



CREATING A MODEL OF CONVERGENCE AND ENGAGEMENT BETWEEN
AFRICAN INDIGENOUS HEALTH AND BIOMEDICAL SYSTEM REGARDING
TUBERCULOSIS (TB) TREATMENT

by

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DECLARATION

I Tinyiko Enneth Nkhwashu declare that “Creating a model for convergence and engagement between African indigenous health and biomedical system regarding tuberculosis (TB) treatment” is my own work, and that all the sources I have used and quoted have been indicated and acknowledged by means of complete references

Miss Tinyiko Enneth Nkhwashu

Date



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ABSTRACT

Introduction: Around 80% of the population in sub-Saharan Africa use indigenous medicine when ill, before consulting biomedical health practitioners, and many only consult doctors when their disease is at an advanced stage or the indigenous medicine has failed. The rise in TB infection has led the South African government to consider collaboration between African indigenous health and biomedical health practitioners in order to counter a pandemic among communities. The World Health Organisation (WHO) advocates incorporating African indigenous health and biomedical health practitioners to promote quality service delivery among the communities. Support for cooperation between these health practitioners was promoted in South Africa with the passing of the *Traditional Health Practitioners Act of 2007 (Act. 22 of 2007)* to promote collaboration. The government introduced programmes and models of health promotion related to TB management but they focussed on the prevention of the disease, promotion of health, and programmes about HIV/AIDS rather than on how a model of convergence and engagement between the African indigenous health and biomedical health practitioners regarding treatment of TB should be created.

Research design and methods: A qualitative, exploratory, descriptive and contextual research design was used. The study conducted within the biomedical health and African indigenous health practitioner's context and was conducted in three phases. Non-probability, purposive sampling was used to choose a population that comprised three groups of participants, namely, biomedical health practitioners, African indigenous health practitioners and supporters of direct observed treatment (DOT). The sample size was large enough to determine differences between groups. The researcher conducted in-depth individual interviews and focus group to explore and describe their views regarding convergence and engagement about the treatment of TB. Questions were asked following the interview guide until data saturation occur. Data analysis was conducted following Tesch method.



Findings: The study found they perceived the treatment of TB differently, largely because of cultural diversity, for instance, differing beliefs and worldviews that had an impact on understanding the meaning of concepts such as disease, illness and wellness. Some believed that it was caused by witchcraft, others the result of cleansing rituals not having been carried out. It was also believed that *Isidliso* entered the victim while sleeping, in the form of food. Thus, the development of the model of convergence and engagement between the biomedical health and African indigenous health practitioners will sort out the myths that is in the mind of the people regarding the cause of TB.

Conclusion: The model of convergence and engagement between the biomedical health and African indigenous health practitioners regarding the tuberculosis (TB) treatment was developed following the steps proposed by Dickoff, James and Wiedenbach and Walker and Avant.

. **Key words:** African indigenous health, biomedical health, Convergence, Culture, Engagement, and Tuberculosis.



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LIST OF ABBREVIATIONS AND ACRONYMS

AG	African indigenous group
BG	Biomedical group
CEO	Chief Executive Officer
CDC	Centres for Disease Control and Prevention
DG	DOT supporters group
DOT	Direct Observed Treatment
DoH	Department of Health
HIV	Human immune-deficiency
AIDS	Acquired immune-deficiency syndrome
MDR – TB	Multidrug- Resistant Tuberculosis
TB	Tuberculosis
WHO	World Health Organisation
XDR - TB	Extensively drug- resistant TB



CHAPTER 1 OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Tuberculosis (TB) remains a major global health problem, ranking as the second leading cause of death from an infectious disease worldwide. Globally, there were an estimated 9.27 million cases of TB in 2007. Worldwide, reported data in 2008 accounts for 99.6% of the world's estimated number of TB cases and 99.7% of the world's population (Klinikleri 2011:1). Comparing the above statistics of TB worldwide there has been major progress in tackling TB in the 21 years since the 1993 WHO declaration of it as a global public health emergency. Globally, the TB mortality rate (deaths per 100,000 population per year) has fallen by 45% since 1990 and TB incidence rates (new cases per 100,000 population per year) are decreasing in most parts of the world. Between 2000 and 2013, an estimated 37 million lives were saved through effective diagnosis and treatment, however, the Stop TB Strategy developed by WHO (2014:1) for the period of 2006-2015 has not yet reached its goals. The latest estimates are that there were 9.0 million new TB cases in 2013 and 1.5 million deaths.

According to WHO (2014:1), in 2013 there were an estimated 3.3 million cases and 510,000 deaths among women, as well as an estimated 550,000 cases and 80,000 deaths among children. Six countries that stand out as having the largest number of incidents in 2013 were India (2.0 million-2.3 million), China (0.9 million – 1.1 million), Nigeria (340,000 – 880,000), Pakistan (370,000 – 650,000), Indonesia (410,000 – 520,000) and South Africa (410,000 – 520,000), these and the other five countries that make up the top ten in terms of numbers of cases (WHO 2014:8).

In sub-Saharan Africa the incidence of tuberculosis (per 100,000 people) was last measured at 282 in 2013, (WHO, 2014:1), from 255 in 2012. South Africa is one of the countries with the highest burden of TB, with WHO statistics giving an estimated incidence of 450,000 cases of active TB in 2013. Out of the 450,000 incident cases in South Africa it was estimated by WHO (2014: 24) that about 270,000 (60%) had both HIV and TB infection. The latest figure from South Africa Department of Health is that 73% of TB patients are HIV positive. Statistics South Africa (Stats SA) indicated a little decrease in tuberculosis to 8, 8% in 2013 according to the Department's 2013/2014



Annual Performance Plan, Statistics South Africa (Stats, SA 2014:27). Despite of the programmes developed to alleviate TB infection around the world, South Africa still reporting high rate of infection.

One of the provinces in South Africa hardest hit by TB, Mpumalanga, has been identified as having a high infection rate, with an estimated 7,831 in 2004, rising to 15,035 in 2006 (Department of Health, DoH 2009:1, Department of Health Mid-term Review Report 2014-2015, 2016:6-9). This poses serious health risks to families, communities and nations, and places financial pressure on the government. TB remains the leading cause of death in Mpumalanga Province. In addition people rely on indigenous health because of their accessibility.

Public Protector Thuli Madonsela visited Mpumalanga in the month of July 2013 in the Kabokweni and Kanyamazane townships in Mbombela to investigate the state of healthcare and remarked about the increase of TB infection and the way in which it was treated (*Nelspruit News* 2013:2).

1.2 PERCEPTIONS OF TUBERCULOSIS

Tuberculosis is perceived differently by a South African population that is diverse. For instance, differing beliefs and worldviews have an impact on understanding and meaning of concepts such as disease, illness and wellness. The condition is perceived differently in various communities, with some believing that it is caused by witchcraft and others that it is the result of cleansing rituals not having been carried out. The work of biomedical health practitioners on TB and treatment has evolved over centuries, with USAID programmes for investigation, treatment and Direct Observed Treatment (DOT) being implemented, but to this day infection remains high (Pretorius & Small 2007:1). The biomedical health practitioners must devise strategies for engaging community belief systems to ensure effective intervention is informed by the context of the patients.

The juxtaposition of two medical practitioners, one formal (the biomedical), the other less formal (the indigenous), has brought into focus the differences between histories and traditions, and the understanding of health and disease (Napolitano 2007:18). Given strong ethnic and family ties and traditional beliefs, communities may only consider using modern health facilities when they realise that the indigenous



medicines have failed. In some communities patients first seek advice from a traditional health practitioner, who in turn prescribes herbal remedies or treatment based on the traditional system of thinking and belief (Oeser et al 2005:571-575; Bateman 2010:1). Only when there is no sign of improvement will the patient consult a hospital or clinics, by which time it may pose a serious challenge to life.

According to Krieg (2009:6), the different types of African indigenous practitioners are diviners, herbalists and faith healers. The latter claim a special relationship with ancestors or healing spirits, with the use of listening, observation and experience to make diagnoses, aided by supposedly supernatural communication and throwing of bones. To become a diviner one follows a calling (*thwasa* in isiSwati), (the word *thwasa* means to undergo an initiation school for few months and taught how to use traditional medicines and throwing of bones) which can be disobeyed only at risk of serious illness (Simmons 2009:231-234).

Herbalists, meanwhile, work primarily with medicinal plants, a category that includes traditional birth attendants, bone-setters and specialists in infertility and childhood disease. Simmons (2009:231-234) describes the herbalist as a druggist, dispensing medicine (*muti*) made from natural substances, including bark, roots, leaves, animal skin, blood or parts of animals, herbs or seawater. The third group, faith healers or prophets, use prayer, candlelight or water (Simmons 2009:231-234). To understand African indigenous medicine it is important to understand the life and worldviews of the traditional peoples (Wessels in Krieg 2009:6). In this study diviners and herbalists was included as they communicate with the ancestors and, respectively, throw bones and use indigenous medicine to treat TB.

Significantly, the indigenous health practitioners are recognised by the communities in which they live as competent to provide healthcare, whether by using vegetables, animal or mineral substances. They invokes their social, cultural and religious background, as well as knowledge, attitudes and beliefs prevalent in the community, to address disease and disability, both physical and mental (Sandlana & Mtetwa 2008:119-131). African indigenous health practitioners are part of the community and share the socio-cultural values of their communities, including beliefs about the origins, significance and treatment of ill-health. Their healing models are holistic and treat the



“whole” person, employing interventions targeted at all forces responsible for ill-health. Both symptoms and causes were addressed in order to ensure health or wellbeing and harmony in human functioning (Comas-Diaz, Edwards & Holdstock 2010:284). This comprehensive approach is concerned with illness prevention, health promotion and/or cure (Gumede & Staugard in Bujuwoye & Sodi 2010:285).

The practice of indigenous medicine served the healthcare needs of most African communities before the introduction of biomedical medicine, otherwise referred to as ‘Western’ or ‘conventional’ medicine, and despite extensive colonisation it continues to be the primary and sometimes only accessible healthcare option for the majority of people living in sub-Saharan Africa (King, Balaba, Kaboru, Kabetesi, Pharris & Homsy 2004:1723-1725). Today, up to 80% of the African population rely on traditional medicine (Al-Rowais, Al-Faris, Mohammad, Al-Rukban & Abdulghani 2010:199), whilst in South Africa specifically, Rautenbach (2005); Mokgobi (2012:1) and Ross (2010:46-48) estimated that 70-80% of the people consult 250,000 indigenous health practitioners as opposed to only 28,000 medical doctors.

During the apartheid era, the African indigenous healing system was oppressed and marginalised, regarded by the ruling white minority as unscientific compared to Western knowledge and healing, which enjoyed greater official acceptance by successive governments because it was seen as being based on “scientific and rational knowledge, whilst traditional healing was seen to be based on ‘mystical’ religious beliefs” (Rautenbach 2005:1; Van Rooyen, Pretorius, Tembani & Ten Ham 2015:4). As a result, state and private funding for healthcare tended to go to the biomedical health sector.

