling [52].

This type of sampling technique is not done randomly as the sample itself represents the range of characteristics of the population but not the size, and cannot, therefore, be generalised [53]. The sample for this study consisted of thirty (30) THPs who were in the NWDoH database.

To ensure richness of data, the sample was chosen as follows: 10 THPs who were serving as members of Ratlou sub-district governance structures, 5 who were serving in clinic committees, and the last 15 who were older THPs who had been practicing Traditional Health Medicine for longer than 10 years. All 30 THPs were members of the THPs' association. The researcher ensured that the sample reflected diversity and was representative of all the types of THPs as defined by the THPs Act 22 of 2007. All 30 recruited THPs agreed to participate in the study.

2.6 Data collection

In-depth interviews with all 30 THPs residing in Ratlou sub-district were conducted. The researcher worked through the chairperson of the THPs in Ratlou Local Municipality who served as a gatekeeper for liaising with the THPs, recruiting them to participate in the study. Furthermore, the THPs' chairperson assisted the researcher by checking on the THPs' availability so that the researcher could make appointments to collect data on days and times which were suitable for the participants. In-depth interviews were conducted in the participants' own households to ensure privacy and a natural setting where the participants lived.

Appointments were made by the researcher telephonically a week in advance and consideration was made to accommodate THPs in their own free time. Data was collected for a period of four months from February 2017 to May 2017. The data collection period was initially projected to be two months; however, due to the unavailability of THPs on some days, this period was extended to four months. In the middle of the fourth month, the researcher finished with data collection and the remaining two weeks were then used to do follow-ups where the responses were not clear.

Prior to data collection, the right to withdraw at any given time if they feel like doing so, was explained to the participants before being asked to complete the consent forms, i.e. the audio recording consent form and the consent form to participate. They were also shown the approval to conduct this research (Annexures D & E). A Setswana interview guide (Annexure H) was used to collect data which consisted of eight open-ended questions exploring the experiences of THPs who worked with the NWDoH in the NWP.

The interview guide was used for data collection in exploring the questions that related to the study objectives. The questions on the interview guide were prepared in English and were later translated into Setswana, which is the most common local language in the area. Participants were encouraged to elaborate in detail and in depth on their experiences, with the use of relevant probes. Interviews were audio-recorded to keep a record of participants' responses and verbal cues were also noted. The duration of collecting data from each participant ranged from 40 to 45 minutes.

2.7 Data management and analysis plan

Although there were two sets of the in-depth interview guide, the English version and the Setswana version, there were two participants who were Xhosa speaking, and though

able to hear some words of Setswana, struggled with the understanding of some of the uncommon words in Setswana. For these two participants the researcher was able to translate the words into isiXhosa, as the researcher is fluent in both languages. (She was taught Setswana at school up to matric level and belongs to the Xhosa clan, “Amhlubi”.)

An audio-recording machine was used during data collection in the field, and it automatically anonymised the participants, through the allocation of fictitious numbers to ensure that in no way certain responses could be attached to a particular participant. The process of transcribing data was done verbatim in a Word document, as per the audio recordings, and thereafter an original copy of the transcript was kept as a master file, including a backup file. Both files were saved with private pin numbers, and safely stored in a lockable file in a password protected computerised zipped file.

The next phase was to upload all transcripts into an Excel 2010 spreadsheet that was numbered with the privacy codes from the audio recorder. The researcher went on to identify commonly emerging codes from the transcripts, and from these codes emerged the main themes, supported by sub-themes. Supporting excerpts and quotations from all participants for each question were extracted. Thematic analysis was used in this study and is summarised in the six-step approach below [54].

Phase 1: Familiarisation with data

This phase of data analysis dealt with the researcher familiarising herself with the data through a deeper reading of transcripts more than twice, for purposes of highlighting common words which most participants kept on repeating and for making sense of data collected [54].

Phase 2: Coding

The coding process included grouping similar excerpts from all transcripts. All those transcripts were later coded, to form a summary of what the transcripts implied. The deductive approach was used [54], as it aimed at testing the theoretical framework, and not necessarily closing up, for generation of new theories and information emerging from the data.

Thomas et al. [54] indicated how important this phase was, as it contributed to the rigour of the research study and assisted the researcher in moving to the next stage of writing up the research findings (coding). They describe the purpose of the deductive approach

as that of entering the research having a theory/hypothesis to either prove correct or false, then basing arguments on a particular theory, and then trying to support these arguments with literature which may either support or negate them [54].

Phase 3: Collection of memos

In this stage, the researcher was noting some outliers, and quotations which could not be grouped in themes and sub-themes, yet which presented important pieces of information for consideration so that they could be brought up during the discussion. These could not be lost but were also preserved to find expression in the report.

Phase 4: Searching for themes

In this study thematic content analysis was used. Thematic content analysis is one of the forms of analysis in qualitative studies [54]. The researcher has chosen this type of analysis for purposes of examining and recording patterns (or themes) within the data that actually contribute to answering the research questions. The codes emerging were then grouped into sub-themes and major themes were supported by quotations from the transcripts, also indicating inter-relatedness with other themes [54].

In this phase, themes were refined, and some were split, combined and a few discarded, as they were not contributing to answering the research questions. This type of analysis is said to be more relevant in answering questions associated with people's experiences; in this study, the researcher was exploring THPs experiences in working with the NWDoH.

Phase 5: Defining and naming themes

In this phase, sorting and clustering the codes into overarching themes were done. At this stage, codes were examined to identify those that could be grouped together. Themes are regarded as higher-order categories that cluster ideas and descriptions within a cultural context; the researcher also looked at direct quotations from the transcripts in providing effective theme descriptors [54].

Phase 6: Defining the sub-topic

In the final phase, the researcher weaved together the themes that were well suited into sub-topics, coupled with contextualizing the analysis in relation to existing literature [54].

Data were anonymised through usage of codes not in any way traceable to the participants' responses. An original copy of the transcript was kept as a master file

including a backup file, both saved with private pin numbers, and safely stored in a lockable file in a password protected computerised zipped file.

2.8 Ethical considerations

Ethical clearance for this study was granted by the University of the Witwatersrand Health Research Ethics Committee WHREC (Clearance certificate No. M150204 – see Annexure A). Furthermore, the Ngaka Modiri Molema Ethics Committee gave a written approval allowing the researcher to conduct the study (Annexure B).

Prior to each session of data collection, each participant would inhale snuff, and thereafter burp continuously until the burping stops involuntarily. During orientation of these THPs by the gatekeeper, the researcher was told that this burping was going to happen, and it should not scare the researcher, as it was an ancestral ritual for THPs to connect with their ancestors. The researcher was also orientated on the correct manner of greeting participants which was to say “Thokoza Gogo” prior to the commencement of data collection.

Data collection started with signing of two consent forms per participant, one for agreeing to participate in the study (Annexure D) and the other one for agreeing to be audio-recorded (Annexure E). These consent forms were read and explained to the participants. For participants who were not able to read and write, consent to participate was given by attaching the participant’s right thumb print as signature on these forms.

In order to ensure confidentiality and anonymity, the participant’s identity was protected through assigning codes as fictitious names. Participants were also informed that their participation in this study was optional/voluntary, and that they had the right to refuse to answer questions or withdraw from the interview process at any time (see Annexure D).

Participants were further furnished with an explanation on the topic, study aim and objectives of the study (See Annexure F). As these THPs were recruited by their chairperson to participate in this study, the chairperson when inviting them also asked permission from the ancestors; and thereafter, the researcher was allowed to proceed with the study.

The following moral principles were adhered to:

- Autonomy: The rights and dignity of participants were maintained. The participant's rights to continue or discontinue the study were explained and accepted without any prejudice. No one was forced to participate in the study.
- Anonymity and confidentiality were ensured by assuring participants that they were not expected to write their names or any form of identification on the interview guide. They were also assured that names of participants would not be disclosed or displayed anywhere in the study. It was also explained that the results of this study would be communicated to THPs through a departmental research seminar, and finally, participants were assured that the information provided would not be accessible to parties other than those involved in the research and that information obtained from the study would not be used against them.
- Justice: The participants were given full information about the nature of the study and their right to refuse to participate.
- Non-maleficence, Freedom from harm: Sensitive questions were carefully phrased to protect participants from psychological harm; debriefing sessions would be arranged if necessary. There was no evidence of psychological harm from the THPs and therefore, it can be concluded that there were no debriefing sessions; instead, participants were acknowledged in the study.
- Freedom from exploitation: Participants were assured that the data collected would not be used against them or their profession in any way; and that the results will be communicated to them during seminars. The researcher ensured that the researcher-participant relationship in the study was not exploited in anyway.
- Beneficence: The outcome of the study will be communicated to respondents through workshops, seminars and publications. After the completion of this study, the results may increase their knowledge about working together with the Department of Health. The findings may be a tool to improve the health of the communities.

A lockable cupboard was used to keep all materials with participants' information safe. The data collection tools will be kept for a period of five years; thereafter these materials will be destroyed in accordance with the records management policy of the NWDoH [55].

2.9 Trustworthiness

Sandelowski [56] explains trustworthiness as an event of ensuring that all the research data is traceable and could be audited. She further argues that a study is trustworthy when it meets the following criteria. In her report [56] she classifies trustworthiness under four criteria, which are:

- Credibility;
- Dependability;
- Transferability; and
- Confirmability.

Sandelowski [56] explains that dependability could be employed through peer checking either by your fellow colleagues with expertise in qualitative methodology, or an expert in qualitative studies. However, Munn et al. [57] and Cope [58], regard member checks as 'the single most critical technique for establishing dependability"; hence, the researcher in this study has ensured credibility by member checking done by the supervisor, starting from ensuring correct transcribing up to the extractions of codes and themes.

"The neglect to give adequate descriptions in the research reports, lead to assumptions and methods, especially regarding data analysis", according to Gunawan [59], who also said "This neglect has contributed to the criticisms of bias in the eyes of the readers". That is why the researcher has ensured that the reader understands what design was used and has included a clear description of the data analysis and management plan.

Dependability is important for trustworthiness because it establishes the research study findings to be repeatable and consistent. Munn et al. [57] refer to dependability where data is consistent and produce similar results when tested against the consistency of the data over similar conditions. To ensure dependability means that if the next researcher should study the same topic with the same participants, using the same data collection tools, findings would be similar [57]. The researcher has ensured that the appointed second supervisor went through the data file and re-checked the data collection tools and finally gave permission to proceed.

In quantitative studies, the term 'inferring results' is used; in qualitative studies the synonym thereof is transferability, which means that the study findings could be applicable in other contexts, situations, times and the same population. Krefting [60] explains

transferability as the ability of the researcher to involve a panel of people familiar with the topic to be studied when selecting a study sample. In this case the gatekeeper was able to select the participants, and ensured representativeness of their fields of speciality as THPs.

Furthermore, as required by Krefting [60] the researcher has described the demographic data and the study setting thoroughly. Though it is difficult for the researcher in this study to prove that the study findings cannot be generalised, the researcher has provided evidence that the findings could be inferred by making explicit connections to the cultural and social contexts surrounding data collection, by explaining how the participants were reached, where interviews took place, duration of data collection and other aspects of data collection that provide a richer understanding of the research setting. This information will assist the reader to reconstruct the scene that surrounds the participants and how implicit biases might affect responses.

Confirmability refers mainly to the level of confidence that the research findings are based on participants' narratives as opposed to potential researcher biases. Cope [58] further argues that confirmability is there to verify that the findings are shaped by participants (participants' voices) rather than by the researcher's voice. In this study, the researcher has gone backwards and forwards to really ensure that the excerpts drawn were the participants' exact expressions. This going backwards and forwards to verify data, has led to the researcher writing down her own thoughts on codes, and providing a rationale why specific codes were merged together, including finding appropriate themes which summed up different codes well. Actually, authenticity and confirmability can be used interchangeably, wherein the researcher expresses the feelings and emotions of the participants' experiences in a faithful manner.

2.10 Reflexivity

Krefting [60] explains that reflexivity in research is built on an acknowledgement of the ideological and historical power that dominant forms of inquiry might exert over the researcher and the researched. This is in line with several other qualitative writers, who explain it as an attitude which the researcher adopts when collecting and analysing data. This attitude also includes self-introspection of the researcher, reflecting on her own background and position in line with the phenomenon studied. It is recommended that the

researcher should spend a period of time in the research environment before data is collected. In the NWDoH, African Traditional Medicine Week is celebrated annually, and it is in those kinds of platforms that the researcher has been in contact with the wider provincial THPs.

Though the researcher is a senior manager in the same department, she has been in contact with the participants without any difficulty in different departmental fora, either participating in the programme as a speaker or just attending meetings with THPs or rendering an opening and welcome note during THPs' events. This interaction with THPs has assisted the researcher to get close to the people under study, and to move from being a stranger or distrusted person to a trusted and friendly person during the research process. Though the researcher herself is not utilising THPs to seek medical care services, she respects other people's cultures, value systems, worldviews and religious beliefs.

In this study the researcher was alone in the field, respecting the sensitivity of the study undertaken, and did not introduce a new field worker. It is believed that when a new member is introduced into an interaction, reactive effects can be expected. This was done to avoid participants' behaving abnormally showing themselves in the best possible light or withholding or distorting certain information; in other words, the researcher has not created social behaviours in participants that would not normally have occurred. To support the statement above, Leininger [47] states that researchers need to be trusted by participants before they will be able to obtain any accurate reliable or credible data.

2.11 Ensuring clear understanding by participants

The researcher has attempted to increase the trustworthiness of responses by:

(1) Making sure that participants are very clear on the nature of the research, e.g. why the research is conducted, what is being studied, how data will be collected and how it will be stored, including communication of results;

(2) First building a trust-relationship with the participants and staying in that setting for a period of time;

(3) Comparing the results obtained with other evidence available; and

(4) Keeping accurate and detailed field notes on the variations in participants' responses.

2.12 Managing the environment

The social context under which the data was gathered was an important consideration in establishing validity and reliability of data. Individuals may behave differently under differing social circumstances. In this study participants were interviewed individually in their own households to ensure that information provided to the researcher within the health context was consistent.

Particular attention to privacy was maintained to protect other household members hearing responses within the environment.

2.13 Data collection methods

Caution was taken to avoid sampling bias. The researcher ensured that in her purposive sampling, bias was avoided by allowing the THPs' chairperson to be the one choosing participants so as not to over-represent or under-represent the phenomena under study. In qualitative research studies, sample selection is based on the ability of the subject to provide data relevant to the research question. To avoid inaccurate or insufficient data, the chairperson of THPs has used her judgement based upon the best available evidence to choose subjects who were willing to participate, can recall well enough and are able to respond precisely to questions asked.

Secondly, the chosen participants should be those who are able to report events not directly observable or accessible to the researcher. Consent forms were completed for audio-recording as a data collection tool to ensure that participants were not coerced into participating in the study. Member checks and recycling of analysis were done back to participants to ensure the accuracy of the content; and to ensure that the researcher and participants are viewing the data consistently.

2.14 Theoretical framework for inter-professional collaboration

Figure 4 below, from the Journal of Interprofessional Care, illustrates key elements of collaboration which may lead to the provision of a comprehensive, integrated PHC service delivery if supported by all stakeholders. The figure illustrates the central or focal area being comprehensive integrated PHC service delivery to communities, including promotive, preventive, curative and rehabilitative services.

These services are provided by both THPs and BHPs. These health care professionals are expected to adhere to the elements of inter-professional collaboration such as mutual respect, trust, acknowledgement, positive attitudes, agreed upon referral systems and support to enable an effective collaboration of THPs and BHPs. In the absence of mutual respect for other health care professionals, measures that are taken towards an integrated comprehensive PHC service delivery to communities will be in vain and the NWDoH will not be responding to WHO's call of ''integration of THPs in PHC service delivery". It is also important to acknowledge that training methodologies are different for the two disciplines. This understanding is critical in closing knowledge gaps and promoting reciprocal learning.

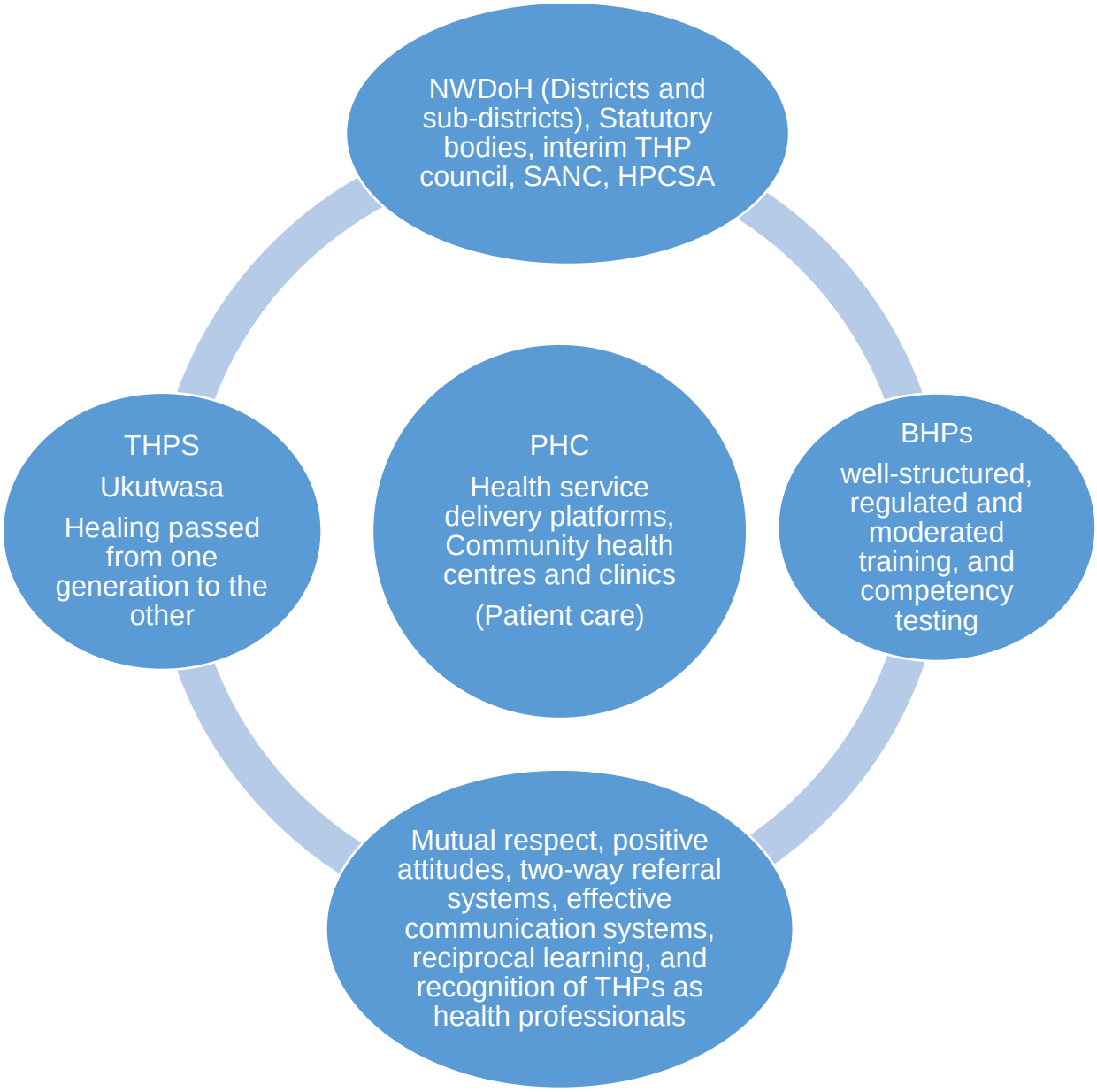


Figure 4: Theoretical framework for intra-professional collaboration.

Source: Journal of Interprofessional Care, volume 19 (sup1), 116-131, 2005

2.15 Conclusion

This chapter on research methodology focused on the methods and processes, which were undertaken in order to carry out the research study. In-depth interviews were conducted with 30 THPs in their own households as per set appointments. The data was recorded using an audio tape recorder, translated from Setswana and transcribed

verbatim from the audio tape. Data was transcribed to the Word document verbatim, then exported to the 2010 Microsoft Excel spreadsheet, and thereafter codes were extracted from the participants' quotations. Thematic content analysis was used for data analysis in this study. The chapter furthermore discussed measures of ensuring trustworthiness of the study results and concluded by discussing the theoretical framework for inter-professional collaboration.

CHAPTER 3: RESULTS

3.1 Introduction

This chapter focuses on the presentation of study results. It provides a description of the participants' socio-demographic characteristics, major themes and sub-themes emerging from the study as well as supporting verbatim quotes from participants. Participants' excerpts include colloquial expressions justifying the authenticity of the participants' experiences.

3.2 Socio-demographic characteristics of the participants

A total of 30 THPs residing within the jurisdiction of Ratlou Local Municipality (RLM) in the North West Province participated in this study (Table 4). All the 30 participants were practising as THPs in their individual traditional clinics and they were mostly female (70%). Amongst the study participants, the oldest was aged 75 years and the youngest 24 years.

Concerning their level of education, 46.6% of the study participants had no schooling while 13.3% had a tertiary qualification. In terms of the type of THP, sangomas accounted for 76.6%, while herbalists and traditional birth attendants accounted for 10% respectively. Of the participants, 76.6% were speaking Setswana as their home language while isiXhosa and Sesotho accounted for 10% each. Most (43.3%) of the participants had been practising as THPs for 21 years and more, while 26.6% had been practising for 6 to 10 years.

3.3 Participants' socio-demographic characteristics

Table 4 details the participants' socio-demographic data.

Table 4: Participants' socio-demographic data.

Demographic variables	No	%
Gender		
Male	9	30
Female	21	70
Age		
21-30 years	5	16.6
31-40 years	6	20
41-50 years	6	20
51-60 years	5	16.6
61-70 years	7	23.3
71-80 years	1	3.3
Level of education		
No schooling	14	46.6
Primary	3	10
Secondary	9	30
Tertiary	4	13.3
Type of THP		
Herbalist	3	10
Sangoma	23	76
Traditional Surgeon	1	3.3
Traditional Birth Attendant	3	10
Number of years practising		
1-5 years	1	3.3
6-10 years	8	26.6
11-15 years	4	13.3
16-20 years	4	13.3
21 years and more	13	43.3

Demographic variables	No	%
Home language		
Setswana	23	76.6
Sesotho	3	10
isiXhosa	3	10
Mongwato[1]	1	3.3

3.4 Major study themes

This study has revealed four major themes, which were supported by sub-themes, emerging from the in-depth interviews of THPs.

