

**Institutional arrangements for integrating traditional health practitioners into the
South African primary health care system**

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**Thesis presented in partial fulfilment for the degree of Master of
Management (in the field of Public Sector Monitoring and
Evaluation) to the Faculty of Commerce, Law, and Management,
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March 2016

DECLARATION

I declare that this thesis titled '*Institutional arrangements for integrating traditional health practitioners into the South African health care system*' is my own, unaided work. I have acknowledged and referenced all sources that I have used and quoted. I hereby submit it in partial fulfilment of the requirements of the degree of Master of Management (Public sector monitoring and evaluation) in the University of the Witwatersrand, Johannesburg. I have not submitted this report before for any other degree or examination to any other institution.

Buyiswa Motloenya

Johannesburg, March 2016

Abstract

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Thesis title: Institutional arrangements for integrating traditional health practitioners into the South African primary health care system

The South African public health care system is and continues to experience shortage of professional health care workers like other developing countries. These professional health care workers leave the country for better salaries and working environment for private sector and developed countries. The aim of the study is to gather and analyse information on how to integrate traditional health practitioners into the South African primary health care system to address the shortage of the health care workers. This qualitative study used a cross-sectional design to explore the perception, knowledge and recommendation of the national and district Department of Health officials, the western practitioners, the traditional practitioners and the SA citizens in Pretoria, South Africa on how to address this problem. Thirteen individual in-depth interviews and one focus group with the four categories of the research participants were conducted using a semi-structured interview guide.

The results indicated that the SA government in partnership with the Interim Traditional Health Practitioners Council have opted for a parallel system to integrate the traditional practitioners into the primary health care level. For the parallel system to be fully implemented there are still issues that need to be achieved by the key stakeholders, one is for the government to build the traditional health care facilities for traditional practitioners, whilst the ITHPC finalise the registration of the traditional practitioners and approval of the Traditional Health Practitioners Regulations of 2015. Lastly, the District Health System has to prepare themselves for a new entrant, which is the traditional health care, into the primary health care to complement the existing system.

Johannesburg, March 2016

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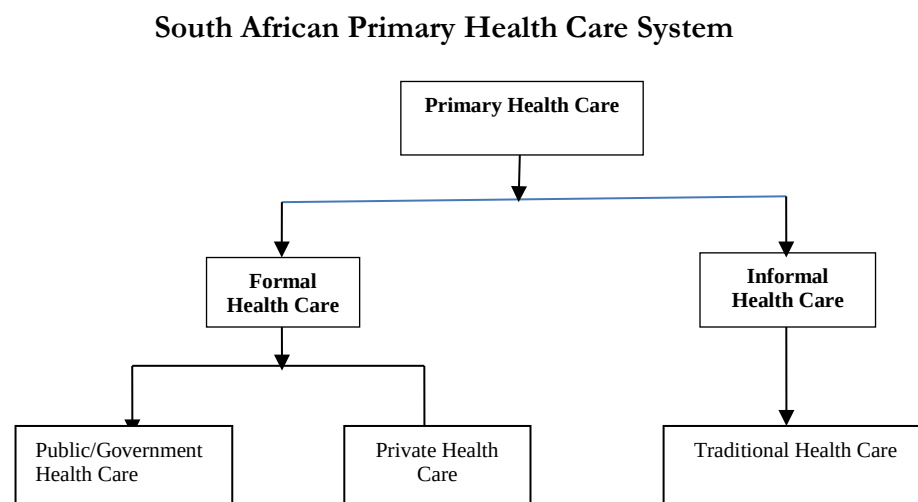
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Background

This Chapter introduces the research context that this study focused on, which is primary health care (PHC) [Section 1.1.1]; it further discusses the history and types of traditional practitioners available to the South African citizens for their health needs [Section 1.1.2]. Thereafter, the research problem statement is introduced, which is the shortage of health care workers within the PHC level; this is the problem that impacts on the delivery of the health care services at the district level [Section 1.2.1]. Consequently, the purpose of this research was to address the two gaps identified from literature review, which are: how will the traditional practitioners be integrated into the PHC system, and, once integrated, what role would they play within that integrated system [Section 1.2.2.]? The research questions that drives the study is: what are the key aspects and approach that should inform integration of traditional health practitioners (THPs), and, once integrated, what role will they play in the new system, and what is the envisaged value-add towards the SA primary health care system and the public at large [Section 1.2.3].

1.1.1 A brief description of the South African Primary Health Care System

Diagram 1: Shows the division of the SA primary health care, which is formal and informal. The formal PHC is provided by the government and the private sector, whilst the informal is delivered by traditional health practitioners. Only the government PHC services can be accessed with little or no payment, and the rest you have to make payment for service rendered. The formal PHC system is controlled by the District Health System. This research will focus on primary health care services that are being provided at the district level by government and traditional practitioners.



The South African primary health care system is part of the country's national health system similar to those found in most countries at local level; it is located at the district level of each provincial government. The government and the private sector provides both public and private primary health care systems, respectively, and it is the first point of contact for individuals, families and communities within the country's health care system (Dookie & Singh, 2012b; Keleher, 2001). The difference between the public and the private health sector is that the South African citizens access public health services with little or no payment, while payment is always required in private health sector. There is an alternative informal primary health care service that is already being offered by the traditional health practitioners, however, it is not recognised by government and hence is not part of the country's health system. This care system is being accessed by a significant number of South African citizens (Dookie & Singh, 2012).

In 1994, as part of the country's reconstruction and development programme (RDP), the South African government took a decision to provide free primary care for all citizens, especially for pregnant women and children under the age of six (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). Some of the services that the government provides at the primary health care level include prevention, care and cure, health promotion, comprehensive health services and health education. A team, which consists of community nurses, health professionals, and community representatives who desire to provide various basic health services lead the district health care system. The South African existing primary health care system is influenced by the decisions taken by the 1978 Alma Ata Declaration Conference. Fendall (1978, p. 1-2) at the Alma Ata Declaration Conference, defined primary health care as "...a service that should be based on scientifically sound and socially acceptable methods and technology that are made universally accessible to individuals and families in the community through their full participation".

When a democratically elected government took over in 1994 in South Africa, it transformed the country's former national health system, which was servicing two race groups, Whites and Blacks, unequally, mainly benefitting the former race, into one public health system serving all South Africans equally. The apartheid policy imposed severe legal restrictions based on race, leaving non-white people with little freedom; the values associated with apartheid extended to public health services (Maillacheruvu & McDuff, 2014). This new democratic government ensured that the country's primary health service was the epicentre of the national health system (Kautzky & Tollman, 2008). The new regime put particular

focus on improving health service within the rural communities, who suffered the most under the apartheid regime (Dookie & Singh, 2012).

This incorporation of the two systems (White and Black health programs) into one came at a high cost; the challenge was that there were limited resources available to share amongst all the citizens who did not have any private medical aid insurance, or any funds to pay for their own medical care themselves. These challenges are still being experienced even today; they include the disparities between public and private health systems and shortage of health care workers, leading to long lines of people who sometimes end up not being served and having to return the next day for various services they needed (Kautzky & Tollman, 2008; Dookie & Singh, 2012; Maillacheruvu & McDuff, 2014). The shortages resulting from health workers who opt to work for the private sector due to better pay packages exacerbate these challenges. Keeton (2010) estimates that only 30% of all South African physicians work in the public sector, despite the fact that it serves over 80% of the nation's population. The fewer number of health care providers along with the increased volume of predominantly poor patients in the public health care system causes public care to be overburdened in comparison to the private sector. In turn, public health care workers are spread too thin and are left unable to provide all of the personalized services of the private sector which would require more time per patient (Keeton, 2010b).

The origins of South Africa's primary health care can be traced back to the 1940s from the Pholela Health Centre model that was introduced in KwaZulu Natal by the apartheid era government, who appointed Dr Sidney Kark to head the first health unit of the Pholela Health Centre (Kautzky & Tollman, 2008). The government established the Centre to provide an integrative curative care and preventive health services with the community's full participation. The Pholela model was a forerunner to community-oriented primary care (COPC), and was among the earliest demonstration efforts to inform and define the practice of the primary health care (Maillacheruvu & McDuff, 2014). The Pholela Model and Alma Ata Declaration informs the South African primary health care services with their key similar components of accessibility to communities and full community participation, which should be free or inexpensive health care to the community.

1.1.2 History of the traditional health practitioners in South Africa

The history of traditional health practitioners and traditional healing in Africa is as old as the African continent itself. Community members define traditional health practitioners as

people who provide health care services using natural herbs, residing within a community in which they live. They also recognise traditional health practitioners as the first contact for treatment of different ailments (Pretorius, 1999). Various authors support this statement by stating that traditional health practitioners are those health workers who provide basic health services to a community in an informal basis (national Department of Health, 2007; WHO, 1978, 2002). These practitioners do not only provide the natural herbs to treat patients with the intent of curing them, but they also provide counselling to their clients. Kale (1995) defines traditional healers as caring people with an extra ordinary skill in psychotherapy and counselling. The practitioners of traditional medicine are also known as indigenous healers, traditional healers, or traditional health practitioners by different authors. Ngubane (1981) refers to practitioners of traditional medicine as indigenous healers. The South African government, through the Traditional Health Practitioners Act of 2007, which regulates these practitioners, refer to them as traditional health practitioners (national Department of Health, 2007). In this research, this author will use the term traditional health practitioner/s (THPs) to refer to the practitioners of traditional medicine; this is to eliminate confusion and to maintain a consistent term to use when referring to traditional health practitioners.

During the apartheid era, the government did not recognise traditional health practitioners, as such; the latter did not participate in the South African health system. The only public health system that was available to the public was the western health care, including other alternative therapeutics, which functioned under the Homeopaths & Allied Health Professions Act of 1996, and were expected to function within the country's regulations (Kale, 1995; Pretorius, 1999). Traditional health practitioners practised and consulted with their patients freely within communities; these practitioners were registered with their own organisations, such as the Southern African Traditional Healers Council, the Association of Traditional Healers of Southern Africa, the Congress of Traditional Healers of South Africa, the African Dingaka Association, and the African Skilled Herbalists Association (Kale, 1995). However, these organisations were not, and continue to be unregistered with the country's health system regulators, such as the Health Professions Council of South Africa (HPCSA).

The election of the new South African government in 1994 also brought some hope of a legalised and recognised participation by traditional health practitioners within the country's health system. The government now legally recognises them as an addition to the country's health practitioners, even though the government is yet to integrate them into the national health system (national Department of Health, 2007; Pinkoane, Greeff, & Koen, 2008). In 1994, the country's democratic government identified the traditional health practitioners as a

body that could play a valuable role in the delivery of the South African health care program. The African National Congress National Health Plan (1994) states that traditional practitioners could play an important role in the health care of the country's citizens, and the government would investigate the need for a coordinating body. The Plan further explains that the role of the traditional health practitioners would be recognised, as a result, the government would investigate the process of integrating them into the country's health program (ANC Health Document, 1994). The White Paper on the Transformation of the Health System in South Africa (1997) provides that the broader health care team should recognise traditional practitioners and traditional midwives as an important component (national Department of Health, 1997).

Types of traditional health practitioners

There are several types of traditional health practitioners that exist within South Africa; they are diviners, herbalists, traditional birth attendants, traditional surgeons, faith healers/prophets and students. Different authors confirm the existence of these types of traditional practitioners, but differ in one or two categories (national Department of Health, 2007; Pretorius, 1999; Richter, 2003; Truter, 2007). Agreeing with these authors, Freeman & Motsei (1992), state that there are broadly three types of traditional practitioners available to the South African consumers, and those are a traditional doctor (inyanga), a diviner (isangoma) and a faith healer (umthandazi). As such, these five types of traditional health practitioners: diviners, herbalists, traditional birth attendants, traditional surgeons and faith healers, are popular and easily accessible in any community.

Towards a framework for integrating traditional health practitioners into the South African primary health care system

1.2.1 The research problem statement

The scene at most of South Africa's public hospitals or health care facilities, in particular, have long lines of people waiting for consultation by the professional health workers, is poor and demeaning to those South Africans who do not have money for private hospitals, and, as such, cannot do without this almost free government service. As much as the government has improved the public health care system since 1994, the country's health sector, in general, continues to face challenges of insufficient health professionals in the public sector. The shortage of qualified health care workers come as a result of an increasing number of professional health care workers leaving the country for favourable conditions in developed

countries, or to receive alternative lucrative opportunities offered by the private sector (Keeton, 2010a; Naicker, Plange-Rhule, Tutt, & Eastwood, 2009). This shortage of health care workers in public health facilities has negative implications on the majority of South African population who need these health services, only to find long queues, with overworked nurses and western practitioners within these facilities before being attended to (Kautzky & Tollman, 2008).

Human resource personnel are an essential asset for any organisation that provides services to the public. The South African public and private health care sectors are not an exception to this requirement. To respond to some of the challenges faced by the public health system, especially the shortage of health care personnel, the South African government needs to incorporate multitudes of traditional health practitioners into its national health system to supplement the current western medical practice. This action would complement the country's current fragile health care personnel. South Africa has approximately three-hundred and fifty thousand (350, 000) traditional health practitioners that could address some of the country's challenges, especially the shortage of health care workers at the primary health care level (De Haan, Dennill & Vasuthevan, 2005; Kale, 1995). These traditional health practitioners consult up to 80% of the South African citizens on a regular basis throughout the country (Pinkoane et al., 2012; Pretorius, 1999; WHO, 2002). The impact that the integration of traditional health practitioners will make into the formal public health sector is unknown as it has not been implemented by government. This study on integration should impact and motivate government on its implementation of the integrated health systems, which will impact on the shortage of the health workers in the public health sector, as well as ultimately improve the delivery of health care to the public at large.

1.2.2. The research purpose statement

The purpose of this research was to address the two gaps identified from literature review, and those are the process on how the traditional health practitioners would be integrated or incorporated into the primary health care, which was not clarified; and secondly, what role the traditional practitioners will play once integrated into the PHC. The study collected information on how to integrate the traditional practitioners into the PHC, and what role they would play at this level once integrated from relevant research participants around Pretoria. The outcome of the research assisted in the development of a framework for integrating traditional practitioners into the PHC system.

This research conducted semi-structured interviews with the national Department of Health and Gauteng District Health officials, traditional health practitioners, western health practitioners and ordinary South Africans around Pretoria. The key context of the interviews centred on whether or not the Department of Health intend on incorporating the traditional health practitioners into the primary health care system as outlined by the following legislations: African National Congress's National Health Plan of 1994, the White Paper for the Transformation of Health System of 1997, the National Health Bill of 2002 and the Traditional Health Practitioners Act No. 22 of 2007. If the Department's response is in the positive, then what role will they play and at what level will the practitioners be introduced next to the community health nurses they would be working with? Traditional practitioners, on the other hand, were asked whether or not they wanted to be integrated into the South African primary health care system, and what their contribution would be in the PHC system. For western practitioners and ordinary South Africans, based on the shortage of health workers currently experienced within the PHC system, would they welcome the integration of traditional health practitioners to alleviate this challenge? Furthermore, what services do they expect from the traditional health practitioners, and what role would they expect them to play within the PHC system?

1.2.3 The research questions

- a) What aspects should inform integration of traditional health practitioners within the 'official' primary health care system?
- b) How should the traditional health practitioners be integrated within the 'official' primary health care system?
- c) What should be the role of traditional health practitioners in primary health care?
- d) What is the envisaged value-add of the traditional health practitioners in the South African primary health care system?

Delimitations of the research

The South African health system is divided into two sections: public and private health care. The public health care system has three divisions: national Department of Health, nine provincial Departments of Health, and several District Health Systems within each Province. The Gauteng Province has five District Health Systems, and one of those is the Tshwane/Metsweding District. This study will only focus on the PHC system that the Tshwane/Metsweding District Health System level implements. This is because the problem

identified is mainly found at the PHC level. This study will only cover three of the seven regions of Tshwane. The research participants from three regions chosen will be representative of the seven Tshwane regions.

Justification of the research

The research outcome will assist the national Department of Health (NDoH) and its stakeholders to understand how it could integrate traditional health practitioners into the South African primary health care system to address the shortage of health care workers and what role they would play if they were to be integrated. The integration of traditional health practitioners into the primary health care level does not just refer to the physical side-by-side working of the traditional practitioners with the nurses, it also refers to the introduction of the primary health care practices to all traditional health practitioners' healing practices, wherever they operate outside. This integration would increase the work force, as well as offer an alternative healing system to patients. According to Meissner (2004), traditional practitioners represent a work force of approximately 300 000 as compared to 32 000 western practitioners who are registered with the Health Professions Council of South Africa (HPCSA) in 2003.

This research will also contribute in other works that other authors have undertaken, including government, in support of integrating traditional health practitioners into the South African primary health care level. References made to several legislations in support of this integration include the National Health Plan of 1994, the White Paper on the Transformation of the Health System in South Africa of 1997, the National Health Bill of 2001, the Traditional Health Practitioners Act No. 22 of 2007 and the Traditional Health Practitioners Regulations of 2015. The latter emphasises that traditional health practitioners should be involved in the official health care services. The gap that this study has identified from the literature review is lack of clarity, from those who support integration, of how traditional practitioners should participate into the PHC; and once integrated, what role they would play at the District Health System.

Preface to the research report

To this end, the report has six chapters. The introductory Chapter covers the research problem, the purpose of the research, the research questions and the delimitations of the study. Chapter 2 provides a literature review covering the problem, the past studies, the

explanatory framework and the conceptual framework. Chapter 3 discusses the research strategy, design, procedures, reliability and validity measures, as well as limitations. Chapter 4 and Chapter 5 present and discuss the findings towards interrogating our research questions, while Chapter 6 summarises and concludes the research.

Introduction

This Chapter reviewed literature on the subject matter similar to what this research is based upon. It begins with a brief history and description of the South African (SA) primary health care system [Section 2.1]. [Section 2.2] discusses advantages and disadvantages of integrating traditional health practitioners into the SA primary health care. In [Section 2.3], literature on methods, data, findings, and conclusions drawn by researchers who have examined the integration of traditional practitioners into the public health care system, is reviewed. This section goes on to highlight authors in three different categories: first, those who provide options for integration, secondly, those who are against integration, and lastly, those who support integration. With this acquired information, in [Section 2.4], we situate our research within public policy and its key components. [Section 2.5] describes the institutional and organisational arrangements for integrated systems. A summary of the relevant theory to this thesis is in [Section 2.6]. The last [Section 2.7] provides a graphical road map on how this thesis intends to explore its main questions: what are the key aspects and approach that should inform integration of traditional health practitioners (THPs), and, once integrated, what role they will play in the new system and what is the envisaged value-add towards the SA primary health care system.

2.1. The history and description of the South African primary health care system

2.1.1. National Department of Health's focus and programmes

Once it took over in 1994, the new South African democratic government began to dismantle the legacy of the apartheid era by integrating the health administration system of the Bantustans or 'homelands' with that of the rest of the country (Kautzky & Tollman, 2008; Maillacheruvu & McDuff, 2014; Mkhize & Kometsi, 2008). This action led to the national and provincial Departments of Health's policy practices that became common in all the country's provinces. The African National Congress (ANC), as part of the new regime called Government of National Unity (GNU), led the government's introduction of the National Health Plan of 1994. This plan laid out goals for a national health system with primary health care (PHC) as its focal point, it assisted in the process of integrating the pre- and post-apartheid government systems mentioned above (Kautzky & Tollman, 2008). In 2002, the South African government passed an additional legislation called the National

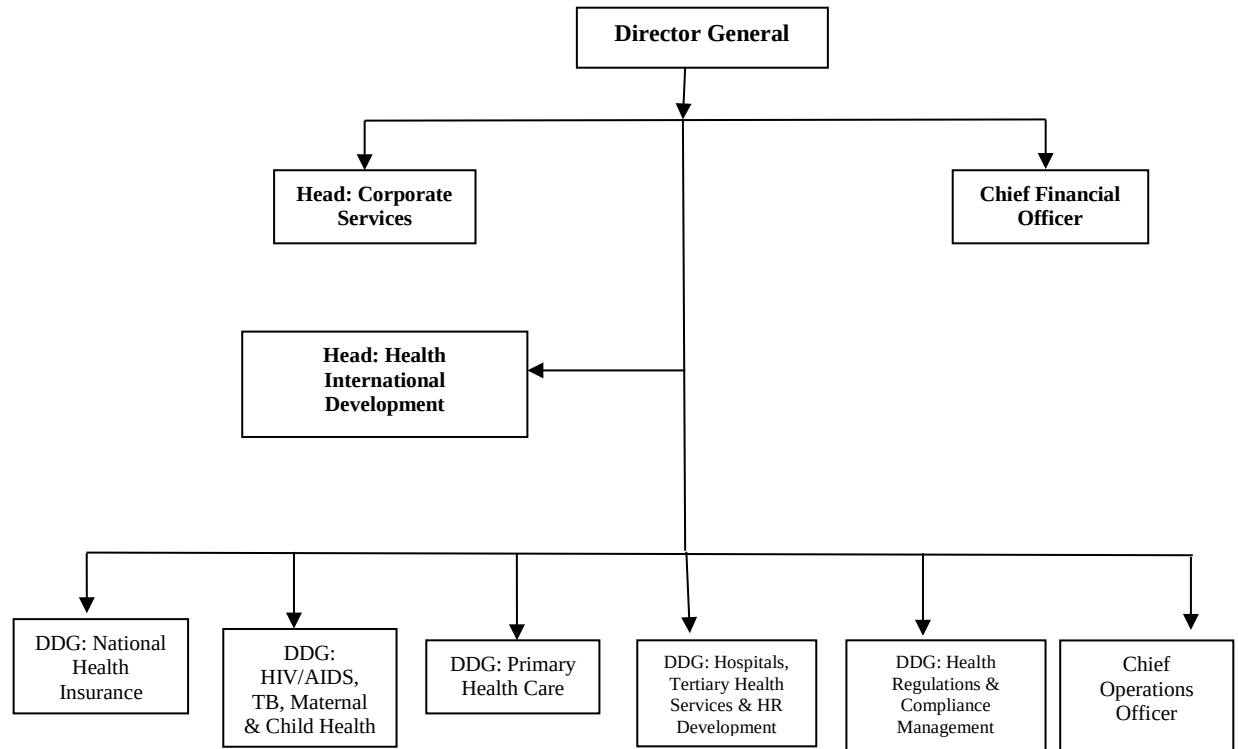
Health Bill of 2002, with standards to provide comprehensive primary health services to all the citizens by promoting 'health and health lifestyles' and community participation in the planning, provision and evaluation of health services (Moosa, 2006). This need to redress the past historical inequalities of the country and to provide essential health care to the disadvantaged, especially rural people, transformed the public health system into an integrated and comprehensive national service (Republic of South Africa - national Department of Health, 2003). All the changes in the public health system and the development of the above mentioned policies were led by the national Department of Health.