Little has changed, at least in terms of accessibility, since the ending of apartheid and introduction of universal suffrage, and Western medicines are still not used by many of the healthcare users of the South African population. This may be attributable to several factors. On one hand the high costs make it difficult for the relatively poor black majority to access, whilst on the other hand, the more holistic approach followed by African indigenous health practitioners continues to be popular (Rautenbach 2005:2; Madamombe 2006:10; Van Rooyen et al. 2015:2). This dichotomy has perpetuated previous segregation, albeit no longer institutionalised.



Against this brief and general background, the researcher was motivated to investigate the underlying differences between apparently irreconcilable alternatives regarding the standard of service by which indigenous health and biomedical health is measured, and develop a model based on convergence and engagement between them. Such a model would incorporate African indigenous health with Western biomedical health practitioners in order to enhance quality service delivery to the people in need of it. As Summerton (2006:143-169) points out, chapter 2 of the South African Bill of Rights states that:

“It is a human right to be able to consult practitioners of one’s choice to meet one’s healthcare needs, and the African indigenous health practitioners have the right to choose and practice their trade, occupation or freely, provided that they are subject to legal regulation”.

It empowers South Africans to decide on which they prefer, without the former oppressive controls, Traditional Health Practitioners Act 2007 (Act no 22 of 2007).

1.3 RATIONALE OF THE STUDY

The WHO advocates incorporating African indigenous health and biomedical health practitioners, as 80% of the population living in developing countries are using indigenous medicine for their illness (Madamombe 2006:10; Van Rooyen et al. 2015:2). The biomedical health and African indigenous health practitioners agreed to work together harmoniously for the benefit of all. Biomedical health and African indigenous health practitioners have co-existed for decades in the selected district in the Mpumalanga province, however, it has not yet been formally established how these two health practitioners relate to each other.

1.4 PROBLEM STATEMENT

Programmes being run by the African indigenous health and biomedical health practitioners include one directed to HIV/AIDS in KwaZulu-Natal (KZN), however, no formally structured programme has been developed or implemented to tackle TB, and whilst information has been widely disseminated about HIV/AIDS prevention and treatment, TB remains relatively unpublicised and continues to produce fatalities on a large scale (Serbulea 2005:1; Rautenbach 2005:1; Mokgobi 2012:1). The biomedical practitioners’ facilities were short of skilled practitioners and have inadequate facilities, especially in the public sector, and whilst some newly affluent blacks use both



indigenous health and biomedical health practitioners simultaneously, the two continue to operate in parallel, at a distance and in isolation. The reliance of most blacks on indigenous health practitioners, and their apparent failure to reduce the number of fatalities to TB and other illnesses, has led the government to consider collaboration between the two groups (Serbulea 2005:1; Rautenbach 2005:1; Mokgobi 2012:1). However, to date no policy has been put in place to facilitate it.

The focus of the provision of healthcare has shifted from curative to preventive and promotive, curative and rehabilitative, the provision of which was largely the responsibility of the state. Chapter 1 Section 3 (1) (c) of the National Health Act, Act no 61 of 2003, assigned this to the Minister of Health, who has to determine policies and measures necessary to protect, improve and maintain the wellbeing of the population. A year later the African indigenous health practitioners gained legal recognition when the government (Serbulea 2005:1; Rautenbach 2005:1) passed the Traditional Health Practitioners Act 2007 (*Act no 22 of 2007*).

In the Mpumalanga province there was no legal collaboration or liaison between African indigenous health and biomedical health practitioners. The practice of each type of health service may have had a detrimental effect on the other practice to the disadvantage of the users of the health services (Oeser et al 2005:571-575; Adjei 2013:24).

1.5 RESEARCH QUESTIONS

Against this background, the following research question gave direction to the study:

- What are the viewpoints of African indigenous and biomedical health practitioners regarding convergence and engagement after the promulgation of the Traditional Health Practitioners Act 2007 (*Act no 22 of 2007*) regarding their practices and healthcare delivery?
- What is the model of convergence and engagement between African indigenous and biomedical health practitioners regarding the treatment of TB condition in a selected district in Mpumalanga province?
- How can a model of convergence and engagement between African indigenous and biomedical health practitioners be created?

1.6 PURPOSE OF THE STUDY

The purpose of the study was to explore and describe the nature of relationship that exists between African indigenous and biomedical health practitioners, with the intention of creating a model of convergence and engagement between the two in the treatment of the TB condition, and so enhance quality service delivery to the patients in need of it.

Objectives of the study were:

- To explore and describe the viewpoints of African indigenous and biomedical health practitioners after the African indigenous legislation regarding their practices and healthcare delivery.
- To conduct concept analysis to identify the meaning of what is the model of convergence and engagement between African indigenous and biomedical health practitioners regarding the treatment of TB condition in a selected district in Mpumalanga province?
- To create a model of convergence and engagement between African indigenous and biomedical health practitioners in the treatment of TB condition to promote quality care delivery.

1.7 DEFINITION OF TERMS

The key concepts and terms used in this study were clarified so that they would be understood.

1.7.1 African indigenous health practitioners

African indigenous health practitioners comprise bone-setters, herbalists and faith healers, recognised by the community which uses vegetables, animal and mineral substances based on social, cultural and religious backgrounds, as well as on the knowledge, attitudes and beliefs prevalent in the community regarding physical, mental and social wellbeing and the causation of disease and disability (Sandlana & Mtetwa 2008; Mokgobi 2012:20). It involves holistic integration of mental and spiritual guidance, herbs, nutrition and physical therapy, and is linked to African cosmology (Ross 2010:46). In this study the term refers to traditional medicines and practices intended to cure TB.



1.7.2 Biomedical health practitioners

A biomedical health system is defined as “formally taught, learned and transmitted professional care, health, illness, wellness and related knowledge and practice skills that prevail in professional institutions, usually with multidisciplinary personnel to serve consumers” (Leininger 2002:492 ; Mokgobi 2012:4). Biomedical health practitioners include doctors, registered nurses and enrolled nurses who work with TB patients. Nurses play a big role because they stay with patients with TB for 24 hours without a break, they know patients behaviour very well. It is based on a belief that life and life processes are largely controlled by physical and biochemical processes that can be manipulated by humans. Those who adhere to this view believe that illness is caused by germs, viruses, bacteria or a breakdown of the human machine, the body (Andrew & Boyle 2002, cited by Kozier, Erb, Berman & Snyder 2004:211). In this study the Western worldview is viewed as having tended to prioritise the body as something to be worked on, altered and adjusted, at the expense of viewing the individual as a complex interaction between mind, body and spirit (Wreford 2005:4).

1.7.3 Convergence

Convergence is defined as two or more individuals sharing information, then over time tending to converge, leading to a state of greater uniformity (Tjale & De Villiers 2004:128; Hall 2010:136). In this study it relates to the meeting point between African indigenous health and biomedical health practitioners regarding treatment of TB.

1.7.4 Culture

Amongst the many definitions of culture, one is of “learned, shared, and transmitted knowledge of values, beliefs, norms and lifeway’s of a particular group that guides an individual or group in their thinking, decisions, and actions in patterned ways” (Leininger 2002:491; Zimmermann 2015:2). Regarded in this research as a set of value systems, it influences all aspects of people’s lives, including everyday behaviour, reaction to health, illness and disease. In particular, the behaviour of the sick is seen as a cultural construct, that is, patients approach illness from the perspective of their knowledge and belief systems. As Leininger (Ibid 2002: 491) and Zimmerman (Ibid 2015: 2) argue, different cultures perceive, know and practice care in different ways. The culture of a patient therefore needs to be considered, when practicable, before treatment is administered. In this study culture refers to the human actions that occur



in meaningful context whereby the African indigenous health practitioners are using indigenous medicine to cure diseases such as TB (Park 2000:1; Mokgobi 2012:52).

1.7.5 Engagement

Engagement is the arrangement to employ or use an arrangement to meet (*Oxford English mini Dictionary* 2007:199; Macleod 2016:1). In this study it is the commitment to meet between the African indigenous health practitioners and the biomedical health practitioners regarding treatment of TB.

1.7.6 Tuberculosis

Tuberculosis (TB) is an infectious disease that primarily affects the lung parenchyma. It may be transmitted to other parts of the body, including the meninges, kidneys, bones and lymph nodes (Brunner & Suddarth 2004:532; Daniels & Nicoll 2012:858). For the purposes of this study, the biomedical definition of TB as an infectious disease caused by mycobacterium tuberculosis is used. African indigenous health practitioners define it as “*isidliso*”, that is, poisoning or bewitching through *muthi* (mixtures of herbs and other magical substances such as animal fats), adulterating food or drink and entering the victim while he or she sleeps. It is placed in food and sent into the dream through so-called ‘witchcraft’, said to be best cured by indigenous health practitioners. The patient reports chronic cough, chest pains and blood in the sputum (Wilkinson, Gcabashe & Lurie 1999:27; Ashforth 2001:9; Viney, Johnson, Tagaro, Fanai, Linh, Kelly, Harley and Sleigh 2014:467).

1.8 SIGNIFICANCE OF THE STUDY

If newly generated knowledge were to be included in the curriculum it would empower nurses with skills in the provision of culturally congruent care and promotion of quality service to patients with TB. The body of knowledge that would be gained by the nurses during their training, if implemented, could help them to integrate theory into practice in the clinical area when nursing patients with TB. This acculturation would enhance quality of service. The significance of this study is that it will also enhance collaboration and integration between African indigenous health and biomedical health practitioners regarding the treatment of TB improve the quality of service delivery by both practitioners. A reduction in the rate of fatalities and spread of infection among the community will be reduced, as will cost to the government of treating MDR. Integration



of African indigenous and biomedical health practitioners will enhance quality service delivery to the people in need of it, therefore this study will be used to develop a model of the convergence and engagement of both to enhance acculturated medical practices for a community in the selected district in Mpumalanga province.

1.9 RESEARCH OUTLINE

The research is written up according to the following structural outline:

- Chapter 1: Overview of the study
- Chapter 2: Research design and methods
- Chapter 3: Data analysis, interpretation and literature control
- Chapter 4: Concept analysis
- Chapter 5: Model development
- Chapter 6: Overview of research findings, recommendations, implications, limitations and conclusion

1.10 SUMMARY

The first chapter has provided an introduction and background to the study, perceptions of tuberculosis, rationale of the study, problem statement, research questions, purpose and aims, definition of terms, significance of the study and research outline. Chapter two, will deal with the research design and methods of the study.



CHAPTER 2

RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

Having provided an introduction to and overview of the study, this chapter focuses on the description of the purpose, the research design and methods as well as the reliability of data, including the ethical considerations. The purpose of the study was to explore and describe the nature of the collaboration that exists between African indigenous and biomedical health practitioners after the legalisation of the Traditional Health Practitioners Act 2007 (Act no 22 of 2007), with the intention of developing a model of convergence and engagement between the two practitioners in the treatment of the TB condition, and so enhance quality service delivery to the patients in need of it. In order to achieve that, the research was conducted in three phases, namely phase 1, phase 2 and phase 3.