Table 5 below presents the themes, with the accompanying sub-themes.

Table 5: Major study themes

Themes	Sub-themes
1. Experiences of collaboration appreciation	• Knowledge enhancement • Collaboration uncertainty and contentment (THPs' expressed feelings and emotions) • Traditional versus western cultural harmony • Patient referral harmony
2. Experiences of collaboration challenges	• Health care provider attitudes • Non-acceptance of traditional treatment methodologies • Strained referral systems • Communication breakdown • Reciprocal learning
3. Experiences of collaboration gains and impact	• Reduction of morbidity and mortality • Involvement of THPs in health-related programmes and activities • Patient inter-referral opportunities

[1] Mongwato is one of the tribes of the Batswana who reside in Botswana

Themes	Sub-themes
4.Approaches to collaboration strengthening	• Two-way referral systems • Effective communication platforms • Recognition of THPs • Mutual respect • Community garden project initiation

3.5 THPs' experiences of working in the Department of Health

This section presents the results based on the first objective of the study.

When presenting the results, each theme will be supported by a set of sub-themes with participants' quotations. Participants' identifiers[2] are added at the end of each quotation.

3.5.1 Theme 1: Collaboration appreciation

Under this theme, the results revealed that most participants had highly enjoyed the collaboration of working with the Department of Health due to a number of reasons as reflected by the four sub-themes, namely: knowledge enhancement; collaboration uncertainty and contentment; traditional versus western cultural harmony; and patient referral harmony and reciprocal learning.

3.5.1.1 Knowledge enhancement

Knowledge enhancement was identified by the participants as emerging from the training, good partnerships and an extension of participants' scope of knowledge on the management of different conditions. Most of the participants appreciated the collaboration due to a belief that working with the Department of Health has enhanced their knowledge. This was reflected by a few participants who highlighted the appreciation of different disease management skills, which made them happy and congratulated this partnership.

> *"Knowledge is what I was delighted about in the end regarding our partnership, even now I am still making it rain because of that. Oh, this marriage has worked for me, this marriage came through for me because it constantly let me know of things that I now have knowledge for compared to how I was before I got married with the department of health."*

[2] #P=participant number; M=Male; F=Females and age in years

#P5 M, 29 years

Concurring with the above participant, another participant said:

> *"Yes, workshops which we attended; we were taught about the collaboration with the department. We were taught about treatment of certain diseases, were taught about how we should help each other as traditional doctors."*

#P2 F, 75 years

Another participant highlighted her excitement about the collaboration with the Department of Health as traditional doctors:

> *"Yes, I did receive training and I was happy to be introduced into that training session as they enlightened me. I am happy that we traditional doctors today we are educationally inclined because of the department of health on how to work together and treat patients collectively as traditional doctors with the department of health."*

#P3 F, 24 years

One participant appreciated knowledge enhancement as a vehicle of capacity building:

> *"They took us to the clinic to examine what this patient lacks. They taught us about patients, they taught us about polio vaccines, its eradication and how these things have worked for us as carers, we indeed have been well equipped us people."*

#P4 M, 36 years

Knowledge enhancement was also reflected by the skills acquired on drug management principles. This was broadening their skills in as far as handling medication:

> *"We have learned new things, because you have to know how much of the herb to use, and how much to measure when you give someone. They taught us correct medication dosages to avoid overdose. They taught us that there should be space between the Setswana medication and western medication, patients should not mix them, as they will not work due to drug interactions, that I did not know, but now I know! I recently experienced that."*

#P1 F, 70 years

Furthermore, the following participants indicated that due to this partnership they were also taught practical ways of handling patients including discarding old harmful practices:

"My knowledge was subject to increase when the department met with us, teaching those of us on how to wash them [patients] this way and do that. They taught us to protect ourselves. We wash them [patients] before we initiate them. When we initiate them [patients], we do not protect ourselves. I might have something that I eventually pass onto the patient."

#P5 M, 29 years

"The first time we started to work with the department I was happy and congratulated this partnership; the reason behind that was because the traditional healers does things differently unlike the department, so I was happy because I knew that I will get exposure to the field of medical practices and that will enrich my state of knowledge. Adding on to that, traditional healers use razors during their traditional practices and that could give a patient another problem or infections passes from one person to the other as we don't use preventative measures."

#P3 F, 24 years

The following participant indicated how she had stopped the harmful practices, and further talked of improvement in personal hygiene of the THPs.

"I'll also be hesitant to put a snake's skin there. I remind myself that by the way I am a partner with the government and if it walked in and found those skins. But some patients are not all the same right. When they walk inside and see the skin, they would get scared and faint. Meanwhile I'm helping people. What am I going to do? When they have fainted, I have to take them to the clinic, but I have to be honest and say they were scared by what I put out in the open. Then I thought no, these people teach us how we should do things. I have removed all those snakes' skins and have also improved my personal hygiene. The olden traditional doctors were always messy and smelling bad, you can see me, and you cannot tell that I am a traditional doctor, you can see are clean right?

#P17 M, 37 years

Knowledge enhancement was not only about knowing diseases and clinical management, but also included patient care strategies in the public sector and this was captured by the following participant:

"Through workshops they workshop us. Throughout the years that I have been walking with these people, they equip me year in year out. I've been walking with them and learning with them. In all those years I was taken to Batho Pele principles workshop, they taught

us that when people come to us, like when these ladies come to us, I shouldn't treat them bad. They showed me ways of doing things from the people in Batho Pele."

#P3 F, 24 years

Good drug management principles were learned, and one participant indicated that it had opened doors for future courses:

"In those courses, that is where you are taught to control a person, to reprimand them if they don't drink their treatment properly, and not to mix traditional medicine and western medicine. And what we must do when we meet the patients on dual treatment. This we will do until our people can a see a better life. Yes, they are there. In the end, the course that I am supposed to attend now another courses, I am going to that one that shows me how to mix two traditional medicines. When I leave there, I have to go to the one about nursing. Even though that nursing isn't at the same level as the normal nursing courses, ancillary I think, yes, we are being taught, they are trying to educate us."

#P19 F, 66 years

There was also a feeling of appreciation from participants for acquiring new knowledge, and this was reflected by one participant who said such knowledge had made it possible for her to be competent in addressing diseases such as STDs, "grieving syndrome" as well as mental illness.

"They teach us about patients, they teach us about polio vaccines and how it presents in children and now these things have worked for us as THPs. As a result, I now specialise in sexually transmitted illnesses which they call drop, grieving syndrome[3] as well as mental illness."

#P5 M, 29 years

A few participants further appreciated that, other than the training conducted as knowledge enhancement, the department was training them at no cost, and food and transport were also free. This was highlighted by the following three participants:

[3] According to participants, a grieving syndrome is the period after a person loses a partner and is not allowed to move around, as she or he will be drinking traditional medicines.

"No, we were not popping monies, not paying; I will be lying if I can say we were paying from my pockets to pay the bus. Even mmmm, food, it would be served on arrival, we found our food served, you see!"

#P22 F, 67 years

"Yes. When we have meetings honestly, we will just see taxis parked outside waiting to transport us to a meeting. When we get there, there is catering, we eat until we are full. You see that they care about us? Yes."

#P17 M, 37 years

"And take they would take us to workshops in [name of the town]; they'll let us sleep at guest houses and hotels which are beautiful. There, we eat well. Well. Yes. They treat us well. They treat us well."

#P18 F, 28 years

Another one said:

"Then we would enter together in those places. No, we were not popping monies, not paying; I will be lying if I can say we were paying from my pockets to pay the bus. Even food, on arrival it would be served, we found our food served, you see! Yes."

#P23 F, 68 years

The following participant appreciated the presence of the officials from the Health Department:

"They received us because we often have those from health when we have meetings and workshops. In those meetings with them when they teach us, the workshops and the trainings, we found everything! They provide us with transport by the way, everything would be there, water would be there, and food would be there. Yes. When we get there, we eat and eat. When we leave after being dispersed, we eat again. And then we leave. Transport is still them again. No, we don't pay for anything my love."

#P26 F, 31 years

Other than being trained and being empowered, this participant appreciated that the Department had gone an extra mile, to the extent of giving them condoms for both personal use and distribution to patients, and self-protection by wearing gloves.

"Because even as we meet, they tell us about those gloves, and condoms, to protect ourselves and to give to patients condoms to prevent HIV/AIDS even as old as we are. What are we doing with condoms at our age? Are they still there?"

#P17 M, 37 years

3.5.1.2 Collaboration uncertainty and contentment (THPs' expressed feelings and emotions)

Though the majority of participants echoed feelings of happiness about the collaboration, some expressed feelings of doubts and insecurities that they had during the early stages, but said their anxieties and fears were since allayed.

> *"The first time when the department initiated this programme I started to ask myself questions which I saw as a challenge but eventually I got answers and accepted that I am embarking on a new way of doing my work as a traditional doctor with the department of health, and that brought happiness within myself. I am impressed because I learned new things from the department; us traditional doctors we use bones to communicate with the ancestors who inform us about the patient's diseases and medical doctors learned the way human body system operates; now the department shared the knowledge they have acquired with us."*

#P3 F, 24 years

The following two participants had expressed feelings of uncertainty and doubt having some concerns and a sense of disbelief that maybe they did not understand the news properly; they had this to say:

> *"In the beginning, when we started to accept that we and the department of health are getting married like a man and woman, and working together on patients, I had a challenge myself. I asked myself questions, but eventually answered them and was delighted in the way everything went."*

#P6 F, 43 years

> *"Initially when we were gathered and told we had to come close to the department of health in the government, I felt like refusing. Because from the beginning, a traditional doctor has not been received well. I didn't believe that it would be the department of health calling traditional doctors. Yes. I thought we must not have heard properly. After not believing, I think the department of health most of the time, likes to bring traditional doctors closer to the department."*

#P21 F, 30 years

These feelings of mixed emotions were further shared by the following four participants, who expressed experiences of being afraid and being anxious to work with the Department of Health, and this led to them having their own perceptions.

> *"Firstly, I was afraid because I could wonder what is going to happen. That definitely posed a question to me that brought anxiety because I was wondering what the department would say to me about my spiritual work."*
>
> *#P3 F, 24 years*

> *"The experience was difficult because I was afraid of coming together with the department, I was afraid that sometimes when you do things alone you think you are doing right, now when I was going to come together with health, I was afraid that am I doing things right?"*
>
> *#P4 M, 36 years*

> *"Yes, when we were called for the first time, mmmm, yes, we were always scared but when we met with them, we saw that there isn't anything that they want from us. In terms of what you use for your people; isn't it mama [researcher] when you are told to do something quickly, you don't know why you are being called so quickly, so we were scared that "ohhh my God" is the department going to arrest us or what?"*
>
> *#P7 M, 50 years*

> *"When we were initially asked to come, in terms of thoughts…everyone had a satanic thought. Hey, they are calling us, what do they want from us these people [Department of Health]? These people don't even want us, what will they say now? They want to see the medication we use and take it. They want to change it. What do they want from us? When we saw others going there some of us just decided to remain behind. Then I said, let me just go there and see. What do these people [Department of Health] want from us? We won't give it to them, they are ours in the first place."*
>
> *#P8 M, 44 years*

Because of the uncertainty of working together with the Department of Health, one participant expressed fearing for her life:

> *"When we started being called, first time, first time, I asked myself, yuu, how are we going to escape? Are we going to work well, or are we not going to work well? When they started calling us. Being told that now, we need to work together now! Being joined together. You know the thing which I have something like a fear, when we started working together with*

the traditional health and the traditional health practitioners, a person is going to die here! Yes Ma, I told [name of other traditional healers] didn't trust that thing, when we started with this thing, starting at [name of village], I said it. One woman came to me then saying 'Sister, now we are going to kill each other.' I said I trust in God, if we can then kill each other just for something so small, we have been brought to work together, to do one thing, you see! She said to me, 'Look here, we black people we are going to kill each other!' I didn't believe in that thing she was saying."

#P23 F, 68 years

The following participant expressed fear in relation to her competency in healing patients.

"Most of the times patients come consult with me but others get healed and the others not. That was the reason that scared me when the department called traditional doctors, and I was thinking that they would say I am not feasibly to help people with my traditional practices."

#P3 F, 24 years

3.5.1.3 THPs' experiences of happiness (traditional versus western cultural harmony)

Participants expressed their satisfaction towards government's initiative to harmonise traditional and western practice.

"I was really proud, and it makes me very happy to know that our government with the department of health did not forget that there is tradition."

#P9 F, 50 years

"Yes, when we met with the department of health, running up and down, with the pronouncement being made, and we heard about it, I was happy. I was happy that we got to meet with the department and became one."

#P29 F, 55 years

One participant expressed her satisfaction of seeing two cultures working in harmony to provide services to patients:

"Yes, so I was proud that indeed we will preserve lives because traditional [culture] and western [culture] have come together with us traditional doctors."

#P1 F, 70 years

The following participants appreciated the small things which were provided to them in merging the two cultures by the department during the initial stages of the collaboration.

> *"I was happy when we were called that we are also appreciated, that the government also loves us, we were happy because we knew that we were given name tags and we were no longer afraid, yes, it meant that our things will go well."*
>
> *#P7 M, 50 years*

> *"They would explain to us, after explaining to us, in the end, they gave us mmmm, what are they called again those things? I remembered, name tags. They gave us name tags. We felt accepted by the department of health, that's when we saw that indeed there is progress. After the name tags, there was a workshop, workshop, workshops many of them."*
>
> *#P8 M, 44 years*

Furthermore, the above participant simply felt that this collaboration was a game changer of bringing back humility, respect and harmony amongst both western and traditional doctors:

> *"Experience of working together with the department of health, it was wonderful, and I liked it. Because it was shown that even when we are being belittled by the society the department did not like it. There are others who see the human in us. Then they took us and put us in the spotlight. So that people can see that these people are also human beings who are always insulted, and they too feel hurt. The government took us and put us on a pedestal so we can be visible. That is the experience I've had. That was joyful."*
>
> *#P8 M, 44 years*

The following participant referred to her previous experience of how government used to treat them, but now she can share joyful moments as THPs were being brought closer:

> *"I was very happy because, because when we were growing up, in our government or in this world of ours, traditional doctors were nothing to the government. Yes. Now we saw the government in [name of the province] coming very close to us, I said to myself this must be a miracle."*
>
> *#P10 F, 25 years*

For some participants, a partnership between western and traditional culture was seen as an opportunity to showcase THPs' talents and traditional skills.

"I became very happy because that granted me an opportunity to prove my ability with my traditional skills to the department. When I am given a patient who is critically ill, I perform to the best level of my ability to treat the patient and when he/she becomes better, that is when the department will start to recognise me."

#P4 M, 36 years

"I felt really delighted to work with the department of health, with love and could not wait for the next morning to come. See myself working with them and stop sitting at home. I was not where I was for fun sake, and I want to show you, grandmothers and grandfathers [paused and burped] that I want this line of work! To work for the department."

#P27 M, 36 years

The following participant felt that the training which was facilitated by the department went to further unite and to promote teamwork amongst THPs:

"They say usually to us, our traditional teachers who teach us, they say to us most of the time we are afraid of each other as THPs. They [department of health] they said we shouldn't be afraid of each other. We should work together and help one another."

#P26 F, 31 years

While all the above participants were appreciating the harmony between the western and traditional culture, one participant highlighted her appreciation that through this working-together THPs were now well presented in society and had done away with all the previous scary traditional practices:

"Since merging with the health traditional doctors are not smellier like before; we are clean, you can look at me, you can hardly tell I am a traditional doctor, neh! Even in our surgeries, we have removed snake skins which used to make people be afraid of us; our surgeries are clean, and medications well labelled in bottles".

#P30 F, 42 years

3.5.1.4 Patient referral harmony

Participants alluded to the fact that this collaboration with the department was seen as coming to improve harmony in referring patients. One participant said:

"My experience, I was glad to work with health. Being happy to work with health is that I am going to treat a patient. Yes, so am happy with health because they can help us with drips. I'm embarking on a new way of doing my work. I am impressed."

#P4 M, 36 years

Another participant talked with pride of her ancestral talent, which guided her to refer patients:

> *"After throwing my bones and I find out that they have TB or asthma, I have to say to them: 'ma this one isn't mine it belongs to nurses, go to the clinic'. They should accept her [at the clinic]. Eya, now, in our collaboration, when they see that it is difficult to help this person. Just like how we work with them, they too should refer her to the traditional doctor and maybe the traditional doctor would be able to break the stronghold. If they can also refer to us, there will be harmony on exchange of patients."*

#P9 F, 50 years

The following participant indicated that patient referral harmony would assist in cases where patients presented late.

> *"Err, as traditional doctors working together with the government. Yes. We are very grateful; I certainly am very grateful. To work together with the government. Yes, ma'am, I was very delighted. Because in the traditional doctor profession, we face a lot of challenges. As a traditional doctor like before, you would help someone who thereafter would pass away as you're handling them. Those who brought them there to you would start to accuse you as a traditional doctor. They would open a case for you, they would call you with bad names. So, if the government brings us closer, they are able to stand against things like these, because we will refer in time."*

#P22 F, 67 years

In the same breath, two participants indicated an improved working relationship between traditional and medical practices that allowed and encouraged an easy patients' referral pathway.

> *"It is easy for us to refer patients since we collaborated with the department. I was happy to start working with the department because that is a great opportunity to explore many things that I have not experienced before. I am able to refer patients to the clinic when I realised that the patient needs supplements that can be provided by a nurse or a doctor. This means there is a relationship amongst traditional and medical practices that allow and encourages patients' referral. We work together to overcome the patient's illness."*

#P5 M, 29 years

A sense of delight was expressed by the following participant in terms of gaining the ability to know which conditions needed straight-forward clinic referrals.

> *"Now when this initiative was brought to light, we were delighted because we will help each other with patients because someone might go to a traditional doctor whereas their condition requires a clinic. So that what was said previously that we kill people does not happen that is what pleased me."*
>
> *#P16 M, 40 years*

3.5.1.5 Reciprocal learning

Other than the clinical training conducted by the department, there were those participants who appreciated the collaboration with the department. These participants indicated that they would be asked and be given a platform to share their own knowledge and skills in treatment and management of some diseases. This approach of dialogue by the department was appreciated by participants as part of reciprocal learning and was further expressed as follows:

> *"A while ago, when the department of health called us to come and attend workshops there and teach each other. Them teaching us and us teaching them. We were given a chance to tell them that, as people of tradition, this is what we do for that to happen."*
>
> *#P8 M, 44 years*

> *"In the department, I have experienced that it is easy to share knowledge. The knowledge I have, I share with them and the one they have, they share with me. We come together and become one thing."*
>
> *#P9 F, 50 years*

According to some participants, the department also showed interest in learning from participants, as was seen through the department asking questions relating to how participants managed some conditions:

> *"They asked us questions that if a person shows signs of mental illness. What do we do to them? They called us and asked us that if a patient complains about pain in the head what do we do to them. If a patient comes to you what do you start off by doing? We shared to them [Department of Health] how we managed such patients."*
>
> *#P6 F, 43 years*

"In [name of town], we were asked, which condition are you able to treat or heal? They wanted three conditions; they asked can you manage mental illness, epilepsy or some other conditions, a condition which if you wake up at night will be able to tell? We responded by telling them how we know the patients' diseases and how we manage those conditions; it was nice."

#P30 F, 42 years

"In the beginning they called us and asked us that if a patient complains about pain in a head what do we do to them. If a patient comes to you what do you start off by doing? Yes. We see through our bones right, we told them! They [Department of Health] asked us questions that if a person shows signs of mental illness, and the other conditions like epilepsy, what you do. In those meetings we answer them Mma [researcher]."

#P7 M, 50 years

Other participants felt it was not difficult to share what they knew with the department:

"We were trained and taught about conditions, so they wanted to find out with regards to these deadly conditions like HIV and AIDS. They asked us, do you come across them? Do you come across them? We answered yes. How you treat these conditions, we then tell them that we use bones to diagnose and we give then traditional treatment. They then explained to us that if you can't see through your bones, you can use someone's symptoms to diagnose the person and they teach us those signs, like sores, body wastage and the others."

#P8 M, 44 years

3.5.2 Theme 2: THPs' experiences of collaboration challenges

Participants' experiences of working with the department revealed a number of collaborative challenges. Most of these challenges were experienced in PHC settings.

Figure 5 below, shows the four main sub-themes linked to collaborative challenges.

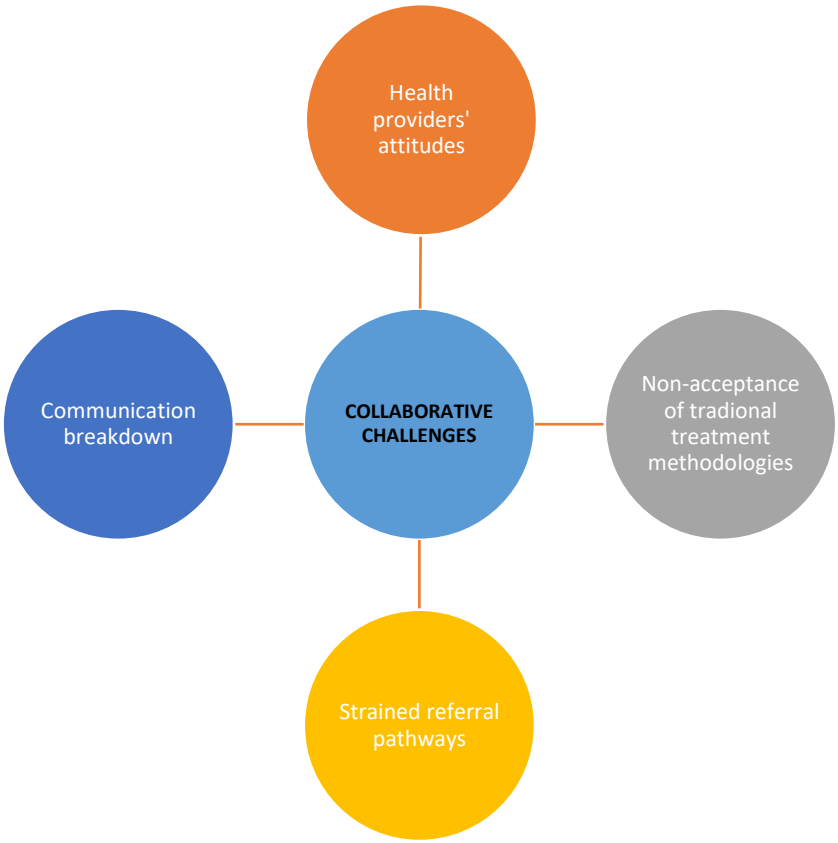


Figure 5: THPs' experiences of collaborative challenges

3.5.2.1 Healthcare providers' attitudes

Amongst the most collaborative challenges mentioned, THPs indicated that on many occasions when they referred patients to clinics, the BHPs' reception was not welcoming, and this happened in the presence of patients that they would be accompanying to the clinics.