The SA government established the national Department of Health (NDoH) with the objective of establishing and taking responsibility for the development of the national health policies. On the other hand, the nine Provincial Departments of Health are responsible for developing provincial policies within the framework of the national policy and public health service delivery, including being an intermediary between the NDoH and the District Health System (DHS). According to Coovadia et al., (2009), the South African public health structure consists of three levels, which include the NDoH, nine Provincial Departments of Health, and the DHS. The DHS is responsible for implementing primary health care system, which is mainly a nurse driven service. The primary health care was introduced at the district level as a strategy to transform the public health so that it can be efficient and effective in the delivery of health services (Dookie & Singh, 2012a; Moosa, 2006). The DHS is in charge of district hospital, community health centres, clinics and private health system.

2.1.1.1 Organogram of the National Department of Health

Diagram 2: Shows the organogram of the national Department of Health (NDoH) senior managers: from the Director General to the Deputy DGs. These are managers that are responsible for development of national health policies. The focus of this research will be on the DDG of Primary Health Care.

NDoH Organisational Structure



The Director General, who is the accounting officer of the Department, leads the national Department of Health. Below the Director General, there are two heads; the Head of Corporate Services, and the Chief Financial Officer. The Head of Health and International operates under both the Head of Corporate Services and the Chief Financial Officer. There are five Deputy Director Generals and the Chief Operations Officer, who serves at the same fourth structural level.

The Deputy Director Generals and Head of Corporate Services are in charge of all the six key focus programmes of the National Department of Health. Those key focus programmes are Health International Development; National Health Insurance; the HIV/Aids, TB, Maternal & Child Health; Primary Health Care services; Hospitals, tertiary health services & human resource development and Corporate Services; Health Regulations & Compliance Management; (national Department of Health, 2014). One of these six programmes is the primary health care (PHC) system, which, this research study will primarily focus on. The national Department of Health revamped the apartheid era national health system, which was divided into one system that was based on race that is serving all South Africans equally.

It further made PHC to be the focal point in implementing its 'Health for All' initiative, through the introduction of the 2010 PHC Re-engineering Strategy (Pillay & Barron, 2011).

2.1.2 District Health System as a vehicle to implement primary health care system

The Pholela Health Centre of the 1940s and, later, the World Health Organisation's Alma-Ata Declaration of 1978, historically, serve as South Africa's national health cornerstone, upon which the country's primary health care system originates. The Pholela model, a forerunner to community-oriented primary care (COPC), was among the earliest demonstration efforts to inform and define the practice of PHC. Kautzky & Tollman (2008); Maillacheruvu & McDuff (2014) and Moosa (2006) confirm this model in their respective journals when they state that the PHC had a unique history in South Africa, where efforts to provide holistic health care to rural communities began in the early 1940s. The WHO's 'Health for All' ideology, whose promotion took place during the establishment of the Declaration in 1978, was the first to put health equity of countries on the international political agenda. To achieve this phenomenon, the global health organisations and national Governments promised to work together toward providing people with basic health needs through a comprehensive approach called primary health care (PHC). As defined by the Conference in the Declaration of Alma Ata, PHC is "...an essential care based on practically, scientifically sound and socially acceptable methods and technology. It is made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (Fendall, 1978, p.1-2; Gillam, 2008, p.53). According to Fendall (1978), this Declaration identified eight elements and eight principles that form the basis of a comprehensive PHC programme intervention in order to achieve the goal of health improvement. These guiding principles determine the success or failure of any PHC programme worldwide.

The apartheid government promoted a public health system that served two race groups, Whites and Blacks, unequally, mainly benefitting Whites. In 1994, the new democratically elected government transformed the country's public health systems by combining the two health systems into one which now serves all South Africans equally. When the African National Congress (ANC) took over in 1994, it pronounced its new vision and policies for a new South Africa through the introduction of the National Health Plan (NHP). The following five models informed this plan, and those were the community-oriented primary care (COPC), the Gluckman Commission of 1945, the Pholela Health Centre, the 1946 Institute for Family and Community Health (IFCH), which was later attached to the Natal

University Medical School as a teaching unit, and the fifth model was the Alma Ata Declaration of 1978. The WHO Division for Strengthening Health Services and UNICEF technical experts assisted the South African government to develop the NHP. The South African government took a decision that the focal point of its public health will be the primary health care.

Primary health care (PHC) is a public health strategy to provide health services to the communities (Dookie & Singh, 2012a; WHO, 2008). It was introduced to deal with three crucial components, and those were – first, transformation of the national public health care by reducing inequalities; secondly, PHC should be the first level of contact for individuals and families who want to access the national public health care; and lastly, to bring health care close to the communities (WHO, 2008). This health strategy is being implemented at a district level of every Province in the country and is led by a DHS. The PHC services include prevention, care and cure, health promotion, comprehensive health services and health education (Dookie & Singh, 2012a; Keleher, 2001). The PHC is a nurse-based-care system that provides the above-mentioned services at the clinic. The government also provides free primary care for pregnant women and children under the age of six at the Community Health Centres. The transformation of public health systems and implementation of the PHC has posed an extreme challenge to every government's attempt of health system reform (WHO, 2008). The South African system was also not immune to these challenges. Some of the challenges that the South African public health system continues to encounter are high rates of migration of professional nurses and western health practitioners to either the private sector or other greener pastures. These challenges continue to translate into severe shortage of health workers, deep-seated imbalance of resources, a complex and evolving burden of diseases with emerging infections, shortage in managerial capacity and a challenge of health system leadership at all levels (Kautzky & Tollman, 2008). However, according to government, strategic measures are in place to address these challenges.

2.2. Advantages and disadvantages of integrating the traditional health practitioners into the South African primary health care system

Before discussing the advantages and disadvantages of integrating the traditional health practitioners into the South Africa primary health care, it is important to provide some definitions and brief descriptions of certain relevant concepts to the topic, and those are integration, and traditional health practitioners.

2.2.1. Description of integration

According to Asante & Avornyo, (2013), the term ‘integration’ lacks one precise definition. Crozier & Friedberg (1980) describe integration as an outcome that results out of negotiations that emerges when practitioners or institutions jointly collaborate in constructing their common goal and how to achieve that goal. On the other hand, according to Boje & Whetten (1982), in an integration processes, there is a convergence of interests and actions to promote a common purpose, hence, when actors have a shared goal, they develop a common appreciation of the contributions of each other and common goal. Parties create shared meanings, perceptions and understanding of the tasks and operations to achieve that common goal. Therefore, the understanding is that integration is the convergence of two systems with a common purpose or objective to provide improved services.

In this paper, integration refers to a process of integrating traditional health care into the South African ‘formal’ or western primary health care system. Integration would, therefore, involve the introduction of traditional practitioners, traditional medicines, techniques and knowledge into the country’s primary health care system (Asante & Avornyo, 2013; Ingle, 2009; Mokgobi, 2014; Summerton, 2005). Integration signifies the exposure of western and traditional systems to the viewpoints and concepts of the two systems in order to provide an effective preventive and curative treatment for all. It is through integration between individual health practitioners, departments and stakeholders that health organisations or health systems occur out of successful conflict negotiations and compromises. Integration between traditional and western health care can take place through two forms, and those are inclusive or parallel (Ingle, 2009; Summerton, 2005; WHO, 2002). In this study of institutional arrangements for integrating traditional health practitioners into the South African PHC, integration will be used to test the extent to which the western practitioners and traditional practitioners can work together to provide a comprehensive health system that is accessible, effective and affordable to the South African citizens. In order to integrate traditional medicine into a modern health care system, such integration should begin at the grassroots level. This can be achievable through joint training of medical doctors and traditional health practitioners to understand their common objective of providing a superior and cost effective service to the patients, as well as through a common goal strategy of fusing their knowledge to produce a stronger force. A successful, integrated health care system would facilitate an efficient use of domestic medical resources, and enhance self-sufficiency in health development for resource poor countries.

2.2.2 History and description of traditional health practitioners in the South African context

The traditional health practitioners are also known as indigenous healers or traditional healers by different authors. For instance, Ngubane (1981, p.13) in her article, *Aspects of Clinical Practice and Traditional Organisation of Indigenous Healers in South Africa*, refers to traditional practitioners as indigenous healers. She goes on to say “...indigenous healers ... are an inyanga, who is male and uses African medicines, but has no clairvoyance; the isangoma is usually female and has clairvoyant powers as well as a comprehensive knowledge of African medicines”. There are broadly four types of traditional practitioners available to the South African consumers, and those are diviners, herbalists, traditional birth attendants, and traditional surgeons (Freeman & Motsei, 1992; national Department of Health, 2007, 2015; van Rooyen, Pretorius, Tembani, & Ham, 2015). Patients consult these practitioners for a wide range of diseases. In this article, the term traditional health practitioner(s) or traditional practitioner(s) will be adopted and used to reflect the practitioners of traditional medicine; this is to eliminate confusion on which term should be used among those stated above.

What is a traditional practitioner? Hassim, Heywood, & Berger, (2007, p.222) define a traditional healer as “...an educated or lay person who claims to have an ability or a healing power to cure ailments, or a particular skill to treat specific types of complaints or afflictions, and who might have gained a reputation in his own community or elsewhere...”. On the other hand, the World Health Organisation (WHO) identified traditional practitioners as those people forming an essential core of primary health care workers for rural people in the Third World Countries. A traditional practitioner can also be defined as a very caring person who is extraordinarily skilled in psychotherapy and counselling (Kale, 1995).

During the apartheid system, the traditional health practitioners were not allowed to participate in the South African health system, whereas the regulations did allow other alternative therapeutics to function within the country. Kale (1995) confirmed that the South African government's Health Act of 1974 banned the traditional practitioners' practices in any form, but they continue to practice. This is a classic example of a law existing only in the statute books; there were many formalised traditional practitioners' organisations that were functional, however, could not register with the country's registration authorities as they were illegal in the eyes of the government. Since the dawn of the country's democracy, most of these organisations did register with the country's company registration authorities. Most of their registrations took place with the Companies Intellectual Property Commission (CIPC), formally known as the Companies Intellectual Property Rights Organisation

(CIPRO), and some registered with the Department of Social Development. These include the Southern African Traditional Healers Council, the Association of Traditional Healers of Southern Africa, the Congress of Traditional Healers of South Africa, the African Dingaka Association, and the African Skilled Herbalists Association (Kale, 1995). However, this registration with the CIPC, was not in recognition of the practitioners' provision of health care to the public, it was only a registration of a company with a domain name that recognises the existence of a business entity.

When the democratic government took over in 1994, it identified the traditional health practitioners as a body that can play a role in the delivery of the South African health care system. This statement supported the National Health Plan of South Africa (1994) where it stated that traditional practitioners should be recognised as part of the health care providers and should be integrated into the public health care system. The South African government continue to be consistent with its 1994 position, where it adopted the National Health Plan, in which it committed itself to involve traditional health practitioners in the official health services. White Paper on the Transformation of the Health System in South Africa (1997) provides that the broader health care team should recognise traditional practitioners and traditional midwives as an important component. Republic of South Africa - National Department of Health (2003) lists the facilitation of co-operation between all health care providers in the district as one of the district functions, including general, traditional and complementary practitioners. As part of recognising the traditional practitioners and their practice, the national Department of Health introduced the Traditional Health Practitioners Act No. 22 of 2007. This Act resulted in the establishment and appointment of the Interim Traditional Health Practitioners Council (ITHPC), which is the regulatory body of the traditional practitioners and their practice (Republic of South Africa - national Department of Health, 2007). In 2015, the ITHPC introduced the country to its new regulations that would control and guide how the traditional practitioners would function.

2.2.3 Advantages and disadvantaged of integrating traditional health practitioners into the SA primary health care

It is important to discuss the advantages and disadvantages of integrating traditional health practitioners into the primary health care system, as this would put weight on whether or not integration of the two systems is an appropriate vehicle to choose in addressing the shortage of the health care workers at the primary health care level. In [Section 2.1.2] this research study identified some of the challenges experienced by the South African public health system, and one of those were high rates of migration of professional nurses and western

practitioners to either the private sector or other greener pastures. This migration has resulted in the shortage of professional health care workers in all levels of public health care.

According to Kautzky & Tollman (2008, p.24) “only 30% of all South African physicians work in the public sector, despite the fact that the latter serves up to 80% of the nation’s population”. This shortage of health care workers was confirmed by an assessment conducted by the WHO in 2003, which found that more than “60% of the health care institutions in South Africa struggled to fill existing posts; there are more than 4,000 vacancies for general practitioners and 32,000 vacancies for nurses throughout all provinces” (Hamilton & Yau 2004; Kautzky & Tollman, 2008; World Health Organization, 2003). It is as result of these challenges that this research is proposing the integration of traditional practitioners into the primary health care level as a solution. Following below are discussions on the advantages and disadvantages of this practice, out of which a better understanding of why they should be integrated into the PHC system will emerge.

Traditional practitioners have an edge, in terms of numbers, over the western practitioners as they have been estimated to be approximately 350,000 traditional practitioners compared to the current 32 000 or less western practitioners in South Africa (Meissner, 2004; Pinkoane et al., 2012). This advantage is echoed by Summerton (2006) and Pinkoane et al., (2012) when they say that approximately 80% of the Black population visit traditional health practitioners, as the latter’s practices are deeply rooted in their culture and religion. With this understanding of numbers of traditional practitioners compared to those of western practitioners, it cannot be ignored that they have a role to play in the South African primary health care level. If the traditional practitioners could be integrated in the PHC level, the doctor-to-patient ratio will be more balanced and acceptable as the waiting periods at hospitals, community health centres and clinics will be greatly reduced.

Traditional health practitioners are a community based healing system; they are firmly established health care providers in their respective communities. This is because they open their practices and offer their services from within the same Black communities they live in, and their working hours could run into the middle of the night, or even throughout the night and beyond. Satisfied patients normally recommend their favourite practitioner to other patients from outside the community. Language is normally not a barrier for a traditional practitioner to communicate and treat community patients as they tend to speak similar languages. Most Blacks understand a minimum of seven to nine of the eleven South African official languages commonly spoken. This means that, regardless of where practitioners open

their practices within Black communities, they are likely to understand and speak the language spoken, as well as being able to share common community issues that may be originating from within. As such, for practitioners interested in being part of the PHC, language barrier will not be an issue, regardless of where they may relocate in the country. A practitioner's good reputation sometimes leads to them rendering services to patients beyond the community they reside in, even to other communities or towns and beyond.

Traditional practitioners' services are holistic as they include physical, mental and spiritual healing of the patient and his or her family. Practitioners do not only treat patients complaining of an illness, but they also treat healthy patients who want to know more about their future and how their fortunes could be expanded or accessed. High numbers of practitioners can result in the reduction or elimination of clogging of patients waiting for service at clinics.

One of the main disadvantages of traditional healing in SA was the lack of regulation; it led to the healing system not to be integrated into the public health care system. Lack of a regulatory body or affiliation of practitioners and their practices to institutions like the Medical Control Council (MCC) or the South African Bureau of Standards (SABS) have led to the practitioners' continued dispensing of unrecognised and untested medicines, which has led them to being rejected by the western health centres. The issue is that these medicines have not been tested by any reputable laboratory, or not consistent with any standardization in packaging or size. It was only in 2007 that the national Department of Health approved the Traditional Health Practitioners Act No. 22 of 2007, which is the legislation that establishes the regulatory body of the traditional practitioners and their practice.

Secondly, there is no database of traditional practitioners, which could be accessed by the public to verify whether a person is a legitimate practitioner or not. The sad part is that the patients are at a disadvantage as they can't distinguish between legitimate and fake practitioners. There are no standard fees for services being offered by the traditional practitioners and therefore each person charges as they please. Each traditional practitioner's training schools follow its training methods and disciplinary mechanisms that have not been approved by any controlling body. Such training lacks any standardization or uniformity, and the curriculum is devoid of any contribution, influence or approval from any controlling body. As a result, practices and graduates remain unregistered with any credible controlling body. The ripple effect coming out of an institution that is unregistered, with

graduates that are also unregistered, is lack of respect, credibility and distinction between qualified and unqualified practitioners, leading to charlatans and imposters in the mix of legitimate traditional practitioners.

Without a regulatory or assessment body to monitor, regulate, censure or give commendations to traditional practitioners, it will always be hard to give credence to breakthroughs or good stories from this informal health sector, and they will remain in the dark, disrespected by their peers in the western practice, and unrecognised by government. These are a few of the disadvantages that stand in the way of traditional practitioners to be considered as part of the PHC in the country.

Comparison between the western and traditional practitioners operating system

The two systems differ on how they deal with the following components:

Major Aspects	Western health practitioners	Traditional health practitioners
Communication	Language of communication is sometimes different and an interpreter is normally required where the doctor speaks a different language to that of the patient. Sometimes could lead to wrong interpretation or misunderstandings.	The practitioner and the patient either share the same language and culture; therefore, there will be a better understanding between the two.
Preparation of the case history	The doctor expects the patient to provide his/her history of the illness and describe the symptoms before the examination commences.	In addition to being told by the patient what he or she suffers from, the practitioner further observes the patient over a day or more at the practitioner's home or at the patient's premises in order to fully assess or diagnose what the patient is suffering from. This provides the practitioner with more time to understand the patient and the ailment.
Patient diagnosis	Less information is given to the patient regarding the prescription or dispensed medicines	As a holistic practitioner, the practitioner will provide the patient with more information on how the medicine will work to cure the patient.
View taken with regard to referrals for further diagnosis or second opinion	Western health practitioners will rather refer the patient to other western health practitioners for further diagnoses or treatment than to a traditional practitioner.	In the event the cure provided does not produce the anticipated results, the practitioner is likely to refer the patient to the western doctor or a clinic or hospital, as well as to other traditional practitioners.

2.3. Methods, data, findings, and conclusions of studies on and evaluations of integrated institutional and organizational arrangements

This section reviews the existing studies about integration as an intervention for traditional health practitioners into the South African primary health care system. The report starts broadly by reviewing past studies that have examined the integration of traditional health practitioners into the public health system. It will further look at those studies that are against integration, however, our interest is on those studies that examined and supports the integration of the primary health care system.

2.3.1 Studies on broad view on integration of traditional health practitioners into the national health care system

Integration of traditional health practitioners into the country's public health system, particularly at the primary health care level, is not a novel idea on its own. A number of countries, both in the African and the Asian continents have tried the idea and succeeded, while others were unsuccessful after only proposing the idea of integration on paper without taking it any further to its implementation (Ingle, 2009). According to Ingle (2009), several developing countries in Africa, Asia and Latin America have attempted to integrate traditional and western health care systems into a single national health care network. However, to date, only China, the Democratic People's Republic of Korea, the Republic of Korea and Vietnam have arguably attained integrated health care systems. Only China achieved true integration in the 1970s after trying for over forty years.

Ingle (2009) conducted a qualitative study to assess the desirability and feasibility of an integrated health care system for South Africa. This study, which used a cross-sectional design to collect data, enabled the research to present arguments for and against integration of 'informal' traditional health care with the 'formal' western health care system. The study further provided options that are available for the SA government to integrate traditional practitioners into the public health care system. These options are exclusive/monopolistic, tolerance, and full integration through an inclusive or a parallel system (Ingle, 2009). The method used for the collection of data was documents and records.

The World Health Organisation (2002) has been at the forefront of promoting interests on traditional medicine and traditional practitioners world-wide. The WHO has also encouraged integration of traditional practitioners and traditional medicine to its member states' national health care system by proposing that its members should develop national health policies

that incorporated the two healing components. According to the WHO (2002), traditional medicine has become popular in the world. In Africa, over 80% of its population use it for its health care needs, while, in Asia, only 40% of the population are users of traditional medicine. It was the WHO's informed decision, based on this information, that, as traditional medicine was already this popular, it only made sense for member states to develop policies that made integration of traditional practitioners into their health systems legal (WHO, 2002). This means that traditional medicine is crucial and, therefore, cannot be ignored. Since this proposal by the WHO, most of its member states have now instituted this proposed national health policy, including South Africa, which still has a draft policy on traditional medicine that has yet to be finalised and implemented. The WHO (2002) has further outlined that traditional medicine or complementary & alternative medicine could be integrated into a country's health care system in three ways, and those are integrative system, inclusive or tolerant system.

The WHO (2002) proposal for integration of traditional medicine into the countries' health care system is consistent with Freeman & Motsei (1992) who also suggested that there are three options available that governments can choose from when exploring integration of traditional health care system, and those are incorporation, cooperation/collaboration and total integration. Incorporation, like an inclusive system, would be where traditional health care is integrated into the primary health care and officially recognised by government as the first contact of treatment for patients. On the other hand, consistent with a tolerant system, cooperation/collaboration means that the two systems are functioning independently but they recognise each other and conduct cross referrals. Lastly, as with an integrative system, total integration is when the two systems are merged and lose independence (Freeman & Motsei, 1992). An example would be when a patient gets a diagnosis from a traditional practitioner and end up with a prescription from a western practitioner or vice versa.

The focus of Freeman & Motsei's (1992) qualitative study, which was consistent with the WHO's similar study, was to provide national governments with three options - incorporation, cooperation/collaboration and total integration - they could choose from when exploring integration of traditional and western health care systems for their citizens. A cross-sectional design of literature from previous research studies was conducted, and a documentation research method was used to collect data. The focus or aim of their study was to answer the question of whether or not traditional practitioners have a role to play in South Africa's future health care programme, and if they will participate in it, what role they would play. The study, which viewed integrating the 'informal' traditional practitioners with

the 'formal' western health care as a viable option, provided arguments for and against integration.