2.2 RESEARCH DESIGN AND METHODOLOGICAL ASSUMPTIONS

A research design sits between a set of research question and the data, showing how the research questions will be addressed (Punch 2005, cited by Gray 2009:173). The design directs the selection of a population, procedures for sampling, methods of measurement, and plans for data collection and analysis (Burns & Grove 2007:49). In this study a qualitative, exploratory, descriptive and contextual research designs was used. The researcher employed an inter-subjective approach (opinions of all participants, engage in conversation) to gather data from the participants and gain insight into the lived experiences of African indigenous health , biomedical health practitioners and DOT supporters regarding the treatment of TB condition (Wehbe-Alamah, McFarland, & Macklin & Riggs 2011:19). A qualitative research approach was used in the collection of data in the natural environment to make explicit what is implicit in a culture (Parahoo 2006:367).

The model developed during this study was used to converge and engage African indigenous and biomedical health sectors to enhance acculturated medical practices



for a community in the selected district in Mpumalanga province. The study developed within an interpretative paradigm, that is, one that stresses the importance of interpreting and understanding the lived human experience (Polit & Beck 2008:229, Ibid 2017:472). For Burns and Grove (2009:522), the interpretative data analysis method allowed the researcher to gain insight into the process occurring and began to move beyond simply sorting statements. The interpretative researcher believed that reality consists of people's subjective experiences of the external world, thus, they may adopt an inter-subjective epistemology and ontological belief that reality is socially constructed. The participants described and explored their experiences about cultural issues, then the researcher interpreted them and classified concepts to be used for the construction of the model. The participants' terms were used to attach meanings to their statements.

A positivist paradigm was not considered relevant to this research because, underlying the traditional scientific approach, which assumes that there is a fixed, orderly reality that can be objectively studied, it is often associated with quantitative research (Polit & Beck 2008:762, Ibid 2017:739) and requires a belief in empiricism, the idea that observation and measurement are at the core of the scientific endeavour.

Positivism tends towards generalisation rather than in-depth understanding of the phenomenon (Ibid 2008:14). Qualitative research, on the other hand, is a systemic, subjective approach used to describe life experiences and give them meaning (Burns & Grove 2007:73). This study took the qualitative approach, derived from the paradigm in which the African indigenous health and biomedical health practitioners were the participants rather than objects of the study. It enabled the researcher to become immersed in the cultural setting and social dimension, and to describe events as accurately as possible, as they occurred (Burns & Grove 2007:79; Gray 2009:170).

This study was concerned with exploring collaboration and integration between the African indigenous health and biomedical health practitioners regarding the treatment of TB condition. The explorative nature of the study implies that the phenomenon was investigated in full, regarding its nature and manner in which it is manifested (Polit &



Beck 2008:20-21; Ibid 2017:15). According to Ritchie and Lewis (2003:52-155), explorative study is used to understand underlying values, concepts and norms, and involves broad questions that encourage the participants to take a lead in shaping their own narrative. The exploratory researcher looked for new knowledge, insights, understanding and meanings (Meyers & Sylvester 2006:5). Whereas data pertaining to the practice of biomedical health practitioners was explicitly documented in the literature, the practice of African indigenous health practitioners was not. In order to develop a model to facilitate convergence and engagement between African indigenous health and biomedical health practitioner, there was a need to explore the field of African indigenous health practitioners as this could help uncover hidden knowledge and practices as well as promote a better understanding of African indigenous health practitioners.

Descriptive research provides an accurate account of the characteristics of a particular individual, event, or group in real-life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorising information (Burns & Grove 2009:696). Hence, in the current study a descriptive approach was used to obtain complete and accurate information about the specific phenomenon. This was achieved by allowing the participants to give additional information in a conversational manner, or to discuss freely and in more detail what their views were of the convergence and engagement between these health practitioners regarding treatment of TB condition and their healthcare delivery and practices.

The study described the nature of the relationship between African indigenous health and biomedical health practitioners in the selected district after the legislation of traditional healers as narrated by the biomedical health practitioners, and the experiences of the biomedical health practitioners as role players in delivering healthcare to the communities in this district and their viewpoints regarding the impact that legalisation of traditional healing would have on their respective practices and ultimately on healthcare delivery. The study further described in detail the mechanisms that could be instituted to assist the development of a model to promote collaboration



between African indigenous health and biomedical health practitioners in order to complement and optimise healthcare delivery. The experiences and viewpoints of the participants were described as accurately as possible, seeking perspectives from the participants in their own words

Qualitative research is a systemic, subjective approach used to describe life experiences and give them meaning (Burns & Grove 2007:73). Qualitative designs are naturalistic to the extent that the research takes place in real world settings and the researcher does not attempt to manipulate the phenomenon of interest. Observations took place in real-world settings and people were interviewed with open-ended questions in places and under conditions that were comfortable and familiar to them (Tjale & De Villiers 2004:251). This study took the qualitative approach, derived from the paradigm in which the biomedical health practitioners was the participants rather than objects of the study, exploring and describing their beliefs and experiences about the collaboration of African indigenous and biomedical medicine in the provision of health service. It enabled the researcher to become part of the cultural setting and social dimension, and to describe events as accurately as possible, as they occurred (Burns & Grove 2007:79; Gray 2009:170).

The focus was on participants' integration regarding service delivery and the way they make sense of their lives. Parahoo (2006:63) describes qualitative research as an umbrella term for a number of diverse approaches which seek to understand, by means of exploration, human experience, perceptions, motivations, intentions and behaviour. The researcher was interested in obtaining data pertaining to the integration and viewpoints of the participants regarding their practices or service delivery. The purpose of the study was not to make generalisations from the results but to gain understanding and insight (Botma, Greeff, Mulaudzi & Wright 2010:195). The researcher in this case belonged to the same ethnic group as the biomedical health practitioners and did not experience any difficulty in understanding the language and terms used. The researcher further wished to determine the mechanisms that were suggested by the biomedical health practitioners that could contribute to the development of a model to facilitate collaboration between them and the African



indigenous health practitioners. The required information would therefore reflect how these health practitioners thought and felt and what they believed in. Such human views are difficult to quantify and the use of quantitative methods in this study would have been irrelevant, hence the choice of a qualitative design

Context is the body, the world, and the concerns unique to each person within which that person can be understood (Burns & Grove 2009:693). In this study, the term is used to refer to the background to and the setting in which the study was conducted. It encompassed physical, social and cultural contexts, namely the geographical area of the selected district of Mpumalanga Province, the setting being the workplace which was the office and ward. The selected district was made up of four sub-districts and the involved district was Mbombela North sub-district, which had 20 clinics and two hospitals, one a general hospital the other a TB hospital. Participants in this study were drawn from the selected TB hospital because of its relevance as they were admitting all types of patients with TB and giving TB treatment until discharge. After discharge patients were given cards for the continuity of treatment at the clinics where they were also given DOT support in the process of their treatment.

2.3 RESEARCH METHODS

According to Polit and Beck (2008:765; Ibid 2017:739), research methodology refers to the techniques used to structure a study and gather and analyse information in a systematic fashion. Methods refer to the steps, procedures and strategies for gathering and analysing data in a study. Babbie (2010:4) describes methodology as an approach to the study of social life that focuses on the discovery of implicit, usually unspoken assumptions and agreements.

This study was conducted in three phases: *Phase one* involved data gathering by means of unstructured in-depth interviews from the biomedical health practitioners and focus group interviews with African indigenous health practitioners and DOT supporters, as well as participant observation, field notes and literature control. The exploration and description of the current nature of the relationship between African indigenous health and biomedical health practitioners, their experience as



stakeholders in the healthcare delivery in the selected district, as well as their viewpoints with regard to the impact of legislation of traditional medicine on their respective practices was narrated.

In participant observation the researcher was half participant because of lack of familiarity with African indigenous practices, but close enough by spending sufficient time with them to gain an understanding (Parahoo 2006:367). A focus group was used because the group processes helped participants explore and clarify their views in ways that would be less easily accessible in one-to-one interviews (Parahoo (2006:331). Interviews were conducted in siSwati with the African indigenous health practitioners and the DOT supporters, then translated into English by the researcher.

Phase two followed the steps of concept analysis advocated by Walker & Avant (1995); Brush, Kirk, Gultekin & Baiardi (2011:160-168), to bring out their meaning so that the readers can understand them. The basis of any theory depends on identification and explication of concepts as they allow us to classify our experiences in a meaningful way both to ourselves and to others. Concepts contain defining attributes, and concept analysis therefore is a strategy that facilitates examination of the attributes or characteristics of a concept. Concept analysis is a rigorous, formal linguistic exercise to determine those defining attributes (Walker & Avant 2011: 157).

The concept convergence and engagement was analysed following these steps:

- Identify a concept
- Determine the purpose
- Identify concept uses
- Determine defining attributes
- Establish a model case
- Antecedents and consequences

Phase three included the development of a model of convergence and engagement between the African indigenous health and biomedical health professionals regarding



TB treatment for quality healthcare delivery. The model development was based on the findings of phases one and two. Data obtained from each group of participants was analysed using Tesch's method as described by De Vos (1998:343-344). Themes emerging from data and the concepts to develop the model was identified from each group. It was based on the steps of concept analysis by Walker and Avant (1995); Walker and Avant (2011: 57). The theoretical framework for this study was based on the process of Dickoff, James and Wiedenbach 1968 (cited by Mokoena 2012:117).

The following concepts was used.

The agent: who or what performs the activity? (The African indigenous health, biomedical health practitioners and DOT supporters in the healthcare service delivery).

The recipient: who or what is the recipient of the activity? (The patients with TB).

The context: in what context is the activity performed? (African indigenous health, biomedical health practitioners and DOT supporters in the healthcare service delivery).

The dynamic: what is the energy source for the activity? (Collaboration; interactive service delivery).

The purpose: what is the end point of the activity? (Convergence between African indigenous and biomedical health practitioners to enhance quality service delivery in the treatment of the TB condition).

2.3.1 Population

- **Research Population**

Burns and Grove (2009:714) describe the population as all elements (individuals, objects, events, or substances) that meet the sample criteria for inclusion in a study, sometimes referred to as a 'target population'. According to Polit and Beck (2008:761), Ibid (2017:739) population refers to an entire set of individuals or objects having some common characteristics, sometimes called 'universe'. The population included in phase one were the biomedical health practitioners. The research population of this study consisted of the biomedical health practitioners, namely the doctors and nurses



providing health service to patients with TB in the clinics and hospitals and African indigenous health practitioners, who are diviners and herbalists residing and working in a selected district of Mpumalanga province. The DOT supporters were interviewed as they collate details and supervise TB patients on taking their treatment (USAIDS 2006:1; Rautenbach 2005:6). A description of the research population, selection criteria, sampling method, sample size as well as data collection method and analysis for each group was as follows:

2.3.1.1 Group no 1 - Biomedical health practitioners

The biomedical health practitioners, namely, medical practitioners (doctors), registered nurses and enrolled nurses, were selected according to the following criteria: they were expected to have at least two years' experience as medical practitioners, registered nurses or enrolled nurses. They had to have worked with or given service to TB patients and be willing to participate. The aim for selecting these categories was that they had different views regarding the TB patients' treatment and felt important in the service delivery.

Participants were selected through purposive sampling, which involves the conscious selection of certain subjects to include in the research project (Burns & Grove 2005:352) and demands that one thinks critically about the parameters of the population in which one is interested, choosing information-rich cases, or those from which one can learn a great deal about the central focus or purpose of the study.