The following participant had experienced a bad reception from nurses:

> *"The problem is that when the traditional health practitioners identify a problem with a patient that they feel they cannot solve, they refer these patients to clinics, but usually nurses refuse to assist this patients. If both stakeholders could work together and are been trained together, then to assist a patient would be much simpler."*
>
> *#P19 F, 66 years*

One participant shared non-recognition of THPs by nurses belonging to a certain religious affiliation.

"It is so mma [researcher]. If you pay attention to people's beliefs there are some people who say they have accepted Jesus [born-again Christians] but yet there are plenty of them in the hospitals, there are plenty of them in the clinics also. In the clinics, so they don't recognise traditional health practitioners."

#P2 F, 75 years

Two participants indicated that nurses were not the same; though there were those who treated THPs well, others treated them very badly, and so did some doctors. These participants expressed themselves in the following ways:

"My experience as a traditional doctor is that I have experienced a lot of ill-treatment as a traditional doctor, we are accepted in some instances and not accepted in others. As I mentioned that we haven't really got involved with patients."

#P16 M, 40 years

"Sometimes when you refer a patient some take it well and some do not take it well, that's when things become difficult. So, these nurses aren't the same. Doctors are just the same. There were some who did not understand and others who did. So, it became a challenge to us traditional doctors to a point where it seemed like we did not want to take a patient to the department of health because of the reception which was not nice when you walk into the clinics."

#P2 F, 75 years

Two participants felt that this collaboration when it was initiated, was not communicated well at service delivery level (clinics), as shown by the behaviour of some health workers:

"The challenge is, the department of health urged us to work with them, but the medical health practitioners seem to have a problem with us, traditional healers. What disappoints mostly is that, when you refer a patient to the clinic, the nurse gives us negative attitude and keeps asking patients whether they were from a traditional healer before coming to the clinic; it's so disappointing."

#P12 M, 49 years

"The challenge is that the government has accepted us very well. They have accepted us as part of them. But it turns out that in some other places, we are included so that we can be punished. Yes. There are times when they punish us. They keep punishing us because I've brought patients many times here at the clinic in my village. And when I bring them to

the clinic, I come across them saying I gave them this and this and that. If this person dies, it means you are the one at fault. I asked them a question and said if this person dies in your hands having used."

#P19 F, 66 years

Other participants indicated that nurses labelled them wrongly and called THPs bad names. One participant stated it in this way:

"Mm, Ma, [researcher] the difficult experience. Mm. The difficulty I faced as a traditional doctor is because I noticed that as traditional doctor our yolk [heart] is hurt, is heavy because we are called and given names such as killers and witches. You see? Now those kinds of experiences test us. Even as we struggle, nothing bad has happened. Even if they say to a person that they will die in your presence, patients survive by the protection of our ancestors. Sorry to say die."

#P16 M, 40 years

One participant also expressed how nurses discouraged patients to drink traditional medicines:

"The reason is that when someone comes with a threatening illness being very sick, I don't treat them first. I only check them, thereafter I take her to them [nurses]. And, when they finish treating other people and they find out what is wrong with them. As part of teaching the patient about us, they tell them [nurses] that if you go to traditional doctor, and drink what they give you, you are going to undo those pills. You are going to undo that treatment with Setswana things."

#19 F, 66 years

As noted by the following participant, negative treatment discouraged the THPs from collaborating with the nurses.

"Yes, those were the initial challenges that I experienced when the government welcomed us, however, the subsections in the government did not welcome us. They've accepted us at the top, at the bottom is still tough, yes. You come rushing here to the clinic, when you get to the clinic, whoever you find working at that time there will not treat you well. That's what disappoints me because you'd be discouraged to take someone there meanwhile you have the desire to help them. You are discouraged by who you'll find and in what they will answer you."

#P20 F, 70 years

Another participant highlighted that collaboration between THPs and the department was not embraced by all.

> *"Yes, I didn't believe that we would work together because they [nurses] do not totally accept that a THP would partner with them [nurses] to help a patient. Patient's benefits, yes because they too don't want our help. The department, the one in charge has that desire. The problem lies in the branches below. MEC is receptive but his workforce not they are the ones who belittle. As a traditional doctor, it is possible to take a patient or find a patient who is well in the line and it occurs to you that if this patient was placed under a particular drip and be sent to the hospital."*

#P14 F, 57 years

The following participants indicated some challenges they were faced with when referring patients to clinics:

> *"Another experience was that some other time we look at a patient and think they need the clinic. When you take them to the clinic, you experience bitter pride coming from the nurses, as if, mmmm, you walk in with a patient and then they overlook you. In the end, they take your patient away. For me, it was better to just be home. Because the patient who comes to you, you're the one who saw it fit for them to visit the department of health. I am making an effort to get them counselling at the clinic if even though they make up their mind and think they will receive their help from a traditional doctor. You see it fit to go to the clinic, when you walk into the clinic saying you brought them a patient it's like, ijoooh miss them, you know them right? When you bring in your patient so that they can help them for you they end up taking them away. Yes, and then they tell them the way that THPs are bad people, they even go as far as saying to them you went to a traditional doctor and now you will die."*

#P2 F, 75 years

While nurses were said to be treating THPs inhumanely and rudely, one participant indicated that she had observed a lack of interest by nurses who often shied away from her:

> *"Yes, acceptance will be there, but they are afraid of you when you first get there. They are afraid of you, when you sit there, you'll see them hiding, in the kitchens and some of*

them are off to labour. Initially, they are afraid of you as a THP. They are afraid. They are afraid of the mere person. Yes, they turn around and hide."

#P26 F, 31 years

3.5.2.2 Non-acceptance of traditional treatment methodologies

One participant felt that the western practitioners were not receptive to their treatment methodologies, although being trained. One participant made observations that nurses despised traditional treatment. This was captured by one participant who expressed how nurses discouraged patients to drink traditional medicines:

"I felt that in the workshops that the department has trained the THPs, they were also taught how to use the herbs, but when they do that the nurses ridicule them, but at the same time, when the nurses prescribe the pill, the THPs does not ridicule the western treatment modalities. When we go there, they berate the people who came to see us. But when someone went to see them [nurses] having drunk some pills, we don't scold them."

#P10 F, 25 years

THPs also noted that nurses did not appreciate the traditional treatment they gave to patients. This was articulated by one participant in the following way:

"So, I have experienced a lot of things from the department, the things I've experienced from the department of health? They are a lot of good things they have done to us, but the health care personnel, on the other hand, those who have not accepted THPs, are still not treating us well. It happens that you leave and go to the clinic. When you get to the clinic you go right ahead and see the nurses. When you explain to the nurses that I've tried this person here and I've tried it there, they don't agree with that. They say you give this person things that will kill them, they are not supposed to be given to them. When the patient gets worse, you're supposed to take them at that very moment and bring them to the clinic, you ask yourself, what are they going to say this time?"

#P13 F, 33 years

Another participant indicated that the lack of trust in traditional treatment was reflected by what nurses told patients when they were consulting at the clinic.

"I was afraid because I know that most of the nurses and doctors do not like traditional things because you would have seen and heard of how they view THPs. I will speak about something that happened to me before I was a THP. I was a pregnant patient, drinking

dikgaba[4]. I would walk into the hospital or clinic, not hospital. In the clinic, they asked me if I drank dikgaba. Then I said no I did not. They then took out some little thing that they used to check me with. Then she said, here they are, you see you drank them. So that's what worries me that will this collaboration indeed go well, with nurses hating our treatments so much!"

#P14 F, 57 years

The following participant felt that the practice of THPs was not regarded as a profession by nurses:

"Nurses need to seriously consider us as traditional practitioners because they disregard our practices."

#P12 M, 49 years

One participant felt that patient sickness history was not always followed up.

"Furthermore, the clinic does not take into account where the patient consulted initially with the condition. They don't do follow ups, upon arriving at the hospital, the patient is healed. The council [name of the doctor] just transfused or put a drip, and then the patient is healed. The hospital does not investigate what the issue was. At the traditional doctor."

#P30 F, 42 years

The use of traditional methodologies was belittled by nurses as expressed by these two participants:

"Ma [researcher], adding on to that, traditional healers use razors during their traditional practices and nurses do not like that; they say it could give a patient another problem or infections passes from one person to the other as we don't use preventative measures. Then that will be quite disappointing to the patient for expecting better service and cure the other thing he/she got transmitted disease unintentional."

#P5 M, 29 years

"When they came to the clinic. Then they see some smears, then hell is broke! The nurses become very angry! The child's mother will go home crying. When you apply children

[4] Dikgaba as explained by this THP, is a medicine which is given to pregnant women in labour, to hasten the contractions.

mesidi[5]you smear them with mesidi to them is wrong. The child's mother will start shouting and saying here is the problem. And then they return home crying. So, it is our culture. We got these teachings from our ancestors. Should we not do it? That is what was done to us. It's not nice. Sometimes you say I should have stayed behind and not partnered with health."

#P8 M, 44 years

"Mm yes there are a lot of challenges because when we refer a patient to the hospital or the patient came to you first, when you take them there the nurses will say you come from so and so. Because they smeared themselves, here are strings they've put them on."

#P5 M, 29 years

One participant explained that nurses despised the medication used by THPs for a woman in labour.

"In terms of challenges, there's still a problem. There's a problem, they still make it hard for us. For instance, you would send a pregnant woman and them just say kgaba. Because they know that traditional treatment, they become angry at you. They know that we work with them. This person is supposed to drink kgaba."

#P18 F, 28 years

3.5.2.3 Strained referral pathways

Most participants indicated their willingness to refer to nurses and doctors; however, the nurses and doctors did not reciprocate that. Participants furthermore alluded to the absence of a uniform referral letter as causing major referral challenges.

This participant had this to say:

"We should help each other when treating a patient, you find that I have a patient who is sick. I then refer to the clinic. When she gets there, they ask her questions. Sometimes they leave a sick patient and they don't even touch her, because she consulted a traditional doctor."

#P15 F, 61 years

[5] Mesidi as explained by the THP, is a black powder which is an end product of a burned traditional medicine.

Three participants viewed patient referrals as strained in that it was only one-sided:

> *"Is that the department recommends that traditional doctors should refer patients to them but us it is still proving difficult for them to refer to us? There is no back referral. They don't take that kind of responsibility. You get them by chance. It's only that a doctor will come to you and say don't you have anyone. Just like how they said refer patients to us. We should keep passing patients to each other as in a partnership. Let it be open to patients just like how they said we should have a database we should have. They should go into the system to check where they are from and call us, we are willing to can help them with these illnesses. Because when we merge with the department, and we will share patients. I hand over a patient to the department and then they give me a patient. Or the department gives me a patient and I return it to them. But what still makes me sad is that the department recommends that traditional doctors should refer patients to them but us it is still proving difficult for them to refer to us. There is no back referral."*
>
> *#P2 F, 75 years*

> *"I am able to refer patients to the clinic when I realised that the patient needs supplements that can be provided by a nurse or a doctor. That means there is a relationship amongst traditional and medical practices that allow and encourages patients' referral. We should work together to overcome the patient's illness. This is made difficult because nurses do not refer to THPs."*
>
> *#P4 M, 36 years*

> *"Just like sharing with our patients. So that we can be able to take forward our nation in the department of health by giving our patients healing. They too must refer to me if they are not able to help a patient. That to me is in order."*
>
> *#P9 F, 50 years*

Interestingly, the participant below had a different view as opposed to the three participants above:

> *"The department should be the one referring patients to us not the other way around. If this is done it will show the seriousness of the department in terms of forging a relationship between these two stakeholders. From our side we do that and we want to see them also doing it."*
>
> *#P19 F, 66 years*

Lack of a formal uniform referral letter was said to cause a strain on referrals between THPs and nurses as most of the times THPs referred patients verbally. This was how this concern was captured:

> *"I would tell someone verbally that you have to go to the clinic. Not that I have written. I have not written; I would just tell them that you have to go to the clinic. Yes, they do go and someone even."*
>
> *#P21 F, 30 years*

> *"My biggest cry is the referrals. The government promised to make us referral documents. So that when we refer patients, we should write down and explain what we have done to the patients. We don't have report books, but we refer. Verbally. We are going to health. Referral, they promise this every day. Every workshop we go to them and say, people, you have since promised us referral forms, where are they? Where are they because they never come? I have noticed this and that from them. So, it seems am not able to do this here. We always continue from that same point of requesting referral forms, but we are not winning; they should be able to provide us with them."*
>
> *#P8 M, 44 years*

Two participants raised concerns about not getting feedback from the nurses regarding the patients they were referring to them.

> *"No, they don't give feedback and sometimes I would be told by the patient about his/her referral and his/her welcoming at the clinic, and that time would be a month or two months ago after referral. I see a difference if the patient uses two different medications at one time. The patient would not definitely know which medication precisely cured him/her, and most probably the medication shouldn't be used simultaneously but that time, there will be a mixture of medication."*
>
> *#P3 F, 24 years*

> *"We share most of our patients with our clinic in the sense that when we share them with our clinic, in the end we refer patients to clinics. What we experience in the end is that they don't give us a report as feedback about the patient we are sharing."*
>
> *#P12 M, 49 years*

One participant felt that BHPs' perception that THPs were uneducated people was one challenge which hampered a two-way referral system with BHPs:

"Yes, they do not refer to us. They [nurses] don't refer to us. Yes, it shouldn't just be on one side. I noticed that they take it that we are not educated, yet it's not the case, some of us have gone to school and have degrees. They [nurses] think they are the only educated ones. This is where they stop us. We are not respected at all, they [nurses] just use us. These people [nurses] should start treating us with the respect we deserve."

#P13 F, 33 years

3.5.2.4 Communication breakdown

Most participants indicated that English was a language barrier to them as it was used during training and workshops provided by the Department of Health. One participant said:

"Difficult experience I encountered was when the department conducted training sessions and workshops with us using the English language which to me is very difficult so I just wish that, as we have partnered with the department of health, they should ensure that all traditional doctors reach a certain level of education."

#P12 M, 49 years

Most participants recommended that the training and workshops should be conducted using their local language, so that they could be able to comprehend well:

"There were trainings and workshops, they used English a lot. Only those who were educated understood, we are not the same because we are not all educated. We did suggest they speak Setswana. Hey, you even try to speak Setswana. The problem is that you would be trying to speak Setswana and some terms, some of the words in Setswana are hard to find in English; I understand English very well, but shame some of us have not attended school by the way. Language barriers the difficult thing is that we can translate there, they can't. One-sided translations."

#P10 F, 25 years

"I don't understand English, I did not hear properly as the facilitator only used English, we told them that we don't understand English, asked them to use Setswana but in vain."

#P15 F, 61 years

One participant highlighted language barriers by saying:

"We went there [name of town] for a workshop, Yes, I have gone there. I've also been to their training. Yes, I understood some of the things we were taught, but I struggled with

others. Yes, I don't know if it was a matter of not having interest to speak Setswana or completely not knowing it. They spoke only in English. Yes, we did tell them that we couldn't understand when they only spoke English. Yes, they spoke English when they came to us."

#P15 F, 61 years

Another participant indicated that over and above language barriers, the training sessions were not inclusive of all THPs, and were leaving some benefiting and others lagging:

"But they can't call us all, why we don't know! Also, when they conduct workshops with traditional doctors, they shouldn't just take some, they should look at their things that those people came. We should all be able to attain this knowledge as traditional doctors they usually take about three to four. But the other one is a traditional doctor but they…They haven't gone to those workshops. That knowledge you see. But they also desire to, but they are falling behind with the knowledge."

#P24 F, 60 years

This participant raised a challenge that the materials were written in English.

"They [workshops] are being attended but something that isn't right in the attendance is that when we read all the documents from those who attended, we find that they are all written in English, and there is no Setswana, And sometimes those who attend come and give you a piece of paper then they'd say, have a look at this from that thing I attended. Even the terms are those that are not easy to explain. They are not well educated. When they speak for the first time, they speak in Setswana. Before you know it, they speak English. They bring our papers. Everything is written in English. Even the terms are those that are not easy to explain. Some of our THPs are not well educated."

#P17 M, 37 years

There was an indication that participants were not happy with the lack of feedback from the Department of Health.

"Just as we have representatives or leadership within us as traditional doctors, when we have complaints, we table them to our leaders. Our leaders then take it to the department of health that traditional doctors were thinking of doing this or they have this complaint. Now they are the ones we wait to bring the answers to our leaders. Our leaders bring the answers to us. And then we wait for the answers. We have not received them till today. They always say that the person with answers or who can do what you are asking for is

not available. Now it's always he is not available we don't know where he's not there at all times, we don't know, do they mean the MEC, we don't really know. That is our biggest issue."

#P9 F, 50 years

"We have leaders, who we attend meetings with. When we have complaints or lack anything, we have a meeting and write a report. We give it to them, and they take it forward. When it gets there, they'll also take it forward to the province, but what we've seen is that we don't even receive responses."

#P14 F, 57 years

"In this job, we have meetings where we are called to come and resolve our problems, share our complaints with the department, and plead with the government. The letter was written and sent to the government. I don't know whether they come back or not. But if they had come back, I know we would have been called and told; nothing has happened, no feedback!"

#P16 M, 40 years

Amongst communication challenges cited by participants, other participants raised challenges of unfulfilled promises by the Department of Health:

"Yes, those were the promises that made when we started. A lot of things are being said, but they don't come to pass. I just don't know whether our superiors are the ones tampering with these things or whether they do go through. Things are being done, as they leave. We don't have the assurance that they do go."

#P19 F, 66 years

"We, we would be promised to be awarded something or been given something that will prove that we have attended workshops or training. We do complain about the empty promises they are given us but that they do not do anything about them to us."

#P15 F, 61 years

"Yes. Because they do not fulfil anything that they promise to do. They should also know that we are important and know where we are coming from! They should make sure that they have our numbers and call us when they need us and bringing us closer to them."

#P1 F, 70 years

A few participants complained about the lack of a structured communication or reporting system by the Department.

> *"In the department, things were easy even though it was difficult at times; the department does not know where they stand so we are still waiting for councils. We used to attend meetings as a traditional doctor and did not even know where to submit reports."*
>
> *#P2 F, 75 years*

> *"Because we attend meetings and come back with no progress. Like there is no timetable or a work plan which has been approved. We do not hold meetings. In our department [THPs] but we don't have meetings with these men or women [nurses] regarding traditional practice. We don't have meetings with them there are no formal reports that we write; it's just that where I stay, we have my own report which we write in a file. It does not go anywhere. It's our personal record."*
>
> *#P30 F, 42 years*

Only one participant raised a concern about fear about the oncoming rules of the THPs' council.

> *"We were waiting for the council. Now the council was here, and we have given them our thoughts and inputs to be put in that council document, we don't know when they will answer us. In the department what I've noticed was that the doctors, the department will end up making decisions for us. Indeed. The documents are available. And the council has come. What I've understood is that a traditional doctor should be taken and sat down with, to be tested whether they are a traditional doctor. Yes, they will be tested, whether they are indeed a traditional doctor. The test should be done after they have completed a form; if it comes back and says they are not a traditional doctor, and they should stop. If they are successful, they should get a ticket."*
>
> *#P2 F, 75 years*

3.5.3 Theme 3: THPs' experiences of collaboration gains and impact

This theme anticipated collaborative gains and impact emerging as one of the four main themes from this study. Participants in this study indicated that they expected that a working relationship would bring both positive gains and a good impact on the management of diseases and treatment. This theme therefore addresses objective number two of this study of exploring THPs' expectations that might enhance their cordial

working with the Department of Health in Ratlou sub-district and is further supported by the following sub-themes as illustrated in Figure 6 below:

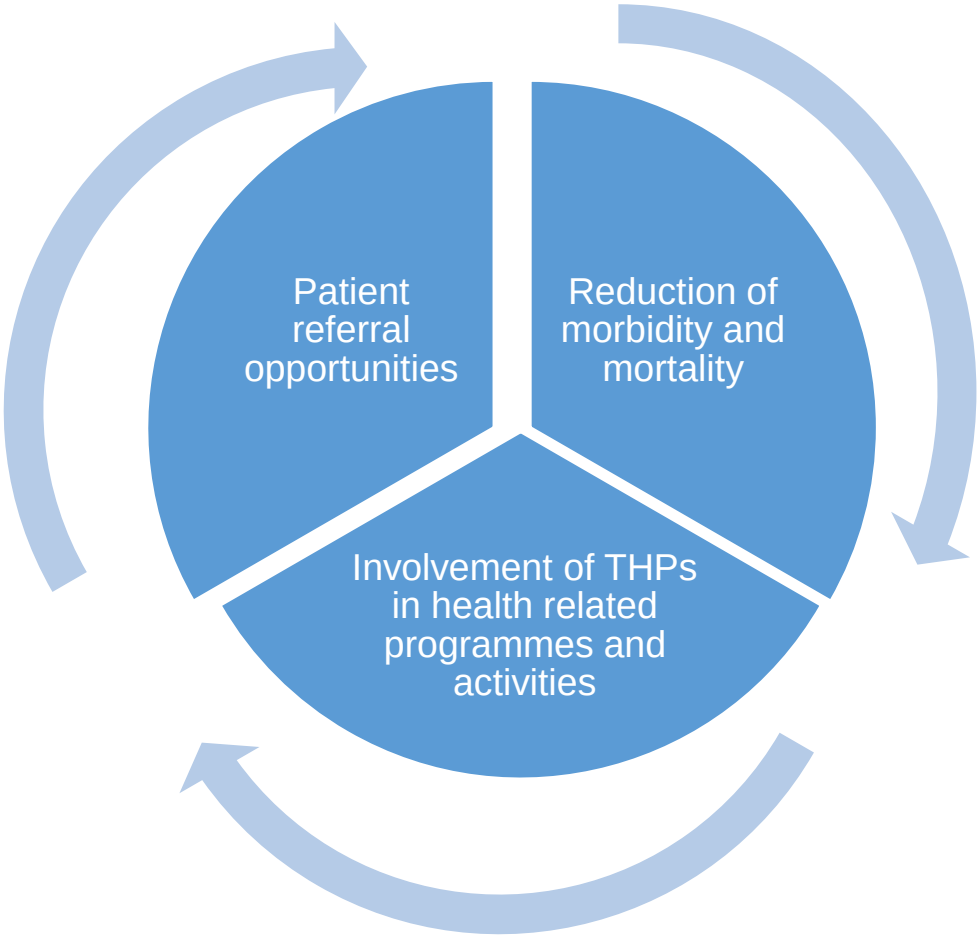


Figure 6: THPs' experiences of collaboration gains and impact

3.5.3.1 Reduction of morbidity and mortality

The positive collaborative gain was seen to mainly revolve around patient care. Participants felt that the main goal of the collaboration with the Department of Health was to preserve lives and reduce illnesses and deaths in communities. Three participants expressed these spin-offs as follows:

> *"So, we can reduce illnesses or reduce the number of illnesses. It made me happy that the department is inviting us to get close to them and they come close to us."*
>
> *#P9 F, 50 years*

"We come together and become one thing, just like sharing our patients, so that we can be able to take forward our nation in the department of health by giving our patients healing and reducing deaths and illnesses. That is in order."