Of the three options, integration in an incorporation system is where traditional practitioners would be integrated as a first line of health care providers. In a cooperation/collaboration system, traditional and western health care remain essentially autonomous with a mutual referral system, with agreements set on what disorders should or should not be referred to each other. In the third option, total integration, a new united healing system, consisting of both traditional and western healing system, is blended to introduce one healing system. The two authors indicate that, currently, there is a one-sided referral system, where patients are referred to the western healing system and not from the western healers to the traditional healing system; this is not likely to change any time soon, (Freeman & Motsei, 1992).

These proposed options by the WHO in 2002, which are available for countries to integrate traditional health care into the primary health care level, are supported by several authors, such as Ingle (2009) and Summerton (2005). These two authors go further than to just agree with the WHO in the types of integration options available to member states, but they add an exclusive or monopolistic system as a fourth option. Based on this review, it is apparent that the parallel system is a relevant option of integrating traditional practitioners into the public health system in South Africa. Summerton (2005) agrees with this statement when she suggests that a parallel system is a better choice for South Africans to follow.

Consistent with Freeman & Motsei (1992); Ingle (2009); Summerton (2006) & WHO (2002) also conducted a qualitative study on the role of the South African traditional practitioners within the public health care system in terms of national and global responses. She further gave options that the SA government could choose from when integrating traditional and western health care systems. Together with Ingle (2009), they add an exclusive or monopolistic system as a fourth option to tolerant, inclusive and integrative systems. Using cross-sectional design to arrive at this fourth system, she offers critical reflections on national and international policies on African traditional medicine. Based on this review, where documentation was utilised as a data collection method, it is apparent that the parallel system is a relevant option of integrating traditional practitioners into the public health system in South Africa. She suggests that a parallel system is a better choice for South Africa to follow.

2.3.2. Studies against integration

The past studies that have been reviewed on integration have all outlined the challenges that face the integration of traditional practitioners into the primary health care level; however, they all are in agreement that traditional health care have a role to play in the public health care system. As a result of challenges that it is experiencing in providing health care service to all the communities, the public health care system cannot afford not to work closely with traditional health care due to the inroads that the latter has made over time in Black communities. However, regardless of these positives that the traditional health care system has made, according to several authors, its many challenges cannot be ignored when it comes to integrating the modern and traditional healing systems due to the extent of challenges facing the latter, especially lack of a regulatory system.

One of the core challenges that obstruct the integration of traditional practitioners into the PHC system has been the lack of regulation. Freeman & Motsei (1992); Ingle (2009); Moagi (2009) & Yeboah (2000) all concur in their respective studies, that lack of a regulatory body has been at the forefront of all the challenges facing traditional practitioners. Another argument is that majority of western-trained health professionals are strongly against the integration of traditional health care into the public health care, which include the state hospitals and clinics in South Africa, as traditional healing can be easily manipulated due its lack of a system that can license and certify the practitioner's authenticity. Since these criticisms on the lack of regulation of traditional practitioners and their practices were expressed by a number of authors, the South African government responded to these challenges by introducing the Traditional Health Practitioners Act No. 22 of 2007. The introduction of this Act resulted in the establishment of a regulatory body called the Interim Traditional Health Practitioners Council (ITHPC), whose members were appointed by the Minister of Health in 2013. This Council has been functioning for the past three years; however, its impact has not been felt as it has not yet begun to implement its mandate.

Another dilemma that traditional practitioners continue to find themselves in is that their sector is operating informally as they are not following any regulated rules and parameters, such as those that western practitioners are using to operate. This statement supports Ingle's (2009) account that traditional practitioners prefer to operate in an informal sector to avoid the cost of running formal surgeries that are expensive and have to be compliant with regulated standards of health care. In light of the lack of rules and parameters that practitioners and their practices operated within, in 2015, the ITHPC developed and introduced the Traditional Health Practitioners Regulations in the country. These regulations

outline what is expected from traditional practitioners to be recognised and practice within South Africa. In order for the Council to apply its rules and regulations that traditional practitioners can function under, there has to be a database of such traditional practitioners that the Council can control. The existence of such a database can enable all stakeholders, especially the Council and the public, to access information that verify each practitioner's authenticity as a bona fide traditional practitioner, not as a charlatan.

Ingle (2009) qualitative study to assess the desirability and feasibility of an integrated health care system for South Africa identified some arguments raised by people who are against the integration of traditional to the western health care system, and those were that people who discuss traditional health care tend to focus on traditional medicine than the holistic service, which deals with physical & psychosocial aspects it provides to the public. Secondly, traditional health care operates from informal business sector and its practitioners are comfortable with that because the cost of running a formal business is expensive. If traditional health care have to be regulated, it means the traditional practitioners and their practice must confine themselves to rules, and restrictions of the Department of Health, which could be difficult to some.

Traditional practitioners treat and prescribe medicine to over 80% of their patients; however, these prescribed traditional herbs are not standardised, and their efficacy has not been verified by reputable bodies, such as the Medicine Control Council (MCC) or the South African Bureau of Standards (SABS). This leads to the western practitioners' argument that there is lack of information in traditional medicine herbal-based treatments regarding the composition of the remedy (Antwi-Baffour, 2014). Freeman & Motsei (1992) say that the process of integrating the western and traditional health systems would be an extremely difficult task and a very complex process that has not been fully achieved anywhere in the world. It is not an overnight process; it needs a good deal of societal 'buy in'.

In the qualitative study conducted by Freeman & Motsei (1992) on whether or not traditional practitioners have a role to play in the SA future health care and several arguments for not integrating traditional with western health care system were identified and those were, lack of regulations by government which resulted in the country not having a register of traditional practitioners. Secondly, the integration of traditional health care would disempower the traditional practitioners but empower the western practitioners. It means the western practitioners would have a better understanding of the two systems and the public

would end up consulting only the western practitioners. Lastly, if traditional practitioners are going to be regulated, it will diminish their remuneration.

2.3.3. Studies for an integrated system

Since 1994, the South African government has accepted a tolerant health system, which means that the national health care provides mainly western health care system but certain practices of traditional health care system are tolerated by law (Summerton, 2005; Ingle, 2009). There has been a one-sided cross referral arrangement in favour of the western health care system (Freeman & Motsei, 1992; Pretorius, 1999; van Rooyen, Pretorius, Tembani, & Ham, 2015). This statement corroborates Pretorius (1999) when she states that the South African government expressed its position of a tolerant system by only accepting the co-existence of the traditional health care within the national health system, rather than incorporating it into the official national health care system. The government's position is captured in the ANC National Health Plan of 1994, the White Paper for the Transformation of Health System of 1997 and the National Health Bill of 2002, where it is stated that the traditional health practitioners should be recognised and be part of the country's health care system. The fear of the government opting for a tolerant over an inclusive system is that if you blend the two systems together, there is a possibility that the weak system, in this case the traditional health care system, will be compromised. On the other hand, there has been a growing government urgency to integrate traditional healing into the national health care system, through a parallel system. According to Summerton (2005, p.145) a parallel systems is when "two systems of health care co-exist within the country".

Pretorius (1999) conducted a traditional health care assessment study in order to provide an overview of human resource and services offered by this sector, its regulations, current information and the role of the traditional practitioners in the District Health System. The research data collection involved was documentation. The results of the study were that since 1994, the SA government had made a promise to its citizens that it would integrate traditional practitioners into the national health care system and has since put systems to achieve that. One of those achievements has been the introduction of the Traditional Health Practitioners Act of 2007, which is to regulate the traditional practitioners and their practice including the establishment of a body to regulate the practice.

Van Rooyen et al., (2015) conducted a qualitative study to explore collaboration between western and traditional practitioners regarding legalisation of traditional healing and their position on collaboration between the two systems. Data collection involved unstructured

interviews, a focus group interview and participant observation. The result of the study was that traditional and western practitioners had experienced negative attitude towards each other. It also concluded that the realities of shortage of health care workers and disease burden in South Africa were crucial, and it facilitated collaboration between western and traditional practitioners.

This position of recognising and integrating traditional practitioners into the country's national health system by the South African government was informed by the WHO 1978 Alma Ata Declaration and the WHO Traditional Medicine Strategy of 2002 – 2005. The WHO (2002) states that up to 80% of the African population make use of traditional medicine, as such, governments should not ignore the role of traditional healing and traditional medicine in Africa. The African continent's statistics is consistent with that of South Africa, which states that approximately 80% of black people in this country use traditional healing in one way or another (Pretorius, 1999; Summerton, 2006). The WHO (2002, p.12) further states that "...in Sub-Saharan Africa, the ratio of traditional practitioners to the population is approximately 1:500, while western practitioners have a 1:40,000 ratio to the rest of the population". These authors have made their arguments to support the case for the integration of traditional practitioners into the country's national health system. This argument for integration is due to the challenges experienced by the western health care system in providing health care for all the citizens of the country. Richter (2003) confirms the above statement when she stated that, due to the HIV/AIDS pandemic savaging the sub-Saharan Africa, the health care system is coming under severe strain and, therefore, cannot afford to ignore traditional health care.

Fendall (1978) suggested that the government must integrate traditional practitioners into the health care system, usually within a primary care approach as a first line of health practitioners. Mokgobi (2014) supports the WHO by saying that traditional practitioners are usually the first port of call when individuals are suffering from illnesses that man has manufactured. The importance of traditional medicine for people in Africa in the past, today and in the future, is enormous. The remedies made from indigenous plants, play a crucial role in the health of millions of Africans. According to the International Development Research Centre (IDRC), one estimate is that a number of Africans who normally use these services for primary health care is as high as 85% in sub-Saharan Africa (Semenya & Potgieter, 2014). On the other hand, the WHO Declaration at Beijing in China stated that about 85% of people worldwide seek traditional health practitioners as first choice of health care before western medicine (WHO, 2002). Developing countries have begun to realise the

high cost of modern health care system as well as the technologies that are required to run it; this proves Africa's dependence on traditional medicine (Mokgobi, 2014). The shortage of western-trained personnel coupled with the fact that the majority of Black people prefer traditional over western healing, necessitated the proposal to integrate the traditional healing and western biomedical model in state hospitals and clinics in South Africa.

Mokgobi (2014) conducted a quantitative study to explore western practitioners' opinions, knowledge and experience with traditional healing and further investigate on how these opinions impact on the practitioners' intentions to make use of traditional practitioner's services in the future. The data was collected using a self-developed questionnaire with 319 health care professionals. The results of the study were that majority of the western practitioners indicated that they would consider working with the traditional practitioners and use their services.

Concluding remarks on the literature review

In all of the literature reviewed, there is consensus by all authors that traditional practitioners have made an indelible mark to everyone for achieving the level of success within Black communities for the health care services they have been offering. It is for these reasons that, those authors who support the integration of the modern and traditional health systems as intervention in addressing the shortage of health care workers in this country, refer to the traditional practitioner's achievements as the basis for their integration. On the other hand, there are also those authors who, while agreeing that traditional practitioners have a role to play in the country's health system, argue against integration with the view that this would be an exercise in futility, as only China achieved full integration after attempting for over forty years; this achievement was realised after the Chinese government changed their top-down approach to a bottom-up approach to reach this achievement (Ingle, 2009). There are also those authors who have neither supported nor rejected integration in their arguments. They have, however, reviewed and highlighted relevant alternatives that the South African government can use to integrate traditional practitioners into the country's national health system, specifically at the primary health care level.

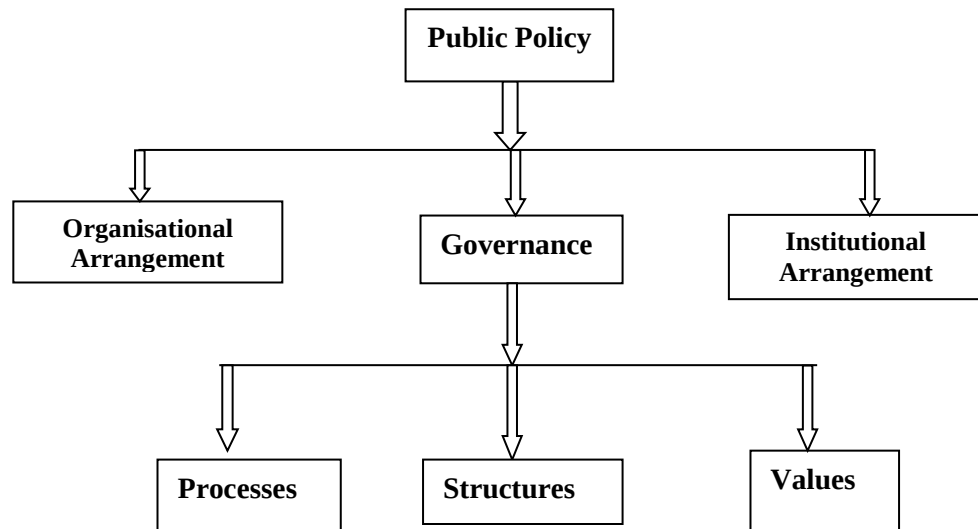
In all the authors that have been reviewed in this study on this topic, there were different views on integration as an intervention; they all agreed that traditional practitioners have a role to play in the primary health care of the country in either a formal or informal capacity. However, they differed on whether or not they should be integrated into the country's health care system. Some saw that role being informal, where traditional practitioners become

Village Health Workers, while others saw them in a formal capacity where they are counsellors in the 'formal' clinics. This statement is supported by Ingle (2009) when he says that "...what one gleans from this (and from the literature general) is that there is considerable openness from African countries to the possibility of an integrated health systems, but what one misses is any details or practical account of how the degrees of inclusiveness attained thus far actually function at the administrative level"(Ingle, 2009, p.59). In support of Ingle, UNAIDS (2006) provides best practice cases of collaboration between western biomedical and the traditional healers in HIV/Aids prevention in Africa. It is difficult to extract fundamental details on how traditional healers, in those previous cases actually participated in the programmes – in terms of professionalization and accountability.

The gap that this study has identified while undergoing literature review were two issues; first, those authors who supported the integration of traditional practitioners into the primary health care did not clarify or provide details on how the traditional practitioners can be integrated in primary health care level. Secondly, once integrated, what role will the traditional practitioners play within the PHC. It is for this study to explore the measures government should take to implement the integration of the traditional practitioners into the country's national health system. Secondly, this study will explore the role that practitioners will play once the government has defined how they will be integrated into the country's health system to alleviate the current challenges faced by the national health system, especially the primary care level.

2.4. An introduction to public policy and its key components

Diagram 3 - Public policy is the home of this research. Public policy is divided into three components: Governance, Organisational Arrangement and Institutional Arrangement. Governance is further divided into three components: processes, structures and values.



2.4.1 Public Policy

According to Roux (2002) public policy is an authoritative government's decision to take action, or not, in addressing a community problem, concern or need. There is no unique and specific definition of public policy, but different authors' definitions agree or similar in stating that it is an action taken by the government to benefit the society. Public policy is also said to be the "...actions of government and the intentions that determine those actions"(Gido et al., 2009, p.1). On the other hand, public policy can be described as a "set of related decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them within the specified situation" (Crouch, 2008, p.527).

Hill & Hupe (2014) state that, for a policy to be regarded as public policy, it must be, to some degree, generated within the framework of government procedures, influences and organisations in the interest of the public. Therefore, the understanding is that, a government of any country will always take policy decisions in the interest of its citizens to address a need, a concern or a problem. The government is the key actor in the development of public policy, whereas there are other actors. Hill & Varone (2014); Lall (2012) & Tantivess & Walt (2008) support this statement by stating that policy development is a complex political process in which there are many actors, which include politicians, pressure groups, civil servants, professionals and passive recipients.

For other actors to contribute effectively in the public policy development, it is important for them to be educated in the process. While the ultimate objective of public policy education is to establish fact and minimize myths, the main purpose of public policy education, on the other hand, is for students to increase the body of fact in order to increase public understanding, and to help the public to make more choices that are informed. The success in public policy education, whereby fact is established and fiction is reduced, means that the task of public policy education has been achieved. In this research study, public policy applied when the SA government propose a legislation that will lead to the integration of traditional practitioners, amongst other outcomes into the primary health care level to increase human capacity. The idea to include traditional practitioners into the primary health care by government first was to recognise the traditional practitioners as health care providers, and secondly, to formalise them as 80% of Africans consult them for various reasons. One of the advantages of integration of this human resource base is to alleviate the shortage of health care workers in the public health sector as the professional health care workers are leaving the system in droves for better salaries and work environment abroad or in the private sector. In this case the government has taken action in the form of introducing the Traditional Health Practitioners Act of 2007 to improve the public health system, which will ultimately benefit the SA society.

2.4.1.1 The purpose of public policy

A public policy is a guideline through which a government addresses a societal challenge, which could include a public health or social problem. According to Roux (2002, p. 425) public policy is a “proposed course of action of government or guidelines to follow to reach goals and objectives”. This statement is supported by several authors, such as Crouch (2008); Gido et al., (2009) & Hill & Hupe (2002). Therefore, the understanding is that government develop public policies to provide services to different communities according to their needs.

This research focused on public health services that are being provided by the South African government. There are challenges that exist within these health facilities to provide quality services to the public as a result of shortage of health care workers, medicine, etc. The government has been aware of these challenges hence, the proposal of integration of traditional health practitioners into the health system of the country. Policies and legislations have been introduced in the country from 1994 until 2007 about this integration of traditional practitioners to participate in the health system but has fall short on how this

process could be achieved. Even the National Health Bill of 2002 attempted to give a specific but fell short where it recommended that facilitation of cooperation between all health care providers in the district should be implemented as one of the district's function. It's only in 2015 the country has come closer in addressing the integration of traditional practitioners into the primary health care system, where the Interim of Traditional Health Practitioners Council has developed and introduced the Traditional Health Practitioners Regulations of 2015. These are the guidelines that outline how traditional practitioners are expected register to the Council and practice.

2.4.1.2 Established facts about public policy

Based on other authors' literature review on myths and facts about public policy, a fact is a verifiable statement of what is true. Several authors identify similar facts about public policy as follows. Public policies are developed to address a public need, concern or problem of a certain group within the community. As soon as the government agrees with the public's concern that action needs to be taken to address the issue, the latter develops a public policy within legal constraints with the objective of a positive outcome. After the public policy has been developed, a plan of action is developed, which is goal oriented to address the problem or public concern. While the community is always the one who sounds the 'alarm' and initiates a call for government action on the public concern, they also participate with government and other parties in the process of finding a solution to the problem, thereby ensuring a 'buy in' to the course. The government, on the other hand, always leads in the implementation of a plan of action to ensure a production of a relevant policy that will address the challenge facing the community. Such a government action and involvement would render the overall action towards addressing this concern legitimacy and credibility. The public policy captures the intentions of government, without which there can be no governance.

In this research study, the participation of traditional practitioners into the public health care system was a need identified by both the traditional practitioners and the government. The government concurred with the traditional practitioners, hence the development of the THP Act of 2007. The Act was developed to regulate the traditional practitioners and the practice as well as the establishment of an Interim Traditional Health Practitioners Council whose role will be to regulate the traditional practitioners.

2.4.2 Governance

As opposed to corporate governance, whose focus is to administer a corporation's daily operations based on its vision, mission, objectives and constitutional mandates to produce goods and/or services in order to make a profit, public governance is based on the government's action or authority to manage or rule the country's affairs based on a set of guidelines. Those guidelines are public policies crafted to guide the public. While the context of what governance is remains consistent, different authors define or describe governance in many different ways. According to Stoker (1998, p. 17) "...governance refers to the development of governing styles in which boundaries between and within public and private sectors have become blurred". Cairney (2013 p.7) defines governance as "...all processes of governing, whether undertaken by a government, market or network, whether over a family, tribe, formal or informal organization or territory through laws, norms, power or language". Hufty (2011, p.10), on the other hand, says governance relates to "...the processes of interaction and decision-making among the actors involved in a collective problem that leads to the creation, reinforcement, or reproduction of social norms and institutions."

According to the World Bank (1999), governance is the exercise of political power to manage the affairs of the state. It can also refer to the exercise of economic, political and administrative authority to manage the country's affairs at all levels (UNDP, 1997). Therefore, the understanding of public governance is that it is a process of governing the society through interaction of various stakeholders to solve the public's problems. The government with the support of other stakeholders leads the process of governing the society. Authors identify different types of governance, but the most similar ones are the public governance, corporate governance, private governance, etc. (Lee, 2003).

In the case of South Africa, the public health system is managed at three levels of government with distinct responsibilities and those are the national, provincial and district. The national government's mandate is to develop policies, whilst the provincial is responsible to monitor and evaluate policies as well as being an intermediary between the national and the district. The district sole responsibility is to implement those policies through services as they are closer to the communities. The District Health System is responsible to implementation of primary health care. The integration of traditional practitioners is proposed that it should be introduced into the District Health System.

2.4.2.1 The purpose of governance

Governance has been introduced in the public sector or private organisations to provide direction and assistance in achieving relevant policies and objectives. Governance was specifically introduced to the public sector to show how government functions and addresses problems faced by society. It has been introduced as a new paradigm shift of interaction of government with other stakeholders as several challenges have been identified within government, such as capacity of the state, loss of policy capacity, and increasing problem of coordination (Peters & Pierre, 2008, 1998). According to Peters & Pierre (2008), traditionally, the state's role was to provide services to the society without consulting and further imposing laws and regulations. Since the introduction of governance, the state's role has slightly changed as it now plays a coordinating role, bringing together public and private resources in providing public services. The state has to interact with other stakeholders within its society, if it wants to be effective.

In its effort to interact with the stakeholders, the government collaborate with them to ensure that there is transparency and buy-in towards enhancing or maintaining the well-being of citizens rather than generating profits. This statement is supported by the International Federation of Accountants (2013) in their article, which states that governance in the public sector is intended "...to encourage better decision making, the efficient use of resources and strengthen accountability". Stoker(1998) further supports this statement when he states that governance is about achieving greater efficiency in the production of public services. The overall purpose of governance is to take the long view and assure the sustainability of a government or organisation into the future. A successful governance structure is one where the government's public policies are developed and implemented with the objective of growing the country, creating opportunities to business and citizens, and where policies appropriately address the needs of the public (Spear, Cornforth & Aiken, 2009).