In this study, the researcher used personal judgement (the researcher deliberately choose who to include in the study on the basis that those selected can provide the necessary data or may have to rely on her own judgement that of those she believes can help her to make the choice) in selecting the participants that represented the topic being studied as professional practitioners in their respective fields. The researcher wrote a letter to ask permission from the selected hospital's Chief Executive Officer (CEO) and the matron of the hospital to conduct a study in the institution and the access to the biomedical health practitioners and their counterparts.



To select the participants, the researcher contacted the TB co-ordinator for health services in the local area of the selected district telephonically and discussed the study with him. The co-ordinator provided the contact number for selected TB hospital to the researcher to make arrangement regarding data collection. The researcher faxed the request letters to the co-ordinator hand them to the chief of the area, head of the African indigenous health practitioners and the head of the DOT supporters. The researcher met the participants to discuss the topic with them and those who were interested were selected for participation in the study.

An individual interview took place on 3 and 4 April 2014 in their offices. The researcher interviewed three registered nurses and two enrolled nurses in the office and one registered nurse in the ward on which she was working on day one. On day two one registered nurse was interviewed in her office as she was the head of the department when the CEO was not in the premises, and three registered nurses in the nurses restroom within the wards on which they were working. Sample size was determined by the saturation of data but the researcher aimed to interview about 20-30 participants. All the participants were female. Medical practitioners were not interviewed because were busy with the patient's rounds and their views about model of convergence and engagement between them and African indigenous health practitioners regarding TB treatment were not heard to strengthen triangulation of the data collected. The selected Hospital was staffed by two doctors only.

Data was collected by means of structured interview, in-depth individual interview, field notes and a voice recorder with the permission of the participants. The aim was to produce reliable data. Ten participants were interviewed in two days and the interviews were conducted in English in the participant's workplace and lasted for 45 minutes to an hour. The following questions were used as guide:

- What are the viewpoints of African indigenous and biomedical health practitioners regarding convergence and engagement after the promulgation of the Traditional Health Practitioners Act 2007 (*Act no 22 of 2007*) regarding their practices and healthcare delivery?



- What is the model of convergence and engagement between African indigenous and biomedical health practitioners regarding the treatment of TB condition in a selected district in Mpumalanga province?
- How can a model of convergence and engagement between African indigenous and biomedical health practitioners be created?

The interviews were discontinued when saturation was reached, after ten participants had been interviewed. Saturation is a term to describe the point when one has heard the range of ideas and is not getting new information (Parahoo 2006:325).

Analysis began during data collection, with transcription of the recorded data which corroborated with field notes. The researcher used open descriptive coding, with the recorded interviews transcribed verbatim and the data analysed according to Tesch's data analysis method (De Vos 1998). This method organises the data, creating a structure, which can then be analysed (Tesch in Creswell 2003). Open coding was done by utilising Tesch's method (De Vos 1998). The researcher formed a sense of the whole by reading through all the transcripts and some ideas were jotted down. One interview was chosen to start the analysis and the researcher wrote down personal thoughts as they occurred. Similar topics were clustered together and formed into columns, arranged according to major topics then returned to the original transcribed data.

The researcher found the most appropriate descriptive wording for the topic and turned this into categories. Grouping topics that relate to each other reduced the total number of categories. The researcher made the final decision on the appropriate abbreviations for the various categories. Data relevant to each category were assembled together and a preliminary analysis was performed. The researcher coded the data then compared the data with the results. In order to ensure trustworthiness of the study, the transcribed individual interview was sent to the study promoter and co-promoter who are experienced in qualitative research and in possession of a doctoral degrees. A meeting was arranged between the researcher and her study promoter to discuss about the study on identified themes.



2.3.1.2 Group no 2: African indigenous health practitioners

The selection criteria for the African indigenous health practitioners were that the person had at least two years' experience as an indigenous health practitioner healing people with indigenous medicine and was willing to participate. The sampling method was purposive sampling, and the researcher used personal judgement in selecting the participants who represented the topic being studied as professional practitioners in their respective fields.

For access to the participants the researcher wrote a letter to ask permission from the village headman or chief and to the Head of the African indigenous health practitioners of the selected district of Mpumalanga province. The researcher Faxed letters to the TB co-ordinator to distribute them to the respective people. The African indigenous health practitioners were contacted through the TB co-ordinator who was having contact with them. The selected home-based care institution manager also helped make contact with the African indigenous health practitioners by providing the researcher with the telephone numbers of the practitioners to discuss about our meeting point and time.

The selected home-based care institution manager had the contact numbers of the practitioners because they met together for the meetings and workshops. After telephoning the Head of the African indigenous health practitioners the time, date and place were agreed upon. The meeting place was the home of the head of the African indigenous health practitioners who telephoned other African indigenous health practitioners to meet in his workplace on the selected date and time. They were residing in different places, such as Gutshwa, Ngodini (Kabokweni), Nkohlakalo and TV trust. On my arrival some had not yet arrived so the researcher and the head of the African indigenous health practitioners brought them in the researcher's car. The researcher did not know the African indigenous health practitioners because she was residing at Matsulu.



To put the participants at ease the researcher greeted them with a smile and announced the reason for her presence. The researcher requested them to relax and explained the aim of research, explaining that their input would add value in developing a model of convergence and engagement between African indigenous health and biomedical system regarding TB treatment. They were informed that they were, however, free to withdraw if they so wished, but they seemed to be interested.

The head of the practitioners explained that approval to conduct the study had been obtained from Mpumalanga Province Research Ethics Committee, Department of Health, and Chief Director of the selected district and the Chief Executive Officer at the selected hospital in the Mbombela area where the data was collected. The researcher made an introduction to the participants and discussed the topic with them, finding they were all interested and were selected. Consent was obtained from the participants prior to their participation in the study (see Annexure B1, B3 & B6).

All the African indigenous health practitioners had two or more years of practice. The novices were available but were not part of the focus interview as they were in the initiation process. The African indigenous health practitioners were 21 in number and were divided in three groups. The first group were five in number, the second group six and third group 10, arranged in circles with the researcher in the middle of each group to facilitate voice capturing on the recorder while also taking field notes. A focus group interview for the African indigenous health practitioners took place on 8 and 10 July 2014 at their workplace, in their homes.

The African indigenous health practitioners were in three focus groups of 6-10 participants. During the focus group interview the researcher found no further explanation, interpretation or description of the phenomenon being studied from different groups, saturation of data was reached and an extra group was not necessary. Data was collected by means of structured interview, focus group interview, field notes, and a voice recorder with the permission of the participants, participant observation and the use of an interview schedule. A focus group interview can be described as a carefully planned discussion designed to obtain perceptions on



a defined area of interest in a permissive non-threatening environment (Burns & Grove 2005:737). It is conducted when the researcher is looking for a range of ideas or feelings that people have regarding the phenomena. Interviews were conducted in SiSwati. The researcher translated the English to SiSwati version to promote understanding because not all African indigenous health practitioners were literate. Interviews were conducted in the home or work situation of the head of the African indigenous health practitioners, a naturalistic setting.

The schedule contained the following three broad questions which were posed to each group:

- What are the viewpoints of African indigenous and biomedical health practitioners after the Traditional Health Practitioners Act 2007 (*Act no 22 of 2007*) regarding their practices and healthcare delivery?

Itsini imibono yabodokotela besintfu nebesilumbi amva kwekushaywa kwemtsetfo we Traditional health practitioners nga 2007, mayelana nekusebenta kwabo kuniketa tinsita tetemphilo?

- What is the model of convergence and engagement between African indigenous and biomedical health practitioners regarding the treatment of TB condition in a selected district in Mpumalanga province?
- How is the integration between African indigenous and biomedical health regarding the treatment of TB condition in a selected district in Mpumalanga province?

Bunjani budlelwane emkhatsini wabodokotela besintfu (tinyanga) nabodokotela besilumbi mayelana nekwelashwa kwesifo sisifuba etigodzini letitsite kulesifundza saseMpumalanga?

- How can the service be integrated between the biomedical health and the indigenous health practitioners regarding the treatment of TB?



Kungahlanganiswa njani kusebenta kwabodokotela besintfu nebesilumbi ekulapheni sifo sesifuba?

- How can a model of convergence and engagement between African indigenous and biomedical health practitioners be created?

Singakhiwa njani sivumelwane emkhatsini wabodokotela besilungu nebesintfu ekulapheni sifo sesifuba?

These questions were asked in siSwati and in sequence as they appear. As the researcher knew little of the cultural background of the African indigenous health practitioners attempts to fit in included calling them ‘*Bogogo*,’ a term used by African indigenous health practitioners when talking to each other. The term ‘*Gogo*’ is a way of showing respect that is attached to their ancestral spirit. In order to motivate the interviewees to participate, several communication techniques were used.

After posing a question the researcher paused to allow them to respond on the content before they broke the *silence* themselves with significant information. *Probing* involved additional questions that encourage the respondent to explore the topic being discussed (Parahoo 2006:329). Tactics such as use of enquiring glance or repeating all or part of the interviewee’s response were used as probes. If the participant’s response was vague or unclear, the researcher repeated the question requested *clarification* by asking him or her to say more about the issue.

The researcher thus changed a vague statement (uncover new perspective) into a well understandable one (Parahoo 2006:329). In order to ensure that the researcher had correctly captured what the participants had said, the ideas, opinions and feelings of the participants were *summarised* in the researcher’s own words to check for accurate understanding. *Field notes* were taken during the focus group discussion though some information was missed because they sometimes spoke quickly. In this case the voice recorder was used to retrieve the data. *Observational notes* are descriptions of the events as experienced through watching and listening (Parahoo 2006:367). In this



study they reflected on what was observed regarding the appearance of the African indigenous health practitioners, non-verbal communication, events and the appearance of the consulting area.

A number of observations were noted by the researcher. The general appearance of the African indigenous health practitioner's home was sound, it being a well-constructed large house and three mud huts. The location was clean and herbs had been put outside to dry under the sun. All the health practitioners were dressed tidily, some wearing their ancestral dress coat and others wearing normal clothing. Some were seated on traditional mats, others on chairs.

2.3.1.3 Group no 3: DOT supporters who are supervising patients with TB to take their treatment

The research population for this group was set to comprise DOT supporters selected according to criteria of helping and supervising patients with TB on taking treatment and being willing to participate. They were selected through purposive sampling, which involves personal judgement in selecting the participants that were representative of the topic being studied as professional practitioners in their respective fields. For the access the researcher contacted the TB co-ordinator for the health services in the local area of the selected district telephonically and discussed the study with him.

The TB co-ordinator provided the contact numbers for the selected home-based care institution to the researcher to make arrangement regarding data collection. The researcher e-mailed the request letter to the manager of the selected institution, stating that permission to conduct the study from Mpumalanga Province had been obtained from the Research Ethics Committee, Department of Health, Chief Director of the selected district and the Chief Executive Officer at selected hospital in the Mbombela area where the data was collected. The TB co-ordinator requested the selected home-based care manager to help the researcher to identify the DOT supporters who were willing to participate in the study. The researcher approached the selected home-based care manager to explain the study and gained permission to conduct it.