#P5 M, 29 years

Three participants alluded to the fact that there was a need to work together to save patients' lives and promote patients' healing.

"The difference that I see is if we could stand up and come together to be one. And overcome the illnesses that plague the nation of South Africa and heal our nation. That is what could make a difference."

#P16 M, 40 years

"I felt very proud because I took it that there will always be patients, this will get better. I was proud because I thought it meant that in this partnership with the department, it will be easy for patients not to lose their lives or lose a good life in the hands of a THP. As we will refer to nurses."

#P1 F, 70 years

"I was proud because I thought it meant that in this partnership with the department, it will be easy for patients not to lose their lives or lose a good life. Because it is important for healing to take place. Yes, so I was proud that indeed we will preserve lives because tradition and the west have come together as one."

#P2 F, 75 years

3.5.3.2 Involvement of THPs in health-related programmes and activities

Participants in this study indicated their participation in health-related activities and in health programmes.

One participant expressed willingness to assist nurses by helping with home-based care of patients on chronic medications.

"The clinic might give us this person's pills; their treatment might be for TB. You crush the pill for them and give it to them to drink it at my place. You crush the pill and mix it with porridge, and they drank it. They drank it, it hasn't come back. Then they say I am better; the clinic had said I have TB."

#P2 F, 75 years

Three participants expressed their participation in other health programmes.

> *"Sometimes we are linked with coordinating HIV/AIDS programmes, by the way, people are still afraid of disclosing their status. Destigmatisation is still a problem, and we help with this programme!"*
>
> *#P16 M, 40 years*

> *"I think perhaps if we traditional doctors became DOT supporters things might get better because your patients come to us. When a patient comes to you saying they have TB, we encourage them to complete their treatment. We are also encouraged to have campaigns. Every year, arts and culture will bring out a cow and give to traditional doctors so that they can celebrate their event, there we talk of all health-related topics for community awareness, and we invite Special Programmes from the MEC's office."*
>
> *#P2 F, 75 years*

> *"Yes, because, we are approaching another time now which is December, there are a lot of illnesses coming here, they come here when you bring a child, when they brought a child it happens that and the people who taught us the day before yesterday about these vaccinations. These people don't inject the complete vaccinations. If you go to church, I went there because of my daughter in law. You will see that; I then use the church platform to market immunisations and shares information with my church members."*
>
> *#P5 M, 29 years*

There were those participants who felt that clinics should also refer women in labour to them to assist the short-staffed clinic nurses, as they had been trained to deliver women and had been delivering women for a long time without any complications.

> *"In the clinics our cell numbers are kept so that when there are many women delivering and nurses are short-staffed, nurses should just call us, and we will come and deliver those women. Has the need of keeping our contact numbers but not been called to assist."*
>
> *#P2 F, 75 years*

> *"I have delivered women for many years and have not registered complications, not once, you see, I was well taught by my grandmother how to deliver women."*
>
> *#23 F, 68 years*

"In the olden days, women were coming to traditional doctors when in labour, and we have done it perfectly".

#24 F, 60 years

The following participant indicated that he also marketed the Departmental programmes belonging to the Department of Health:

"I say to her look here little baby, tell me, there are people called engineering team, right? That programme of PHC reengineering, where nurses and community workers visits households, I do refer patients to them. Yes, I told them that those people did go to households. She said no they have not. I said these ones here, I said do you live in this division, she did not reply. She knew that I write with the spirit I don't write with a pen. My heaven has given me words through the spirit. But finally, she met the engineering team."

#20 F, 70 years

One participant showed willingness to assist patients who were defaulting treatment:

"I then would agree with the western doctor. We can see your patient; our patients know that traditional doctors are taught confidentiality. As a traditional doctor, when you go there and come across a nurse with a patient that you do not have, you are able to know that this person is a defaulter. And then you say this patient is there in your files at my place. They might be able to give you this person's pills, their treatment might be for TB. You crush the pill for them and give it to them to drink it at my place. You crush the pill and mix it with porridge, and they drank it. They drank it, it hasn't come back. Then they say I am better; the clinic had said I have TB."

#P2 F, 75 years

3.5.3.3 Patients' referral opportunities

Most participants expressed that an opportunity to inter-refer patients between the two disciplines had been created through working together with the Department of Health. The following participants cited examples of those conditions which needed western management:

"Yes, we'll be traditional doctors having patients in your clinic, treating them, but not knowing that they need water and blood. You will see that they need things that require

the west. But you just put them, just saying that they will get well. But not noticing that they need water. Now we have a chance to refer such patients to clinics."

#P11 M, 53 years

"I appreciated the knowledge and skills that I haven't had before, I was very delighted. I was not scared but I was delighted because as traditional doctors, if it happens that I have a patient that I cannot manage, and I find out that this patient needs fluids related assistance, as a traditional doctor, I cannot put fluids in the patients', I would refer. Now, I was delighted that we were going to work together. Meaning there will be extra help for our patients and things will be easier."

#P12 M, 49 years

"The challenge is that patients have different diseases. There are patients that we can't manage completely. Wherein there are things which we do not have that westerners do. Like drips and blood transfusions. We do not have those sorts of things. I was happy [paused and burped] to deal with the fact that if there is a problem and we have to work together; I will send the patients to clinics. Western doctors and traditional should come together."

#P13 F, 33 years

Prompt referral to clinics was seen by some THPs as an opportunity to refer complicated and very sick patients in time.

"I have experienced that walking with them [department] is good for me. Maybe there might be things that I cannot do for the patients, but for this short period that I have been with them [department], yes, because there are things that I should experience like I have to know that if it is a patient at the clinic, I should refer them to the clinic. If there is a medication that they are taking, then I should know they drink western medication."

#P1 F, 70 years

"If I have to give the patient traditional blood medicine, it could be better to refer the patient to the clinic to receive blood with a drip unlike given him/her traditional blood medication because it will be slower than the process at the clinic."

#P3 F, 24 years

"But now when you heal a person, at times, they bring him/her being finished, neh! They bring him/her being finished when they start putting him/her there next to you, the person

dies. Then you are being blamed for that death. Now when they get with her/him here: Are you from the clinic? If not so, go to the clinic. Go to the clinic, yes. When they start to enter, a person is asked, are you from the clinic? No. When you heal a person, at times they bring him finished, neh! They bring the patient already finished when they start to put him/her there in front of you a person dies. Then they say it's you! Now we will be able to refer patients to the clinics and be saved."

#P23 F, 68 years

Other participants indicated some children's diseases which western doctors could not treat, which should be referred to THPs:

"It shouldn't be that your practice is no more useful, it is no more, only the west will work. I often hear it western is the only one that should work. No. Meanwhile, you can see that the child has Metlhala [6]seeing that this child's head has a dip. They don't stand a chance. The child's head has a dip. This child has Metlhala[7], they have kokwane[8]. And you can clearly see that this child needs Setswana intervention. They'd keep insisting that it's not working. You can clearly see that this condition is a result of kokwane it's not working, it's not working. Only the west is at work now! What do you do? You become powerless. Nooo, these people must also refer to us. Such conditions are not managed by western treatments."

P#26 F, 31 years

"When the child takes it that they are being discharged, they start again to show the same symptoms. What does that thing do? Eats where it eats. When the antibiotics are done, what have they accomplished? The child gets thin and that thing starts to produce pus, and that is what their faecal matter turns into. A drip is tried, a drip is tried, err? That is when they pass away. They take blood tests all day and find nothing. In the western and traditional practice, there are conditions that we cannot manage. However, it might happen

[7] Participants explained Metlhala as a condition which is fatal, killing new-born babies and children and is contracted though a mother having walked over the road with her child, where the other women has walked there after having an abortion.

[8] Participants explained Kokwane as a condition which is fatal, killing new-born babies and children and is contracted though a mother having walked over the road with her child, where the other women has walked there after having an abortion.

that the same child is shown to a traditional doctor, and in a days' time they are healed, and they go back home."

#P2 F, 75 years

THPs feel when they experience "Amadlozi"[9], and when that happens, such patients should be referred to them for treatment.

"There are many things Mama [researcher] you know, which can bring about change at the clinic and is because some conditions are not for clinics only, they need us traditional doctors to treat. At times when I visit the clinic, on arrival, my Madlozi awakens, my ancestors talk to me, and I am supposed to take the patient and tell that patient that your illness is not to be treated for in the clinics. I should then take you and subject the patient to a process of Gothwasa[10], or to find another way and take it."

#P27 M, 36 years

3.5.4 Theme 4. Approaches to collaboration strengthening

This section presents results based on study objective number two which seeks to explore the THPs' expectations that might enhance their cordial working relationship with the Department of Health in Ratlou sub-district. The theme's approaches to collaboration strengthening are presented below, accompanied by supporting sub-themes.

[9] Amadlozi are described by participants as their ancestors, who present to them spiritually, to guide them on how to treat certain conditions.

[10]Gothwasa is a traditional training process, which finally, after completion produces a THP.

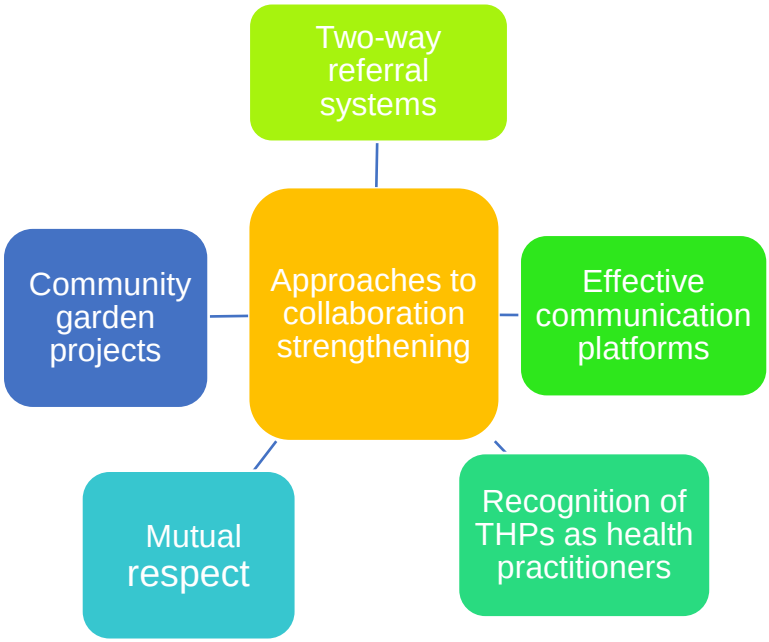


Figure 7: Approaches to collaboration strengthening

3.5.4.1 Two-way referral systems

Participants in this study have recommended that, for collaboration to be strengthened, there should be an effective two-way referral system in place.

The participant below explained this collaboration as a platform to share patients cordially:

> *"Because when we merge with the department, we will share patients. I hand over a patient to the department and then they give me a patient. Or the department gives me a patient and I return it to them. We should keep passing patients to each other like in a partnership."*
>
> *#P2 F, 75 years*

To facilitate a cordial referral pathway between the two disciplines, the following participant highlighted the importance of referral:

> ***"****If the Traditional Health Practitioners and the Modern Health Practitioners work together, it could make life a bit simple for both stakeholders, because when the THPs refer patients to the clinics, the THPs could ensure that their patients take the medication that they have been given from the clinics appropriately."*
>
> *#P3 F, 24 years*

One traditional birth attendant (TBA) suggested that clinics should also refer women in labour to the TBAs:

"But what we are saying is that when the nurse realises that a traditional birth attendant is close by, they should refer the relevant person to them so that work becomes easier. It should not be that every now and then we just say take to the clinic, take to the clinic, and take to the clinic. We can also help to deliver women; we have been doing it for a long time. Everything can become easier that way. Do you see it? It would make a difference if they also refer also to us in this partnership."

#P24 F, 60 years

Patient referral harmony was seen to assist in cases where patients presented late to THPs:

"We face a lot of challenges. As a traditional doctor like before, you would help someone brought to you in an advanced stage of diseases, being just about to die, who thereafter would pass away and die as you're handling them. Those who brought them there to you would start to accuse you as a traditional doctor. They would open a case for you, they would accuse you of killing their patients. So, if the government brings us closer, we will rush the patients to the clinics to be helped. They [nurses] are able to stand against things like these. Where you are to blame, they [family] point fingers at you. They are the ones who brought him to you late."

#P22 F, 67 years

3.5.4.2 Effective communication platforms

Participants in this study further noted that, for this working relationship to be a success, communication platforms should improve. One participant advocated that THPs' reports should reach their destination:

"Our reports should, I mean that one thing, our reports are written, if it could happen that our report are late if we don't go to meetings as traditional doctors, and they should reach those at health. We speak about our complaints usually in meetings. Mm, we can speak about this and that. Yes. They should go to the MEC so our leaders should make an appointment with him that he hears our cry. How we so want to want to advise him. These reports end up in the wind. Just like we have minutes, we have reported, we have cries there."

#P18 F, 28 years

Another participant talked about how joint meetings assisted in fostering good working relationships:

"Between the nurses and us, as a person in the committee here at the clinic, I have a lot of things that I say when we go to meetings where it turns out to worry that arise from traditional doctors. I am referring to things on our side that this and this and that. This helps in solving problems."

#P5 M, 29 years

One participant emphasised consistent communication as a need to strengthen this collaboration:

"As I stated previously, I emphasise that, let the department and clinics have consistent communication with traditional doctors as patients' referrals is concerned to both us the traditional and medical doctors in the health care provision of our patients".

#P3F, 24 years

The following participant simply thought an opportunity for dialogue could assist to strengthen this collaboration:

"Both stakeholders, THPS and BHPs, should meet once in a while to discuss the challenges and achievements that they have experienced."

#P13 F, 33 years

Joint training at workshops was also raised by two participants as an approach to strengthen collaboration:

"Both stakeholders, that the traditional doctors and nurses should attend one workshop and share information amongst one another should attend one workshop."

#P15 F, 61 years

"It's that when the department of health should organise a workshop, they should say this workshop is fitting for traditional doctors, this workshop is fitting for doctors. They should put us in one class. Yes we must unite. How can we be united if some are workshopped there alone? If we are united in the same class, we could learn better. It is not evident for now. It's us and them separately. We won't be united if we don't work together, neh! We won't not unite."

#P10 F, 25 years

"The difference it's, only that when we attend workshops, nurses and doctors have their own. Should also attend workshops. We should attend in the same place. In one class."

#P14 F, 57 years

Provision of uniform Departmental referral letters to be used by THPs was also highlighted by two participants:

> *"We should have regular training, monitoring and evaluation of referral letters from traditional health practitioners to clinics."*
>
> *#P3 F, 24 years*
>
> *"The relationship should be formalised, and the department should provide the traditional health practitioners with referral letters that have departmental letterheads and stamps. They should give us forms so we can write on them. Those paper that we write on when we refer patients. They should come from the department to show that we are working together with them, so we can write for these patients who are going to clinics."*
>
> *#P4 M, 36 years*

3.5.4.3 Recognition of THPs

Participants in this study have shown interest in forging a relationship with the Department; as a result, they outlined a few approaches to strengthen THPs' recognition in the collaboration with the Department.

Three participants felt that their presence in local clinics with BHPs could strengthen the collaboration and act as a way of formally recognising THPs as partners with the Department of Health:

> *"There should always be a traditional health practitioner at every clinic".*
>
> *#P2 F, 75 years*
>
> *"I would recommend even if we are not many, at least one in a clinic. We should be able to help the nurses. Be a part of them and helping them with several things. Yes, they do, mama. The improvements would be, well, there are patients that you see often at the clinic whose illness you can treat. Traditional doctors should be there always, in their rooms in clinics, so you can prepare that herb for them. Where you see a lack, you supplement the nurses' hands."*
>
> *#P25 F, 55 years*

"We should be always present in clinics so that when we are there, a little room should be spared for THPs, it should be that whoever would be there and is struggling, bring them here so that I can have a look in her."

#P26 F, 31 years

While the three participants above advocated for THPs in the clinic setting, the majority of participants felt that THPs should also be allowed space in hospitals' wards:

"Yes. I would suggest that traditional doctor should be able to work in the hospitals. Be given space in the hospital and work together with the nurses and doctors."

#P1 F, 70 years

"What would ensure that we always worked together is if the department of health agreed about traditional doctor so that when traditional doctors work, they should also have a place to do so. I think that we would all work together. When you look at where patients stay, it's at the hospital. Even if there was a ward that say, in here there are traditional doctors, in here, is where they work. So that when a patient gets worse, they can take them quickly and bring them to a traditional doctor. It is an idea that has been sent up, mma [reseacher]."

#P13 F, 33 years

"Yes, what I see is that if only they could find us a little place like BoMakhosi has always mentioned to show that they've welcomed us, we should stay there and always be available to tackle any problem the nurse might encounter. The second thing is that when a nurse sees in a pregnant woman that the baby isn't turned around, we have to be close by, nearby in our own ward. You are not going to be fetched far."

#P20 F, 70 years

"Another thing I think they can change can be maybe it will make a difference between us and the department, is in terms of representation. They should have a little room in the hospital, as we have always mentioned, that when there is an illness, there is an illness where like what Ma'am [name of another THP] once said, there is an illness that is put upon someone and western doctors don't know of it, THPs should then assist."

#P21 F, 30 years

"As I have said, yes there is a difference and a lot of it. Some of which involve us traditional doctors and western doctors like I have just mentioned that if they gave us a room in the

hospital nearby, where they say, traditional doctors work here; western doctors work here. You see? We can manage to save people's lives."

#P22 F, 67 years

The two following participants gave an indication that the proposal to allow THPs to work together with BHPs in hospitals had been tabled a long time ago with the department, yet to date no response had been received.

"I would suggest that those in health should be able to reach traditional doctors. Traditional doctors should also be present and unite with nurses in the wards at hospitals so that they can work together with us. I have suggested it so many times. With no answers. I'm still waiting".

#P10 F, 25 years

"I was thinking that in a matter of time I would be walking into a hospital with a briefcase full of my healing bones going to heal patients free at the hospital. Yes, it is known and then I put butter on them for free. Then they sign some documents, as easy as that, walking in and looking at their hands and taking them from the nurses. How it's going. Walking alongside a doctor and having them say this is what I think of this patient and we can share them, I too will say this is I how I assess the patient. And share them. Until we preserve life, where there is no healing, things are tough."

#P2 F, 75 years

Only one participant raised the need to be given an opportunity to book working patients off sick for recovery and felt if this could happen collaboration with the Department of Health could be strengthened:

"Eya mma [researcher]. As a traditional doctor is that when we are close to the government's doctors, it's just an opinion of mine. The government has to pay attention to us that as a doctor a patient might come to me, they are sick, and I think I can help them for three days or more depending on the condition. They are also employed. I don't have a sick note that I could write for them, mmmm, it's sad! I don't have a sick note, for me to write them off sick, whilst they are still being treated. I thought of giving them a two, three days or so, to recuperate well before I send them back to work. So when the government says we should collaborate with them, the department of health should also feel sorry for us that traditional doctors, let us also put them in the process of receiving a sick note they can use to give patients, when patients come to them. I would be grateful."

#P18 F, 28 years

Furthermore, one participant expressed the need for a special THP hospital:

> *"Infrastructure, such as a traditional medicine hospital should be provided by the department, where all or most traditional health practitioners will practise their profession."*
>
> *#P13 F, 33 years*

The following participant became specific on one condition to be treated in that special hospital.