2.4.2.2 Major Components of Governance

Public policies are developed by government to address a societal need or problem in conjunction with other relevant stakeholders. In the development and implementation of public policies, the government takes a leading role. That leading role being taken by the government in the public policy process must be “controlled by regimes of laws, administrative rules, judicial rulings & practices that prescribe and enable government activity” (Lynn, Heinrich & Hill, 1999, p2-3). The exercise to control those regimes of laws, and administrative rules is governance.

According to the United Nations Development Programme (1997) Governance is the exercise to manage a country’s affairs at all levels by government. Government does not manage governance alone; there are also other key stakeholders, such as the civil society, private sector, political parties, the media and social organisations (Renukumar, 2010). Through their participation, these key stakeholders ensure that the whole citizenry have a buy-in into the government, thus assuring that government is accountable and transparent in all its actions. Each key actor assumes responsibility by ensuring that there is a balance of power in the management of governance. The government, on the other hand, creates a favourable political, legal and economic environment for all stakeholders to function in the country through laws that ensures security, economic growth, employment opportunities, and ensuring the rule of law. The civil society’s role is to ensure that it mobilises people to participate in government decisions. Lastly, the market creates opportunities for the citizens to start businesses through existing laws whose purpose is to enable growth countrywide. Therefore, governance has “social, political & economic dimensions” (Sahni, 2003: p1-2). IFAD (1999) & Peters & Pierre(2008) support Sahni’s statement that governance, as a process of governing, is not a new phenomenon, but comes because of the political, economic and social developments. Campbell, Hollingsworth & Lindberg (1991) further elaborate governance as the political & economic processes that coordinate activity among economic actors.

The focus of this research is on political dimension, which deals with values, processes and structure. The structure dimension is about government structures that are key actors in the implementation of governance. The structure component on the diagram will further be divided into two components: organisational and institutional arrangements. The organisational arrangements deal with organisational structures, whereas the institutional structure deals with the substance of administration. According to the UNDP (1997, p.1)

“...institutional arrangements are the policies, systems, and processes that organisations use to legislate, plan and manage their activities efficiently and to effectively coordinate with others in order to fulfil their mandate.”

2.4.2.3 Organisational versus Institutional Arrangements

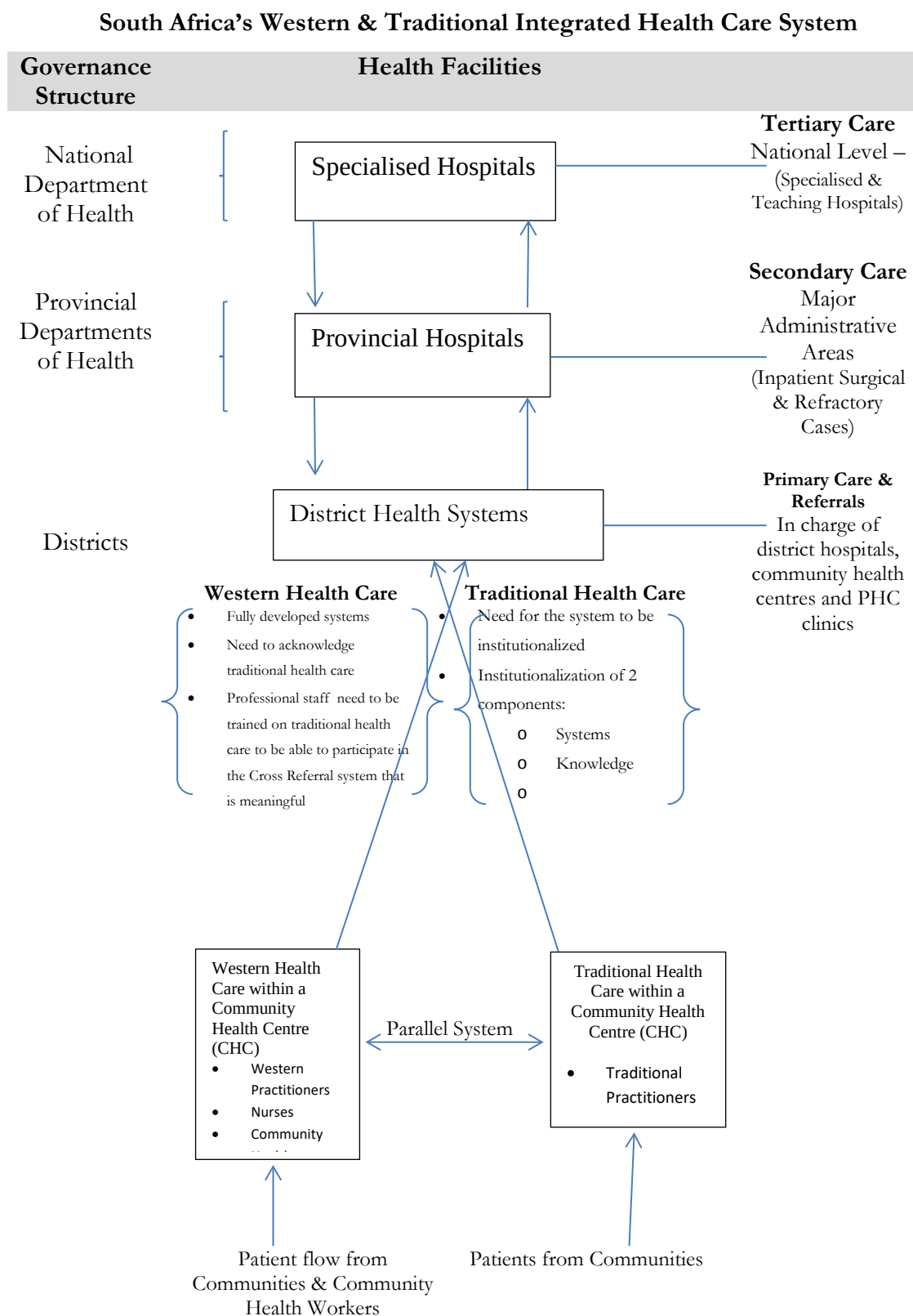
While an organisation is defined as people, working towards realising a certain common objectives by following commonly agreed rules and procedures; an institution, on the other hand, is said to be norms and behaviours that persist over time by serving collectively valued purposes (Uphoff, 1986). Organisations are composed of or require people or groups, who intend to achieve a particular objective, which will be achieved by following certain rules, procedure or a constitution. As such, key characteristics to an organisation are inputs of several people, a common understanding among members about the objectives, and how they are to be achieved.

Institution can be concrete or abstract. Concrete institutions refer to institutions with certain durability and are involved in a development intervention. A concrete institution has a certain degree of value and stability; these include government, school, law courts, etc. While abstract institutions are also durable and commonly accepted, they, on the other hand, are based on an agreement or common understanding in society. As opposed to being a development intervention in the case of concrete institution, abstract institution set the boundaries for development activities.

Institution, whether concrete or abstract, have a degree of value stability and durability; they form the context upon which an organisation is based. For an organisation to be referred to as such it is as a result of its institutional context and objective; in a similar way, institutions are found within an organisational structure. Therefore, an organisational arrangement exists with the intention of achieving a certain objective by following a particular institutional procedure, or by functioning within a particular institutional arrangement, such as a political government, or institution of law. Organisational arrangement and institutional arrangement are intertwined as the latter is the procedure, and the former is the driver.

2.5. Institutional & Organisational Arrangements for integrated systems

Diagram 4: Source: This amended diagram was borrowed from May, Roth and Panda on traditional practitioners as first contact in providing health care services in India. This diagram depicts an integrated western and traditional health system



In this study, a problem was identified, which was a shortage of professional health care workers at the primary health care (PHC) level. An analysis of the environment within which health care is offered, which is the District Health System (DHS), was conducted. A further analysis on the western and traditional health organisational structures to assess their abilities and challenges of offering an efficient and effective health service was also undertaken. An analysis is normally undertaken if the service that is being offered needs to be improved upon by such as an organisation (Wiseman, 2007). Having understood the outcome of such an analysis, this study proposed that the traditional healing system should be roped in as an intervention to alleviate the shortage of health care workers within the PHC system.

Before this intervention could occur, the outcome of the analysis of the traditional health care system revealed that this institution needed to be readjusted and improved upon. This means that the traditional system needed to be institutionalised in order to conform to the newly established integrated health care system. According to Wiseman (2007, p. 1113) institutionalisation is a “deliberate effort to incorporate knowledge at the organisational level so that it may persist and be available for future reuse”. As a traditional institution is to be incorporated into the primary health care system, it means that there will be two health care systems that will provide health care services to the communities. As a result of the impending integrated health care system, the western health care at that level would also have to re-adjust itself to acknowledge and complement traditional health care system.

Integration takes place where two systems converge to provide improved services for a common objective. Out of the past studies reviewed on integration systems, some authors provided national governments around the globe with options that gave them choices to choose from in the event they wanted traditional practitioners to participate in their national health systems, and those are tolerant, exclusive and integrative health system. An integrative health care system can either be inclusive or parallel. The South African government is currently in the process of integrating the western and traditional health systems by using a parallel approach to create an integrated national health care system that will see traditional practitioners participating into the country’s public health care system.

2.5.1 The levels of public health care in South Africa

The discussion that follows below will continuously refer to the Diagram 3 above. South Africa health care is divided into the national, provincial and District Health System. The national Department of Health is responsible for development of health care policies and is also in charge of all the specialised and teaching hospitals, whilst the provincial Departments

of Health are intermediary between the national and the District Health System (DHS). The provincial departments are responsible for monitoring and evaluation of the implementation of policies to services by the DHS. These departments are also in charge of provincial hospitals, that provides surgical and refractory cases. The last level is the District Health Systems, which is in charge of providing health care services to the communities and are also of district hospitals, community health centres and PHC clinics. The parallel system will be introduced at the district level, where the District Health System (DHS) is in charge. According to Pillay & Barron, (2011), the DHS is responsible for the delivery of primary health care and district hospital services in South Africa.

2.5.2. Introduction of a parallel system within the DHS

Traditional and western health care systems have long worked in parallel in South Africa health care system without being sanctioned by the government (Campbell-Hall, 2010). In a parallel system, traditional and western practitioners are be in charge of their own health care facilities, which means that these facilities function independently, parallel to each other, as well as co-exist and participate in some form of a patients cross referral system agreement (Summerton, 2005; van Rooyen et al., 2015; WHO, 2002). For the first time since democracy, the SA government is in the process of formally sanction parallel system of the western health care and the traditional health care systems, which will be introduced at the District Health System (DHS). The western system has a long and rich historical existence, traditions, literature and training systems that are well established globally (Ingle, 2009). This is a system that is internationally integrated and offers similar services anywhere in the world. In order for the parallel system to function smoothly in South Africa's DHS, several adjustments will have to be incorporated into the country's western health care system to acknowledge the formal existence of traditional health care. The western practitioners, nurses, community health workers and specialists that are part of the western health system will have to undergo training that will expose them to how the traditional health system works in order to be able to implement effective cross referrals of patients.

The traditional health care system is the other party that will participate in this parallel system. Its key drivers are the traditional practitioners who already practice informally within their own traditional health institution. Unlike the western system, traditional health care, regardless of its long historical existence with over 80% of the country's citizens having visited it at least once in their lives is not recognised as a formalised health care system by government arising from the legacy of apartheid (Mokgobi, 2014; Pretorius, 1999; Summerton, 2006). Following the government's introduction of the Traditional Health

Practitioners Act of 2007 that brought the ITHPC into existence, this action by government will bring the integration of the traditional practitioners and their practice into reality through this parallel system. As the traditional health care system is a new formalised entrant into the country's health system, it has no infrastructure system in place yet. In fact, for it to fully participate as a newly formalised health system, the government has promised to build their own traditional health care facilities. These facilities will operate under the DHS. The responsibilities of traditional practitioners and the DHS will be to institutionalise these traditional health care facilities with the support of the national and provincial Departments of Health, including the ITHPC. There are two issues that will need to be incorporated into this institutionalisation, and those are systems and knowledges. It means the stakeholders would have to develop organisational structure as they appoint personnel to manage these facilities as well as the establishment of institutions. These integrated systems will have to cooperate and complement each other in order to provide a better and effective health care service delivery.

Each health care system's employees will have to be well trained on how the other (Muluadzi, 2001). These improvements and adjustment will assist in the two systems' participation in a meaningful cross referral system. The two systems' participation and collaboration within the PHC will rely heavily how they offer a smooth and effective health services towards their respective communities, as well as how they collaborate with each other within this integrated system. As the DHS is in charge of the two health systems, it will be incumbent upon it to ensure that the two systems function as a well-oiled operating unit whose primary purpose is to offer health care to the public. Incorporation of the respective regulatory body's rules and regulations to the DHS administration, as well as the compliance of each system to all regulations will produce a successful integrated national health care system.

2.6 Established frameworks that can interpret empirical evidence on institutional and organisational arrangements for an integrated system

Theoretical framework is the blueprint for the entire research study; it serves as a guide on which to build and support one's study, as well as to provide the structure to define how one will methodologically and analytically approach the whole study (Grant & Osanloo, 2014). It also attempts to answer two key questions: what is the problem being studied? Secondly, what approach will be feasible to use in collecting the data (Swanson, 2013)? There are many theoretical frameworks available to researchers when conducting research, and the

importance of developing one for one's research is to understand the complex ideas or concepts by representing them in diagrams (Roberts, Dawn & Khattri, 2012). How far your study goes is controlled by our key concepts with definition from literature review. In this study the key concepts are traditional health practitioners, western health practitioners, integration, primary health care and District Health System.

The relevant theory that will apply in this study is the change theory. This theory will provide structure to this whole study as it seeks to recommend changes within the primary health care (PHC) sector. Those changes will affect the western and traditional health care system. Three theories will be applied in this endeavour; those are Kurt Lewin's Change Theory, Institutional Theory and Organisational Theory. These theories don't duplicate each other; they instead complement each in their application, when an organisation is being studied first needs to be understood in order to be able to identify the challenges facing the organisation, prepare the environment for change before recommendations could be applied. Further when conducting organisational analysis, the focus is on two areas and those are the organisational structure and the institution. When conducting organisational analysis based on the organisation's structure, you don't only consider internal stakeholders but all relevant stakeholders as they have different role to play. The question that needs to be answered is how these stakeholders will be affected by the recommended changes. Is there a possibility of getting resistance? Once applied, each or collectively, will either produce anticipated changes or the organisation will have acquired improvements to its core structure. At the end of the process, the challenges facing the organisation should be eliminated, and new changes will be produced either a new or improved institution and/or organisation.

How you expand on your theoretical framework is informed by the following components: What is the problem being studied? South African is experiencing shortage of professional health care workers in the public health care sector who leave for better salaries and working environment in the private sector and developed countries. What approach will be feasible to use in collecting the data? The second issue is how this challenge will be alleviated, and what steps will be taken to recommend and apply the new changes. To be able to undertake this task, relevant questions that are pertinent to the problem at hand will be drafted and presented to a sample interview group, out of which the responses will provide a good guidance on how the problem can be addressed.

2.6.1 Change Management Theory

Change management theory is a model for introducing change in an organisation that is experiencing problems. Kurt Lewin's Change Management Theory will form the basis upon which I will base my theoretical framework. The model has three stages and those are Unfreeze; Change and Refreeze. The first stage is to understand how the organisation function to meets its mandate, then identify the organisation's challenges and then prepare the environment for change by sensitizing them about the challenges facing the organisation (*unfreeze*). Second stage is to introduce and implement the changes (*change*). Finally, is to analyse the changes and its effect (*refreeze*). Change management gives a manager or other change agent a framework to implement a change effort, which is always very sensitive and should be as seamless as possible. This model provides guidance on how to go about getting people to change: change will only be effective if the people involved embrace it and help in putting it into practice (Schein, 1968).

In order to gain efficiency, people will have to take on new tasks and responsibilities, which entail a learning curve that will, at first, slow the organization down. A change process has to be viewed as an investment, both in terms of time and on the allocation of resources. After the new organization rolls out the processes, certain chaos might ensue, but that is the price to pay in order to attain enhanced effectiveness within the structure. Change will only reach its full effect if it is permanent. Once the organizational changes have begun, and the structure has regained its effectiveness, the organisation must ensure that it cements all its efforts to ensure that it becomes the standard operating system of the organisation. This model is relevant to this study as we are proposing an intervention within primary health care level, which will address the shortage of health care workers. The traditional and western practitioners should be willing to learn and understand each other's world in order to be able to work together. Out of the three stages of Kurt Lewin's Change Management Theory, this study will focus on the first stage, which Kurt Lewin calls 'unfreeze'.

2.6.2 Organisational Theory

Organisational theory is a process of analysing the structures of the organisations, how they function and perform to deliver on what they are intended to do and the behaviour of groups and individuals within them (Laegaard & Bindslev, 2006). In this study, the researcher needs to understand the existing structure of a PHC clinic, which provides primary health care services, how it functions and provides the basic health care services to

the community. This will enable the researcher to understand where the gap exists in order to make a recommendation for the integration of traditional practitioners into the PHC level. Organisational theory will assist to identify where the problems are and which structure would be able to address these challenges.

2.6.3 Institutional Theory

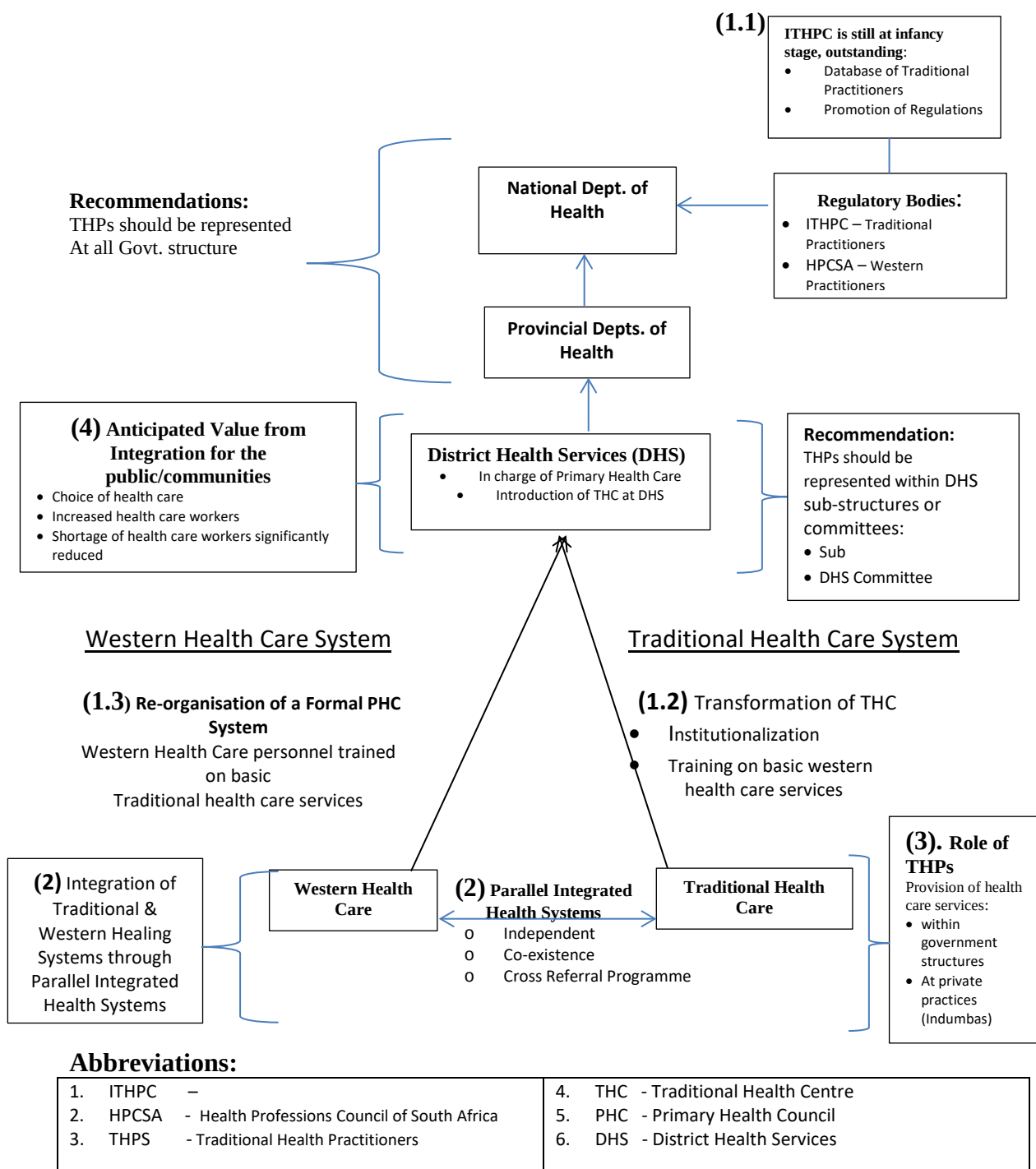
Institutional theory involves a deliberate effort to incorporate knowledge at the organizational level so that it may persist and be available for future re-use. Institutional theory means the inner workings of an institution within an organisation. According to Crossan, Lane & White (1999, p. 525), institutional theory is a process through which the “learning that has occurred by individuals and groups is embedded in the design of the systems, structures, and procedures of the organization ...”

2.7. Integrating traditional health practitioners into the South African primary health care, a conceptual framework

CONCEPTUAL FRAMEWORK

Diagram 5: This diagram depicts a course of action for achieving anticipated results.

Conceptual Framework's use in research is to outline possible course of action or to present a preferred approach to an idea or thought



Below are summaries of the research report from Section 2.1 to 2.6 above

2.7.1. History & description of the South African Primary Health Care System & advantages and disadvantages of its integration

When the democratic government took over in 1994, it had a responsibility to dismantle the legacy of the apartheid era by integrating different health administration systems into one. That process resulted in South Africa having three levels of public health and those are national, provincial and District Health System, with distinct mandate that complement each other. The national Department of Health is responsible to develop health policies, whilst the nine Provincial Departments of Health are mandated to monitor and evaluate the implementation of the health policies. They are also an intermediary between the national and the District Health System. The last level is the District Health System (DHS), which is responsible for implementation of the primary health care. The DHS is also in charge of district hospitals, community health centres, primary health care clinics and private health system. This research was conducted at the Pretoria District Health System.