The researcher indicated a desire to recruit participants from variety of clinical settings zones. This would provide richness of experiences on the nature of the relationship that had existed between DOT supporters and the patients with TB. The title and purpose of the study were explained to the participants who were willing to participate they were requested to give informed consent and sign the participation information leaflet.

The researcher purposively selected the participants who were representative of the various clinical areas. Because of the health and social challenges in the clinical area, on the day that the focus group was to be conducted, at Nkohlakalo zone only six DOT supporters made themselves available. At Kabokweni zone only five availed themselves and others reported sick, but the number was not specified. At the TV trust zone five made themselves available and others were reported to be having medical and social challenges. To all the three zones the researcher went to their working places for data collection. The selected home-based care manager provided accompaniment for the researcher to show where the DOT supporters met before distributing themselves for consultation with their TB patients. The DOT supporters gathered by the street they chose before distributing themselves, since they did not have offices and they only met together at the selected institution on Fridays.

The researcher selected all the participants in all three groups because they were meeting the selection criteria. Six DOT supporters at Nkohlakalo, five at Kabokweni and five at the TV trust were all females and focus group interview conducted. They were all Swazi speaking ethnic group. A focus group interview was conducted and field notes taken. A voice recorder was used to record the interview and participant observation was monitored. Six days before the focus group interview the participants were reminded about the interview date and time through the selected home-based care manager. On the day of the interview, an official who had been assigned by the selected home-based care manager went out with the researcher to the place where DOT supporters gather before they distribute themselves to go and check their



patients to ensure the availability of the participants. The participants welcomed the researcher at the street on which they usually gathered.

The interview was conducted on the street before distributing themselves to their patients. The venue was convenient as all the participants were meeting at the same place and for them to meet was not costly as they were staying around. The participants comprised six female DOT supporters working at Nkohlakalo zone, five at Kabokweni zone and five at the TV trust zone. In this case the participants were working in the same home-based care as DOT supporters but in different clinical areas. The number of participants was small enough to allow everyone to share experiences, opinions and insight and provided diversity of perceptions. In all three a focus group was formed.

The researcher assembled and tested the voice-recorder and arranged the participants in a circle to facilitate voice capturing and took field notes. After introductions the researcher welcomed and thanked the participants for making themselves available. They were provided with the context for the interview by briefing them about the research objectives, purpose of the interview and the use of the voice-recorder as a tool to help capture everyone's views. They were requested to complete a consent form to indicate their voluntary willingness to participate in the research study and they were also assured about the confidentiality of the interview. Their right to withdraw from participating whenever they wished was highlighted in their consent form.

The focus group interview was conducted in SiSwati and English, as not all the participants were able to understand English. As the researcher had no assistant, it was necessary to take notes and observe non-verbal cues. In order to be full control of the situation, the researcher requested that any participant wishing to contribute to the discussion should wait until the person talking stops. After establishing ground rules, the focus-group interview was conducted using interview guide that had been prepared in advance to ensure that the appropriate topics were covered in the session.

The questions in the guide were as follows:



- What are the experiences of the DOT supporters when supervising the patients with TB when taking their treatment?

Ngutiphi timo labahlangabetana nato bantfu labasita tigulane letidla emaphilisi esifo sesifuba?

- What are the viewpoints of the DOT supporters about the integration between the biomedical health and the African indigenous health practitioners regarding the treatment of TB?

Itsini imibono yabo ngaloluhlelo lwekuhlanganiswa kwabodokotela besintfu nebesilumbi kulapha sifo sesifuba?

On the 7th July 2014 a focus group interview took place with the DOT supporters. The researcher travelled to the places of the DOT supporters were because they were stationed at different places. The researcher created a relaxed environment and encouraged discussion and expression of differing points of view. The researcher emphasised that each participant's views were important and had to be expressed freely.

The researcher made an introductory statement by asking the participants to focus on the work they were doing and their experiences towards working with the patients with TB and the biomedical health practitioners. The reason for giving an introductory statement was to make them focus so that the researcher would get a clue about the participants' views. The researcher posed the questions and used probes and pauses to allow sufficient time for full discussion of these questions.

The participants participated actively and exhausted the information they had. The voice-recorder played back to the participants in order to verify if the information recorded was a true reflection of what they had said. The researcher once more thanked the participants and provided them with contact details. The researcher indicated to the participants the possibility of contacting them later when transcribing the interview to help clarify or verify a point that had been discussed. A focus group



interview took an hour and 30 minutes, with participants expressing their experience on the part of their field of work.

Following data analysis, as described above, trustworthiness of the study was ensured through sending the transcribed focus group interview to the study promoter and co-promoter who were experienced in qualitative research. A meeting was arranged between the researcher and the study promoters to discuss and reach consensus on identified themes.

2.3.2 Sampling

According to Polit and Beck (2008:765; Ibid 2017:743) sampling is the process of selecting a portion of the population to represent the entire population. Burns and Grove (2009:721) describe it as selecting groups of people, events, behaviours, or other elements with which to conduct a study. Non-probability, purposive sampling was used to obtain the sample, because the participants were believed to have the knowledge and experience needed by the researcher (Botma, Greef, Mulaudzi & Wright 2010:126).

They had to have two years or more of experience in the service. The sample size was determined by the saturation of information, when it began to repeat itself (Burns & Grove 2009:721; Polit & Beck 2008:765; Ibid 2017:745). The goal of purposeful or purposive sampling was to select information-rich cases from which the researcher could obtain in-depth information needed for the studies (Morse 2007, cited by Burns & Grove 2007:313).

2.3.3. Inclusion criteria

The inclusion criteria were all African indigenous health practitioners who practiced indigenous African medicine using natural substances, including bark, roots, leaves, animal skin, blood or parts of animals, herbs or seawater in the treatment of TB at the selected district villages, DOT supporters and all biomedical health practitioners providing health services to patients with TB within the selected district.



DATA COLLECTION AND ANALYSIS

Data analysis took place during data collection and thereafter. The researcher had to meet a number of methodological criteria when collecting data as recommended by Parahoo (2006:391), including the processes of data collection and making judgements relating to aspects of the phenomenon. They were systematically and accurately recorded, analysed and synthesised while talking to respondents in order to make sense of what participants said or what was observed. The aim was to produce reliable data.

2.4 DATA COLLECTION

Data collection is referred as a precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions, or hypotheses of a study (Burns & Grove 2009:695). Focus group discussions with African indigenous practitioners were conducted in three groups of 6-10 participants in each. The DOT supporters were also in groups of three, with each consisting of 6-10 participants (Burns & Grove 2009:513).

In structured observations the researcher was a tool of data collection and analysis during the process. Notes were taken as inconspicuously as possible so as not to disturb the normal flow of events (Parahoo 2006:362). Data collection was guided by the qualitative research method whereby the researcher interviewed the participants in their focus group in their natural setting and collected rich and valuable data for analysis from their points of view (Plowden & Wenger 2001:34-39). The method helped the researcher learn about the culture, beliefs, attitude and practices of the African indigenous health practitioners towards treatment of TB. The interviews were tape-recorded with the participants' permission and field notes taken during interviews. Data collection methods from the doctors and nurses was structured interview, in-depth individual interview and field notes. The researcher collected data from three sources to obtain diverse views about a topic for the purpose of validation.



2.5 DATA ANALYSIS

Data analysis is the systematic organisation and synthesis of research data (Polit & Beck 2008:751). According to Burns and Grove (2009:695) it involves reduction, organisation, and the giving of meaning to data. The voice-recorded data was transcribed verbatim and the transcriptions used as a database for the study. The data was analysed using Tesch's method, as described by De Vos (1998:343-344); De Vos et al (2011:397-405). This method helps create structure (Tesch in Creswell 2003:192; Creswell 2013:182-188).

Open coding was performed when the researcher sorted raw data into conceptual categories and created themes or concepts for analysis (Neuman 2000:240), utilising Tesch's method (De Vos 1998:343-344; De Vos et al (2011:397-405). The data was be analysed as follows:

- The researcher formed a sense of the whole by reading through all the transcripts. Some ideas were jotted down.
- One interview was chosen to begin the analysis. The researcher wrote down thoughts as they occurred.
- Similar topics were clustered together and formed into columns. The columns were arranged according to major topics.
- The topics were returned to the original transcribed data.
- The researcher found the appropriate descriptive wording for the topic and returned it to the categories. Grouping together topics that related to each other reduce the total number of categories.
- The researcher made the final decision on the appropriate abbreviations for the various categories.
- Data relevant to each category was assembled together and a preliminary analysis performed.
- The researcher coded the data and compared it with the results.

Analysis of data collected by structured observation is similar to that for qualitative interviews (Parahoo 2006:362), using Tesch's method (DeVos 1998:343-344); De Vos et al (2011:397-405).



2.6 LITERATURE CONTROL

A literature review provides a background to the problem studied, including a description of the current knowledge of the topic and identification of the gaps in this knowledge base. It allows for identification of the contribution of the present study to the filling of such gaps and contributions to existing areas or knowledge related to the topic (Burns & Grove 2007:189). The literature review was to examine theories relevant to the topic, established as a framework in which to answer the research questions. As indicated in the introduction, during the apartheid era the African indigenous healing system was oppressed and marginalised, and for centuries regarded as unscientific (Rautenbach 2005:1). Western knowledge, on the other hand, was considered the only universal scientific form.

Western healing enjoyed greater official acceptance by successive governments because it was seen to be based on “scientific and rational knowledge, whilst indigenous healing was seen to be based on ‘mystical’ religious beliefs” (Ibid 2005:1). As a result, most state and private funding has been dedicated to Western healing, perpetuating segregation of health services along socio-economic and urban-rural lines. In general, the white minority enjoyed the best health services, and the black majority received the worst because medical costs made it impossible for the poor to get medical attention, so people opted for traditional healers (Rautenbach 2005:1; Madamombe 2006:10).

In addition to the medical underpinnings of western treatment and indigenous healing, the framework incorporate a spiritual component. Ironically, for many centuries Europeans and other healthcare systems also had strong spiritual and religious components, before scientific thinking relegated it (Rautenbach 2005:4). The colonial movement largely ignored indigenous methods, regarding them as ‘witchcraft’ and conflating the politics of race with a dismissal of the ‘other’ as inferior and irrelevant (Health & Democracy 2001:204). Political developments in the second half of the twentieth century placed the dichotomy within a postcolonial paradigm, in which indigenous peoples began to openly question the dogma of their former oppressors, including in the field of medicine and healing. The struggle becomes clear within the



public health system, when users of biomedicine and African indigenous medicine are not receiving the same standard of care, for example in the treatment of HIV/AIDS as compared with TB. Most programmes are catering for HIV/AIDS, for example, AIDSCAP and AIDSCOM (Green 2004:1). Other programs are THETA, TAWG and ZINATHA, but there is not one for TB (Unite for Sight 2000-2013).

Currently, research into indigenous medicine is being conducted at the University of Cape Town and some indigenous medicines have been found to be effective in the treatment of conditions such as diarrhoea and malaria, with the potential to cure or improve the quality of life of people living with HIV/AIDS (Health & Democracy 2001:206; Mpinga, Kandolo, Verloo, Bukonda, Kandala and Chastonay 2013:5). Again, however, TB has not been mentioned among them.