> *"If it turns out that there are chronic patients who don't get better from western treatment, that patient should be referred to the THP hospital. Yes, there should be a special THP hospital for such cases, some of the patients have sores and some of those are deep sores, like there are sores that eventually lead to the loss of a leg when that was preventable. Just like that! Those things have traditional origin, and traditional doctors who can remove them only with visions and avoid cutting off peoples' legs. However, if there was a good sharing relationship, when a decision has to be made, a traditional doctor has looked at them whether they can't salvage the patient leg and heal that leg."*
>
> *#P2 F, 75 years*

One participant further recommended a fee for service as a form of recognizing THPs:

> *"The experience that I saw in my practice, in terms of me as a traditional doctor, is that I'd be helping sick people on credit, and when I finish helping someone and they get well, it becomes difficult for them to pay me. I then don't know where to turn to. And it's hard for me to go protesting because I am someone who walks according to my ancestors. Then I don't know where to turn to. And it's hard for me to go protesting because I am someone who walks according to my ancestors. That's why I said the department should involve us, make letters for us and help us, and assist us to get paid for the services we provide to the patients. So that when we help a patient… Yes, mma, this patient how can I stand on my feet and say pay me when I see she does not have. You also have to take their money in the same way they do when they go see a western doctor. Because we will also be helping because of sympathising with them. As poor patients trying to help them and saying, you will pay bit by bit. When they get better, they're gone! Now the department should pay us."*
>
> *#P17 M, 37 years*

Benchmarking to incorporate and recognise THPs in hospitals was raised by the following participant as one of the collaboration-strengthening approaches:

> *"Send them there. Just like how some hospitals, right now they have those rooms. Yes. Here in [name of the hospital]. I know that there is a gentleman who is always there. They initially utilised his services him from home. They initially utilised his services him from home they secured him, and he now works at [name of the hospital]."*
>
> *#P19 F, 66 years*

Professional recognition by virtue of designation was also suggested by one participant, while another one advocated that THPs should be allowed to open muti shops:

> *"Traditional Medicine should be taken seriously and should also be regarded as a profession, mos now of late they call us practitioners, is it not?"*
>
> *#P12 M, 49 years*
>
> *"We are insisting that there should be opening muti shops as traditional doctors and sell traditional medicines as doctors in them."*
>
> *#P2, F, 75 years*

Participants also expressed views on a need for them to be recognised and be given an opportunity to treat certain disorders, which they saw that BHPs could not treat, and expressed it this way:

> *"There was a workshop that we attended at [name of the hospital] where we were showed people with mental illness sick patients, but it was difficult for them to release patients who do not need the department of health. Even when we Sesotho doctors look at them, we see that these ones are in need of tradition treatment."*
>
> *#P11 M, 53 years*
>
> *"Just like one who would be at the hospital, as it was mentioned that some are mentally unstable patients some of them are head related. There is a headache that doesn't need the west."*
>
> *#P14 F, 57 years*
>
> *"Sometimes a person looks like he is mentally ill, but when we look at him, this person is troubled by ancestors, and is not normally seen by western doctors, it's seen only by us THPs."*

#P22 F, 67 years

One participant raised recognition of THPs by allowing them to do post-death rituals in hospitals:

> *"Usually it is in the hospitals and sometimes in the clinics. Our department of life in the hospitals, I'm brought into the ward and placed on the bed, then I pass away. Another gentleman walks in and is placed where I was sleeping. Another one is in the maternity ward. A child passes away, the mother comes goes screaming, another mother is brought in and given to the nurses. In the spirit of our culture, that thing is a curse. In our Setswana cultural spirit, it is a curse. What is supposed to happen be that, after I pass away, the bed has to be put outside and be aired and rituals be conducted in order before another patient is brought onto it. What took that man could take me as well, according to our spirit. Yes. I think that can be improved. Elsewhere children fall into a death trap, you find that a child just got born but when you look at them, their temple has fallen in. We should be allowed to come in and do our traditional cleansing ceremonies in hospitals."*

#P21 F, 30 years

3.5.4.4 Mutual respect

Some participants felt that mutual respect was a key ingredient to foster collaborative strengthening. Participants felt that if they could meet with the MEC, then mutual respect would be regained.

> *"A meeting with the MEC of Health is what is being required because the department does not take the traditional health practitioners seriously. If they meet with the MEC it would probably make things much simpler."*

#P18 F, 28 years

> *"MEC must know where we meet to discuss further our concerns, and meet with us to resolve these issues, of non-respect by nurses on us."*

#P30 F, 42 years

Two participants further stated that mutual respect could be attained through recognition and honesty by the department.

> *"The Department should recognise the traditional health practitioners and should also be honest to them in terms of providing them with accurate information."*

#P9 F, 50 years

"What I would like to be changed by the Department is for them to be honest. Yes. Because they do not fulfil anything that they promise to do. They should also know that we are important and know where we are doctors. They should make sure that they have our numbers and call us to help. That will bring us closer to them you know! Telephonically when there are cases that they couldn't solve."

#P25 F, 55 years

Honesty in provision of information was highlighted by one participant, while the other felt there was now a need to escalate the THPs' frustrations to the MEC.

"A meeting with the MEC of Health is what is being required because the department does not take the traditional health practitioners seriously. If they meet with the MEC it would probably make things much simpler."

#P18 F, 28 years

"The department should recognise the traditional health practitioners and should also be honest to them in terms of providing them with accurate information."

#P19 F, 66 years

3.5.4.5 Community garden project

A few participants expressed the planting of medicinal traditional herbs in clinics as one collaboration strengthening strategy:

"I believe that if something was needed, traditional doctors would be able to use their medicine on patients, I mean traditional safe cough remedies. It should be planted at the clinic. Not that the doctor should bring it from home because we would have traditional medicine that would reduce colds and flu from patients in winter seasons. So that you can help a child. When someone has a cough, the traditional doctor can prepare a cough mixture for them and give to the patient. That is how things might improve."

#P2, F, 75 years

"The difference could be brought by, ehhhr, a big vegetable garden, however, we don't want it to be this small. We want it to be big, so that we can plant freely there and eat the spinach there. We also eat herbs because of some of them, these medicinal herbs, like leshokolela flowers. They were there, it's not that much anymore. If someone says, hey

leshokolela[11], there is no magasine[12], we pick for them and off they go. Lengana[13]is available, here is benerate[14]."

#P8 M, 44years

"We are currently requesting seeds and nets for the clinic herbal gardens as of now there are some here in Ratlou that have promised to give us, as we've asked them to give us something and we've asked if they can do a garden for us. Yes. Our own so we can be independent, plant vegetables and traditional herbs, and whatever, give the patients fresh vegetables and prepare fresh herbs for flu in clinics."

#P18 F, 28 years

Three participants indicated that BHPs needed to be educated on traditional herbs.

"Educating modern health practitioners about traditional medicine and plants, and also providing them with a garden in their clinics with these plants. Unity among the stakeholders will make a difference."

#P8 M, 44 years

"The department should allow us to plant a large garden, whereby it will occasionally use the traditional medicine to assist patients. This will, in turn, assist the department with having knowledge about different herbs."

#P9 F, 50 years

"What we want is for them to give us our own things so that we can plant so that we can also bring forth something. We can share it with the nurses and show them that this one does this, this one does this, and this one does this. Afterwards when we told those from the department that we want herbs, they said they can help us at the clinic. We should look for our own place outside. We have planted already planted in our local clinic herbs, it's just near from here, and I will show you, Mma, after talking with you now."

#P7 M, 50 years

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[11] Leshokolela is one of the traditional colds and flu remedy herbs as described by participants.

[12] Magasine also is a traditional colds and flu remedy herb as described by participants.

[13] Lengana is also a traditional cold and flu remedy herb as described by participants.

[14] Benerate is also a traditional cold and flu remedy herb as described by participants.

3.6 Conclusion

This chapter presented the findings of this study, which were the results of an exploration of the experiences of THPs who were working with the Department of Health in the rural sub-district of Ratlou. Participants' demographic data was analysed. The majority of the participants in this study were females, accounting for 70% of the study sample. From the experiences of the THPs who worked with the Department of Health in Ratlou, four major themes emerged from this study, namely collaboration appreciation, collaboration challenges, anticipated collaboration strengthening and approaches to collaboration strengthening. These themes were further supported by sub-themes and they were broadly presented in this chapter.

The findings indicated that most of the participants were willing to work together with the department. However, they highlighted that this working-together had been faced with difficulties. These difficulties were reported to be caused by negative attitudes of clinic nurses coupled with poor respect, poor communication, poor referral systems, poor recognition of THPs as equal partners in health service delivery and a one-way referral system which was always coming from THPs referring to BHPs. Furthermore, THPs suggested the ingredients to strengthen collaboration with the Department of Health by ensuring effective referral systems, effective communication platforms, recognition of THPs, mutual respect and planting of traditional herbs in the clinic gardens.

CHAPTER 4: DISCUSSION OF RESULTS

4.1 Introduction

Chapter 4 discusses the main study findings presented in chapter 3. The researcher engages in a cross-reference with other literature which supports or negates the study findings. The discussion is presented according to the study objectives. Furthermore, the discussion seeks to respond to the study questions.

4.2 Participants' demographic characteristics

The sample size for this study constituted 30 THPs, who occupy dual positions of working in their individual THP clinics and with the Department of Health primary care facilities and hospitals. In this study, 70% of the participants were female, which is consistent with Kaboru's study conducted in two cities in Zambia, which also showed a higher female sample (52%) compared to male [42]. Similarly, another study conducted in two villages in the Eastern Cape Province of South Africa, showed that 75% of the sample were female THPs [61]. Conversely, two other studies had different findings, as studies conducted by both Ragunathan et al. [41] and Burnett et al. [43], had a male-dominated sample of 78.95% and 56.4% respectively, which were similar to findings from the study by Peltzer et al. [62] where males dominated the sample with 72% being male.

The high dominance of female THPs in the current study could be due to the socio-demographics of the Ratlou Local Municipality, according to which there are more females than males. In the Ratlou Local Municipality IDP budget for the 2016/17 financial year [10], the gender difference in numbers is 51.31% males compared to 56.03% females. This implies that there are more females than males in this local municipality. The other reason for female dominance could be that, naturally, females have from time immemorial assumed the responsibilities of caring, comforting and nursing the sick in their different households; this attestation concurs with literature, that the first person to pursue caring and taking care of the sick, Florence Nightingale, was a female. This background has since been confirmed with women generally being the carers in their respective households and communities.

The socio-economic background further indicates that 46.6% of the sample had no formal schooling. This high percentage with no formal schooling did not come as a surprise based on the literacy level in Ratlou Local Municipality where, in 2001, 40.7% of the population had no schooling, and this figure further declined in 2010 to 28.9% [10]. Similar

results of illiteracy rate amongst THPs were found by Ragunathan et al. [41], where 21.1% have not attended school at all, and another 21.1% were only able to read and write.

Contrary to the common perception that THPs are not educated people, 13.3% of the study sample in the current study had acquired a degree or a diploma. Findings from two other studies showed similar results, i.e. Peltzer et al. [62], found that 5.3% of THPs had matric or had studied beyond matric, while in the study by Ragunathan et al. [41], 10.8% of THPs had matric or had studied beyond matric level. The current study further revealed a younger generation of THPs with the youngest aged 24 years. Ragunathan et al. [41] registered the age of the youngest THP even lower than the one in the current study at 20 years. This younger generation of THPs might need to be further investigated as very little scientific evidence about them exists.

The current study shows that the older THPs have practised more than 21 years as THPs, and these results concur with the study of Omowunmi et al. [63] where participants' years of experience were more than 20, as some had inherited their practice from their parents. The fact that so many participants in the two studies have been practising for more than 21 years is an indication of consistency in traditional healing methods and suggest that it is maintained because there is a demand for and clientele requesting this service.

In terms of the type of the THP, this study showed that most participants were practicing as Sangomas (76%), which is similar to findings from a study by Sorsdahl et al. [64], with Sangomas constituting 90% of his study sample.

4.3 Key experiences of THPs working with the Department of Health

4.3.1 Collaboration Appreciation

The study revealed two major themes outlining THPs' experiences namely: collaboration appreciation and collaboration challenges. The majority of THPs in this study embraced collaboration with the Department of Health due to the experiences of knowledge enhancement, harmony between traditional and western cultural practices, patient referral harmony and reciprocal learning. The results further highlighted that though the majority of participants were supporting this collaboration and embracing it, there were some who expressed their fears and serious concerns around their profession, thinking that the Department of Health had undisclosed agendas of wanting to arrest them or to take their profession away from them. Amongst these THPs, there were those who were influencing

other THPs not to agree to this collaboration, citing reasons that THPs were going to kill each other. These few uncertainties were later allayed when they realised that there were no ulterior motives as previously anticipated by the THPs. The findings further revealed that THPs had observed that in the NWDoH, at the level of the MEC for Health, there was an effort to embrace THPs, and the MEC was making plans to make this collaboration work.

These efforts were demonstrated by the department celebrating THPs' specific activities like the Traditional Medicine Week, and these activities are normally hosted at the provincial office, with full participation of senior health officials including the MEC. The THPs in this study further highlighted that they had observed that at the clinic and hospital level, where this collaboration should take place, BHPs were not that receptive, and this made the collaboration with BHPs to be difficult. From the NDoH policy maker's perspective, collaboration of THPs with BHPs was advocated. In South Africa, policy makers were positive and were supportive of these harmonious working relations, though they had some reservations and advocated for targeted training and some form of regulation [33].

It is however noted that in two studies, conducted in Ethiopia [65] and in South Africa [66] in the post-apartheid era, BHPs were not in support of collaborating with THPs. In Ethiopia [65], medical practitioners were advocating that scientific research should be conducted before collaborating with THPs to check on the feasibility of the collaboration, while in South Africa [66], reasons cited by BHPs revolved around the fact that there were no policy guidelines in place to guide this working-together and the probability that quality of care would be compromised was perceived as being high.

While indications in the current study and in the other two studies above give a picture of BHPs not willing to work together with the THPs, a different perspective comes from a study by Van der Geest [67], where BHPs were supporting working together with THPs. These BHPs were citing reasons of gross shortage of BHPs, the choice of BHPs to work in urban areas, leaving rural areas short staffed of BHPs, and the fact that, training THPs to close the gaps in the shortage of BHPs was cheap and lastly advancing the reasons of accessibility of THPs within rural communities [67].

The study by Bodeker et al. [68], however, released findings that, for an efficient and effective collaboration between THPs and BHPs to take place, governments need to take

this collaboration seriously, and put in place both policies and strategies for the implementation process between these two healing systems. Though the willingness to work together was stated, THPs cited some challenges of non-recognition of THPs by BHPs [68]. Bodeker et al. [68] further indicated that THPs had indicated their willingness to learn and improve their medical knowledge and were looking forward to good working relations, patient referral platforms and opportunities for improved communications with BHPs.

Shai-Mahoko [20] in the North West Province (NWP) argued that, for the mere reason that both indigenous healers (THPs) and BHPs dealt with the same health problems confronting the same population especially in the paediatric field, as well as infertility, mental illness and sexually transmitted diseases, which are ranked high among adults brought to healers, there is a need for BHPs and THPs to work together. Interestingly, this study brought up new knowledge that there seemed to be health conditions that could only be handled by THPs due to their cultural nature [20]. Findings also showed that the services of indigenous healers were not confined to any specific group or social class within the black population [20].

In essence, THPs' willingness to work together with the NWDoH, is a stride in the right direction which affords them an opportunity to manage diseases in line with departmental protocols, guidelines and policies, while contributing to the reduction of morbidity and mortality in the country.

THPs in this current study felt that they had the ability and capacity to better manage mental illness as opposed to BHPs. They indicated that there were families who brought mentally ill family members to them for treatment, while some took their family members to the hospital where they believed BHPs were not able to treat mental illness. The THPs in this study further alluded to the fact that in their management of mental illness, they did not only focus on the patient's symptoms, but they managed the patient as a holistic being.

Furthermore, THPs in the current study indicated that some mentally ill patients seek medical care from THPs, as at times BHPs were not accessible or were not able to diagnose mental illness correctly, and only THPs were able to see that the patient was not mentally ill, but was troubled by the ancestors, depression or witchcraft.

In the whole Ngaka Modiri Molema District, there is only one mental health hospital (Bophelong Psychiatric Hospital), and according to THPs, when they visited that hospital, they had observed high bed occupancy rates, which lead at times to patients being discharged while still being sick. THPs, therefore, in this study are calling for the Department of Health to allow them to assist in treating and managing mentally ill patients.

This finding is supported by an official from a mental health non-governmental organisation in Ghana, who remarked in a study conducted by Ae-Ngibise [69], “I would say that the greater percentage of all cases of mental illness are addressed by healers and fetish priest organisations, and so by virtue of their presence and number of cases they see, you cannot easily brush them aside”.

Campbell-Hall, a social worker, also corroborated Ae-Ngibise’s findings that communities were more comfortable to be attended by THPs for mental conditions [31]. Her findings indicated that members of the community often attributed mental health problems to cultural rather than genetic or biological causes [31]. She further reported that there was a widespread belief that mental illness was caused by witchcraft or the ancestors, which made THPs to have confidence in treating any ailment associated with ancestors [31].

In Johannesburg, Padayachee et al. [70] supported above findings, in that Hindu psychologists believed that Hindu THPs had a critical role to play in the management of psychosis. They, furthermore, saw religion playing a critical role in the management of mentally ill patients, with expressions that mental illness was caused by either witchcraft or ancestors troubling patients. The psychologists in this study also shared that, because of their own cultural practices and knowledge, there was tension between what they believed in and what the profession dictated, and this tension resulted in these psychologists being faced with a professional and ethical dilemma [70].

While the current study and most studies above, revealed that THPs had a contribution to make in the management of mental illness based on their capacity to heal mental illness, Sorsdahl et al. [64] are opposing this finding, indicating that the general physician's group in their study were sceptical of working together with the THPs, as they were questioning the quality and genuiness of the traditional healing practice in managing mentally ill patients. However, some THPs also had views that there was no need to work together with BHPs, as these two disciplines of health care provision used different treatment modalities [64].

The general physician's group further thought that traditional healers were mostly illiterate [64]. Contrary to these attitudes, in the very same study, a focus group consisting of psychiatrists favoured informal co-operation with THPs [64].

The knowledge of management of mental illness by THPs from the current study are further supported by the findings in the study by Van Niekerk et al. [71]. In their study THPs indicated that they measured the patient's state of mind through the ability to perform household chores correctly, to maintain good personal hygiene, coupled with being able to buy correct goods and bring back home the correct change when sent to buy groceries at a local shop [71]. These measures from the study by Van Niekerk et al. [71] are almost similar to how BHPs conduct mental status examinations on mentally ill patients, which shows that there are similarities in diagnostic practices between these two disciplines.

In a study where participants were asked if they thought THPs should be incorporated in mental health services in Norway, a majority (81%) of participants with a strong Sami background and having Sami grandparents showed a desire that THPs should be incorporated in the Sami mental health services, with 48% of them indicating that they visited THPs for some mental conditions [72]. While at the same time, Pouchly [73] counters that it is imperative to train THPs first before incorporating them into the broader stream of mental health services, for purposes of preserving ethics in terms of maintaining confidentiality and consent by patients [73].

The studies above show that there is still room to engage THPs and enter in a constructive dialogue in which both parties could learn from each other regarding both the diagnosis and the management of mental illness. The fact that there is a scarcity of mental institutions especially in rural areas coupled with the NDoH's latest approach to decentralise mental health services so that mentally ill patients will be managed in their own communities, could be seen as an opportunity to forge a structured partnership with THPs using them at community level to bring outreach services to mentally ill patients.

The perception that THPs are illiterate was brought up by an academic THP in the current study. The importance of literacy levels might be argued on the basis that THPs need to be able to read which medication they give to patients and should also be able to measure patients' dosages.

THPs in this study shared experiences that their ultimate goal in collaborating with the NWDoH was to assist in the reduction of morbidity and mortality in their communities. THPs indicated that they do that through their participation in health programmes and activities. The programmes which they indicated to be participating on, were the TB programme, HIV/AIDS programme, Maternal Child and Women's Health programme and Nutrition (MCWHN).

One positive experience of THPs, as a finding in this study, was the training platform offered by the NWDoH to THPs at departmental cost for both conferencing and transportation. This experience made THPs feel respected and recognised as partners in health services. These THPs continued to share experiences of appreciation and indicated that they had gained more knowledge on management of some conditions particularly the management of conditions like HIV/AIDS and TB.

Among the examples cited was the knowledge gained on what to do when patients were on dual treatment, particularly referring to dual treatment of traditional medicines and ARVs. They explained that they knew that in those instances the patient must first drink the western medicine (ARVs) and later, when it was finished, the patient could continue with their traditional medicine. When asked why these two medicines were not to be mixed, they indicated that it was so that drug interaction could be avoided.

They further highlighted that due to the training they were now well informed on modes of transmission of HIV/AIDS, causes, preventative measures, including how HIV/AIDS ought to be managed. There was also a feeling of appreciation that they were taught infection prevention strategies like to wear gloves, and to use one blade per patient when cutting patients' skins to insert their medicines. Interestingly the THPs further indicated that they were informed that it was also for their own benefit not to be infected by patients, who consulted them being HIV-positive.

In this study participants acknowledged their improved practices in terms of practising infection prevention and control (IPC), and that this had also assisted them to improve on their own personal hygiene and presentation. This change was indeed observed by the researcher, as all the THPs interviewed, were clean and healthily dressed, and she could only identify them as THPs through their beaded dress codes and the artefacts on both legs and arms. These THPs further shared with the researcher that they had since abandoned all harmful practices like usage of one razor for many patients, hanging of

snake skins in their “Ndombas” and had generally improved on the way their medications were packed and labelled in their traditional clinics.

THPs appreciated that they were also encouraged to use condoms themselves to prevent contracting sexually transmitted diseases and to assist the NWDoH to distribute condoms to their patients. Another interesting observation in the current study, was the confirmation by THPs, that they knew that once a patient was diagnosed with HIV/AIDS, that patient should be on lifelong ARV medication, as THPs were not able to cure HIV. They explained that their contribution to those patients was to encourage them to have safer sex by using condoms, eat a nutritious meal to boost their immune system, and to take their medication daily.

As much as training offered by the NWDoH were appreciated by THPs in this study, serious concerns were raised that the NWDoH did not furnish them with certificates after being trained; hence, they could not produce any valid proof that, indeed, they had been trained.

The knowledge that HIV/AIDS was an incurable condition and that patients diagnosed with HIV/AIDS should be on lifelong treatment were also findings in the study by Zuma et al. [74]. However, in that study THPs indicated that they were not aware of the risk of drug interactions when using both traditional medicines and ARTs. They also indicated that they were not opposed to patients taking ART medication [74]. These THPs were committed to instead prescribe a low dose of traditional medicine to their patients on ART [74]. They also indicated that they embraced the empowerment which had enabled them to participate in health programmes as supporters of patients on ARVs and on TB medications [74].

While in the current study, razors were used cautiously to avoid the spread of infection, in Mozambique, a study by Audette et al. [75] revealed that because of lack of knowledge, THPs were still following the harmful practice of using one razor to insert medications in a number of patients.

In a study by Wreford [76], THPs indicated their disappointment, when they met with the BHPs on issues relating to HIV/AIDS, because they were told of old things which were already known to them, such as not using razor blades more than once, and 'safe sex' and condom use. To these THPs, being told things they already knew, instead of being

told new trends in the management of HIV/AIDS, was an indication that BHPs were not really interested in collaborating with them; the approach was one sided and not reflecting BHPs' interest in empowering THPs with professional skills [76].