In 2010, the Department of Health revamped its national health system to make the PHC its core implementation tool within its health programmes (Pillay & Barron, 2011). The South African primary health care history dates back from the Pholela Health Centre model that was introduced in the 1940's in KwaZulu Natal, as well as the World Health Organisation's 1978 Alma Ata Declaration, where the latter was promoting a 'Health for All' ideology. The Pholela Model and the 1978 Alma-Ata Declaration became the foundation from which the current South African primary health care system is based upon. The PHC service, which is a nurse-based-care system, provides services that include prevention, care and cure, health promotion, comprehensive health services and health education.

This research has identified one of the challenges experienced by all three levels of public health care; especially the primary health care is a shortage of health care workers due to high rates of medical professionals' migrations outside the country. An assessment by the WHO (2003) found that more than 60% of the health care institutions in South Africa struggled to fill existing posts; it further stated that there are more than 4,000 vacancies for general practitioners and 32,000 vacancies for nurses throughout all provinces (Kautzky & Tollman, 2008). As result of the shortage of health care workers at the primary health care level, this research proposed integration of the traditional health practitioners into the South African primary health care system to alleviate this shortage challenge. Traditional health

practitioners are an untapped human resource, which is already providing an informal primary health care service in different communities. While integration seems to be the best option to address the challenge of health care personnel shortage, there are advantages and disadvantages of integrating traditional health practitioners into the primary health care system, and whichever has higher preponderance between the two would sway the decision on whether or not integration of the two systems is a good idea.

Traditional practitioners have an edge, in terms of numbers, over the western practitioners, as they have an estimated to be approximately 350, 000 compared to 32, 000 western practitioners (Meissner, 2004; Pinkoane et al., 2012b; Pretorius, 1999). This significant number of traditional practitioners could undoubtedly contribute significantly towards the shortage of health providers within the PHC sector. Language is normally not a barrier for traditional practitioners to communicate and treat community patients as they tend to speak similar languages, whereas western practitioners tend to rely on interpreters. Lastly, traditional health services are holistic as they include physical, mental and spiritual healing of the patient. The above statement corroborates (Pretorius, 1999, p.252) when she states that “traditional practitioners’ treatment is comprehensive and has curative, protective and preventive elements”.

On the negative side, the use of unrecognised and untested traditional medicines prescribed by traditional practitioners will continue to be a problem negating the traditional practitioners’ possible contribution towards the solution to the challenge, as well as their medicines’ acceptance within the western health system. The second obstacle is that a large number of traditional health practitioners are unregistered with any regulatory body. Only now the SA government is in the process of addressing non regulation of traditional practitioners and their practice by introducing the Traditional Health Practitioners Act of 2007, which is the establishment of a Council to regulate this institution. Lastly, there is no standardised fee structure for consultation and prescription of medicine, each traditional practitioner charges as he/she wants.

2.7.2. Methods, data, findings, and conclusions of studies on integration

The literature review that this study underwent for this research has recommended three options that could be used by the national governments to address its public health challenges, which includes the shortage of professional health care workers, inaccessibility of the health care facilities in rural areas, etc. The first option is where some authors, like

Freeman & Motsei(1992) and Ingle (2009), provided alternatives to governments on which option to choose from when addressing the public health sector challenges. This option recommends alternatives from which government can choose a suitable integration format; these alternatives are incorporation, cooperation, collaboration or total integration of traditional practitioners into the national health care systems. The second option is where other authors, such as the Ingle (2009); Meissner (2004); Pinkoane et al., (2012b) and Zhang (2002), state that integration of traditional health practitioners into the PHC level is a viable option, as they are a human resource base that is already available to the country's citizens. These practitioners are already providing the primary care in their respective communities.

The third option is where authors like Moagi (2009); Mokgobi (2014) and Yeboah (2000) state that integration of traditional practitioners into the national public health system should not be an option as these practitioners first need to organize their institutional affairs. These authors state that the practitioners' challenges and negatives far outweigh the positive contribution that they would make toward alleviating the shortage of health care workers. This third option will not be relevant to this study as the preliminary literature review that this author has conducted thus far indicate that integration of some kind is possible, and thus still a viable option. It then follows that options one and two are still possible to this study as they are consistent with the direction of this research. However, the challenges stated in all three options need this study to investigate them to assess their weight or influence before the study can make a recommendation for or against full integration.

While options one and two are consistent with this study, from the literature reviewed, it is apparent that the case studies stated in support of integration do not go far enough to explain how this integration should be implemented. The first option provides alternatives from which an integration option can be chosen, while the second option recommends integration as a viable option. However, both lack details on how this integration should take place. Even some of those authors who shared case studies on 'success stories' on true integration, such as China, Vietnam and the two Koreas, all fail to provide details on how these countries implemented full integration. A gap exists from previous studies. To fill this gap, this study needs to answer two questions: first, which strategy exists that this integration process can follow in order to achieve a true and successful integration of traditional practitioners into the PHC? Secondly, what roles will these practitioners play once integrated?

2.7.3. Introduction to governance, key components, attributes and variables in governance studies

This Section provides possible solutions or options to address the gap identified in [Section 2.7.2] above. The home of this research study is governance. Governance has four basic components, and those are accountability, transparency, participation and rule of law. Health care system is a service that government provides to communities, and, therefore, falls under participation. Participation has two components - informal and formal primary health care, which traditional practitioners and government provides. Informal primary health care refers to the practice and care that traditional health practitioners provide, whilst formal primary health care refers to the western structure of health care level, which provides primary care and referrals.

Public participation is central as lack of citizen involvement in the decision making process of the state is likely to lead to the failure of a national health care system in any democratic environment. According to the United Nations Development Programme (2011), public participation is the process in which the state consults with interested individuals and organisations before making a decision. This research study is interested in the public's participation, which allows citizens to contribute in the activities of the government. The inclusion of traditional health practitioners into the South African primary health care level is to propose the participation of these traditional practitioners in addressing some challenges experienced by the public health care system, such as the shortage of health care workers.

This research study's proposal is to derive an arrangement for integrating traditional health practitioners into the South African primary health care level. The study proposes to move the services of the traditional health practitioners into the primary health care, which healers are currently offering informally within their communities. The movement of informal services to formal has to go through a governance process of transformation for the current health system in order to succeed in integrating traditional health practitioners into the current health system. The success of such a governance transformation process will resolve the challenge of the shortage of health care workers through the addition of 350 000 traditional health practitioners or more into the public health sector, especially at the PHC.

The key attributes towards the development of any policy are inputs, activities, outputs and outcomes and the resulting impact, which form a conveyor belt or value chain that churn out anticipated products. A change in any of the attributes will affect the functionality of the

value chain and impact on the outcome of the final product, which is the impact that the policy will make to the society, especially those directly affected. In this research, the components of the value chain begin with the government's establishment of a policy at national level; the provincial level's responsibility is to then monitor and implement the policy at provincial level. The Provinces are in charge of various regional and district facilities within the province, and those districts, in return, concentrate on the implementation of the policies through the health centres and community clinics. The community health centres and clinics are closer to the communities and are the first contact or entry for people to receive government health services. This is where this research is proposing that the integration of traditional health practitioners into the primary health care should take place. This will be possible by deriving a framework for this integration to be possible.

2.7.4 Theoretical frameworks in governance studies

Theoretical framework is important in qualitative research as researchers use it to guide their studies and organise their ideas. There are many theoretical frameworks available to researchers who are conducting qualitative research. According to Grant & Osanloo (2014) the importance of this framework is to understand complex ideas or concepts by representing them in diagrams. Theoretical framework attempts to answer two questions: what is the problem under study? Secondly, what makes the chosen approach to collect data feasible? In this research study, there are three theories that this study will use to provide rationale and further interpret its findings - they are theory of change, organisational theory and institutional theory.

Kurt Lewin's Change Management Theory, which is called *unfreeze*, *change*, and *refreeze*, is one of the theories identified above; it has three steps it follows to address the challenges experienced by an organisation. Firstly, in *unfreeze*, before introducing changes in an organisation, you must understand the organisation's structure, as well as how it functions in order to be able to identify its challenges. Secondly, *change*, this is the introduction and implementation of the viable changes that will address the organisation's challenges. Finally, *refreeze*, this is the analysis of the changes and its effect. Changes to the organisation will affect its policies when addressing challenges that influence its structure and employee performance due to the new changes. It will be necessary to introduce the organisational and institutional theories to address the new changes. The process needs to clarify the organisation's structure and its institutional processes in order to implement true changes.

3 RESEARCH STRATEGY, DESIGN, PROCEDURE AND METHODS

This chapter will provide extensive information on how the study was conducted in some regions of Pretoria in Gauteng. It will further provide an analysis on what strategy and design or plan of action the research followed, as well as the method on how data was collected for institutional arrangements for integrating traditional health practitioners into the South African primary health care system.

This study, which was qualitative, was about collecting in-depth information on the perception and understanding of the research participants on this identified topic. To enable the research to collect this data effectively, the study used a cross-sectional design as it allowed the research to collect data on more than one case at a single point in time (Bryman, 2012). The research procedure and methods, which outline the instruments that were used, are also explained. The instruments used were tested to determine their accuracy and validity. The research also specified the limitations that restricted the extent to which the study could have been conducted.

This chapter outlines key salient aspects of the research procedure and method on what instruments were used to collect data, which population was targeted and how the sample was extracted. Research on human beings is always very sensitive as it deals with private and confidential matters, hence the chapter outlines what ethical issues were considered when data was collected, such as ethical letter authorising and giving the researcher permission to conduct the research. How data from research respondents would be collected, stored and processed is also clearly outlined. The section concludes with the detailed description of the research respondents on who they are, where they resided, their age group and understanding of the research topic.

3.1 Research Strategy

A research strategy is a plan of action that gives a researcher direction to conduct a systematic research (Dinned 2014). Bryman (2012, p. 35) describes a research strategy as "... a general orientation to the conduct of social research". Wagner, Kawulich and Garner (2012) define research strategy as a process that a researcher chooses to proceed with when conducting his/her research. Therefore, a research strategy can be defined as

a process or plan that directs the researcher towards a strategy to proceed with when conducting a systematic social research. There are three types of research strategies: qualitative, quantitative and mixed methods. Qualitative research uses words to assess, analyse or summarise information as the researcher is collecting in-depth knowledge from the research participants; quantitative research, on the other hand, uses numbers to give meaning to collected information. Mixed research is about integrating the two research methods in a single study to achieve a better understanding from narrative and numerical viewpoints (Creswell, 2014).

This research used a qualitative research strategy in order to enable this researcher to understand and interpret the perceptions of the research respondents, which included the following: government officials at two levels¹, the traditional health practitioners, western health practitioners and South African citizens on the institutional arrangements for integrating traditional health practitioners into the South African primary health care system. This research further used an inductive strategy to interpret collected data. According to Kawulich et al. (2012), inductive strategy is about describing a phenomenon, whilst a deductive approach is about explaining an event.

The articles about to follow were selected because they also used qualitative research strategy; similar to my study, these research articles focussed on primary health care, and collaboration between western and traditional practitioners in the treatment of patients.

Moyo, Madale, Ogunmefun, & English (2013) conducted a qualitative study to determine the general management and public health competencies essential for the primary health care (PHC) clinic managers in the context of the South African PHC re-engineering framework. The study was conducted with ward-based outreach team leaders and other clinic managers in the North West Province. The primary data was collected using in-depth interviews and focus group discussions. This method assisted researchers in reaching a conclusion that all PHC clinic managers required skills training (Moyo et al., 2013).

Shelley, Sussman, Williams, Segal & Crabtree (2009) conducted a qualitative study utilising focus group and in-depth interviews to explore factors influencing

¹national Department of Health, and Gauteng District of Health

communication between patients and the primary care clinicians in the use of traditional medicine (TM) and complementary and alternative medicine (CAM) in South-western United States of America. The conclusion was that there are communication challenges between the patients and their primary care clinicians on TM and CAM.

Campbell-Hall et al. (2010) conducted a qualitative study about the perception of patients and practitioners of traditional and western practitioners within the public sector system in healing mental health. The study, which utilised individual and focus group interviews, was conducted in a district within KwaZulu Natal in South Africa. It focussed on collaboration between western and traditional practitioners in the district, with respect to mental health care and what form the collaboration should take. The conclusion was that there is a need for cooperation between the western and traditional healing with regard to mental health care as communities continue to use them simultaneously.

3.2. Research Design

Research design is a blue print on how a researcher intend on conducting his/her research (Symington, 2015). It can also be referred to as a plan of action that the research must follow in conducting his or her research (Wagner et al., 2012), or a framework on how data can be collected and analysed (Bryman, 2012). A choice of research design is a reflection on the decision and priority the researcher places on the research process (Bryman, 2012). Therefore, research design is also a template that a researcher can use in any research to collect and analyse data.

Of the five different research designs available (experimental design, cross-sectional/survey design, longitudinal design, case study and comparative design), my research used a cross-sectional design for the collection of data. Bryman (2012) explains cross-sectional design as a collection of data on more than one case and at a single point in time. This research design enabled this researcher to collect information through interviews and focus group from traditional health practitioners, western health practitioners, government officials from the national and district Department of Health and the South African citizens.

The following articles were selected because they used a cross-sectional design; the authors conducted research on public health care system and focussed on traditional practitioners, as it is the case in my study. They also dealt with collaboration between western and traditional practitioners in the treatment of diseases, as well as contribution of traditional practitioner's practices towards the national health system. Therefore, these articles are similar with my study as they applied the same design technique and their research content focussed on those that my study dealt with.

Gyasi, Mensah, Osei, Adjei, & Agyemang (2011) undertook a descriptive cross-sectional survey study that examined public perception on the role of traditional medicine in relation to accessibility, safety and interactions between traditional & western health systems in Ghana. The design enabled the researchers to collect data from a sample of seventy (70) traditional health practitioners, thirty (30) health care users and twenty (20) western health practitioners. The sample was selected and used based on snowball, random sampling and purposive technique. Administered questionnaires and interviews enabled both qualitative and quantitative data to be collected. The findings of the study were that traditional medicine is effective in treating different medical conditions, such as malaria, HIV/Aids, stroke, infertility, etc. However, safety use of traditional medicine is not standardised. There is interaction between the two health care providers through cross-referrals, whereas they are not coordinated.

Birhan, Giday, & Teklehaymanot (2011) conducted a cross sectoral study to assess the contribution of traditional healers' clinics to the public health care system in Addis Ababa. The researchers interviewed ten (10) traditional healers who were willing to participate in the study, as well as three hundred and six (306) patients who visited the traditional healers' clinics using two types of semi-structured questionnaires. The clinics treated diseases, such as, wounds, cancer, back pain, liver, etc. Fifty two (52) percent of the patients reported that traditional healers' clinics were the first choice when faced with health problems. The study displayed that those clinics contributed significantly to the Ethiopian public health care system.

Kaboru et al. (2006) conducted a study to explore biomedical and traditional health practitioners' experiences and attitudes towards collaboration of the two healing system for patients with sexually transmitted infectious (STIs) and HIV/Aids. The cross

sectional design study was conducted in two Zambian urban sites using structural questionnaires. The researchers interviewed one hundred and fifty two (152) biomedical and one hundred and forty four (144) traditional health practitioners who reported attending to patients with STIs and HIV/Aids. The study showed low level of experience of collaboration between biomedical and traditional practitioners on issues of safe delivery.

3.3. Research Procedure and Methods

3.3.1. Data collection instrument

A data collection instrument used in research is a device or a tool used by researchers when collecting data to enable themselves to answer their research question (Gill, Stewart, Treasure, & Chadwick, 2008). Several data collection techniques are available to researchers for use to collect data. However, the techniques differ according to whether the study underway is either qualitative or quantitative. Wagner et al., (2012) describes qualitative data collection instrument as a technique that depends on three gathering methods: observation, interviews and documentation. Bryman (2012) refers to the data collection instruments as data-collection strategy.

In my research, the data gathering method used was interviews. An interview is a two-way conversation between the researcher and the research participant, and it is about the collection of ideas, experiences, beliefs, views and opinions of the research participants (Wagner et al., 2012). There are three types of interview methods available for the collection of data in qualitative research; those are semi-structured interview, structured interview and unstructured interview (Bryman, 2012; Gill, Stewart, Treasure & Chadwick, 2008; Kajornboon, 2005). Structured interviews are based on standardised questions that are conducted telephonically or face-to-face with research participants; while semi-structured interviews have open-ended questions, and are captured in the interview guide. Unstructured interviews are based on questions without specificity and are intended to collect in-depth information (Gill et al., 2008).

This research used semi-structured interviews and focus group interviews for the collection of data in order to obtain a rich descriptive data from the research participants. A focus group is part of data collection method where group members sharing similar interest are interviewed for a specific topic (Gill et al., 2008). It is used in

combination with other collection methods to clarify some findings or questions from another method (Morgan, 1997). Both semi-structured and focus group interviews use an interview guide to collect data, which is a basic structure that provides an idea on how to conduct the interview. That basic structure is a research data collection instrument (Bryman, 2012). My research problem, research questions, literature review conducted and any other necessary questions to fill the identified gap, were used to source the questions that were included in the collection instrument structure. One focus group was organised by the researcher to clarify some concepts and questions. It was attended by the three traditional practitioners, two government officials and the three South African citizens.

The articles below used interviews and focus groups as data collection instruments. These instruments used were applied in a similar setup as this researcher as they examined primary health care as well as collaboration between traditional and western healing within their country's health systems. The articles further reviewed the safety of dispensed traditional medicine to the patients.

In the Birhan et al., (2011), a cross-sectional study to assess the contribution of the traditional healers' clinics towards the country's public health care system within Addis Ababa was conducted. The study utilised two types of semi-structured questionnaires as a collection instrument of choice to gather information from traditional healers' clinics. The Gyasi et al., (2011) study, which examined public perception of the role of traditional medicine in relation to the accessibility, safety, efficacy rate and interactions between traditional & orthodox medical systems in Ghana, used an administered questionnaire and in-depth interviews as a data collection instrument.

3.3.2. Target population and sampling

3.3.2.1 Target population

A 'target population' is what researchers usually refer to as a population sample. Banerjee & Chaudhury (2010); Bryman (2012); and Yount (2006), all define a target population as a population from which to draw the sample; it is also known as a theoretical population. Researchers further refer to target population as the entire group of individuals or units of analysis. The research's objectives always determine the target group and the sampling size that the researcher will use to gather information.

The target population for this research on the institutional arrangements for integration of traditional health practitioners into the SA primary health care were the traditional health practitioners, professional health care workers from the National Department of Health and Gauteng District of Health, western health practitioners and South African citizens from around Pretoria. This target population contained certain key characteristics, such as the understandings of the public health care sector, especially the primary health care system and traditional healing.

The study population were the individuals within the target population from whom the researcher gained easy access and had extensive knowledge about the research problem (McLeod, 2014). The Pretoria region, from which this research was conducted, is divided into seven regions, and those are Region 1: North Western part of Pretoria (Akasia, Beirut, Soshanguve, Ga-Rankuwa and Mabopane), Region 2: Hammanskraal, Region 3: Atteridgeville, Region 4: Centurion, Laudium & Olievenhoutbosch, Region 5: Cullinan and Roodeplaat, Region 6: Mamelodi and Eersterust, and Region 7: eKangala and Bronkhorstspuit. The research participants in this study were sourced from Region 1, 3 and 6.

3.3.2.2 Sampling

Sampling is a process of selecting a suitable sub-section of the defined population (Bryman, 2012; Yount, 2006). Different authors, such as Hardon, Hodgkin & Fresle, 2004 and Onwuegbuzie & Leech, 2007, have written extensively on the research studies supporting this description of sampling. Sampling strategies that researchers normally use in either qualitative or quantitative research are 'probability' and 'non-probability' sampling. Probability sampling involves some form of random selection whereas non-probability is about participants who are willing to participate in the study. There are four techniques within probability sampling and they are: simple random sample, systematic sample, stratified random sampling and multi-stage cluster sampling. Non-probability sampling, on the other hand, includes quota sampling, convenience sampling, snowball sampling and purposive sampling (Bryman, 2012). This research used the non-probability sampling, which is associated with a qualitative research study.

In this study, the researcher used a purposive sampling process to select the traditional health practitioners, professional health care workers, western health practitioners and

the South African citizens around Pretoria. What is unique about purposive sampling is that the researcher has a clear understanding of the targeted population that will be utilised during the development of the research proposal. This is done so that the sample is representative of the target population with specific criteria used to identify these individuals. Sample size is usually small in qualitative research, as compared to quantitative research (Wagner et al., 2012). The sample size for this research consisted of thirteen (13) participants. The breakdown of participants was as follows: four traditional health practitioners, two western health practitioners, two officials from the national Department of Health, two professional health care workers from the Gauteng District of Health that implements the PHC and three South African citizens.

The articles below used purposive sampling technique for identification of research participants. This research also used the same technique to identify its research participants around Pretoria.

Mall (2007) conducted a qualitative study that investigated the impact of African traditional healers' (ATHs) treatment of HIV/Aids patients who are on antiretroviral (ARV) treatment in South Africa. His study focused on the insights and opinions of the health care workers (HCWs), ATH affiliated with the treatment of HIV/Aids care services and HIV positive patients. He selected this target population due to lack of concrete data on the role played by ATH on HIV/Aids care and treatment in South Africa. The study showed that HCWs were concerned with the possibility of ATHs undermining an ARV roll out programme where ATHs may provide untested substances to HIV positive patients, by adversely interacting with ARV drugs; as a result, ATHs could discourage patients from adhering to their ARV regimen. Despite these concerns, most of the health care professionals were willing to collaborate with traditional healers, as long as HCWs were solely in charge of the ARV drug regimen and trained traditional healers were only supporting them by providing symbolic rituals. ATHs, on the other hand, were in favour of a partnership with health care workers as long as such a partnership is based on mutual collaboration and respect. The study concluded that a partnership between traditional healers and the formal public health sector was feasible but must incorporate respect for cultural rights.

Hlabano (2013) conducted a qualitative study that explored traditional healers' perceptions on collaborating with bio-medical professionals in uMkhanyakude in KwaZulu Natal. Hlabano used purposive sampling to select the study participants; the study used an individual in-depth interview process to collect data. The reason for selecting traditional healers as the target population was to document their perception in collaborating with western health practitioners. The main findings of the study were that healers are very popular and highly respected amongst African communities and were also willing to collaborate with western health practitioners, whereas the latter were sceptical.