A model was constructed, using aspects of culture, ethnicity, race, post-colonialism and neo-colonialism, to develop an understanding of the gap between the two systems, and therefore build a foundation for bringing together the two systems as mutually accommodating and understanding of each other's differences, and potentially beneficial applications (Health & Democracy 2001:205; Mpinga et al 2013:3). To focus the research within realistic parameters, it was to explore the nature of the relationship that exists between African indigenous and biomedical health practitioners with specific regard to the treatment of TB, in the healthcare delivery at a selected district in Mpumalanga province.

2.7 MEASURES TO ENSURE TRUSTWORTHINESS

To ensure the truthfulness, appropriateness and meaningfulness of the data, each participant verbalised confirm that the transcription of her/his interview was a true reflection of what have been said. Therefore, the participants met with the researcher again after interpretations have been made to verify the transcription interviews. Trustworthiness was ensured according to the four criteria of credibility, transferability, dependability and confirmability (Lincoln & Guba 1985; De Vos et al 2006:345-347).



- **Credibility**

Establishing credibility focuses in the truth of the data and conclusions of the study. It was ensured through the participants' engagement in the study. The researcher spend 30 to 45 minutes with each group so as to allow time to describe the nature of the relationship between African indigenous and biomedical health practitioners regarding the treatment of TB condition (De Vos et al 2006:346). According to Polit and Beck (2008: 539), credibility refers to confidence in the truth of the data and interpretations of them, whilst for Shenton (2004:64-66) the investigator must attempt to demonstrate a true picture of the topic. This was achieved through a number of techniques.

Firstly, Shenton (2004:65-66) states that credibility can be enhanced through *triangulation*, that is the use of different methods, in this study a focus group, interviews and field notes. The data gathered was cross-checked and compared to results from the literature review to confirm the findings. Secondly, *prolonged engagement* is essential for building trust and rapport with the participants (Lincoln & Guba 1985; De Vos et al 2006:345-347). The researcher spent sufficient time with the president of the African indigenous health practitioners by visiting him a day before the scheduled interview to establish rapport and building up mutual trust, confidence and a proper understanding of their way of thinking about the subject through the communication with him. Thirdly, a *member check* was carried out, that is discussion of the results with the participants to confirm that the transcription was a true reflection of what they said during the interview (Lincoln & Guba 1985; De Vos et al 2006:345-347). The researcher replayed a voice recorder to the participants who participated to discuss the interpretation of the data collected and to reflect if the true reflection was of what they have said.



- **Transferability**

The fourth aspect of Lincoln and Guba's framework (1985:289) is transferability, an alternative to external validity, that is the extent to which the findings from the data can be transferred to other setting or groups (De Vos et al 2006:347). Shenton (2004:69) cites Webster (2014:3) as writing that external validity "is concerned with the extent to which the findings of one study can be applied to other situations". Transferability is the strategy employed to attain applicability. The researcher employed a *nominal sample*, with purposive sampling regarding selection of the African indigenous and biomedical health practitioners.

- **Dependability**

Dependability refers to the reliability of data over time and over conditions, and is necessary for achieving credibility (Polit & Beck 2008:539;Ibid 2017:724). According to De Vos et al (2006), dependability is the alternative to reliability, in that the researcher attempted to account for changing conditions in the phenomenon as well as changes in the design created by refined understanding of the study. In this study complete description of the methodology used, verbatim transcription of interviews, data analysis and literature control provided to support and confirm the results

- **Confirmability**

Confirmability is the objectivity or neutrality of the data and to this end the researcher conducted a confirmability audit by using a tape-recorder, collected field notes, employed analysis reconstruction and synthesised the product (De Vos et al 2006:347). The researcher ensured that data collected was documented and participant's voice recorder for the evidence was safely kept for those who have authority in accessing the data. According to Lincoln and Guba (1985:300), it is the exclusion of the researcher's own prejudices from the research procedure and results. Preconceived ideas and bias did not influence the results, so neutrality is therefore the degree to which the research findings was the actual product of the participants.



An additional factor in ensuring trustworthiness was authenticity, or the extent to which researchers, fairly and faithfully, showed a range of realities. It also referred to genuine, real, veritable sharing of the sense of actuality and lack of falsehood or misrepresentation (Elo et al 2014:2). According to Edmunds & Scudder (2009:544) it focuses on the degree to which researchers faithfully and fairly described participants' experiences.

2.8 ETHICAL CONSIDERATIONS

The conduct of any research study requires honesty and integrity, to recognise and protect the rights of the subjects. To conduct a study ethically the protection of the participants' human rights is of paramount importance. Burns and Grove (2009:189) list these rights as self-determination, privacy, anonymity and confidentiality, fair treatment, and protection from discomfort and harm. Whilst for Parahoo (2006:112) they are beneficence, non-maleficence, fidelity, justice, veracity and confidentiality.

The right to *self-determination* means that the participants can decide voluntarily whether or not to participate in a study, without the risk of penalty or prejudicial treatment. It was explained to them that they have the right to withdraw from the study at any time, and even to refuse to give information or to ask for clarification about the purpose of the study (Burns & Grove 2009).

Subjects were treated *fairly* to promote good relationships between each other. The researcher respected the right to *privacy* of individuals, that is the freedom to determine the extent and general circumstances under which private information was shared with or withheld from others. Private information includes one's attitudes, beliefs, behaviour, opinions and records. Privacy of the participants was ensured by assembling them in their place of preference, for instance a natural setting such as home, hospital or clinic, in which they felt free and relaxed. The source of the information was not disclosed to anyone (Burns & Grove 2009).



The *anonymity and confidentiality* of individuals who agreed to participate in the research was and shall be protected. Their names were used for the research and pseudonyms are used where necessary. They had a right to know that the information collected from or about them will remain private. No data gathered within the scope of the project was or will be divulged or made available to any other person (McMillan & Schumacher 2010:338-339).

The researcher respected any agreement made with the participants. If data collection requires appointments the researcher was on time and terminated the data-collection process at an agreed-upon time (McMillan & Schumacher 2010:338-339). The researcher made every effort to *protect participants from discomfort and harm*, whether physical, emotional, spiritual, economic, social or legal. If the research problem was one that involved a potentially harmful intervention it would have to be abandoned or restated to allow investigation within ethical guidelines (McMillan & Schumacher 2010:338-339).

Permission to conduct the research in the selected district was obtained from the Mpumalanga province. The researcher applied to healthcare authorities of the Ethics Committee for permission to conduct the research study in the province. For access to the biomedical health practitioners permission was sought from the Chief Executive Officer (CEO) of the hospital and to the African indigenous health practitioners from the village headman of the selected district of Mpumalanga province.

Consent was obtained from the participants prior to their participation in the study. Their language was used to gain co-operation and understanding. A consent form was read and interpreted by the researcher to each participant in their language to gain their co-operation. The participants were requested to read and sign a consent form. The researcher visited them through healthcare and the African indigenous authorities to establish a good relationship and to gain their trust so as to enable them to be free and open during the research process.



2.9 SUMMARY

This chapter has described the research design and methods followed in this study. Methods to establish and enhance trustworthiness were also described as well efforts to ensure ethical rigour in this study. In the next chapter, Chapter 3 provided the data analysis, interpretation of the findings as well as the literature control.



CHAPTER 3

DATA ANALYSIS, INTERPRETATION AND LITERATURE CONTROL

3.1 INTRODUCTION

A description of the research methodology followed in this study was provided in Chapter 2. In this chapter, the data obtained from the interviews (phase one of the study) will be analysed and presented in the form of themes, categories and sub-categories, identified through data analysis and discussion supported by the quotations from the transcribed interviews. The findings were described and subjected to a literature control as appropriate.

3.2 RESEARCH FINDINGS

Data was first collected from the biomedical health practitioners. The biomedical health practitioners were named collectively as 'Group 1', consisting of registered nurses and enrolled nurses of patients with TB. All had experience of two or more years in the field of nursing patients with TB, either TB MDR, HIV/AIDS or normal TB and HIV/AIDS. The MDR and normal TB section were about 1 to 2 metres apart. The biomedical health practitioners were all females. Group 1, data was collected through unstructured in-depth individual interviews, field notes and a voice-recorder that was used with the permission of all. Ethical principles were observed throughout the interviews and the interviewees were made aware that they could withdraw from participating at any time if they wished, without any penalty. The results of the biomedical health practitioners were discussed as well as the themes, categories and sub-categories that emerged.

3.3 INDIVIDUAL INTERVIEWS: BIOMEDICAL HEALTH PRACTITIONERS

The participants gave their views regarding their experience as role-players in the healthcare delivery in the selected district of Mpumalanga Province. The themes that emerged from individual interviews outlined below:



- Acknowledgement of integration with the African indigenous practitioners
- Acknowledgement of establishment of Traditional Health Practitioners Act 2007, Act no 22 of 2007
- Empowerment of African indigenous health practitioners

3.4 THE DEMOGRAPHICS OF THE BIOMEDICAL HEALTH PRACTITIONERS

Participants in the individual interviews (Group1) displayed the following characteristics:

- GENDER

There were only 10 biomedical health practitioners in this study, all of them female. One male professional nurse and one male enrolled nurse were on night duty, with the other male enrolled nurse was two days off. All three were males.

- RACE

The 10 participants were all black, with no other races represented. The staff were all black except one Indian doctor who was not available during the interviews.

Table 3.1: Age of the participants

Age group	Frequency	Percentage	Cumulative Percentage
35-40	1	10%	10%
40-45	3	30%	40%
45-50	1	10%	50%
50-55	3	30%	80%
50-60	1	10%	90%
55-60	1	10%	100%
Grand Total	10	100%	

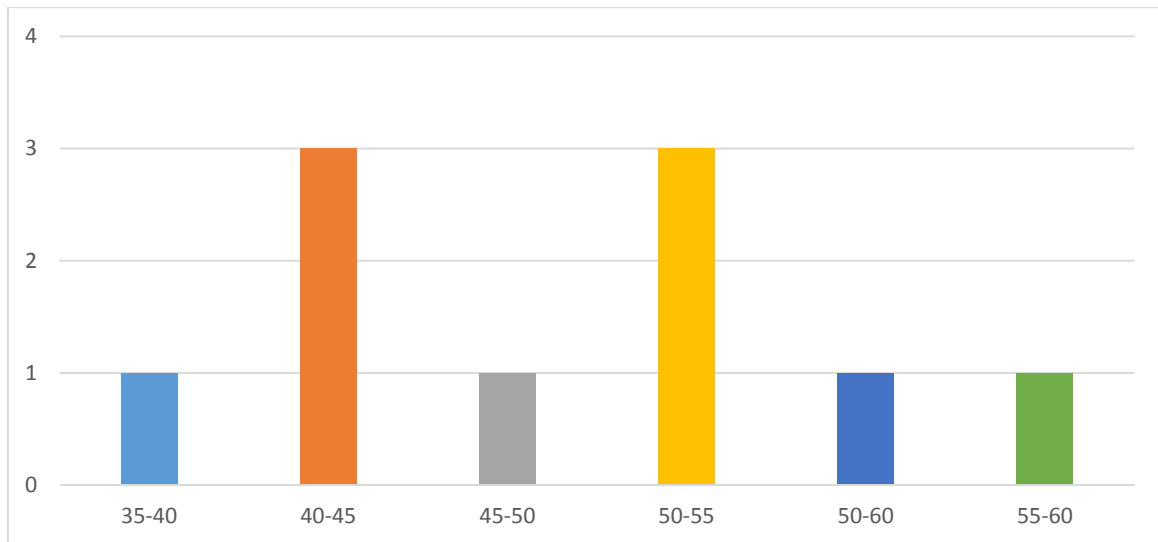


Figure 3.1: Age of participants

30% of participants were between the ages of 40 and 45 and another 30% between 50 and 55 years