The above studies give an indication of the importance to empower and train THPs, so that task shifting could be initiated as an extension of ensuring treatment compliance, support and care, especially at household level. However, when not well informed, THPs could instead of assisting the health sector by reducing morbidity and mortality, cause unintended harm by doing the opposite and increasing the burden of morbidity and mortality in communities.

Ghana took an effort of not only exposing THPs to short courses of training but made some considerable strides in the integration of the two health care systems, by establishing a postgraduate programme in traditional medicine for THPs in one of Ghana's leading medical schools [77]. Ghana, as a trailblazer in this programme, might be opening up an opportunity for other countries to benchmark and improve both skills, competency and empowerment of THPs in their respective countries.

4.3.2 Experiences of collaboration challenges

THPs in this study shared their experiences which hamper a seamless collaboration as BHPs' negative attitudes, BHPs' non-acceptance of traditional treatment modalities, strained referral systems between THPs and BHPs, and communication breakdown. This study revealed that health care provider attitudes were reflected by BHPs' derogatory utterances of referring to THPs as "witches/killers", which were echoed many times in the presence of the THPs' patients. This attitude was viewed by THPs as an indication that nurses still ridiculed THPs and had not yet accepted working with THPs.

They further explained that, while they diagnosed and treated patients using ancestral powers, and throwing the bones, BHPs used medical instruments and equipment and furthermore performed diagnostic tests to confirm pathologies. For instance, in the current study, THPs revealed that this gift of healing was passed from one generation to the other, and all they did were to undergo the ritual training called "Ukutwasa", while western practitioners were subjected to a well-structured, regulated and moderated training, and competency testing done after training.

Struthers' study [78] supported this finding through a participant narrating how she linked with the ancestors and how she was taught to diagnose using bones and that this gift of healing was bequeathed to her by her grandmother. While western practitioners take a history from their patients, THPs throw bones and communicate with their ancestors, a skill which their western counterparts do not possess at all [78].

When THPs were invited for the first time to come and work with the NWDoH, some had mixed emotions, others felt very happy and elated, while some expressed doubt and scepticism to join the NWDoH and forge ahead with this partnership. Some THPs expressed fear that the NWDoH may have bad intentions, as maybe they wanted to take away THPs' knowledge and skills, or there were hidden plans by the NWDoH to arrest them.

In Ethiopia, most of the BHPs (73.9%) had indicated that they believed in the importance of traditional medicine [41]. In that study, 67% of BHPs indicated that the use of traditional remedies should not be limited to patients without conventional medicine, and 78% of respondents agreed with the idea that the government should support traditional healers [41]. These results may be influenced by the fact that in that country traditional medicine is the only alternative health service for the majority of the Ethiopian population. However, as in the current study, it is not all BHPs who are willing to collaborate with THPs, as many have usually ignored and avoided contact with traditional healers [41].

The findings from the current study highlighted that nurses were not the same: THPs said that there were those who treated THPs very well, in contrast to those who treated them very badly. A few participants in the current study indicated how nurses who were "born again Christians" treated them badly. In the presence of the bad treatment received by THPs from BHPs, Mills et al. [79] in their study revealed the eagerness of THPs to collaborate with BHPs, so as to assist in the management of common conditions, which confronted both sectors, and these THPs indicated their willingness to learn from BHPs. This eagerness of THPs to collaborate with the BHPs was geared at assisting the local hospitals; as these THPs say, they had observed that after a patient died in a hospital in a certain bed, the next patient was admitted and made to sleep in the same bed. This practice according to THPs was making the local hospitals to turn into death traps, as the next patient would follow suit and also die. These THPs expressed their willingness, to ensure that this did not happen by conducting a traditional ritual called "the cleansing

ceremony" after the passing of a patient, by thoroughly preparing that bed, so that whoever would be next to sleep on it, would have a bed that is clean and safe; this ritual would protect patients from dying, one after the other.

Even in those uncomfortable situations where THPs were not treated well by BHPs, THPs in this study continued to acknowledge that both the THPs and BHPs used different treatment modalities to treat and diagnose patients, and this could be a challenge which made the BHPs not to embrace working with the THPs. In Swaziland, Upvall's study [80] revealed that nurses who were openly opposed to working together with THPs had cited bad effects as a result of patients having been delayed by THPs, some patients coming to clinics severely dehydrated, and nurses also feeling that THPs had a lack of skills to manage and cure patients.

The majority of THPs in this study shared experiences of training being conducted in a foreign language (English) which was not understood by most THPs. Other THPs shared experiences relating to training/workshops which were offered to THPs by the NWDoH, as not reaching all THPs in the NWDoH database. This experience was raised as a challenge as some THPs would be knowledgeable in management of priority programmes (HIV/AIDS and MCWH) leaving a knowledge gap in the untrained THPs.

The fact that this training was conducted in an environment which was foreign and unfamiliar to the THPs, even when coupled with dominance of BHPs in those training venues, did not make THPs to feel uneasy; they indicated that they actually felt honoured and treated as "VIPs" by the NWDoH through hosting them in guest houses and hotels.

The findings of Viney et al. [81] supported training of THPs and concluded that THPs were a rich resource to health services as long as they were well capacitated and well informed on what to do and how. In their findings, THPs were seen as skilled people, who would be able to use their knowledge if that knowledge was supported and was channelled properly, with appropriate referral systems being put in place by the health sector [81].

In the North West Province, where the current study was taking place, another study was conducted, but like many other studies the approach was to explore experiences from the community health nurses' perspective, but not from the perspective of THPs [21]. Findings in that study revealed that 90.5% of community health nurses indicated that referrals

should come from THPs to BHPs, while 88.4 % felt that patients should first start seeking medical attention from nurses before going to see THPs [21].

Though these community nurses felt that collaboration could be pursued, there was a level of superiority displayed by these nurses towards THPs, as they felt referrals should come from the THPs to the health facilities [21]. This experience confirms the experiences of THPs in the current study that nurses did not see them as equals, but felt that THPs were inferior to BHPs, and in the opinion of THPs, if this mind-set could be addressed, then this working-together could be implemented cordially and smoothly.

THPs in the current study have shared experiences of not having a uniform referral form, and they further indicated that it should bear the NWDoH logo to show its authenticity. These experiences of THPs wanting to be provided with a uniform referral form had not been raised as findings in the literature reviewed thus far and is a unique finding in the current study. The request for a uniform referral letter calls for a policy framework and guidelines to be developed on a referral system by the NWDoH, with the THPs being given an opportunity to give their inputs in a referral letter formulation session. The two stakeholders (BHPs & THPs) involved in rendering health care to patients, should use this opportunity to encourage a two-way referral system.

Despite this feeling by nurses of being superior to THPs, most (83.2 %) community health nurses in a study by Peu et al. [21] supported accepting referral letters from THPs to ensure continuity of patients' care and to avoid deterioration of patients' conditions. These nurses valued referral of patients to the next level, whereas THPs realised their limited capacity and wanted to refer patients for purposes of saving patients' lives. This attitude of nurses was also seen in the current study, where some THPs indicated that not all nurses were the same; there were those who were willing to work with THPs and accepted referred patients from THPs positively.

This trend of nurses not willing to refer to THPs but expecting THPs to refer to them was also found in the study by Kaboru et al. [42] in Zambia. Their findings released a skewed picture of referrals between the two disciplines. Only 4% of BHPs had referred patients to THPs while 53% of THPs were referring to BHPs [42]. Most BHPs in this study cited not seeing any need to refer patients to THPs as they were capable of managing patients well by themselves [42].

While the issue of inter-referral of patients was skewed to referral of patients mainly coming from THPs, Furin [35], based on her findings, expressed an appreciation for the collaboration of THPs with BHPs. THPs in her study, which was conducted in Lesotho, were being paid for their referrals to BHPs [35]; however, some THPs expressed concern about the biomedical providers' lack of understanding of HIV in the local cultural context.

Furin's study [35] shows that traditional healers can provide a variety of community-based HIV services and are not obstacles to advancing care in the communities they serve. Lesotho's experience can be used by other countries to benchmark how their referral system between BHPs and THPs could be tailored, and other countries can copy those best practices, or even adapt them to their own country's needs.

The studies, discussed above, show that health professionals are autonomous due to having their own belief system and working according to the legal governing prescripts of their professional bodies, the South African Nursing Council and the Health Professions Council of South Africa. Being under the regulation of these two bodies, makes it difficult for BHPs (doctors and nurses) to initiate a referral system to THPs.

The initiation of a referral system to THPs by BHPs will need health authorities to give guidelines on how to do it, as currently those guidelines are not in place. The literature reviewed thus far supports the findings of this study that the referral pathway is not a two-way exercise, as expressed by THPs in this study, but is mainly coming from THPs; furthermore, BHPs have expressed words of complacency, that they can manage without the THPs and they do not need to refer patients to THPs. This attitude might probably come from these three factors:

- The training platforms of these two health service providers differ. While THPs undergo a ritual training and at the end of the training are certified as THPs by a traditional ceremony, BHPs attend a detailed organised curriculum training, and on completion, the confirmation of their competency is tested through formal examinations [39].
- The BHPs still see themselves as the superior cadres compared to THPs. In all honesty, THPs and BHPs are different in how they render their treatment plan to patients. While THPs use ancestral modalities and throwing of bones for diagnosis, BHPs use history taking, looking at clinical signs and symptoms, medical

equipment to diagnose, and they confirm their diagnoses through scientific tests [36].

- Cultural and religious differences continue to affect how human beings behave and live and collaborate with other human beings [39].

These differences in treatment modalities and training methods are not supposed to bring in an element of belittling and elevating one cadre over the other. Mutual respect, professionalism and humility should continue to guide human beings on how to interact with one another.

Another vehicle to successful collaboration, i.e. communication, was expressed as missing by the THPs in this study. Communication breakdown was experienced by most THPs as a result of lack of a reporting template and a work plan which could guide them to package their reports for meetings. Findings also revealed experiences of THPs not receiving feedback from the NWDoH on issues raised to the NWDoH by the THPs. This breakdown in communication had led to some THPs not holding meetings anymore, and some holding meetings on an ad hoc basis, coupled with the inconsistent submission of reports to the province, where they were supposed to report their activities on a monthly basis.

THPs in this study shared the experience that it was only a few clinics who invited them to their meetings, and this was seen by THPs as not getting the necessary platform/support to discuss health issues as a collective. Scholarly articles searched did not have similar findings like the experiences of THPs in the current study, regarding reporting THPs' activities to the NWDoH, and therefore, no information was found to compare how reporting channels of THPs elsewhere were structured.

4.3.3 Experiences of collaboration gains and impact

This study has highlighted experiences of collaboration gains in this partnership of working with the NWDoH. These gains included reduction of morbidity and mortality, patient referral opportunities and the involvement of THPs in health-related programmes and activities.

With regard to the reduction of morbidity and mortality, THPs shared their experience that they were playing a key role to enhance and support the BHPs through their involvement in a home-based care programme, where they acted as DOTS supporters for diagnosed

TB patients and ensured retention in care of patients on ARVs. Similarities were found in a study conducted in KZN [37], where THPs were trained on HIV/AIDS management; however, unlike in the current study, those THPs were given certificates after training.

Linkage of patients to care become possible when both THPs and BHPs have a platform to discuss health matters. This statement was supported by findings from Musyimi et al. [83] in Kenya. Their findings shed the light that lack of inter-referral of patients, calls for a dialogue amongst THPs and BHPs, which will further facilitate a platform to harness both trust and respect amongst these two disciplines. A need for creation of a dialogue between THPs was also supported by findings in Kenya, which indicated that inter-referrals of mentally ill patients between both THPs and BHPs were non-existing [83].

Setswe [84] in his study recommends that THPs should be fully incorporated in PHC and be allowed to join primary health care teams in the new programme called PHC re-engineering. He further argues that the leading departments for policy formulation should be the departments of Justice and Health [84]. In the meantime, Sullivan et al. [85] in their review found that most articles reviewed ascribed patients being lost to follow-up (defaulters) to a lack of community continuum of care, which in this context would be THPs closing up that gap, and ensuring that patients on TB treatment completed their treatment without defaulting. In the current study the contribution of THPs would close that gap and ensure that patients were retained in care and completed their treatments.

In the current study, three TBAs who participated, expressed the experience of not being fully utilised by BHPs in clinics, yet they were asked to provide local clinics with their cell numbers. This was done so that when there were shortages of nurses and there were many women in labour, TBAs should be called to come and assist. They indicated that they had never been called since they started working together with the NWDoH. They further expressed that this non-utilisation of TBAs by BHPs made them sad, because they had been delivering women in the past with no reported complications. They further indicated that they were exposed to training by their grandmothers and were competent to perform home deliveries.

In one study in Indonesia, the use of traditional birth attendants and home delivery were preferred by some community members despite the availability of the village midwife in the village [86]. This preference was attributed to either financial challenges, or the fact that clinics and hospitals were far from the communities, coupled with the shortages of

BHP midwives [86]. Furthermore, the community perceived the role of both village midwives and traditional birth attendants as essential for providing maternal and health care services [86]. At the Thai-Myanmar border, in another study [87], there was an accelerated training of TBAs, which concurred with the findings of the current study that these TBAs could assist in the marginalised population to complement the work of midwives in ensuring safe maternity services.

The risk of poor infection prevention methods were findings from the study by Aziato et al. [88], which stated that TBAs shared information that they performed per vaginum examinations in pregnant mothers with bare fingers, and this was done to check the women's cervical dilation. TBAs also shared that they also gave herbal medications to women in labour to fast-track contractions [88]. The usage of fingers without gloves on, is a breach of aseptic procedure, and this practice may pose a risk of injuring the baby and/cause infections to both the mother and the baby. These are harmful labour practices, which call for gradual modifications through training of TBAs.

4.3.4 Approaches to collaboration strengthening (recommendations)

A need for collaborative strengthening could be in terms of having a two-way referral system, effective communication platforms, and recognition of THPs, mutual respect, and community garden projects. Currently there is no system in place to facilitate patient referrals from THPs to BHPs. The availability of a uniform referral letter which will be used by both disciplines is important as it will facilitate patient continuum of care and promote mutual relations between BHPs and THPs.

It is for this reason that participants in this study have recommended that for collaboration to be strengthened, there should be an effective two-way referral system in place. It is, however, worth noting that BHPs do not have to refer patients to THPs only for the sake of promoting a two-way referral system, but also as a means of providing feedback to THPs. While there was mention by THPs of not receiving feedback from the BHPs, findings also indicated that as another recommendation to ensure a seamless referral system, THPs would appreciate if the NWDoH could provide the THPs with a uniform referral letter which must be branded with the Departmental logo and be developed on a Departmental letterhead, to justify its authenticity and professionalism.

Most THPs have indicated that they do respect BHPs as health professionals and for that reason they wish to see that respect being reciprocated by BHPs (mutual respect). The study of Pinkoane et al. [89] concurred with this recommendation of THPs in this study that it was important to have a two-way referral system between BHPs and THPs to improve communication and embrace mutual respect. Their findings indicated that discussions should focus on how best a two-way referral system could be deployed between THPs and BHPs [89].

In Tanzania, two-way referrals between BHPs and THPs are seen to be playing a significant role in assisting children suffering from severe malaria [82]. In this instance, BHPs offer advice to THPs on acceptable first aid treatment of children with severe malaria, so as to prevent complications and then to refer them to the nearest health facility [82]. This suggests that THPs can be used as a health resource if they are trained and directed on what to do, and by so doing, patients' lives could be saved [82].

In terms of communication, the findings in this study indicated that there is no structured form of communicating with the NWDoH. Participants indicated that they are expected to hold monthly meetings and to report their activities to the NWDoH. The findings further indicated that participants were despondent as they did not receive support from the department, either through attending such meetings, or in case where THPs had submitted reports to the department they did not receive feedback on issues raised in those meetings.

There was also an indication that most clinic nurses were not attending collaborative meetings with THPs, which had led to some THPs giving up holding those meetings as they felt that holding those meetings on their own were just futile exercises. The venue to host such meetings were raised by most participants as a challenge, and it was also seen as a factor contributing to the non-attendance of meetings. Due to these reasons cited by THPs, submission of reports was silently fading away. THPs have expressed that they needed to see collaborative meetings happening, and those meetings should be attended by both clinic nurses and the provincial delegates from the sub-directorate Special Programmes. THPs felt that, if these meetings could be initiated, they would feel the support which they needed, and would start to be efficient and focussed, as currently they felt not motivated and supported enough by NWDoH.

As a way of ensuring effective communication, THPs further suggested that meetings and workshops should be well structured and be inclusive of all THPs. They further suggested that meetings should be conducted jointly with the NWDoH to allow an opportunity for continuous dialogue between THPs and BHPs. Musyimi et al. [83] concurs with the finding from this study and indicate that meetings and dialogues are a basic necessity to foster good collaboration between THPs and BHPs.

This was said in the context where both parties would come together and have a common understanding of mental illness [83]. Identification of referral gaps and mistrust among practitioners were key aspects which that study delved into in order to establish a basis for dialogue and collaboration among practitioners in the provision of mental health services in the local community context [83]. Dialogue formation was a process and required identification of barriers at the initial stage to guide the formation of a peaceful joint dialogue. It was therefore imperative to look at requirements necessary for collaboration in order to enhance the sustainability of communication [83].

Pinkoane et al. [89] concurred with the importance of having joint meetings and workshops, indicating that effective communication was important to foster a professional relationship between THPs and BHPs. This professional relationship was strengthened when information was shared; when it enabled understanding of each other's world and treatment methods; and when there is an agreement on a modus operandi to effect incorporation [89]. Opening up to each other enhanced mutual respect and trust and reduced the idea of witchcraft associated with traditional healing [89].

Participants further recommended an improvement with regards to the language used for training and for the documentation to be provided in the vernacular (Setswana). They requested this as some THPs had no formal schooling, and using English in workshops and training as a medium of instruction was a futile exercise, as many times, they would come back from such training not having an understanding of what was taught.

The language barrier was indicated as a hindrance to the THPs' empowerment, and these THPs indicated that they had requested facilitators to use their local language, but despite numerous requests, their requests were not acceded to. These THPs further felt there should be reciprocal learning, and training should not only by given by the NWDoH; THP's, too, should be given an opportunity to share with the NWDoH their knowledge and skills, including information on the type of medications they prescribed to patients.

This request by THPs in this study is in accordance with the contents of the guidelines on training THPs, which stipulate that both the content and scope of the training of THPs should be accommodative of the participants' level of education and understanding [89]. This guidance further emphasises a need to use the language understood by the participants during training/workshops, so that at the end of the training, participants would have grasped what was taught and would be empowered [90]. Interestingly, in Zimbabwe, the Health Department has also started training of TBAs, focussing on improving THPs antenatal care services [91]. Similar findings as in the current study have emerged that training was pitched very high and illiterate TBAs were not following, and training was seen by TBAs as being complicated [91].

It is important that facilitators who train THPs should follow the guidelines on training of THPs, as they are simple to follow, and if implemented could produce the desired goal of empowering THPs. The perpetual non-implementation of these guidelines disadvantages the THPs who are sent to this training for capacity building, and does not only frustrate THPs, but also gives false estimates to the department on the number of THPs trained. Training which is not addressing capacity building and empowerment of THPs could be classified as fruitless and wasteful expenditure; moreover, that the training materials produced, traveling to the venues, meals and conferencing are all done at departmental cost.

As part of THPs' recognition, THPs advocated for a THP hospital which would manage conditions which they felt were not well managed by the BHPs, such as mental illness, chronic wound care and epilepsy. Additionally, THPs also indicated a need for a space or a ward in an existing hospital setting where THPs could work jointly with BHPs; however, few were recommending that this allocation of space should happen in each clinic. This was a peculiar finding of this study, as other scholarly articles did not have such a finding.

Allowing THPs to work in a hospital, might be a tall order for the authorities for now, as BHPs who manage patients in both clinics and hospitals, have a regulatory body, and are licensed to practice, while in THPs' case, registration with the applicable council has not yet materialised. This situation calls for authorities to fast-track THPs' registration with a THP regulating body. This study further indicated that the recognition of THPs as equal partners with BHPs will require that they be remunerated by the department for the service they provided to patients. Furthermore, THPs in the current study explained that they at

times had to travel far, even outside South African borders to the mountains, to go and either dig or buy traditional medicines.

The travelling and buying of traditional medicine were explained as being very costly. The request to be remunerated was because patients were often unable to pay for the service after being offered treatment courses. It was for the above stated reasons that THPs in this study recommended that there should be a fee for service, standardised, by the NWDoH.

Findings by Zimba et al. [61] corroborate the current study findings. In their study THPs indicated that they faced financial challenges, which were attributed to patients who consulted without money, and who gave THPs promises that they would pay later on, when they had money. Unfortunately, this usually did not happen, as when these patients felt better, they didn't come back to pay their debts [61]. Birhan et al. [92] highlighted that THPs in their study had no problem with patients who did not pay, as payment happened immediately after the patients received treatment. This could be difficult for authorities to implement without THPs having a licence to practice and belonging to a professional body [92].

THPs furthermore indicated that collaboration could be strengthened by having mutual respect between them and BHPs. Such mutual respect would include not being referred to as witches or killers. Similarly, a study conducted by Innocent [93], highlighted a need to capacitate THPs in order to improve their skills, knowledge and confidence so as to be almost on the same level with BHPs. This training would improve trust between THPs and BHPs in the process of patient healing [93].

In the current study, the majority of THPs showed an element of trust towards the BHPs, which is important for this collaboration, while it is seen lacking from the side of BHPs. Other researchers are also of the view that mutual respect is an important element of collaboration as it forms the basis for dialogue between THPs and BHPs [21, 42, & 76]. It is through these dialogues and discussions where similarities, differences, complementarities, myths, challenges and uncertainties can be identified and strategies employed to handle such discussions' outcomes and health care approaches [21, 42, & 76].

A few THPs felt that, as they are rightfully being addressed as Traditional Health Professionals, they too should be recognised as professionals and must be allowed to offer sick notes to working patients. This recommendation came so that THPs could book off working patients seen by them, while on medication, to recuperate well. This request for recognition was found in the study by Mbatha et al. [94]. Mbatha is a THP in possession of an Honours degree in Social Work, and currently busy with her master's degree [94].