Makoa (2000) conducted an exploratory qualitative study that examined the perceptions, opinions and interpretations of traditional healers and nurse practitioners in relation to their collaboration in primary health care in Maseru, Lesotho. This approach to the study was appropriate in Lesotho because it revealed the values, traditions and customs that the traditional healers take into account during the healing process. It is the incorporation of these traditions and values that makes traditional healing a popular system. Hlabano (2013) and Makoa (2000) came to the same conclusion in their respective studies, which stated that the traditional practitioners were willing to collaborate with biomedical doctors, whilst the latter were sceptical as the former is not regulated.

3.3.3. Ethical considerations when collecting data

Ethical considerations are a code of conduct that researchers abide by when interacting with participants in the field. Öttinger & Christian (2011) define ethics as a code of behaviour that is considered to be correct when conducting social research. Ethics is also a preventative measure in place to ensure that researchers do not abuse or harm participants during the interview process of a research. It is important that all researchers are aware of the research ethics. There are certain ethical components that the researcher clearly articulates before, during and after the research process; those may include words such as "...informed consent, right to anonymity and confidentiality, right to privacy, justice, beneficence and respect for persons" (Fouka & Mantzorou, 2011, p.4-7). The researcher should respect the rights of research participants throughout the study. Privacy and confidentiality means that the researcher will not disclose the research participants' identities, and information that may embarrass or

harm them in any way. Wagner et al., (2012) conclude that it is the researcher's primary responsibility to ensure that the study does not harm the participants by participating in the research.

The University that the researcher affiliates with will always issue an ethical clearance letter to the researcher before the fieldwork can begin. This ethical clearance letter will include the name of the student, the study's approved research topic by the university, and how ethical the researcher will handle the vulnerable participants in the study. Secondly, the researcher must inform the research participants about the purpose of the study, and the intended possible use of the information that he/she is going to collect. The participants will contribute in the research voluntarily; they have a right to decline to participate and can stop the interview whenever they wish to.

A full explanation on the purpose of the research was given to the participants. A copy of the ethical clearance letter from Wits which outlined the title, purpose and objectives of the research was sent to all participants to secure the meetings. The individual's rights to confidentiality were guaranteed to all participants. In return, the participants gave this researcher consent that they were willing to participate and cooperate with the study; they signed a consent form attesting to this consent. The research participants were given assurance that this research would use the information collected consistent with the purpose that they were informed of and agreed to. The participants signed the informed consent form before the interview started, in which the participants stated that they agreed to be part of the study.

As this research did not directly deal with health issues, a second ethical clearance letter was not necessary. This research complied with all the required ethical components of the study. An ethical clearance letter was applied for and received from Wits University and produced to respondents, where needed. Attached to this report is a one-page bio of the researcher.

3.3.4 Data collection and storage

Research data collection is the process of collecting data from the research participants to answer the research questions. There are a variety of tools available to the researchers

to collect data from the field, and some of those tools are participant observations, interviews, focus groups and documents (Gill et al., 2008; Wagner et al., 2012). These research data methods are more popular in qualitative research than in quantitative or mixed research methods. Some of these methods provide the researcher with different options through which he/she can interact with the research participants. This interaction is to enable the researcher to either have direct or indirect contact with the participants in order to collect in-depth information.

The research data collected in this study required some level of data management to ensure that the data is secured accordingly and that good data management practices are followed. Managing data is an integral part of the research process. According to Van den Eynden, Corti, Woollard, Bishop, & Horton (2011), data management is how a researcher plans to collect, document, store and share the researched data. Data management can be challenging, particularly when studies involve several researchers, and/or when studies are conducted from multiple locations. How data is managed depends on the types of data involved, how that data is collected and stored, and how it is used, throughout the research life cycle.

As already stated above, this research on the ‘institutional arrangements for integrating traditional health practitioners into the South African primary health care system’ used a semi-structured interview process and a focus group to collect data. Individual face to face interviews were conducted with the thirteen participants in different venues. An individual interview took approximately 45 minutes to complete by each respondents. An interview guide was used to collect data from the research participants. Thirteen research participants were interviewed over a seven week period, from October 2016 to November 2016. Later one focus group interview was organised to verify some of the data collected. According to Gill et al., (2008, p. 293), focus groups are used to “...generate collective views and the meaning that lie behind those views”. The data collected for this research is stored on the computer and extended hard drive, which could be accessed through a password. Other information such as hard copies, are stored in a secured storage area and will be accessed only by relevant people.

3.3.5. Data processing and analysis

Data processing is a method of transforming raw researched data collected towards being useful information or knowledge (Hardon, Hodgkin & Fresle, 2004; Sridhar, 2007). The processing and analysis of data collected is an important step in research. Often researchers either under-process or over-interpret the data. Prior to conducting a study, a plan for data processing and analysis should be prepared. Such a plan helps the researcher to ensure that, at the end of the study, all the necessary information has been collected (Hardon et al., 2004). This means that the plan for data processing and analysis must be closely linked to the study's objectives and research questions. The procedures for analysis of data collected through qualitative and quantitative techniques are quite different. Qualitative data collection technique involves subjectivity, feel and flavour of the situation, and hence consumes more time and efforts for collection as well as processing (Sridhar, 2007).

The researcher's notes are expanded from interviews and/or involve transcribed tapes; the next step is ordering, describing, summarizing, and interpreting data obtained for each study unit or from each group of study units. Here the researcher starts analysing data while collecting the data, so that questions that remain unanswered (or new questions that come up) can be addressed before data collection is over. Preparation of a plan for data processing and analysis will provide the researcher with better insight into the feasibility of the analysis to be performed, as well as the resources that are required. It also provides an important review of the appropriateness of your data-collection tools.

In this research the collected data after the participant interviews were transcribed immediately. It took approximately one and half hour for this researcher to transcribed one interview and the data that was transcribed from the recording of the interviews and field notes taken by the researcher. The recording device was important as it assisted the researcher not to spend more time writing extensive notes. The transcription of thematic analysis was done to code the data, which ultimately resulted to the identification of themes.

According to Bryman (2012) and Wagner et al., (2012) there are four approaches to data analysis, and those are narrative analysis, thematic analysis, interpretative

phenomenological analysis and discourse analysis. These approaches are used to interpret data collected and they differ according to content. This research of institutional arrangements for integrating traditional healers into the SA PHC has used thematic analysis for interpreting data. The thematic analysis assisted the researcher to move from broad data towards discovering patterns and framing a specific research question. The themes on Chapter 4 came from the four broad questions developed in Chapter 1. Themes from question 1 and 2 produced three sub themes each. Question 3 and 4 produced one theme each. All of these questions were attempting to address the gap identified for this research, which needed to define how the traditional practitioners would be integrated and what role they would play in the SA primary health care system.

3.3.6. Description of the respondents

In this research, there were five different categories of respondents. The five categories were divided into District Health Department and national Health Department officials, western practitioners, traditional practitioners and ordinary citizens. The age of the research respondents ranged between 35 and 60 years. There were thirteen (13) research participants, all of whom resided and worked in Pretoria, Gauteng, South Africa. The qualification of the respondents ranged from Diploma to Doctor of Philosophy (PhD). The traditional health practitioners were interviewed first, the health care professionals from the National Department of Health and Gauteng District of Health were next, the western health practitioners were then interviewed, and I concluded by interviewing the South African citizens. These research participants, who were Pretoria residents, were identified and assessed as meeting this researcher's outlined minimum criteria, which included the need to understand the South African primary health care level and the traditional healing institution.

There were four traditional health practitioners, out of which two were lawyers; all the traditional practitioners who were interviewed had been practicing for more than ten years. These traditional practitioners had an understanding of what primary health care is, and had knowledge and good understanding of their own traditional healing industry. The four health care professionals included officials who are working at different levels of government –national and district level. These two levels of government dealt with primary health care system differently; those at national level concentrated on

development of policies, whilst those at district level were mainly responsible for the provision of PHC services to the communities. The officials who participated worked directly with the primary health care and traditional medicine programmes. There was one Director and one Deputy Director from national office as well as the nurse with over ten years' experience and a pharmacist with eight years of experience working at the district level.

The western health practitioners that the research targeted for the study were registered bio-medical practitioners with the Health Professional Council of South Africa; they were working in both public hospitals and ran their own private surgeries. They had a practising experience of over twenty years, another with over ten years working experience. Lastly, there was an entrepreneur and two South African citizens, both of whom understood both healing systems. The reason to approach the citizens was to understand where they support the inclusion of traditional practitioners into the SA health care system, especially at the District Health System.

3.4. Research reliability and validity measures

3.4.1 Reliability

Reliability relates to the accuracy and consistency of measure of the instrument used in the research, furthermore, it estimated the consistency of your measurement (Bryman, 2012; Wagner et al., 2012). If used on a similar group of respondents in a similar context, at a different time, the instrument should yield similar results (Shenton, 2004). Accurate and careful phrasing of each question to avoid ambiguity and leading respondents to a particular answer ensures reliability of the tool. Reliability is commonly used in quantitative research, whilst dependability is associated with qualitative research. According to Shenton (2004), dependability has been popularised by Guba and Lincoln; it could be achieved by using focus groups and individual interviews as overlapping methods. Wagner et al., (2012) states that Guba and Lincoln emphasis four criteria that should be used to ensure trustworthiness of the data collected, these are credibility, transferability, confirmability and dependability. Dependability in qualitative research relies on thick description of concepts. The respondents were informed of the purpose of the interview and of the need to respond truthfully in order to produce an outcome that is consistent. In this case a focus group was conducted containing six of the

interview respondents; the objective was to assess the dependability of the information collected.

3.4.2. Validity

According to Shenton(2004) & Wagner et al., (2012), validity means that the study should measure what it is supposed to be measuring. There are three types of validities, and those are content validity, criterion validity and construct validity (Wagner et al., 2012). As validity of research refers to the extent to which research conclusions can be considered accurate and generalizable, there are threats that can influence the validity of the research tools (Wagner et al. 2012). Such threats need to be controlled through the questions that should avoid or take influential circumstances into consideration; this will ensure that potential errors do not put research conclusion into question.

There are two kinds of validities that are relevant in such threats – internal and external validity. They apply in all three validities mentioned above, and such threats can be evident in either qualitative or quantitative research methods. Internal validity has to do with conditions present in the participant or their environment while the research experiment is in underway (Wagner et al., 2012). External validity, on the other hand, refers to the extent to which results can be generalised to other groups or settings. The popular terms for internal and external validity in qualitative research are credibility and transferability, respectively (Golafshani, 2003; Morrow, 2005; Shenton, 2004).

This researcher mostly focused on credibility, which refers to the accuracy with which an instrument measures the factors under study. Therefore, credibility will be concerned with how accurately the questions asked tended to elicit the information sought (Brink, 1993). This research instrument was tested in this research for its credibility in a pilot project conducted, where the researcher interviewed a national Department of Health official responsible for the establishment of primary health care system in all government health institutions as well as the ordinary South African citizen. External validity applies to this research by ensuring that questions asked produced outcomes that are credible and useful to the society in proposing a solution of addressing the shortage of health care workers at the primary health care level. In this case a focus group was conducted containing six of the interview respondents; the objective was to

assess the credibility of the information collected. This research covers external validity as this useful to the society.

3.5. Research limitations

The study's target population was around Pretoria. This research study only limited itself with research participants who consented to be part of research. The researcher did not interview all traditional health practitioners, as the sample already planned for interviews was diverse enough to produce reliable data; the second reason is that the differences in the categories of healers were immaterial as this did not influence the outcome sought. Not all western health practitioners participated in the process; the study only interviewed a sample of western practitioners who were already directly working with primary health care processes. Measurement validity will be a limitation to this research as it applies primarily to quantitative research and to the search for measures of social scientific concepts (Bryman, 2012).

4 PRESENTATION OF RESEARCH RESULTS

4.1. Introduction

The data collected for this study is intended to address ramification resulting from a gap identified, which is how will the traditional health practitioners be integrated into the South African primary health care level, and what role will they play once integrated to address the shortage of health care workers at the primary health care system? This research proposed solution to this challenge is the integration of multitudes of traditional health practitioners into the primary health care (PHC) system to supplement the current western health care workers. This multitude of traditional practitioners is confirmed by Kale (1995); Meissner (2004) and Moagi (2009) where they state that there are about 350 000 traditional practitioners in South Africa. These traditional practitioners consult up to 80% of the country's public on a regular basis throughout the country (Pinkoane et al., 2012; Pretorius, 1999; WHO, 2002). There are approximately 350 000 traditional health practitioners in South Africa, compared to the current 32 000 or less western practitioners (Meissner, 2004; Pinkoane et al., 2012b).

The data of the study was collected around Pretoria. This city is part of the Gauteng Province and consists of seven regions; these are Region 1 (Akasia, Beirut, Soshanguve, Ga-Rankuwa, and Mabopane), Region 2 (Hammanskraal), Region 3 (Atteridgeville and Lotus Gardens), Region 4 (Centurion, Laudium and Olievenhoutbosch), Region 5 (Cullinan and Roodeplaat), Region 6 (Mamelodi and Eesterus) and Region 7 (eKangala and Bronkhostspuit). The research participants for the study were sourced from Region 1, 3 and 6.

This section presents crucial information that was sourced from research respondents' answers to questions raised to them about the country's 'formal' and 'informal' primary health care systems. Out of the four main broad questions outlined in Chapter 1, which were developed to elicit a representative outcome from respondents, six specific questions were derived out of the four, excluding questions on the individual's demographic details. The purpose of these six questions was to receive answers that would address the gap identified for research.

4.2. Aspects underlying the integration of traditional health practitioners within the 'official' primary health care system

What are the components that need to be considered in order for the traditional practitioners to be integrated into the 'formal' primary health care system to alleviate the shortage of health care workers? The mix pool of research participants were expected to produce varying core aspects upon which this integration depended on in order for primary health care services to be efficient and effective. The following information is an excerpt of salient varying recorded aspects from the five different participant categories.

4.2.1 Establishment of a regulatory structure for traditional practitioners

The South African government officials were asked why the integration of traditional practitioners into the national public health care system had still not taken place, whereas proposed government policies, such as the National Health Plan of 1994, the White Paper on the Transformation of the Health System in SA of 1997, and the National Health Bill of 2001, had been introduced as far back as 1994, and, what difference would it make once implemented now. The government representatives agreed that the integration of traditional health practitioners into the national public health system had taken a long time to be implemented; however, this was due to the fact that systems, such as regulator body, had not yet been put in place to accommodate the traditional healing institution. One of the obstacles that prevented the implementation of these policies was lack of a regulator under whom this 'informal' traditional health care institution, including its practitioners, would be regulated. This statement supports that of Mokgobi (2014) where he stated that, for traditional practitioners to be accepted as part of the national health care system, they need to be regulated so that consumers are adequately protected from abuse and malpractice.

The Director went on to say that, it was as a result of this lack of regulation of the traditional healing institution that the national Department of Health introduced the Traditional Health Practitioners Act of 2004, which was later amended in 2007 (Act No. 22 of 2007). In 2013, the national Department of Health started with the implementation of the Act, by establishing an Interim Traditional Health Practitioners Council (ITHPC). The Council's responsibility is to be a regulatory body that would regulate the traditional practitioners as individuals, as well as the traditional healing

practice. Some of its functions are to issue licences to practice, approve training, and introduce disciplinary measures to suspend offending members of the profession (national Department of Health, 2007; Moagi, 2009). The Interim Traditional Health Practitioners Council (ITHPC) is a body that is equivalent to South Africa's western medical practitioners' regulatory body called the Health Professions Council of South Africa (HPCSA). The responsibilities of both Councils are to implement the Department of Health's regulatory frameworks, which is contained in their respective Acts.

According to the Department of Health representative, the introduction of the Council will serve to fulfil the government's promise of bringing the traditional practitioners and their institution in line with the above mentioned policies and the Council's regulatory framework. Once the regulatory framework is in place, traditional practitioners and their practice will be able to operate parallel with the western practice and practitioners. He went on to say that, as the Council's regulatory framework will affect every traditional practitioner and his/her practice in the country, this change will bring multitudes of positive aspects that will facilitate majority of the obstacles that were facing the traditional practitioners and their practice. The Director explained the traditional practitioners Council's immediate functions will include the introduction of systems that would assist itself in the commencement of being a regulator. The systems to be established by the Council for its functionality will include the identification of an office, appointment of support staff and development of a database of traditional practitioners around the country according to their specialisations. The national Department of Health statement comes on the heels of Moagi (2009, p.119) who, following the enactment of the Act in 2007, wrote that "...the ITHPC exist to further the interest of the profession and its members by paying salaries, ensuring conditions of employment, holding annual conferences and organising meeting for its members..."

When all these components of regulations have been put in place, the Council will then facilitate the integration of traditional practitioners into the primary health care system. He confirmed that the national Department of Health has opted to introduce and promote a parallel system, instead of an inclusive system of integrating traditional practitioners into the country's national primary health system. He said, "...as the Department of Health, we prefer to promote both traditional and western healing

systems that are running parallel instead of being inclusive within the primary health care system. The traditional healing system will mirror the western system, while each will be operating separately within its own system. The national Department of Health intend on establishing traditional public care facilities that will be run by the traditional practitioners themselves.”

The national Department of Health’s representative concluded by saying that the introduction of the traditional health care facilities will benefit a number of stakeholders, especially the public, for whom the Act and the new facilities were introduced; SA citizens will have a choice of visiting either a western or traditional health care facility. The Department will further promote referrals of patients from a traditional practitioner to a western practitioner, and vice-versa. Once the traditional health practitioners are fully regulated and challenges facing them have been addressed, the government will then consider introducing other facilities that were only extended to western practitioners. These facilities will include the writing of prescriptions, recognition of medical leave notes to patients, acceptance of medical insurances, to name a few.

Whilst the Council is still waiting for funds from the South African Treasury to commence its duties of addressing the issue of capacity, the Traditional Medicine Directorate from the national Department of Health, which already has its own responsibilities that are closely related to the functions of the Council, will continue to take the role of a Secretarial on behalf of the Council. The Directorate is currently continuing with the introduction and implementation of some tasks on behalf of the Council. This assistance is being managed through a service level agreement signed by the Department and the Council.

The rest of the research participants agreed that the traditional healing institution needs to be regulated to protect traditional practitioners and the public. All the traditional practitioners that were interviewed supported the establishment of the Interim Council, while some were not happy with the pace that it was taking to implement its work as it had been appointed in 2013. One of the traditional practitioners said “since the Council has been appointed in 2013, it has not visited practitioners in the provinces and informed them about the progress they have done since they have been in office.”

4.2.2 Transformation of the traditional healing institution

All research respondents in this study agreed that integration of traditional practitioners into the primary health care level has a long way to go before it can be achieved by the country. They stated several reasons that are mentioned below.

Traditional healing institution's need to be transformed from an 'informal' to 'formal' practice: the Director from the national Department of Health qualified this by stating that this can be achieved by regulating and registering all traditional practitioners into a national database called a national register, which will be controlled by the Interim Traditional Health Practitioners Council (ITHPC). The ITHPC would ensure that the traditional practitioners provide quality health services (Republic of South Africa - national Department of Health, 2007). According to Ingle (2009) the traditional surgeries should be run as small enterprises that will comply with all the rules and regulations of the country. Some of the compliance will include registering their companies with the Companies and Intellectual Property Commission (CIPC). They must also register with the South African Revenue Services for personal income taxes.

There is a need for a regulatory body that would result in traditional health practice complying with accepted health care standards. The government officials, western practitioners and the traditional practitioners welcomed the fact that the Council will be responsible to issue registered traditional practitioners with licenses to practice, once they meet all the pre-requisite of the regulations. The Council will also approve the training that should be offered to the traditional practitioners, as well as to discipline and suspend offending members (Moagi, 2009; Republic of South Africa - national Department of Health, 2007).

The national Department of Health official said that the *standardization of education and training for all traditional practitioners* was necessary. He said that the Traditional Health Practitioners Regulation of 2015 had set out minimum standards for the qualification of traditional practitioners. The regulation further outlines the minimum requirement for training of practitioners in all the four categories of the profession. Traditional practitioners emphasised that there is a need for them to be adequately trained on the basic western health care services in order to be able to serve the patients consistent with the western practice. These training areas would include patient diagnosis, taking

vital signs, use of stethoscope and basic primary health care services. Western practitioners insisted that the Council should ensure that *traditional health products should be standardized in the way that they are produced, packaged and measured*. This may even include approval by the South African Bureau of Standards (SABS) and the Medicine Control Council (MCC), if conformity and standardization within the traditional practitioner environment has to be achieved (Richter, 2003).

The government officials conceded that the national Department of Health has a long way to go towards achieving the formalisation of traditional healing as an alternative health care system as it has budget implications. On the other hand, traditional practitioners felt that the government was not taking them seriously as their integration into the public health care system was proposed as far back as 1994. As such, their integration into the country's health care is long overdue, and that it should be an issue of when they will be included, than whether or not they will be included in the national primary health care system. All participants agreed that the traditional practitioners have a role to play within the public health care system but that role was defined differently, depending on who you spoke to.

4.2.3 Re-organisation of the South African 'formal' primary health care system

Following the establishment of the ITHPC to regulate the traditional healing institution according to the Traditional Health Practitioners Act and the national Department Health statements, as well as participants' opinions on how the traditional healing institution should be transformed, as stated above, the next question asked to the research participants was on how the country's primary health care system should be restructured to accommodate the traditional health care system through a parallel system.

One district health care official, a pharmacist, felt that some of the policies within the primary health care level were creating some challenges, such as the fact that there is no control of patient movement residing in one service area moving to another area to get health care service or medication. This normally results in other health care centres within the districts spending more than their allocated budget funds, while others have a surplus due to those patients who have opted to receive health care from other centres outside their areas. He went on to say that "...shortage of health care workers is also

exacerbated by the provincial governments' inaction towards replacing health care professionals who go on retirement or resign, as a result, the system continue to serve patients with less capacity and resources.” This statement supports Kautzky & Tollman, (2008) when they state that an assessment that was conducted by World Health Organisation (WHO) in 2003 find out that 60% of health care institutions in SA struggled to fill existing posts, with more than 4 000 vacancies for general practitioners and upward of 32 000 vacancies for nurses throughout all provinces.