Table 3.2: Years of experience in TB hospital

Years of Experience	Frequency	Percentage	Cumulative percentage
6 years	1	10%	10%
9 years	2	20%	30%
11 years	1	10%	40%
12 years	1	10%	50%
17 years	1	10%	60%
19 years	1	10%	70%
22 years	1	10%	80%
36 years	1	10%	90%
42 years	1	10%	100%
Grand Total	10	100%	

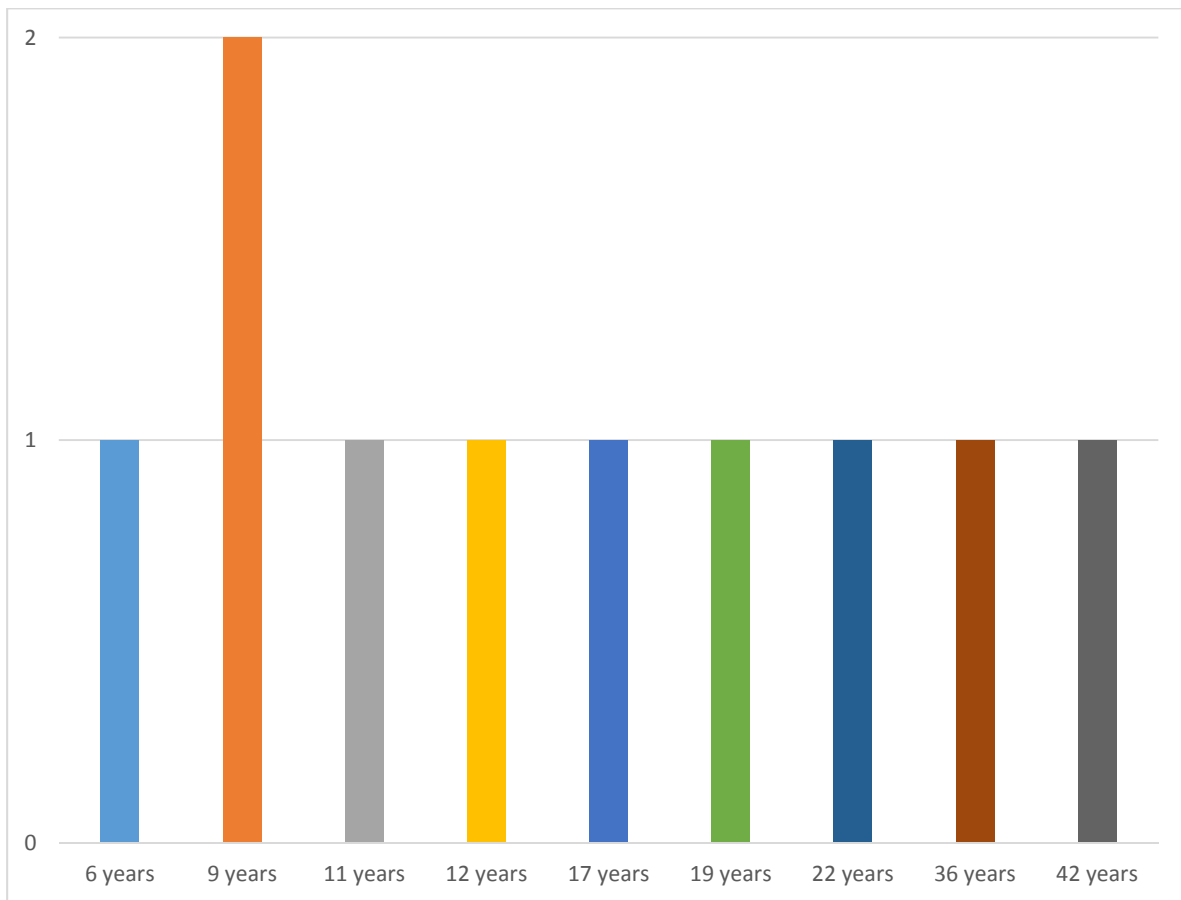


Figure 3.2: Number of participants

Table 3.3: Descriptive statistics of the years of experience

Descriptive Statistics of the Years of Experience	
Mean	19,3
Median	17
Minimum	6
Maximum	42

The years of experience of participants in the biomedical practice ranged from six to 42 years, spread widely between 19 years and 17 years.



Table 3.4: Highest professional qualification

Highest Professional Qualification	Frequency	Percentage	Cumulative Percentage
Diploma in General Nursing and Diploma in Midwifery and Occupational health	7	70%	70%
Diploma in General Nursing and Diploma in Midwifery and Occupational health and safety	1	10%	80%
Enrolled nurse	2	20%	100%
Total	10	100%	

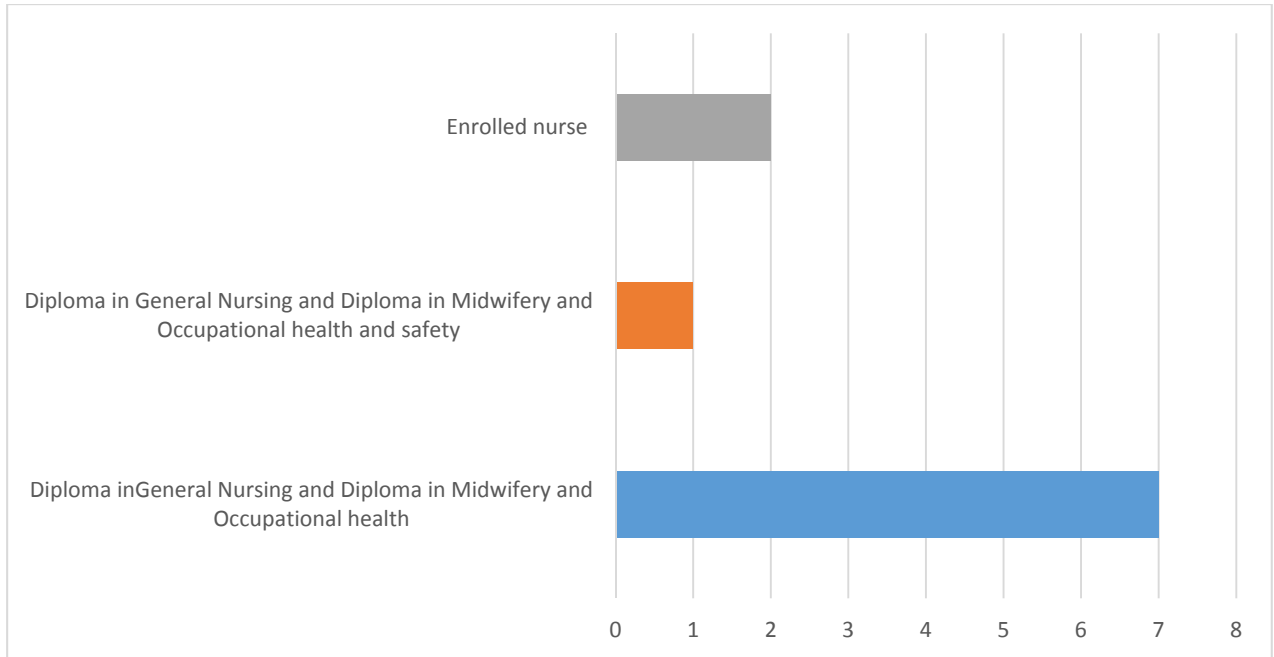


Figure 3.3: Number of participants

70% of participants had both diploma in General nursing, diploma in Midwifery and Occupation health, while 20% were enrolled nurses. Group 1 consisted of Shangaan- and Swazi-speaking people, all female and working with who had with TB for two or more years.



Table 3.5: The themes, categories and sub-categories are summarised below and will be discussed afterwards

THEMES	CATEGORIES	SUB-CATEGORIES
1.Acknowledgement of integration with the African indigenous practitioners	1.1 Referral method	1.Acknowledgement of expertise 2.Inability to identify signs and symptoms 3.Strong unmeasured African medicine 4.Delays in referral 5.Defaulting of treatment 6.Lack of food
	1.2 Group interaction	1.meetings 2.awareness campaign
2.Acknowledgement of establishment of Traditional Health Practitioners Act 22 of 2007	2.1 Acceptance of the Act	1. collaboration 2. health education
	2.2 against the Act	1. unhygienic conditions
3.Empowerment of African indigenous health practitioners	3.1 mutual respect	1. changing mind-set 2. building relationship
	3.2 understanding each other's sector	1. communication 2.research regarding treatment



The following themes emerged from the data collection.

3.4.1. THEME 1 - Acknowledgement of integration with the African indigenous practitioners

Biomedical health practitioners acknowledged the steps that the government have taken to integrate them with the African indigenous health practitioners by establishment of the Traditional Health Practitioners Act 2007, Act no 22 of 2007. Some praised the collaboration between the biomedical health and the African indigenous health practitioners but others felt it did not show any change because they were still experiencing problems from the African indigenous health practitioners regarding patients with TB. The following statements were made regarding their integration:

Participant B5 added by saying that:

“At first, at first “-----“most of the patients had TB. When they are diagnosed TB, they go to Sangomas and they tell them that they have something. Here at Mpumalanga they decided to call the Sangomas to give them health education about TB. Now they know the signs and symptoms of TB and they refer patients to the hospital. I think now we became one. Most of them they comply, Sangomas bring patients who brought to them for “ku thwasa”, when they see the signs and symptoms of TB on the patient they bring them here”.

B11

“Our society need to be educated that at hospital we don’t oppose the traditional way of healing but some of the things like TB they should refer to the hospital. TB is common that in African way they say is ‘Mafulatsa’ (is when a person coughs and become emaciated after death in the family when the rituals were not taken care of) and is a common disease”.

In other parts, the biomedical health practitioners showed reluctance and negative attitudes regarding integration with the African indigenous health practitioners. The researcher noted that some of the biomedical health practitioners did not approve the integration and did not wish to mix with them, despite the existence of the



Traditional practitioners Act 2007, Act no 22 of 2007 by the national government in Mpumalanga province, which had been established with the aim of reinforcing harmonious working relationship between biomedical health and African indigenous health practitioners.

The following views were expressed during interviews:

B3

"I can't rely to the traditional healers really because they give this not measured treatment, they give treatment to already damaged liver. Hygiene is poor. They give overdose because they can't measure, whether is too strong to the body weight, they don't measure".

B4

"My opinion, I think the herbalist cannot treat TB patient .They can't treat them. If a patient is having swelling they give them treatment to smoke and they sweat, thinking that sweat will reduce swelling and the condition become worse".