Mbatha et al. [94] revealed that elsewhere in South Africa, THPs were already issuing sick notes, though some employers were still having difficulties in accepting those sick notes as legitimate. They indicated that, while some employers have problems in accepting sick notes from THPs, two institutions as employers had accommodated traditional methods, and accepted such sick notes from THPs for a specified period [94]. These institutions were the National Education, Health and Allied Workers' Union (NEHAWU) that had entered into an MOU with the University of Pretoria, and the National Union of Mineworkers (NUM) that had entered into an MOU with the Chamber of Mines [94].

Kaboru et al. [42] shared findings that BHPs continued to lack trust in THPs, and that this mistrust by BHPs was one of the major obstacles that justified their fear of not openly referring patients to the THPs, while Peu et al. [21] argued that nurses showed mixed attitudes: though a positive attitude towards working with traditional healers was present, the intra-professional collaboration would remain unequal in relation to professional attainment, ethical and legal adherence and practices. Attitudes of BHPs towards consultation, referral system and cooperation were outlined as negative [42].

Leininger's theory of Culture Care Diversity and Universality supports the researcher's theoretical framework and could be explored to further facilitate trust between the BHPs and THPs through the three modes of Culture Care Diversity and Universality guiding nursing care decisions and actions [47]. Culture care preservation is whereby the BHPs and THPs would discuss retention and preservation of cultural activities that have a positive impact on the wellbeing of patients [47].

There are cultural practices which are not harmful and are practiced by THPs. Common examples in rural communities of these cultural practices include putting woollen artefacts around the child's waist, wrist or ankle to assess and monitor his or her growth and development; making a homemade rehydration solution for a child with diarrhoea;

and closely monitoring the child's milestones, by using boxes at a certain stage of the child's development to assist a child to sit. These simple best practices can be maintained. This will also assist in exploring ways of working synergistically and promoting mutual respect, rather than aiming at assimilating each other's approaches without valid reasons.

There are THPs elsewhere, who are not working with the health sector, who, however, share almost the same experiences as those shared by the THPs in this study. In their study, Keikelame et al. [95] examined THPs understanding, knowledge and management of epilepsy. These THPs showed in-depth knowledge of the clinical signs, causes and management of epilepsy, and felt that epilepsy responded well to traditional treatment methodologies, as compared to the BHPs management and treatment [95]. In THPs view, collaboration with BHPs could yield better outcomes on patients with epilepsy, but BHPs did not want to work together with THPs [95].

Based on results from their study, Keikelame et al. [95] further recommended that to solve this resistance from BHPs, collaborative efforts should be well planned and should further embrace freedom of expression of THPs' indigenous knowledge. Regarding these challenges, participants emphasised that collaboration must incorporate their right to freedom of expression of their indigenous knowledge and practice [95], which agrees with the current study where reciprocal learning through inclusive participation by both parties and the acknowledgement of THPs indigenous knowledge was recommended. This finding further corroborates the current study findings where THPs felt that BHPs were not able to manage epilepsy.

4.3.5 Recognition of African THPs

The KZN Department of Health has trained five THPs who are participating in a programme called Integration of TB in Education and Care for HIV/AIDS (ITEACH) [96]. These THPs have been offered certificates after completion of training [96]. Recently these THPs were honoured for their prestigious work in the United States of America (USA), and were welcomed by the Director, Professor Bruce Walker in a gala event held at the Ragon Institute [96]. The KZN province has made these collaborative efforts with these THPs, not only to improve working relations, but as a strategy to improve the provincial HIV/AIDS and TB outcomes [96]. Figure 8 below is a picture of the five THPs during their tour of the USA.



Figure 8: Five traditional healers from RSA have been honoured in the USA

Source: Brent Lindeque on May 3, 2019.

4.3.6 Planting of community gardens

Planting of community gardens came as a finding from most participants in this study. THPs further alluded to the fact that the collaboration could be strengthened if in all clinics THPs were allowed and given space to plant both traditional herbs and vegetables and that funding for initiating this should come from the NWDoH. THPs made this request based on the understanding that health facilities had access to water, with appropriate parameter fencing, and that vegetable gardens would also benefit malnourished patients. This recommendation by THPs to plant herbs in clinic gardens is also a peculiar finding in this study, as most other studies focussed on THPs' participation in health service provision rather than lifestyle and nutrition related activities. It seems feasible for the Department of Health to have organic vegetable gardens at clinics which will benefit patients.

THPs' willingness to share their knowledge of herbs with BHPs, including teaching them which herbs are used for which conditions came as one of the findings in this study. Most of the herbs which were recommended by THPs to be planted at clinics were herbs used for the treatment of common colds and flu as traditional safe remedies. This

recommendation is also unique to this study, as it focuses on the experience of THPs during their interaction with the NWDoH. This recommendation is actually a follow up activity, since it was the NWDoH's innovation of allowing THPs to plant herbs in clinics' gardens; however, to date, only one facility in Ratlou sub-district has that kind of a garden where both traditional herbs and vegetables are ploughed in one garden. As this was initiated by the NWDoH, it would be possible for other THPs to benchmark at that clinic and roll out similar gardens at all clinics in Ratlou sub-district.

Many scholarly articles explore THPs' participation in different health programmes, but not necessarily exploring experiences from the perspective of THPs' contribution to the food security of communities.

4.4 Conclusion

Findings from this study indicated that THPs in Ratlou sub-district appreciated working together with the NWDoH, and this is supported by their participation in health-related programmes and activities of the NWDoH. Reflecting on the discussed models of working together with THPs in chapter 1, THPs in this study, have shared experiences that whilst their wish was to see a complete integration as a model to be implemented by the NWDoH, they have experienced some level of dominance by the NWDoH, coupled with little support and poor communication. The one way referral system has also come out from the results as a concern from THPs, which they indicated that it is mainly coming from the THPs to BHPs, whilst no referral is seen coming from BHPs to the THPs.

Furthermore THPs, amidst several cited experiences of challenges regarding this collaboration, are still pushing forward to be partners with the NWDoH. THPs expressed this as a need to be allowed to work in clinics and hospitals side by side with BHPs. THPs' plea to the NWDoH is the need to be recognised and appreciated as equal partners in the health service by being paid a fee for service by the NWDoH, and for strengthened mutual respect and a two-way referral system. These are in their view key elements for a successful collaboration with NWDoH and will stimulate harmony and good working relationship between THPs and BHPs. Fast-tracking of the Traditional Health Practitioners Council as a regulating body for THPs will put South African THPs

on the same level with BHPs. The current growing international recognition of THPs can create a new era for traditional healing.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The purpose of the study was to explore the experiences of the THPs who are working together with the Department of Health in the rural sub-district of Ratlou in the North West Province. This chapter provides concluding remarks as guided by the study results, and general discussion and interpretation of the findings. It also addresses objective number four of this study, which seeks to table the recommendations coming from the study to the NWDoH, in order to strengthen working relations with THPs. These recommendations will be drawn from the THPs' experiences, including the researcher's recommendations for future studies, and the study limitations.

5.2 Conclusion

To respond to the call by WHO on ''integration of THPs in PHC service delivery", relevant stakeholders need to have dialogues to clarify their positions, roles, and contributions towards inter-professional collaboration in PHC service delivery. There is also an urgent need for the development and formulation of inter-professional collaboration guidelines by all stakeholders. With reference to Chapter 2 of the Constitution of South Africa, section 31, the respect towards people's cultural and religious beliefs in the country may not be denied; however, it continues to require from both THPs and BHPs, regardless of their different religious backgrounds, customs and beliefs, to respect fundamental human rights.

Importantly, the state has the duty to always act rationally and reasonably and to always promote and maintain a high standard of professional ethics, particularly in the realm and provision of health care, especially since access to health care has been defined in the Constitution of South Africa as a basic human right. The need for collaboration between THPs and BHPs has always been there in the health system, instead of them functioning in parallel health systems. This situation, therefore, calls for a greater tolerance, holistic care and legitimising of traditional approaches through coherent policies. This tolerance is not only limited to the political will of governments but also extends to a profound sense of commitment from THPs, policy makers and BHPs.

5.3 Study recommendations

5.3.1 Strengthening communication between THPs and BHPs

From the results of this study the following recommendations were raised by THPs:

- There is a need for a platform where THPs will hold scheduled meetings with the MEC of the NWDoH and the coordinating office (Special Programmes) to discuss serious issues of concern.
- Meetings between THPs and BHPs should take place at a local level (clinics) with nurses in attendance to strengthen this collaboration.
- The Department should be honest with THPs, by providing accurate information, and timely feedback in cases where there are challenges in implementing any promised activities.
- Nurses should be brought on board and be orientated on this collaboration of the THPs and the NWDoH.
- In order to meet the desired goal of harmonious working relationships, THPs also called for the NWDoH to have a uniform referrals policy which will be promoting two-way referrals from the THPs to the BHPs and vice versa.
- THPs should also be provided with referral letters which have a Departmental logo on a Departmental letterhead to justify authenticity.
- In terms of meetings, THPs recommend that the NWDoH should provide them with a work plan, including a uniform reporting template, coupled with local and provincial support in those meetings.
- All THPs should be exposed to workshops and training where the medium of instruction would be their home language as English is a foreign language to them and makes it difficult for them to understand and gain knowledge.
- THPs should be provided with certificates after training as proof that training has been conducted.

5.3.2 Recognition of THPs as equal partners in health service delivery

- Each clinic or Community Health Centre should be allocated a THP, who will be working in collaboration with nurses. This will allow swift patient referrals between nurses and the THPs.

- THPs should be allocated wards in hospitals and allowed to work with doctors and nurses in hospitals. These THPs should be provided with a working station/space and working tools and be partners in hospitals with both nurses and doctors.
- A THP Hospital should be built by the Department where all THPs in the Department's database would officially practice their traditional medicine and healing; government should give them space to practice their profession.
- The THP hospital, other than treating conditions which THPs strongly feel are traditional conditions, like epilepsy and mental illness, should also admit patients with chronic conditions.
- TBAs should be called by sisters in the clinics to assist in delivering women, particularly when there are many women in labour at the same time.
- A universal fee for service by THPs should be implemented by the NWDoH.
- The NWDoH should address negative attitudes of BHPs towards THPs in order to promote mutual respect and recognition of THPs as equal health professionals.

5.3.3 Reciprocal learning

- The Department should conduct joint training between THPs and BHPs to allow these two disciplines to learn from one another and engage in dialogue in order to have synergy in implementation of health programmes.
- Training should be conducted in THPs' mother tongue, which is Setswana.
- THPs should be given certificates after attending training and workshops which are facilitated by the Department of Health.
- Training and workshops conducted by the NWDoH should include and cover all THPs registered in the departmental database.

5.3.4 Stakeholders' involvement

- The National Department of Health should fast-track the finalisation of a Traditional Health Practitioners Council as BHPs belong to governing bodies, and to date these bodies have not given clear guidelines on collaboration with THPs.
- Stakeholders such as SANC, BHPs, the Interim Traditional Health Practitioners Council, THPs, community representatives, and NDoH should be involved to develop an inter-professional collaborative framework, monitoring and evaluation

strategies and professional teams to monitor implementation, once the framework and policy guidelines have been developed.

- THPs should be encouraged to undergo Adult Basic Education and Training (ABET) especially those who have never attended school; this will assist if a written referral is needed, and any formal training is required for attending workshops.

5.3.5 Initiation of community garden project at PHC level

- The implementation process of community gardens should start, and it should allow for the planting of both traditional herbs and vegetables at clinics. THPs' views that these herbs will assist patients should be supported; and staff should be able to occasionally use traditional medicine to assist patients.
- The willingness of THPs to share knowledge about different herbs with the NWDoH should be officially tabled.
- Support should be given to THPs' recommendation that these gardens be funded by the Department in terms of covering nets, watering utensils, manure, seeds and seedlings, and testing of the soil by the Department of Agriculture.

5.4 Recommendations for future research

The results of this study have provided valuable insights into the research topic. However, it is crucial for this study to be carried further for more information to be gathered. Future studies should:

- Increase the sample size, and include other health sector participants, particularly the MEC, the officials responsible for this programme at the Provincial Office as well as nurses in the clinics as participants in such studies;
- Explore experiences of working together with THPs in the entire District (Ngaka Modiri Molema) so that findings could be generalised;
- Use focus group discussions between THPs and BHPs to stimulate engagement and greater understanding between the two disciplines;
- Explore THPs' collaborative work with other sectors, like Non-Governmental Organisations (NGOs) which are also dealing with patient care; and
- Explore experiences of children and other close family members who have THPs in their families.

5.5 Study limitations

The sample of this study consisted of 30 participants, with an imbalanced ratio of females versus males and the study was only based in one sub-district in Ngaka Modiri Molema District; therefore, the findings cannot be generalised to the entire Ngaka Modiri Molema District. All participants in this study were rural dwellers of Ratlou Local Municipality and this could probably have led to social desirability where participants' expressions are limited to a few participants' views. Failure to capacitate all THPs in the sub-district database may have led to a knowledge imbalance between the trained and untrained THPs on health-related issues. Training of only some THPs created a knowledge gap, which was noted during the interviews, as THPs who had been adequately trained by NWDoH displayed higher levels of empowerment and knowledge on health related matters and the latest trends of managing common diseases as opposed to those who had not been trained.

REFERENCE LIST

1. Promoting the role of traditional medicine in health systems: a strategy for the African Region 2001–2010. Harare: WHO; 2000.
2. Republic of South Africa Traditional Health Practitioners Act [Internet]. South Africa: Department of Health; 2007 [cited 2017 Jun 3]. Available from: http://www.doh.gov.za/docs/index.html
3. Flint AG, Payne JR. Reconciling the irreconcilable? HIV/AIDS and the potential for middle ground between the traditional and biomedical health care sectors in South Africa. Forum Develop Stud. 2013; 40:47-68.
4. Smith LT. Decolonizing methodologies: research and indigenous peoples. 2nd edition. United Kingdom: Zed Books Ltd; 2012.
5. Declaration of Alma-Ata: paper presented at the international conference on primary health care, 6-12 September 1978. Geneva: WHO; 1978.
6. Wilkinson D, Gcabashe L, Lurie M. Traditional healers as tuberculosis treatment supervisors: precedent and potential. Int J Tuberc Lung Dis. 1999; 3:838-842.
7. WHO traditional medicine strategy 2002-2005 [Internet]. Geneva: WHO; 2002. [Cited 2017 Jun 3]. Available from: https://apps.who.int/iris/bitstream/handle/10665/67163/WHO_EDM_TRM_2002.1_eng.pdf?sequence=1&isAllowed=y
8. The Constitution of the Republic of South Africa, 1996 [Internet]. UNHCR; 1996. [Cited 2019 Aug 27]. Available from: http://www.refworld.org/docid/3ae6b5de4.html
9. The Patients' Rights Charter [Internet]. Pretoria: Department of Health; 2007. [Cited 2017 Jun 3]. Available from: http://www.justice.gov.za/VC/docs/policy/Patient%20Rights%20Charter.pdf
10. Ratlou Local Municipality. Integrated development plan: 2016/2017. Setlagole; 2014.
11. Community Survey 2016: statistical release P0301 [Internet]. Pretoria: Statistics South Africa; 2016. [Cited 2017 Jun 3]. Available from: http://cs2016.statssa.gov.za/wp-content/uploads/2016/07/NT-30-06-2016-RELEASE-for-CS-2016-_Statistical-releas_1-July-2016.pdf
12. Ratlou Local Municipality – Annual Performance Plan – 2016/17: Quarter 1 Report. Setlagole (South Africa): Ratlou Local Municipality; 2016.
13. Davis K, Marshall R. Primary health care services for medically underserved populations, in United States Department of Health Education and Welfare: Priorities

of section 1501, Papers on the National health guidelines. DHEW population No. (HRA) 77-641. Government Printing Office.

14. Department of Health – Vote 03 – North West Province: Annual performance plan 2015/16. Mahikeng (South Africa): North West Department of Health; 2015.
15. Mulaudzi FM. Synergy between indigenous knowledge systems, modern health care system and scientific research: a vision for the 21st century. Health SA Gesondheid [Internet]. 2001 [cited 2017 Jun 3];6(4):14-20. Available from: https://hsag.co.za/index.php/hsag/article/view/80/74
16. Department of Health – North West Province: Memorandum of understanding with the Traditional Health Practitioners. Mahikeng (South Africa): North West Department of Health; 2013.
17. Bruce JC. Marrying modern health practices and technology with traditional practices: issues for the African continent. Int Nurs Rev. 2002 Sep; 49(3):161-167.
18. Krah E, de Kruijf J, Ragno L. Integrating Traditional Healers into the Health Care System: challenges and opportunities in rural Northern Ghana. J Community Health. 2018 Feb; 43(1):157-63.
19. Pretorius E. Traditional and modern medicine working in tandem. Curationis. 1991 Sep 26; 14(4):10-13.
20. Shai-Mahoko SN. Indigenous healers in the North West Province: A survey of their clinical activities in health care in the rural areas. Curationis. 1996; 19(4):31-34.
21. Peu MD, Troskie R, Hattingh SP. The attitude of community health nurses towards integration of traditional healers in primary health care in North-West province. Curationis. 2000 Aug; 24(3):49-55.
22. The operational plan for comprehensive HIV and AIDS care, management and treatment for South Africa, comprehensive plan. South Africa: Department of Health; 2003.
23. Department of Health. Draft policy on African traditional medicine for South Africa: for public comments. Government Gazette [Internet]. South Africa; 2008. Notice No.: 31271:2-47. [Cited 2016 Aug 12]. Available from: http://www.doh.gov.za/docs/index.html
24. The challenge of implementation: district health systems for primary health care. Geneva: WHO; 1988.

25. Freeman M, Motsei M. Planning health care in South Africa: is there a role for traditional healers? Soc Sci Med. 1992; 34(11):1183-1190.
26. Grace S. CAM practitioners in the Australian health workforce: an underutilized resource. BMC Complement Altern Med. 2012; 12(1):205-208.
27. Piper CJ. Is there a place for traditional midwives in the provision of community-health services? Ann Trop Med Parasitol. 1997; 91(3):237-345.
28. Miller LC, Jami-Imam F, Timouri M, Wijnker J. Trained traditional birth attendants as educators of refugee mothers. World Health Forum. 1995; 16(2):151-156.
29. Suwankhong D, Liamputtong P, Runbold B. Traditional Healers (mor pheun baan) in Southern Thailand: the barriers for cooperation with modern health care delivery. J Community Health. 2011 Jun; 36(3):431-437.
30. Collaborating with traditional healers for HIV prevention and care in sub-Saharan Africa: suggestions for programme managers and field workers. Geneva: UNAIDS; 2006.
31. Campbell-Hall V, Petersen I, Bhana A, Mjadu S, Hosegood V, Flisher AJ, et al. Collaboration between traditional practitioners and primary health care staff in South Africa: developing a workable partnership for community mental health services. Transcult Psychiatry. 2010; 47(4):610-628.
32. Mngqundaniso N, Peltzer K. Traditional healers and nurses: a qualitative study on their role on sexually transmitted infections including HIV and AIDS in KwaZulu-Natal, South Africa. Africa J Trad Complement Alt Med. 2008; 14:380-386.
33. Pinkoane MG, Greeff M, Koen MP. Policy makers' perceptions and attitudes regarding incorporation of traditional healers into the national health care delivery system. Curationis. 2008; 31(4):4-12.
34. Leclerc-Madlala S, Green E, Hallin M. Traditional healers and the “Fast-Track” HIV response: is success possible without them? Afr J AIDS Res. 2016 Jul 11; 15:185-193.
35. Furin J. The role of Traditional Healers in Community-Based HIV Care in rural Lesotho. J Community Health. 2011 Oct 1; 36(5):849-856.
36. Barker RD, Millard FJ, Malatsi J, Mkoana L, Ngoatwana T, Agarawal S, De Valliere S. Traditional healers, treatment delay, performance status and death from TB in rural South Africa. Int J Tuberc Lung Dis. 2006; 10:670-675.

37. Colvin M, Gumede L, Grimwade K, Maher D, Wilkinson D. Contribution of traditional healers to a rural tuberculosis control programme in Hlabisa, South Africa. Int J Tuberc Lung Dis. 2003; 7(9 Suppl 1):S86-S91.
38. Lindow M. Academic Medicine meet Traditional Medicine. Chron High Educ. 2008; 54(37):A21-A22.
39. Heinzerling LM. Attitudes of traditional healers towards western medicine in rural Cameroon. Trop Doct. 2005 Jul; 35(3):161-164.
40. Madiba SE. Are biomedicine health practitioners ready to collaborate with traditional health practitioners in HIV and AIDS care in Tutume Sub-District of Botswana. Afr J Tradit Complement Altern Med. 2010; 7(3):219-224.
41. Ragunathan M, Tadesse H, Tujuba R. A cross-sectional study on the perceptions and practices of modern and traditional health practitioners about traditional medicine in Dembia district, north western Ethiopia. Pharmacogn Mag. 2010; 6(21):19-25.
42. Kaboru BB, Falkenberg T, Ndubani P, Höjer B, Vongo R, Brugha R, Faxelid E. Can biomedical and traditional health care providers work together? Zambian practitioner experiences and attitude towards collaboration in relation to STIs and HIV/AIDS care: a cross sectional study. Hum Resource Health. 2006; 4(16):1-8.
43. Burnett A, Baggaley R, Ndovi-MacMillan M, Sulwe J. Hang'omba B, Bennett J. Caring for people with HIV in Zambia: are traditional healers and formal health workers willing to work together? AIDS Care. 1999;11(4):481-491.
44. Dowrie FM, Pacquiao DF. Practices of Traditional Birth Attendants in Sierra Leone and perceptions by mothers and health professionals familiar with their care. J Transcult Nurs. 2014;25(1):33-41.
45. Moshabela M, Zuma T, Orne-Gliemann J, Iwuji C, Larmarange J, McGrath N, et al. “It is better to die”: experiences of traditional health practitioners within the HIV treatment as prevention trial communities in rural South Africa (ANRS 12249 TasP trial). AIDS Care. 2016 Jun 2;28(sup3):24-32.
46. Promoting the role of traditional medicine in health systems: a strategy for the African Region [Internet]. Regional Office for Africa: WHO; 2000 [cited 2018 Aug 14]. Available from: http://apps.who.int/iris/handle/10665/95467
47. Leininger M. Transcultural nursing concepts, theories and practices. New York: John Wiley & Sons; 1994.