The district official concluded by stating that, when the parallel system is implemented, the existing PHC system would have to make some changes as well, and these would include the health care professionals working at all levels of public health care acknowledging that there is another alternative health care system, which would be consulted by some patients. The South African population depend on pluralistic health care (Campbell-Hall et al., 2010; Kale, 1995; Meissner, 2004). The national Department of Health's Director and one of the traditional practitioners, both agreed on the fact that, in light of the proposed referral system that will be put in place to engender a fluid working relationship between the western and traditional health care systems, there should be a cross referral system between the two healing systems, whereas, at this moment, only traditional practitioners refer patients to the community health centres and the clinics (Gyasi et al., 2011; Kale, 1995; Meissner, 2004). The Director went on to say that, “...outside of the Council, a coordinating body consisting of both western and traditional representatives will be established; this body will be responsible to explore on how the two systems will pull their resources together, as well as how to put systems in place to exchange efforts on the transfer and referral of patients between them.”

One of the traditional practitioners felt that all other stakeholders are represented in the existing PHC outreach team; she stated that, they too should be part of the stakeholders that are represented in this outreach team. The role of the PHC outreach team is to promote good health and prevent ill health through a variety of interventions (Pillay & Barron, 2011). The national Department of Health's official conceded that implementation of the Act in its endeavour to restructure, not just the traditional health system, but the whole country's health care system, will be “...an arduous task that will, in one way or another, affect all stakeholders.” He said that, in light of this mammoth task, the Council's responsibilities will include reorientation training programmes for the

nurses and other public sector health personnel on traditional healing and traditional medicine, which will help trainees to be able to understand the basics of the traditional healing institution. Muluadzi (2001, p. 18) corroborate the above-mentioned view when she stated "... there is a need to include traditional healing as a field of medicine taught in nursing schools, Technikons & universities."

4.3 Proposed approach of integrating traditional health practitioners within the 'official' primary health care

All those interviewed offered different opinions on the best approach of how traditional practitioners could be part of the 'official' primary health care system. As the interviews proceeded, it was clear that integration meant one thing to one participant, and something different to the next. For instance the national Department of Health proposed a parallel system that would serve as some form of integration.

4.3.1. Establishment and implementation of a parallel health care system for the traditional practitioners

The Department of Health officials expressed the need for traditional practitioners' participation within the public health care system, and indicated that plans were already underway for a parallel than an inclusive PHC system within the country. This introduction of a parallel system has been discussed within the Department and the ITHPC but has not been discussed with the traditional practitioners in the country. However, according to Ingle (2009) and Summerton (2006) full integration could be inclusive or parallel. An inclusive parallel system is where traditional and western practitioners are legally recognised and traditional healing has not been fully integrated into all components of public health care (Summerton, 2005; WHO, 2002). A parallel system, on the other hand, is where traditional and western practitioners work parallel and independently but provide the same health care service to patients; they also have some form of a cross referral agreement with the existing system (Kale, 1995; Summerton, 2005; van Rooyen, Pretorius, Tembani, & Ham, 2015).

The national Department Health officials further explained that the success of this parallel system will rely mostly on the implementation of the government's Traditional Health Practitioner's Act of 2007 (Act No. 22 of 2007) by the Interim Traditional Health Practitioners Council (ITHPC), which was established by the Department of

Health. The Act was established to legally recognise traditional practitioners as part of health care contributors towards the public health care system of the country. The responsibility of the ITHPC is to function as a regulatory body, which will issue traditional practitioners with licences to practice, approve all training to be provided to the traditional practitioners, as well as discipline and suspend offending members of the profession. The Council will be further responsible to implement and manage the traditional parallel health care system through the Traditional Health Practitioners Regulations of 2015.

When asked what the difference between inclusive and parallel system was, the Department of Health official stated that, with an inclusive system, traditional practitioners would operate within the 'formal' PHC system in whatever capacity they would be assigned. However, the 'formal' PHC system is not designed to accommodate traditional practitioners. With the parallel system, on the other hand, traditional practitioners will operate as they are operating today, however, their practices would be functioning under a regulated system accountable to the ITHPC. He said that, through the parallel system, all the practitioners, wherever they may be in the country, would be formalised, once they have applied and approved to be a member of the Council. They would be listed in a database of categories of traditional practitioners of the Council, which would issue each qualified traditional practitioner with a licence to practice. The Council will, as it is the norm with the HPCSA practice, ensure that standards of operation are set and rules and regulations are put in place to ensure that traditional practitioners function within this regulated system. The achievements of the ITHPC in regulating practitioners will also depend on the willingness of the traditional practitioners to participate in this system, as well as the necessary training that will be provided to enable them to understand the western PHC operations. He concluded his response on this question by saying that success will also rely on the healers' cooperation and collaboration with the Council.

The district health officials and western practitioners, on the other hand, spoke of the traditional healers' participation within the PHC system and stated that their participation should be limited to informal than integrated. They also felt that the two healing systems are not ready to be integrated. Their view is that integration of the western and traditional systems is premature due to a number of challenges facing this

traditional healing system, such as lack of regulations. However, based on the western view, traditional practitioners' unrecorded success in patient healing and lack of western training in human physiology purely disqualifies them in delivering an equivalent care to that provided by the western practitioners.

Traditional healers did not concur with the western healers' concerns when it comes to their participation within the PHC system. They believe that PHC system would benefit and function better with the participation of traditional practitioners if they are integrated. They believe in practicing within a regulated system, which would ensure compliance within the traditional practitioners' fraternity, while consider the holistic healing of their institution's. However, they believe in a gradual integration system that recognises the traditional practitioner's prior learning and experience in patient care. They believe that they should be afforded basic training on the use of equipment as practiced in community health centres and western health care systems, including training on taking patient's vitals, patient health history recording process and relevant administration. Through the Council, such training should apply to all traditional practitioners in order to ensure conformity and standardisation within all traditional practices, regardless of whether or not they are affiliated with the PHC system. In addition to working within the PHC environment, they still want to run their own private practices within their indumbas (traditional practitioner's working surgery existing within their homestead or homes). Traditional practitioners also felt that western practitioners should be trained on how they function so that their practice can be better understood, especially by the western practitioners.

4.3.2. Introduction of traditional health care at the District Health System

Collective responses of the interviewed participants were that this 'informal' traditional healing institution is an important human resource within the public health care of the country, which cannot be ignored. This participants' opinion reinforced Pretorius, (1999) and Summerton (2006) statement that traditional practitioners are an "important source of health care for many South Africans. Thus, they are a health resource in this society." The interviewed participants agreed that there are challenges facing traditional practitioners and those challenges need to be addressed before the traditional healing institution is integrated within the primary health care system through a parallel system. With the exception of the traditional practitioners, the public and the national

Department of Health officials, the rest are of the view that practitioners should not be integrated into the country's PHC system, but they should be recognised as part of the alternative health care system. Other participants that suggested that traditional practitioners should be integrated into the PHC level were supported by the previous studies when they suggested that traditional practitioners are more suited to serve the public at the PHC level as they are already providing similar services (Dookie & Singh, 2012a; Meissner, 2004; Pretorius, 1999; WHO, 2002).

The national Department of Health officials and the traditional practitioners emphasised that, for the ITHPC to be effective in regulating the traditional institution, traditional practitioners have to be willing to be part of the regulated system and be registered with the Council. The profession will be regulated under the Traditional Health Practitioners Regulations of 2015. One of the regulations (Republic of South Africa - national Department of Health, 2015, p. 2) stated that "...any person wishing to be registered as traditional health practitioners must apply to the Registrar to be registered and practice as a Practitioner..." This supports Ingle (2009) that traditional practitioners should comply with the Council's rules and regulations.

4.3.3 Expectations of traditional health practitioners from government

The national Department of Health officials confirmed that, under the parallel system, which will be implemented to accommodate traditional practitioners within the national public health system, the government's responsibility would be to establish infrastructure for traditional health care facilities. These health facilities will be run by traditional practitioners themselves. They will provide South African citizens with a regulated alternative health care system. The government will be working closely with the Interim Traditional Health Practitioners Council, which is the regulatory body of the traditional healing profession. One of the responsibilities of this Council is to continue to develop its members. The government, through the Traditional Medicine Directorate, and the ITHPC are responsible to continue to avail financial resources to enable researchers to continue to develop knowledge on this sector.

Other research participants expected the government to allow traditional practitioners to participate in the public health care system, especially on the primary health care system, which are already providing services to the communities. The western

practitioners and district officials supported their idea but emphasised that their role should be limited.

4.4. The role of the traditional health practitioners in primary health care

All research participants interviewed on this study agreed that traditional practitioners have a role to play within the ‘official’ public primary health care system. Some of the participants stated that traditional practitioners should augment the existing health care professionals within the primary health care (PHC) system as needed as they are already providing ‘unofficial’ primary health care services. They also indicated that this should only be the case if they are adequately trained on the basic components of the western health care system, such as how to take vital signs and diagnose the patients, otherwise they should be confined to the parallel system. For instance, one of the traditional practitioners, who is a lawyer, stated that “...we are already providing primary health care services to our communities and the government needs to acknowledge that. We are the primary health care givers and some of our services are better than those being provided in the clinics as they are broad and include counselling, mediation within families, psychiatric services, and diagnosis.” This statement confirms Yeboah (2000a) when he stated that traditional practitioners serve as counsellors, social workers and skilled psychotherapists as well as custodians of indigenous knowledge systems.

However, each group of participants defined traditional practitioners’ role in the PHC as either formal or as informal. The district government officials and western health practitioners concurred that the role of traditional practitioners should be informal and limited to basic primary health care services, such as being counsellors, taking vital signs of patients visiting the formal clinics, and referring patients within their practices to formal clinics. One of the western practitioners further stated that the role of the traditional practitioners should be “limited to sub-primary”. He was supported by a pharmacist in his statement when he said “...one of the challenges I have identified with traditional practitioners was that they refer patients to clinics for consultation very late, to an extent that, by the time the physicians or even hospitals see them, they are very dehydrated and suffer from diarrhoea.”

While ordinary citizens and traditional practitioners saw the role of traditional practitioners as being more than just counsellors; the latter felt that they could play roles

from a staff nurse to Matron in charge of the health facility within a District. An older traditional practitioner from Mamelodi explained that "... traditional practitioners' participation within the PHC level should be based on a practitioner's choice as they are trained differently." This role that traditional practitioners see themselves playing within the PHC is supported by different authors and different policies. For instance, Meissner (2004, p.902), states that "...traditional practitioners can treat different illnesses and educate people in various aspects of preventable conditions." All the research participants went on to agree that the traditional practitioners cannot be ignored as they were used and continue to be used by communities to treat different ailments. According Mokgobi (2014); Pretorius, 1999; and Truter (2007a) between 70% and 80% of Africans utilise the services of traditional practitioners for different spiritual reasons.

All four traditional practitioners that were interviewed agreed to be part of the cross referral system within the two healing systems, however, two of them felt unsure of being part of the merger. It is unclear as to whether they were unsure of the benefits to be derived out of integration, or maybe they treasured their independence much more than to be integrated. Some even felt that a system similar to the parallel system would be better than to be integrated. On the other hand, western health care workers and western practitioners preferred that only traditional practitioners should refer patients to the western practice system, but the opposite should not happen as the traditional practitioners level of expertise cannot be verified at this stage.

4.5. Anticipated value-added of the traditional health practitioners in the South African primary health care system

The collective view of all the interviewed participants was that the integration of traditional health practitioners into the SA primary health care system will address the shortage of health care workers at this level of service. The value added will be two-fold: first, there will be an increased human capacity within this level of health care, which will result into improved, efficient and faster health care service delivery to the communities; it will also reduce the long lines of patients waiting to be served. The increased human capacity within the health care is confirmed by Meissner (2004) when he stated that there are approximately 300 000 traditional practitioners compared to 32 000 western practitioners as registered with the Health Professions Council of South Africa (HPCSA) in 2003.

According to the government officials interviewed for this study, South African citizens' health needs will be served better through the implementation and functionality of a parallel health system which will provide them with a choice of western or traditional health care services. As a result, there will be efficient and affordable traditional health care facilities closer to people's homes, while the formal primary health care will be there to provide the rest of the country with any other health care not provided by the regulated traditional health care. These facilities will complement each other, as well as provide standardised primary health care services in the country. The western practitioners saw the value-add of the integration of traditional practitioners into the PHC system as the South Africans will have alternative health care services. The traditional practitioners' views were that, for the first time, they will receive recognition and respect from government, western practitioners and citizens, which they have long been waiting for. By working with western practitioners within the same environment, their patients will receive the same benefits that have been afforded to the western practitioners' patients, such as the use of medical insurance, issuance of sick notes, etc. Furthermore, the fear and shame of patients who wanted to visit traditional healers during the day will disappear.

They believe that PHC system would benefit and function better with the participation of healers who have addressed their challenges. They believe in practicing within a regulated system that is equivalent to the government's Interim Council, who would ensure compliance within the traditional practitioners' fraternity.

4.6 Conclusion

This research collected data to answer a gap identified in the literature review, which is how traditional practitioners would be integrated into the South African primary health care system, and what would be their role once integrated. The key questions to answer were to delineate the underlying aspects towards this integration, outline traditional health practitioners (THP) proposed approach of integrating them into the primary health care (PHC) sector, define what role the THP would play into the PHC, and what value, if any, this integration would bring towards the national health of the country.. The integration of THPs into the SA PHC has been raised by government as far back as 1994 through different policies, but those policies had been dormant. In 2004, the government introduced the Traditional Health Practitioners Act of 2004, which was

later amended in 2007 (Act No. 22 of 2007). The Act was introduced to establish a regulatory body of the profession and its practice. It was responding to one of the challenges raised by different stakeholders and the past research that said that the traditional healing institution is unregulated, and functioned on an informal basis, among other challenges, whereas it is used by 70% to 80% of the country's population (Mokgobi, 2014; Pretorius, 1999).

Following the introduction of the Act, an Interim Traditional Health Practitioners Council (ITHPC) was established in 2013 by the National Department of Health. This is a body that is equivalent to South Africa's western medical practitioners' regulatory body called the Health Professions Council of South Africa (HPCSA). The objective is to regulate the traditional practitioners as individuals, as well as the traditional healing institution. This would include issuing licences to practice, approval of training and disciplining and suspending offending members of the profession. Through this Council, the government would be fulfilling its promise of bringing the traditional practitioners and their institution in line with the health policies. Once the regulatory framework is in line, traditional practitioners and their practices would be able to operate parallel with the western practice and practitioners. The responsibilities of the Council are to transform the traditional healing institution through the Traditional Health Practitioners Regulations of 2015. This regulation would enable the THPs to be recognised as part of the health care workers, and will provide them the platform to participate in the public health system.

The National Department of Health has proposed a parallel system, which is one form of integration. This means that the Department of Health, on behalf government, is promoting the traditional and western healing system to run parallel instead of being included into the primary health care system. The introduction of these facilities will enable the SA citizens to have a choice of visiting a western or traditional healing facility. Once the traditional health practitioners are fully regulated and challenges facing them have been addressed, the government would then consider introducing other facilities to them, which were only extended to western practitioners.

All research participants agreed that THPs have a role to play within the 'official' primary health care system. However, they were divided on what role the THPs will play

in the future, whether it would be formal or informal. The THPs felt that some of their services were better than those provided within the 'official' PHC system. The collective view of all the interviewed participants was that the integration of traditional health practitioners into the SA primary health care system would address the shortage of health care workers at this level of service. Other value added would be an increased human capacity within this level of health care, which would result into an improved, efficient and faster health care service delivery to the communities and it, would also reduce the long lines of patients waiting to be served in clinics.

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5 DISCUSSION OF RESEARCH FINDINGS

5.1 Introduction

This chapter presents the interpretation of the research findings which were based on the theoretical framework that was highlighted in Chapter 2. The interpretation is divided into the following four categories: first, aspects that should inform integration of traditional practitioners within the primary health care system; secondly, the approach that should be followed to integrate THPs; thirdly, the role that will be played by THPs within the PHC; lastly, the envisage value-add of integration of THPs.

5.2 What aspects should inform integration of traditional health practitioners within the ‘official’ primary health care system?

The essence of this question was to identify components that are essential in facilitating the integration of the traditional health practitioners into the SA primary health care (PHC) system. Three components were identified from the data collected; the first was the establishment and functionality of a regulatory body of the traditional practitioners, transformation of the traditional healing institution was the second, and the third was the re-organisation of the SA PHC.

5.2.1 Establishment of the regulatory body, ITHPC of the traditional practitioners

In this case, the theory that applies is Kurt Lewin’s Change Theory. Lewin introduces a three-step change model, which is unfreeze, change and refreeze (Schein, 1968). In the first stage, the organisation under review is assessed to understand how it functions; existing challenges are identified; internal and external stakeholders are sensitised about the challenges identified; finally, recommendations are made on how to resolve the challenges. Stage two is about implementation of recommended changes, and the third stage is about reviewing the impact of the changes made. Lewin’s Change Theory is supported by Lippitt’s seven step Phases of Change Theory, which focusses more on the role and responsibility of the change agent than on the evaluation of the change itself; information is continuously exchanged throughout the process (Kritsois, 2005).

This study only followed stage one of Kurt Lewin’s Change Theory, which includes the understanding of the organisation, identify challenges within the organisation, sensitise

the stakeholders and make recommendations that will resolve the challenges identified. This was because this stage was more relevant to our study than the other two stages. As mentioned in 4.2.1, the integration of traditional practitioners into the PHC system depends on the establishment and functionality of the regulatory body, which would be in charge of regulating THPs and their practices. This body, ITHPC, was established in 2013 through the Traditional Health Practitioner's Act of 2007. One of the responsibilities of the Council was to develop the regulations and establish an office that will support their operation; however, their only achievement was the introduction of the Traditional Health Practitioners Regulations of 2015. As per Kurt Lewin's model of change, the first step of assessing the need for change within the national health system, especially in the PHC, was followed by government, where it appointed the ITHPC. The Council, in turn, developed draft regulations, which have not been finalised as they are still at the public comments stage.

The regulations' objective is to stipulate the criteria that need to be met by traditional practitioners in order to be registered with the national traditional practitioners register. It further outlines categories of traditional practitioners, it lists all the rules and regulations that practitioners should always abide by in order to be compliant and remain licensed with the Council and minimum standard of education and training required for a student to be accepted as a trainee (Republic of South Africa - national Department of Health, Regulations of 2015). However, the government is yet to sensitise internal and external stakeholders about the impending changes, which is the integration of traditional health care with the 'formal' western health care system. This integration process will only be effective if it is implemented in partnership with the ITHPC, the District Health System (DHS), traditional and western practitioners. It then follows that the Council need to be stable to be able to participate in this process. This study recommends that the government has to fully capacitate the Council to enable it to establish a fulltime office that is expected to support its work.

5.2.2 Transformation of Traditional Health Care

When you transform an organisation, it means you bring some changes that are needed so that the organisation can achieved its goals. When an organisation is being reviewed for its effectiveness, it means you are reviewing the structure and the policies using organisational and institutional theories. According to Lawrence & Shadnam (2008, p.

2288 -2289) institutional theory is a “theoretical framework for analysing a social event, which comprised of rules, practices and structures”. Lawrence & Shadnam’s (2008) statement is corroborated by Suddaby (2010) when he states that institutional theory is used to study an organisation’s structures, processes, and functions whether or not it achieves what it was established for.

According to the findings highlighted in paragraph 4.2.2, traditional health care needs to transform itself to be able to be integrated into the PHC system and complement western health care. This system is in the process of being integrated with western health care, the latter, on the other hand, has been regulated over centuries and have well-documented traditions, literature and training systems which can be studied and continued (Ingle, 2009). Traditional health care has also a long rich historical and successful health provision background that has a strong following among the Black community in South Africa. However, a number of challenges were stated by the research participants, including authors during literature review. The findings identified key requirements necessary for the transformation of traditional health care system to be integrated into the primary health care; these findings, which were emphasised by all the research participants, would facilitate the implementation of this process. The collected data identified four areas that are a pre-requisite for this transformation; they were as follows: this practice should move from practicing within the informal sector towards incorporation as a formal health care provider. Secondly, this sector need to comply with accepted health care standards, thirdly, the training and education provided to the traditional practitioners should be standardised. Lastly, the traditional health products should be standardised. These are components that are necessary to improve and/or reorganise an organisation’s institutional content

Institutional theory is the relevant theory that was applied. This theory involves a deliberate effort to incorporate knowledge at the organizational level so that it may persist and be available for future re-use. Institutional theory further refers to the inner workings of an institution within an organisation and its collective knowledge. As this traditional structure was fragmented, even though traditional practitioners shared a common knowledge on the key principles of traditional healing, incorporating various practitioners’ knowledges would improve upon this institutional structure. For these conditions to be placed before the THPs for compliance, it means that such compliance

will only strengthen the way the institution operates, including how practitioners practice medicine, including the standardisation of medicinal products and training curriculum.

5.2.3. Reorganisation of the ‘formal’ western primary health care

As traditional health care is in the process of being integrated into the PHC system, this means the country will have two health care systems that will provide health care services to the SA citizens. The changes that are recommended affect the existing health systems, which are the western healing and other health structures that fall under the District Health System. By the traditional practitioners’ integration into the PHC system, thereby bringing its own institutional knowledge of healing, the DHS and the PHC management and employees will have to make informational adjustment to all the western systems in general. This may come in the form of training on basic traditional health care services so that the differences in the provision of health care can be understood and accommodated, or in other forms of informational dissemination. It is important for the current ‘formal’ PHC system to re-organise and prepare itself to accommodate these changes.

The DHS, on the other hand, have to go even further by instituting some organisational structural changes within itself and in the ‘formal’ PHC structures in light of the areas of collaboration, especially on cross referral system and formal coordinating mechanisms that the two systems will be participating in. The responsibilities of some managers would have to be amended, increased or even decreased as they will also be managing the resources and human capacity within the traditional health care facilities. In some instances, those knowledgeable in traditional practice may have to be brought in to offer these training programmes. This statement supported Robbins & Barnwell (2006, p. 7) when they stated that organisation structure is about “how tasks are allocated, areas of responsibility and authority, reporting relationships, and the formal coordinating mechanism and interaction”.

The theories that were applied here were the institutional theory and organisational theory. As stated above, institutional theory involves a deliberate effort to incorporate knowledge at the organizational level so that it may persist and be available for future re-use. Organisational theory, on the other hand, is a process of analysing the structures

of the organisations, how they function and perform to deliver on what they are intended to do and the behaviour of groups and individuals within them. The changes that are about to happen at the DHS, the PHC level, hospital and other facilities under the DHS, with regard to the training that will take place in order to understand the traditional system, will all improve upon their institutional memory, thereby relating to the institutional theory. On the other hand, all the physical changes that the DHS will have to conduct relate to the organisational theory.

5.3 How should the traditional health practitioners be integrated into the ‘official’ primary health care system?

5.3.1 Establishment and Implementation of a Parallel health care system for traditional practitioners

According to Robbins and Barnwell (2006, p. 60), “Institution Theory is organisational responses that are often repetitive and products of past actions and practices”. They go on to say that those responses become institutionalised as a result of social pressures to conform. Based on this theory, the government develops some policies following pressures from certain lobby groups to address certain needs. In case of South Africa, the government was lobbied by the traditional practitioners and citizens to develop the Traditional Health Practitioners Act of 2007 that would facilitate integration of traditional practitioners into the PHC system.

Based on the 4.3.1 findings, the government opted to integrate traditional practitioners into the PHC system through a parallel system. In a parallel system, the traditional and western health care systems will function independently and co- exist within the same primary health care system it means that a new integrated health care system has been developed. This means that in the parallel system, the traditional health care system will function along-side the western health care system; it will be independent, in mutual recognition and respect to western public and private health care systems (WHO, 2002). Previous studies have shown that, in South Africa, traditional and western health care has always been working parallel (Campbell-Hall et al., 2010; Summerton, 2005). On the other hand, this parallel system that Campbell-Hall et al., (2010) refer to was not under government regulation, which would have made it a formalised system. With this development, new institutional information will be brought into this integrated health

system, especially as the ITHPC will be responsible in developing regulatory guidelines within which the traditional practitioners will operate. For the two health systems to be able to provide better services they have to develop a strong working relationship that complements each other's strengths; this means that they will be part of a new integrated system. Robbin and Barnwell (2006, p.11) state that "...a system is a set of interrelated and interdependent parts arranged in a manner that produces a unified whole". This proposed traditional health care system still has to be promoted; it also needs a buy-in from the traditional practitioners in the country.

5.3.2 Introduction of traditional health care at the District Health System

As traditional practitioners are already providing 'informal' PHC services to their communities, it means that the parallel system will have to be implemented first at the district level. According Pillay & Barron (2011), the District Health System is the 'institutional vehicle for the delivery of the PHC. PHC is the first contact for a patient to receive medical care within a public health care system. Primary health care services are provided by the District Health System, which is in charge of district hospitals, community health centres and clinics. The services being provided at the PHC level include comprehensive care, prevention, promotion and rehabilitative care within the context of community participation and multiple stakeholder collaboration (Dookie & Singh, 2012b; Keleher, 2001; WHO, 2008).

By the traditional health care, which is an informal health care system, being introduced into the formal PHC system, it means that two components will be introduced. The first is that the traditional health care will move from informal to formal where it will function according to standardised guidelines of health care, secondly, the PHC will receive a complementary system and new knowledge. The fragmented structure that the traditional system operated under will now operate according to the DHS operational guidelines. These changes are related to the Institutional theory model as the introduction of a new knowledge into the PHC will affect the current institutional content.

Once the entry point for the implementation of the parallel system has been established and agreed upon by all stakeholders, the next point will be to outline how the traditional health care system will be offered to the public. Within this parallel system, the

traditional health care will be guided by, and will operate under the Council's authority, which will endeavour to ensure that the health services offered are at par with not just western health system, but are consistent with its rules and regulations. Operating under the Council, the traditional health care will be regarded as a formal health care system if it is compliant with the ITHPC's rules and regulations, as the HCPSA is with the western health care providers. The traditional practitioners will provide a public health care system that will be composed of both traditional and western services. The traditional practitioners' services will not be different from those they are already offering, whilst the western services will be offered after traditional practitioners have been trained on basic western practice. Those basic practices will include prevention, promotion, comprehensive health services, health education, taking of vital signs, rehabilitative care, the use of stethoscope, and counselling services. The traditional health care services will be offered at both newly built traditional health centres as well as the private traditional surgeries.

Two theories will apply on this research question; these are the organisational theory and the institutional theory. Organisational theory is a process of analysing the structures of the organisations, how they function and perform to deliver on what they are intended to do and the behaviour of groups and individuals within them (Christensen, Roness & Rovik, 2007; Mcauley, Duberley, & Johnson, 2007). According to Crossan, Lane and White (1999, p. 525), institutional theory is a process through which the "...learning that has occurred by individuals and groups is embedded in the design of the systems, structures, and procedures of the organization ..."

5.3.3 Expectation of traditional practitioners from government

According to the findings highlighted on paragraph 4.3.3 above, for the traditional system to take place, the government will build new structures that will house the public traditional health care facilities. On the other hand, the ITHPC will contribute towards the building of the new structures with ideas on how the traditional institution will be improved upon, in addition to its rules and regulations. These are changes that are going to take place at the District Health System, which is responsible for the implementation of PHC. These changes are going to bring new players to the fore and therefore, 'new rules of the game' would have to be developed. Institutional theory and organisational theory become relevant as they provide concepts to study change (Lawrence &

Shadnam, 2008; Suddaby, 2010). The DHS, in partnership with traditional practitioners, will have to develop rules and procedures to direct managers and employees' behaviours in managing those traditional health care facilities. Furthermore, the personnel who are going to provide services will have to be appointed. The process of developing the structure and design of the organisation will be informed by the organisational theory (Robbins & Barnwell, 2006).

5.4. What should be the role of traditional health practitioners in primary health care?

According to Biddle (1986) role theory, roles are an array of actions accepted by an individual within an organisation. This statement is supported by Parker & Wickham (n.d.) when they state that roles are repetitive actions that are important for a particular position within the organisation. Parker & Wickham (n.d., p.2) go on to say that, "Organizational role theory (ORT) ... provides insight into the processes that affect the physical and emotional state of an individual in the workplace that affects their workplace behaviour". Based on the findings on paragraph 4.4, various roles are recommended by the research participants; however, being a traditional practitioner for each one of them is already a societal role that defines who they are and what their responsibilities are. Traditional practitioners and the public felt that their role should be formal, especially as they would be operating within the Council's regulations. The western practitioners and district officials felt that their role should be informal and limited to basic primary health care services, such as being counsellors, taking vital signs of patients visiting the formal clinics, and referring patients within their practices to formal clinics as they would not be at the same level as the western practitioners. The government felt that the practitioners should run their own system under the Council's regulations. In these traditional health care facilities, traditional practitioners' roles would vary from health care providers to management.

In addition to being a traditional practitioner, as it is the case with a western practitioner, it will be an added benefit to be given a named position as these named position will determine their responsibilities and their position in the organisational hierarchy. It is assumed that majority of position as health care provider and some administration roles will be assumed by them, such as a staff nurse, matron or even a doctor, will not change their societal role and responsibility, it will, however, confirm their stability, buy-in and

responsibility within this formalised traditional health structure. As such, Organisation Role Theory (ORT) applies well in this new environment as practitioner will identify with their roles of being a traditional health care provider over the named role.

However, organisational theory is also applicable. Organisational theory is a process of analysing the structures of the organisations, how they function and perform to deliver on what they are intended to do and the behaviour of groups and individuals within them. As traditional practitioners will be entering a new structure, their new roles, positions and responsibilities will affect how the new traditional health care system will function, particularly with regards to their functions, performance and behaviours.

5.5. What is the envisaged value-add of the traditional health practitioners in the South African primary health care system?

Institutional theory will apply towards this question's responses. This theory is used to study an organisation's structures, processes, and functions whether or not it achieves what it was established for. According to the findings that are in paragraph 4.5, the anticipated value-add out of the integration of traditional practitioners into the PHC system are: increased human capacity at the primary health care level, leading to improved, efficient and faster health care service delivery to the communities. The third value that traditional practitioners' integration will bring is that, for the first time, traditional practitioners will receive recognition and respect from government, western practitioners and citizens they have always felt they deserved, and a choice of health care service from a western or traditional health care service provider. Patients will receive the same benefits that have been afforded to the western practitioners' patients, such as the use of medical insurance, issuance of sick notes, etc. Furthermore, the fear and shame of patients who wanted to visit traditional healers during the day will disappear. As a result, there will be efficient and affordable traditional health care facilities closer to people's homes. All these improvements will impact positively towards the PHC system, resulting in the system achieving what it was established for.

5.6 Conclusion

Whether or not traditional practitioners are integrated in the public health care system, specifically at the primary health care level, they will continue to be used by most South Africans, especially Africans. What makes the traditional healing institution popular with

the public is its accessibility and affordability to the communities. One of the findings in this study was that the integration of traditional practitioners into the primary health care (PHC) will be a parallel system, which is a form of integration. This finding supports Summerton (2005, p.146) when she suggested that "...the best system that will suit South African traditional practitioners will be a parallel system, as this will not compromise each system during the process of integration." Summerton (2005) & Ingle (2009) further state that integration has two forms, it is either inclusive or parallel. An inclusive system is where traditional and western practitioners are legally recognised and traditional practitioners are not fully integrated in all components of public health. A parallel system, on the other hand, is where traditional and western practitioners function parallel to each other, independently co-exist within the country and have some form of a cross referral agreement existing (WHO, 2002, Summerton, 2005 & van Rooyen, Pretorius, Tembani, & Ham, 2015).

Once traditional healers are integrated, through a parallel system, within the PHC system, as recommended by government, there will be benefits for different stakeholders. For the PHC system, there will be an alternative health care provider who will offer the citizens with health care choices. It will also ease some of the challenges experienced by the PHC at this level of health care, such as the shortage of the health care workers that have resulted into long queues that are endured by the patients before being served. For the public, the benefits will be a formalised alternative health care system that can serve them without fear of embarrassment or recognition by the employer, in some case. On the other hand, traditional practitioners' benefits would include recognition and respect from government, western practitioners and the public at large, including the pride of being certified to practice, similar to their western peers. For the western practitioners, benefits would be the reduction of patients to be served, who could now also choose an alternative health care system that is accessible and regulated. For government, in addition to regulating an institution that has long being unregulated, tax levies will be an additional income benefit. The parallel system of traditional practitioners into the public health care system will be managed by the Interim Traditional Health Practitioners Council (ITHPC), in partnership with the national Department of Health. The ITHPC is a regulatory body for the traditional practitioners and their practice.

6 SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

6.1. Summary

Quality and an abundance of human resource personnel is an essential asset for any organisation or government entity that provides services to the public to operate effectively. The South African public and private health care sectors are not an exception to this requirement. Human resource shortage is one of the challenges faced by the South African public health care sector, both in quality and quantity, and scholarly literature has comprehensively documented this. These professional health care workers leave the country for the private sector and developed countries seeking better salaries and improved working environment. To respond to some of the challenges faced by the public health care system, especially on the shortage of health care personnel, this study proposed integration of approximately three-hundred and fifty thousand (350, 000) traditional health practitioners (THPs) to reinforce staff at the primary health care level (Kale, 1995; Meissner, 2004). However, based on the literature review, especially on those authors who also recommended integration of traditional practitioners into the country's PHC, a gap was identified. These authors did not provide details on how THPs should be integrated, as well as what role they would play once integrated into the PHC. As such, the purpose of this research was to address these two gaps identified from literature review.

Out of the gaps identified from the literature review, four questions were developed. These research questions were compiled to source relevant data from the research participants. Those questions were: what are the key aspects and approach that should inform integration of traditional health practitioners (THPs), once integrated, what role they will play in the new system, and what is the envisaged value-add towards the SA primary health care system and the public at large? This study focussed on the PHC system that the Tshwane District Health System level implements. This is because the problem identified is mainly found at the PHC level of the country. This study covered three of the seven regions of Tshwane. It was concluded that the research participants from the three regions chosen would be representative of the seven Tshwane regions. It was anticipated that the research outcome would assist the national Department of Health (NDoH) and its stakeholders to understand how it could integrate traditional

practitioners into the country's PHC to address the shortage of health care workers and what role they would play once integrated.

This qualitative study used a cross-sectional design to explore the perception, knowledge and recommendations of the national and district Department of Health officials, the western health practitioners, the traditional health practitioners and the SA citizens in Pretoria, on how to address this problem. Thirteen individual in-depth interviews and one focus group with the four categories of the research participants were conducted using a semi-structured interview guide. A focus group is part of data collection method where group members sharing similar interest are interviewed for a specific topic (Gill et al., 2008). The relevant theories that were used to interpret the data in this study were the change theory. This change theory provided structure to this whole study as it sought to recommend changes within the primary health care (PHC) sector. Those changes will affect the western and traditional health care systems. Three theories were applied in this endeavour; those are Kurt Lewin's Change Theory, Institutional Theory and Organisational Theory. These theories complement rather than duplicate each other.

6.2. Conclusions

This was a crucial research study that set out to find a solution towards a shortage of health care workers problem facing the PHC, thereby offering an effective health care delivery to the public. With the solution to the problem being integration of traditional practitioners with the western practitioners within the PHC system, the THPs massive numbers compared to their western counterpart can make a sizeable difference in resolving this problem. The findings responded to the research gaps identified from the literature review, where authors did not provide details on how THPs should be integrated, as well as what role they would play once integrated into the PHC. These outcomes arose out of the research questions already outlined above.

The results of this study produced four outcomes; the first one was that the regulatory body of traditional practitioners, which is the ITHPC, should finalise and implement the Traditional Health Practitioners Regulations of 2015, which are going to regulate traditional practitioners and their practice. Secondly, the study provided areas that need to be improved upon by the western and traditional health care systems in order for a

parallel system to be effective for the benefit of the SA citizens. These include the fact that western and traditional practitioners need to be trained on each other's basic health care systems so that the differences in the provision of health care can be understood and accommodated. Thirdly, the SA government opted to integrate traditional practitioners into the PHC system through a parallel system. Fourthly, the SA government would build new traditional health care facilities, which will be run and managed by the practitioners themselves. The fifth outcome was that, with the integration of traditional practitioners into the PHC through a parallel integration system, the practitioners' added-value will be that there will be alternative health care for the public to choose from.

Successful implementation of the integrated health system will reduce the shortage of health care workers in the PHC as the government would have access to the 350, 000 traditional practitioners available in the country. The benefit for traditional practitioners in this process would result in their recognition and respect by the western practitioners and the public. Traditional health practitioners will also gain confidence in their delivery of health care under a regulated health system. With the new parallel health system, the THPs within the government structures and in private practices will operate within a formalised system with access to all the benefits that their western counterparts enjoyed alone before.

The study recommends that future research could be conducted, first on how the ITHPC could be effective in enforcing regulations to the THPs and their practices. Secondly, further research should be conducted on the successes and challenges of the implementation of parallel system between traditional and western health care systems. With regard to the theoretical recommendations, Kurt Lewin's change theory focussing on three stages; however, as this study only focussed on the first stage, stages two and three need to be implemented to complete the process of change, based on the Kurt Lewin's theory. Implementation of the recommendations made in this study also has to be followed to ensure the success of the integrated health system.

6.3. Recommendations

In light of the findings identified in this study, the researcher makes the following recommendations:

- The national Department of Health should ensure that the integration of traditional practitioners take place at the primary health care level as traditional practitioners are already playing a meaningful role at that level.
- The decision of integrating traditional practitioners into the public health system should not remain at the national level; it should be trickled down to all levels of government, especially at the District Health System, which is the one that provides health care services to different communities.
- The traditional practitioners should be represented in all the District Health System' teams as they are part of health care providers. These teams include the District Management Teams (DMTs), Sub-DMTs and Ward Committees. According to Pillay & Barron, (2011, p 1-2), these teams are “responsible and accountable for all the services that take place in all the facilities and communities in the district”.
- Training of the western and traditional practitioners on each other's basic health care services is essential so that the differences in the provision of health care can be understood and accommodated.
- A well-established referral system should be developed and referral should be reciprocal.
- Traditional practitioners should have a buy-in for the proposed integrated system to be effective and offer a good health care system.
- The ITHPC must access enough financial support from the government to ensure that it achieves its goal and is comparable in service delivery to the HPCSA.
- The Council need to be effective and put goals that are achievable; for instance, the ITHPC has been in place since 2013, but in 2017, the only evident action they have taken is the publication of the Traditional Health Practitioners Regulations of 2015. More should have been done and achieved within this period, including the completion of the TPHs national database.

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Appendices

1. An interview schedule
2. A consent form for research participants
3. Ms Buyiswa Motloenya's short biography

APPENDIX 1.1: INTERVIEW SCHEDULE

1. Opening

- A. My name is **Buyiswa Motloenya** and I am currently a Master's student at Wits University. As part of my requirement to graduate I'm conducting a research study titled:

Institutional arrangements for integrating traditional health practitioners into the South African primary health care system

- B. I would like you to take part in my research study because I am trying to learn more on how the traditional health practitioners could be integrated or incorporated into the South African primary health care system. The study makes use of the semi-structured interviews and focus group to gather information from research participants.
- C. By interviewing you I would like to document your in depth views and information on how this incorporation of traditional health practitioners could be achieved.
- D. The interview should take about 45 minutes. Are you available to some questions at this time?
- E. Before we start I will give you a consent form to sign. The objective of this form is observe and protect your right as a research participant.

2. Body

A. General Demographic information of respondents

- Gender:
 - ☐ Female or ☐ Male
- Age Group Scale:
 - ☐ 18 -30 ii) 31 – 40 iii) 41-50 iv) 51 and above
- Education
 - ☐ No formal schooling
 - ☐ Completed primary schooling
 - ☐ Completed secondary schooling

- Completed high schooling
- Completed tertiary qualification
- Residential Location: Pretoria, Gauteng
 - Where do you live?

B. Experience: What is your occupation?

- What is your specialization (traditional healer/health care professionals/bio-medical doctor)
- How long have been practicing (traditional health practitioner or bio-medical doctor or community nurse)

C. Focus

A. What aspects should inform integration of THPs within the ‘official’ PHC system?

- What is your understanding of traditional healing and traditional health practitioners (THPs)?
- Have you ever used the services of a THP before?
- What is your understanding of the South Africa primary health care (PHC)?

B. What should the role of THPs in the PHC system be?

- Do you think THPs have a role to play in the public health system (PHC)?
 1. If there is, at what level in the primary health care system?
 2. What should that role be?

C. How should the THPs be integrated within the ‘official’ PHC system?

- Do you think THPs should be incorporated into the South African primary health care system and why?
- Have you worked with western health practitioners and what was your experience?

- Have you worked with traditional healers and what was your experience?

D. What is the envisaged value add of the THPs in the SA PHC system

- Do you know of another alternative solution that can address the shortage of health care workers in the primary health care in addition to THP?

3. Closing

- a. I appreciate the time you took for this interview. Is there anything else you think would be helpful to me to be able to learn more about this integration of traditional health practitioners into the South African primary health care system?
- b. Would it be alright to call you again if I have more questions? Thanks again.

APPENDIX 2.1: CONSENT FORM

My name is **Buyiswa Motloenya** and I am a currently a Master's student at Wits University. As part of my requirement to graduate, I am conducting a research study titled:

Institutional arrangements for integrating traditional health practitioners into the South African primary health care system

NATURE AND PURPOSE OF THE STUDY

I am asking you to take part in my research study because I am trying to learn more on how the traditional health practitioners could be integrated into the South African primary health care system. The study makes use of the semi-structured interview and focus group to gather information from research participants.

RESEARCH PROCESS

1. The study requires your participation in this interview to document your in depth views and information on how this integration of traditional health practitioners could be achieved.
2. There is no right or wrong answers and all answers are welcome and valued.

CONFIDENTIALITY

All the information is viewed as strictly confidential. Only the researcher and the Supervisor will have access to this information. No data published in research report or journal will contain information, which might enable participants to be identified. Therefore, your anonymity is ensured.

WITHDRAWAL CLAUSE

Participation in this research is voluntarily therefore participants are free to withdraw.

POTENTIAL BENEFITS OF THE STUDY

Your involvement in this study will help us to understand whether the South African government have to explore the integration of traditional health practitioners into the South African primary health care system as proposed by the World Health Organisation to achieve 'Health for All'.

INFORMATION

If I have any questions, you may contact my Supervisor from Wits Graduate School of Governance at (011) 717 3926

CONSENT

I, the undersigned, have read the above information related to the study. I have been afforded this time to discuss the study's relevant aspects, and declare that I understand its objective. I, therefore, declare that I agree to participate voluntarily in the project.

Signature of the participant

Signed in Pretoria on the 2016

APPENDIX 3.1: PROFILE OF THE RESEARCHER

I am Buyiswa Motloenya, and am currently working for the Indigenous Knowledge Systems of South Africa (iKSSA) Trust, a non-profit organisation whose mission is to promote and protect Indigenous Knowledge Systems (IKS) and its practitioners. I have been working for the iKSSA Trust since 2002 in various capacities, from being a Programme and Development Manager, Chief Operations Officer until my current position as a Chief Executive Officer, a position I am currently occupying.

Before joining iKSSA Trust, I worked for different organisations, such as the Parliamentary Portfolio Committee on Arts, Culture, Language, Science and Technology at the National Assembly in Parliament, I moved to the United Nations Development Programme, South Africa office, where I managed different projects.

I have Honours in Public Administration (BPA Hons) from the University of Stellenbosch. Other qualifications include National Diploma in Public Administration and Post Graduate Diploma in Public Management and Administration. I have also completed a Certificate on Strategic Leadership Programme with the Gordon Institute for Business Sciences (GIBS).

I am currently registered for a Masters in Management, specialising in Public Policy at Wits University.

I declare that this research is conducted in the interest of fulfilling the requirements of my studies. I do not stand to benefit financially or otherwise except for the above stated purpose.