48. Rossman MC. Designing qualitative research. Newbury Park, California: Sage Publications; 1989.
49. Creswell JW. Research design: qualitative, quantitative and mixed method approaches. 2nd edition. Thousand Oaks, California: Sage Publications; 2003.
50. Pope C, Mays N. Qualitative research in health care. London: BMJ Books; 2000.
51. Polit DF, Beck CT. Nursing research: principles and methods. Philadelphia: Lippincott Publishers; 2004.
52. Coyne I. Sampling in qualitative research: purposeful and theoretical sampling; merging or clear boundaries? J Adv Nurs. 1997 Sep;26(3):623-630.
53. Rigour, ethics and sampling. In Liamputtong P, Ezzy D, editors. Qualitative Research Methods. 2nd ed. Sydney: Oxford University Press; 2005. p. 38-52.
54. Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Med Res Methodol [Internet]. 2008 Dec [cited 2018 Oct 15]; 8(1). Available from: http://bmcmedresmethodol.biomedcentral.com/articles/10.1186/1471-2288-8-20
55. Department of Health. North West Province. Records Management Policy. 2014; 17(12):99-105.
56. Sandelowski M. Rigor or rigor mortis: the problem of rigor in qualitative research revisited. ANS Adv Nurs Sci. Dec 1993;16(2):1-8.
57. Munn Z, Porritt K, Lockwood C, Aromataris E, Pearson A. Establishing confidence in the output of qualitative research synthesis: the ConQual approach. BMC Med Res Methodol [Internet]. 2014 Dec [cited 2018 Oct 29];14(1). Available from: http://bmcmedresmethodol.biomedcentral.com/articles/10.1186/1471-2288-14-108
58. Cope D. Methods and meanings: credibility and trustworthiness of qualitative research. Oncol Nurs Forum [Internet]. 2014 Jan [cited 2018 July 16]; 41(1):89-91. Available from: http://onf.ons.org
59. Gunawan J. Ensuring trustworthiness in qualitative research. Belitung Nursing Journal. 2015; 1:10-11.
60. Krefting L. Rigor in qualitative research: the assessment of trustworthiness. Am J Occup Ther. 1991 Mar 1;45(3):214-222.
61. Zimba Z, Tanga PT. Challenges faced by Traditional Healers when treating people living with HIV and AIDS: the case of Intsika Municipality, Eastern Cape Province of South Africa. Studies on Ethno-Medicine. 2014 Dec; 8(3):269-275.

62. Peltzer K, Mngqundaniso N, Petros G. A controlled study of an HIV/AIDS/STI/TB intervention with Traditional Healers in KwaZulu-Natal, South Africa. AIDS Behav. 2006 Oct 11;10(6):683-690.
63. Omowunmi A, Nkiru O, Yekeen R, Chinyere E, Muinat J, Segun A, et al. Knowledge, attitudes and perceptions of HIV/AIDS among traditional birth attendants and herbal practitioners in Lagos State, Nigeria. Afr J AIDS Res. 2004 Nov; 3(2):191-196.
64. Sorsdahl K, Stein DJ, Flisher AJ. Traditional Healer attitudes and beliefs regarding referral of the mentally ill to western doctors in South Africa. Transcult Psychiatry. 2010 Sep; 47(4):591–609.
65. Tolera G, Wabe N, Angamo M, Wega S, Dekama N, Abdella S, et al. Attitude of modern medical practitioners towards the integration of modern and traditional medical practices in Ethiopia. Spatula DD. 2011;1(4):199-205.
66. Nemutandani SM, Hendricks SJ, Mulaudzi MF. Perceptions and experiences of allopathic health practitioners on collaboration with traditional health practitioners in post-apartheid South Africa. Afr J Prim Health Care Fam Med [Internet]. 2016 [cited 2018 Oct 29]; 8(2):a1007. Available from: http://dx.doi.org/10.4102/phcfm.v8i2.1007
67. Van der Geest S. Is there a role for traditional medicine in basic health services in Africa? A plea for a community perspective. Trop Med Int Health. 1997 Sep; 2(9):903-911.
68. Bodeker G, Kronenberg F. A Public health agenda for traditional, complementary, and alternative medicine. Am J Public Health. 2002 Oct; 92(10):1582-1591.
69. Ae-Ngibise K, Cooper S, Adiibokah E, Akpalu B, Lund C, Doku V, et al. 'Whether you like it or not people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. Int Rev Psychiatry. 2010 Dec; 22(6):558-567.
70. Padayachee P, Laher S. South African Hindu psychologists' perceptions of mental illness. J Relig Health. 2014 Apr; 53(2):424-437.
71. Van Niekerk M, Dladla A, Gumbi N, Monareng L, Thwala W. Perceptions of the Traditional Health Practitioner's role in the management of mental health care users and occupation: a pilot study. South African Journal of Occupational Therapy. 2014 Apr 30;4j4(1):20-24.

72. Sexton R, Sørlie T. Should traditional healing be integrated within the mental health services in Sámi areas of northern Norway? Patient views and related factors. Int J Circumpolar Health. 2009 Oct 18; 68(5):488-497.
73. Pouchly CA. A narrative review: arguments for a collaborative approach in mental health between traditional healers and clinicians regarding spiritual beliefs. Ment Health Relig Cult. 2012 Jan; 15(1):65-85.
74. Zuma T, Wight D, Rochat T, Moshabela M. Traditional health practitioners' management of HIV/AIDS in rural South Africa in the era of widespread antiretroviral therapy. Glob Health Action. 2017 Jan;10(1):1352210.
75. Audet CM, Blevins M, Moon TD, Sidat M, Shepherd BE, Pires P, et al. HIV/AIDS-related attitudes and practices among Traditional Healers in Zambézia Province, Mozambique. J Altern Complement Med. 2012 Dec; 18(12):1133-1141.
76. Wreford J. missing each other: problems and potential for collaborative efforts between Biomedicine and Traditional Healers in South Africa in the time of AIDS. Social Dynamics. 2005 Dec; 31(2):55-89.
77. The Kwame Nkrumah University of Science and Technology, Department of Herbal Medicine. Bachelor of Science Degree in Herbal Medicine. https://www.knust.edu.gh/admissions/prospective/ug_programmes
78. Struthers R. The artistry and ability of traditional women healers. Health Care Women Int. 2003 Apr; 24(4):340-354.
79. Mills E, Singh S, Wilson K, Peters E, Onia R, Kanfer I. The challenges of involving traditional healers in HIV/AIDS care. Int J STD AIDS. 2006 Jun;17(6):360-363.
80. Upvall MJ. Nursing perceptions of collaboration with indigenous healers in Swaziland. Int J Nurs Stud. 1992; 29(1):27-36.
81. Viney K, Johnson P, Tagaro M, Fanai S, Linh NN, Kelly P, et al. Traditional healers and the potential for collaboration with the national tuberculosis programme in Vanuatu: results from a mixed methods study. BMC Public Health. 2014 Apr 23; 14(1):393.
82. Makundi EA, Malebo HM, Mhame P, Kitua AY, Warsame M. Role of traditional healers in the management of severe malaria among children below five years of age: the case of Kilosa and Handeni Districts, Tanzania. Malar J. 2006 Jul;18(5):58.
83. Musyimi CW, Mutiso VN, Nandoya ES, Ndetei DM. Forming a joint dialogue among faith healers, traditional healers and formal health workers in mental health in a

Kenyan setting: towards common grounds. J Ethnobiol Ethnomed [Internet]. 2016 Jan 7 [cited 2018 Aug 9]; 12. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4705751/

84. Setswe G. The role of traditional healers and Primary Health Care in South Africa. Health SA Gesondheid. 1999 Nov 29; 4(2):56-60.
85. Sullivan BJ, Esmaili BE, and Cunningham CK. Barriers to initiating tuberculosis treatment in sub-Saharan Africa: a systematic review focused on children and youth. Glob Health Action. 2017 Jan; 10(1):1290317.
86. Titaley CR, Hunter CL, Dibley MJ, Heywood P. Why do some women still prefer traditional birth attendants and home delivery? A qualitative study on delivery care services in West Java Province, Indonesia. BMC Pregnancy Childbirth [Internet]. 2010 Dec [cited 2018 Aug 7]; 10(1). Available from: http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-10-43
87. White AL, Min TH, Gross MM, Kajeechiwa L, Thwin MM, Hanboonkunupakarn B, et al. Accelerated training of skilled birth attendants in a marginalized Population on the Thai-Myanmar border: A multiple methods program evaluation. PLoS One. 2016 Oct 6; 11(10):e0164363.
88. Aziato L, Omenyo CN. Initiation of traditional birth attendants and their traditional and spiritual practices during pregnancy and childbirth in Ghana. BMC Pregnancy Childbirth [Internet]. 2018 Dec [cited 2018 Aug 14]; 18(1). Available from: https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-018-1691-7
89. Pinkoane MG, Greeff M, Koen MP. A model for the incorporation of the Traditional Healers into the National Health Care Delivery System of South Africa. Afr J Tradit Complement Altern Med. 2012 Feb 13; 9(3 Suppl):12-18.
90. Guidelines for training Traditional Health Practitioners in Primary Health Care [Internet]. Geneva: WHO; 1995 [cited 2018 Aug 13]. Available from: http://apps.who.int/medicinedocs/en/d/Jh2940e/
91. Mathole T, Lindmark G, Ahlberg BM. Competing knowledge claims in the provision of antenatal care: a qualitative study of Traditional Birth Attendants in rural Zimbabwe. Health Care Women Int. 2005 Nov; 26(10):937-956.

92. Birhan W, Giday M, Teklehaymanot T. The contribution of traditional healers' clinics to public health care system in Addis Ababa, Ethiopia: a cross-sectional study. J Ethnobiol Ethnomed. 2011; 7(1):39.
93. Innocent E. Trends and challenges towards integration of traditional medicine in formal health care system: historical perspectives and an appraisal of education curricula in Sub-Sahara Africa. J Intercult Ethnopharmacol. 2016; 5(3):312.
94. Mbatha N, Street RA, Ngcobo M, Gqaleni N. Sick certificates issued by South African traditional health practitioners: current legislation, challenges and the way forward. S Afr Med J. 2012 Feb 23; 102(3):129-131.
95. Keikelame MJ, Swartz L. 'A thing full of stories': Traditional healers' explanations of epilepsy and perspectives on collaboration with biomedical health care in Cape Town. Transcult Psychiatry. 2015 Oct; 52(5):659-680.
96. Lindeque, B. 5 South African traditional healers honoured in the USA! [Internet]. Good Things Guy. 2019 [cited 2019 Jul 3]. Available from: https://www.goodthingsguy.com/people/traditional-healers-honoured/

ANNEXURES

Annexure A: Human Research Ethics Committee (Medical) Clearance Certificate No. M150204

R14/49 Ms Nomvula Hazel Legobye

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M150204

NAME: (Principal Investigator)	Ms Nomvula Hazel Legobye
DEPARTMENT:	Family Medicine Ratlou, North West District
PROJECT TITLE:	Experiences of Traditional Health Practitioners Working with the Department of Health (DoH) in a Rural Sub-District of Ratlou
DATE CONSIDERED:	27/02/2015
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Abigail Dreyer
APPROVED BY:	Professor P Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	04/12/2015

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.
I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature

Date 17/12/2015

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Annexure B: Ngaka Modiri Molema Clearance Certificate

health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

Corner James Moroka &
Dr. Albert Luthuli Drive
SABC Building
Mafikeng, 2745

Tel: (018) 384 0240

NGAKA MODIRI – DISTRICT OFFICE

TO : THE CHAIRPERSON
ETHICS COMMITEE
UNIVERSITY OF WITWATERSRAND
PRIVATE BAG X3
WITS
20150

FROM: Dr V.TITUS
CHAIRPERSON ETHICS COMMITTEE
NGAKA MODIRI MOLEMA HEALTH DISTRICT

DATE: 21.05.2015

SUBJECT: ETHICS CLEARANCE APPROCVAL TO CONDUCT A RESEARCH STUDY

Sir/ Madam

Pursuant to Ms N.H Legobye, student No.679393, application to conduct a research study in the Ngaka Modiri Molema Health District, approval is hereby granted to allow the student to proceed with her study as presented to the committee.

Your approval will be appreciated as it would facilitate the completion of the above mentioned student's studies.

Regards.

Approval granted by ..... Date 22/05/15

Chairperson Ethics Committee

Department of Health
Chief Directorate (DHS)
Ngaka Modiri Molema District
22 MAY 2015
Private Bag x116, Mmabatho, 2735
North West Province

Annexure C: Letter of request to the North West Department of Health Ethics Committee

P.O. Box 1754

Mafikeng

2745

Cell: 079 525 4967

19 May 2015

Chairperson of the Ethics Committee

Ngaka Modiri Health District

Attention: Dr V Titus

Dr Albert Luthuli Drive

Mmabatho

Dear Sir

SUBJECT: APPLICATION FOR APPROVAL TO CONDUCT RESEARCH.

I am a third-year master's student registered with the University of Witwatersrand, Johannesburg. As part of my degree, I will be conducting a study on experiences of Traditional Health Practitioners (THP's) who work with the department of health in Ratlou Sub-District. My participants will be Traditional Health Practitioners registered on the database of Ratlou Sub-District.

I will be conducting in-depth one on one interview to participants and will spend two hours per participant. I wish to complete this data collection during June 2015 and July 2015. I would like to assure you that all information gathered will be utilised for the purpose of this study only.

Attached receive a copy of the research protocol, a copy of the research instruments that will be used and the letter from the University confirming proof of registration as student.

Yours sincerely

Nomvula Hazel Legobye (Ms)

Approved / Not Approved by ……

Chairperson NWDoH: Ethics Committee

Date ……

Annexure D: Study participants' consent form

By signing this form, you indicate that:

1) You have read or understood the consent form,

2) Your questions about the research have been answered to your satisfaction, and

3) You voluntarily agree to participate in this study.

A copy of this signed consent form can be provided upon request.

I_____ agree to participate in the study. I understand the following information provided to me by the researcher:

 The aims of this study as shared to me is to explore the experiences of THPs, who are working together with the Health Department in Ratlou Sub-District.

 The information that I provide in this interview will be used solely for the purposes of the study,

 I can refuse to answer certain questions, discuss additional topics, or withdraw from the interview without penalty,

 All data collected in this study will be kept confidential in a lockable cupboard, and I will not be addressed you by own name, instead fictitious names will be used in the study.

For any further questions, participants can contact Abigail Dreyer, my supervisor for this research project at her office on this number (011) 7172438.

Participant Signature/Thumbprint ……

Date …….

Name of the researcher: Nomvula Legobye

Researchers Signature Date ……...

Witness Date ……...

Annexure E: Audio recording consent form

The reasons for recording the interview have been clearly explained to me. I am aware that I may discontinue the interview at any point without any consequences. The researcher assured me that she will take reasonable measures to make sure that the recordings are kept safe and confidential at all times.

I consent to having the interview audio-recorded

Participants Name ……

Participants Signature/Right thumb print

……

Date

……

Researcher's name: Nomvula Legobye

Researcher's Signature

……...

Date ……

Annexure F: Information sheet

Good Day Madam/Sir

My name is Nomvula Legobye. I am a third-year student completing my Master's in Public Health, studying at the University of Witwatersrand.

I am conducting a research project in the Ratlou Sub-District.

The title of my research is: Experiences of traditional health practitioners, working with the Department of Health in a rural Sub-District of Ratlou

You are kindly requested to participate in this research project.

Should you agree to participate in this project, I will conduct an interview using a semi-structured questionnaire which you are to give responses to.

I will not write your name, but I will use fictitious names in the study and your answers will be treated with strict confidentiality.

Your participation is voluntarily, and you are not obliged to answer any questions you do not want to answer.

You are also allowed to withdraw from participating at any given time should you so wish.

The interview will be completed in one hour thirty minutes' time.

For this study I am being supervised by Abigail Dreyer from the Department of Family Medicine, Centre for Rural Health at the University of Witwatersrand. She is contactable on her office line (011) 7172438 should you have any further questions.

For any other queries about the study, you can contact the following officials:

1. HREC Chairman Prof P Cleaton-Jones, Chairperson tel: 011 717 2301 peter.cleaton-jones1@wits.ac.za

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Yours Faithfully

Nomvula Legobye …… Date……

Annexure G: In-depth interview guide

Interview guide modified

The experiences of Traditional Health Practitioners who work with the Department of Health in Ratlou Sub-District.

1. Tell me about your experience as a THP. (Note the interviewer: Probes to include type of a THP, duration of practice, achievements and challenges, relationships with other partners (Nurses and the NWDOH) in patient care)
2. Tell me about your experience of being a THP Tell me about experience of being a THP working with the department of Health.
   NB Interviewer: You may need to probe to gather the information about the length of time, coverage, type of work community support/ reactions both positive and negative experiences)
3. Describe to me how you felt when asked to work together with the Health Department.
   NB Interviewer: You may need to probe feelings and further explore each expressed feeling by asking e.g. when you say happy why you were feeling that way. What was in your mind then? Give individual time to respond to each probe then continue to probe specific activities which might be not be addressed, like what has the work been like?
4. Tell me about how the process unfolded during the initiation phases of fostering the partnership with the department of health until you were in the data base and working with the department.
   NB Interviewer: Probe on induction process, how was it done? (How trainings were conducted, any formalised work plans)
5. Describe to me any particular difficult experience you were faced with since you started working with the department of health.
   NB Interviewer: Probe on how did that manifested? Do you know why it happened? How did you handle it?)
6. Explain to me your reporting and communications channels when working with the Health Department.
   NB Interviewer: Probe on relations with other THP's? Relationships with the clinic nurses and communication channels reporting lines? Organogram, powers? Channels of communications?)
7. Explain to me things which you think will make a difference in patient care among stakeholders.
   NB Interviewer: You may need to further probe what they do better, or what the department is doing better)
8. What, if anything, would you change about this working-together, if you could? (Note to the interviewer: You may need to probe to gather the information you need e.g. I would introduce this, or I would do this, or I would improve this)

NB: Follow ups on probes will ask for more details "Can you tell me more about it" "When you say this what do you mean"

Annexure H: Kaelo e e tseneletseng ya Dipotsolotso

Kaelo ya Dipotsolotso e e tokafaditsweng

Maitemogelo a Dingaka tsa Setso tse di dirang mmogo le Lefapha La Pholo mo Ratlou Sub-District.

1.Mpolelela ka maitemogelo a gago jaaka Ngaka ya Setso. (Ela tlhoko Mmotsolotsi: Dipotsolotso/ dipatlisiso di akaretse mefuta yotlhe ya Dingaka tsa Setso, diphitlhelelo le dikgwetlho tsa bone, dikamano tsa go dirisana le ba tsaya-karolo ba bangwe mo tlhokomelong ya balwetsi)

2. Mpolelela ka maitemogelo a gago a go nna Ngaka ya Setso le go dirisana le Lefapha la Pholo. (Ela tlhoko Mmotsolotsi: O tlhoka go ka botsa ka go kgobokanya tshedimosetso ka boleele jwa nako, kakaretso, mofuta wa tiro ya baagi ya go fa tshegetso/ maitemogelo a ditsibogo a a itumedisang le a a swabisang.)

3.Ntlhalosetsa ka fa o neng o ikutlwa ka teng fa o kopiwa go dirisana le Lefapha la Pholo. (Ela tlhoko Mmotsolotsi: O tlhoka go botsa ka maikutlo le go tlhotlhomisa botebo jwa maikutlo a mangwe le a mangwe a a tlhagisiwang; jaaka “Fa o re o ne o itumetse” go reng one o ikutlwa ka tsela e? Ke eng se se neng se le mo monaganong wa gago ka nako eo?

Naya Mmotsolotswa nako ya go araba potso nngwe le nngwe, mme o tswelele go tlhotlhomisa dintlha tse di ka neng di sa akarediwa, jaaka “go ne go utlwala jang go dira tiro e”.)

4.Mpolelela ka fa tshimologo ya tirisano mmogo le Lefapha la Pholo e tsamaileng ka teng go fitlhelela o tsena mo lenaneong la go dira le Lefapha. (Ela tlhoko Mmotsolotsi: Botsolotsa ka kamogelo mo tirong le tshimologo ya yone, e ne e dirwa jang? Katiso mo tirong e dirilwe jang, a go ne go na le lenaane la tiro la semmuso?

5.Ntlhalosetsa ka maitemogelo mangwe le mangwe a a neng a le boima a o ileng wa lebagana le one fa o sale o simolola go dira le Lefapha. (Ela tlhoko Mmotsolotsi: Botsolotsa go re se se iponaditse jang, A oitse go re goreng se diregile jalo? O ne wa se tsibogela jang?)

6.Ntlhalosetsa tsela yotlhe ya go tsamaisa dipegelo/diripoto le ditsela tsa tlhaeletsano tse o di dirisang fa o dira le Lefapha la Pholo. (Ela tlhoko Mmotsolotsi: Botsolotsa ka dikamano le Dingaka tse dingwe tsa setso. Dikamano le tirisano mmogo le Baoki kwa Kliniking, ditlhaeletsano mmogo le go isa dipegelo/diripoto. Organogram/lenaane la Badiri go latela maemo a bone, dithata le ditsela tsa tlhaeletsano).

7.Ntlhalosetsa ka dilo tse o akanyang fa di dira phapang le pharologano mo tlamelong ya balwetsi magareng ga batsaya-karolo ka go farologana ga bone. (Ela tlhoko Mmotsolotsi: Botsolotsa ka tseo ba di dirang botoka, kgotsa se Lefapha le se dirang botoka).

8.Ke eng, fa go na le sengwe, se o ka se fetolang, mo go direng mmogo ga batsaya-karolo botlhe, fa one o ka kgona?

(Ela tlhoko Mmotsolotsi: O tlhoka go botsolotsa dikarabo le go bona tshedimosetso e e fetang, mo dikarabong jaaka: “Ke tla simolola/ tlhagisa”, “Ke tla dira se”, kgotsa “Ke tla tokafatsa se”.

Ela tlhoko: Boeletsa dipotso go fatolola tshedimosetso: “A o ka mpolela go feta mo ka “Fa o re se, o raya go reng?).