B8

"In Mpumalanga here at Bongani I never see the African healers. I never met them here at Bongani".

B10

"Aa-----h! What I have seen is that, this two don't collaborate".

The signs of acceptance (acknowledgement) shown by the biomedical health practitioners were health education and workshops for the African indigenous health practitioners regarding signs and symptoms of TB, referral of patients with TB by African indigenous health practitioners to biomedical health, integration between biomedical health and African indigenous health practitioners.

The challenges that were experienced by the biomedical health practitioners regarding the service that African indigenous health practitioners were rendering to the patients with TB were delays by the latter in referring them to hospital and the clinic, defaulting on treatment by some patients who continued with the indigenous



medicines, strong and unmeasured African indigenous medicine and poor hygiene. These acknowledgement and challenges were presented as categories and sub-categories, discussed as follows.

3.4.1.1 CATEGORY ONE: Referral method

Some biomedical health practitioners were concerned that African indigenous health practitioners did not refer patients with TB earlier to the clinic or hospital for consultation, but rather kept them under their care until complications set in, placing them in a critical condition.

The following were reported by participants B3 and B2:

B3

"They keep them until they see that is "five to" then they bring them to the hospital."

B2

"I can say, this is a bit problem because most of our patients when having the signs and symptoms of TB instead of going to the clinic and hospital they go to the traditional healers for consultation and they take time to come. By the time they come here they are critical ill. Then we start collecting sputum and you find that is late. Some they do make it some they don't."

Rautenbach (2005:1) and Viney, Johnson, Tagaro, Fanai, Linh, Kelly, Harley and Sleigh (2014:14) found that around 80% of the population in sub-Saharan Africa used indigenous medicine when ill, before consulting biomedical health practitioners, and many only consulted doctors when their disease was at an advanced stage or the indigenous medicine had failed (Bateman 2010:1). This type of behaviour was of concern to the biomedical health practitioners because it delayed diagnosis and treatment, resulting in spreading the condition to the community. Because of the patients' strong beliefs in African indigenous medicine after discharge some were returning to the practitioners with the mind of having 'tindzhaka' or 'mafulatsa', then defaulting on treatment. When the condition became worse they sought biomedical



assistance, by which time their TB had complicated to MDR-TB. MDR-TB, with an impact on the government in terms of treatment cost and families in removing their breadwinner during long-term hospitalisation (Lamsal, Lewis, Smith & Jha 2009:26).

The following sub-categories emerged.

- ***Acknowledgement of expertise***

The practice of indigenous medicine served the healthcare needs of most African communities before the introduction of biomedical medicine, otherwise referred to as 'Western' or 'conventional' medicine, and despite extensive colonisation it continues to be the primary and sometimes only accessible healthcare option for the majority of people living in sub-Saharan Africa (King, Balaba, Kaboru, Kabetesi, Pharris & Homsy 2004:1723-1725).

According to Jali (2009), indigenous knowledge systems refer to the body of knowledge and skills that African people have accumulated over time and that have been passed from generation to generation. Indigenous knowledge systems are dynamic because new knowledge is continuously being added, and innovative as they adapt to external knowledge to suit the local situation. In this study they are understood to be the bodies of knowledge accumulated over time, kept in the minds of the local people and shared through culture. African indigenous health practitioners are recognised by the communities in which they live. They invoke their social, cultural and religious background, as well as knowledge, attitudes and beliefs prevalent in the community, to address disease and disability, both physical and mental (Sandlana & Mtetwa 2008:119-131). It is also believed that they can heal diseases such as diarrhoea in children and suppress the activity of HIV/AIDS in the body, as the patient feels better when taking traditional medicine (Hlabano 2013:7). African indigenous health practitioners treated themselves as the pioneer of the indigenous medicine. They know plants, the use of it and also to mix and become what they want it to be. During interviews they indicated that biomedical system want to steal their knowledge as they want to learn types of plants, how it is mixed and types of diseases they treat.



- ***Inability to identify signs and symptoms***

There are positive acknowledgements of the African indigenous health practitioners regarding their contribution towards the health system in Africa, however, they lack training on the part of identifying the signs and symptoms to a patient with TB infection as they cannot differentiate TB from mafulatsa. Health education was important as they meet with the biomedical health practitioners in different workshops and when teaching each other about this killer disease. African indigenous health practitioners become empowered with knowledge during education activities so that they can identify signs and symptoms of TB to patients who need their care and handle the situation responsibly by referring to the clinic or hospital for further investigations before they attempt to give traditional medicine.

- ***Strong and unmeasured African medicine and the dirty environment***

Participants indicated that patients believe in tradition and when they are ill or discharged from the hospital they go to the African indigenous health practitioners and continue with their indigenous medicine. The participants further reported that African indigenous health practitioners do not measure their treatment when giving it, often so strong that it causes patients to become worse rather than better.

Van Rooyen et al (2015:4) found that patients consulting African indigenous health practitioners may develop abdominal distension, diarrhoea, dehydration and sores, all potentially fatal complications.

Participants B3 and B10 confirmed the above finding:

“They give overdose because they can’t measure, whether is too strong to the body weight, they don’t measure”. “African medicine, have got no scale measurement, they take a cup of medicine, it damages liver”.

The study conducted by Mngqundaniso and Peltzer (2008:388) also revealed that biomedical health practitioners felt that African indigenous health practitioners should



undergo some form of recognised training to rectify improper dosage to patients and poor environments in which they are working. Participants strongly emphasised that African indigenous health practitioners should be trained on the correct measurement of their medicine as they are giving overdoses, which in turn cause such problems as liver disease. According to Summerton (2006:15) the perceived weaknesses of the African indigenous health practitioner system include harmful treatment regimes, especially for people with TB, and also prolong the seeking of appropriate healthcare when traditional remedies fail to produce the desired effect.

- ***Delays in referral***

Biomedical health practitioners were concerned about the delay of TB treatment when patients began consulting the African indigenous health practitioners before attending a hospital or clinic. As the patients has their cultural beliefs they regarded the TB condition as '*tindzhaka*' or '*mafulatsa*', , the signs and symptoms are similar as that of TB. They did not believe that TB is caused by mycobacterium but associated it with not taking care of family rituals after a bereavement. The delay in referring the patients to the biomedical health practitioners resulted in spreading the disease to the entire family and the community, as TB is an airborne disease.

- ***Defaulting on treatment***

Biomedical health practitioners were concerned about the default of the TB treatment by patients after discharged from the hospital, as they returned to the African indigenous health practitioners to commence from where they had ended with the indigenous medicine, and they defaulted on the treatment they had received from the hospital. As the patients has their cultural beliefs they attached the TB condition as *tindzhaka* or *mafulatsa*, as above. The interruption of the treatment compromised the effectiveness of the hospital treatment. Taking of indigenous medicine by patients with TB results in sudden change in condition and even death if they are given strong indigenous medicine which damages the patient's liver.



Participant B3 said the following regarding this issue:

“In Mpumalanga “aa-----h”, since is a rural place people do believe of the Traditional healers which is really disturbing because patients end up defaulting treatment unless we can find a facility where we can keep them until they complete. When we discharge they go to traditional healers and default”.

The interruption of the treatment by the patients with TB result in developing MDR-TB with the patient needing to be given special treatment and also stay in hospital for a longer period (Lamsal, Lewis, Smith & Jha 2009:25-30).

- ***Lack of food during the period of treatment***

Lack of food leads to defaulters who in turn lead to MDR, which has an impact for a long period of hospitalisation with expensive treatment. Participants stated that patients defaulted on treatment because of hunger, scant knowledge about treatment, or not taking their treatment intentionally because they did not want to be discharged or healed for fear their pension will be cut off.

The following statement confirms the above:

DG1

“They do not know how to count the months and they discharge themselves before they complete the full prescribed months. Some are doing this because they receive pension and do not want to be healed because their pension will be cut off. They want their pension to be renewed. Some they do not take treatment accordingly because they default when they are drunk but they tick “.

Some default on TB treatment because of them believe that they have *Mafulatsa* or *Tindzhaka* which need to be treated by indigenous medicine and this condition have similar signs and symptoms as TB.



One highlighted the issue as follows:

DG3

“We blacks we believe in traditional healers because when they become ill they go to the traditional healers and they tell them that they has Mafulatsa not TB and traditional healers give them treatment to inhale and treatment that cause vomiting and the treatment does not work. Some patients mix alcohol and treatment and it does not work in that way”.

Summerton (2006:16) found that a large proportion of South Africans, hold strong traditional cultural beliefs and practices, which influence their reactions to illness, whilst, according to Van Rooyen et al (2015:5), patients consult the African indigenous health practitioners, are kept there for too long and only referred when their condition is at an advanced stage. Delays in referral result in prolonged hospitalisation and made it difficult to implement certain diagnostic, surgical and medical procedures.

DOT supporters also indicated the challenges that they are facing with when supervising patients with TB on taking their treatment. Participants expressed frustration when supervising patients taking TB treatment who were in poverty, misunderstood the TB condition and the treatment, defaulters and those who held to beliefs of cultural practices. They found it difficult to convince them about TB treatment compared with indigenous medicine and suggested intervention by the government to prevent foreseen problems that would hinder the eradication of the TB condition, especially for those in poverty.

DOT supporters reported the challenges hindering them from eradicating TB as patients were hungry and hence terminating treatment before completion. This attitude resulted in defaulters and more MDR.



The participants deliberated on the challenges that they experience during supervision of the patients with TB. These are words that they have said:

DG1, 2 &3

“They take treatment but they do not take it accordingly because they do not have food”. “What causes people to default treatment is lack of food”. “First challenge, first challenge patients take treatment at different times and some want to take treatment after meals while it should be taken before food. Some are crying of hunger. They want grant to be able to buy food, fruits and vegetables”.

DG1

I suggest that they should be given food parcels to encourage them to take treatment not to default. The government give them pension and the patient wish as if their sickness can continue so that they continue getting pension”.

DOT supporters further indicated the misconception of treatment by the patients with TB not having knowledge of the condition or that if hungry any treatment will result in side effects. Some patients defaulted on TB treatment because they felt dizzy and suffered swelling of the lower limbs. One participant reflected the following in her statement:

DG1

“They say when they take treatment they feel dizzy and their lower limbs become swollen”.

The above misconception requires health practitioners to have sufficient knowledge regarding treatment of TB condition and to be able to educate their patients to prevent myths or misconceptions around the condition and its treatment. The DOT supporters explained about the challenges that they are faced with, with the mind



that the government will take initiation in resolving the problems of poverty (hunger) among the patients with TB.

3.4.1.2 CATEGORY TWO: Group integration

Integration is taking place between biomedical health and African indigenous health practitioners whereby they share views regarding the treatment of TB condition (Mokgobi 2012:2). One participant reported the following:

B7

“Since then there is a great improvement. When the patient go to the traditional healer, the traditional healer will transfer the patient to the medical staff”.

According to the participants the integration between them and the African indigenous health practitioners had a positive impact on the service being rendered to patients with TB (Green, Short and Associates 2006:1).

In a study conducted by Mngqundaniso and Peltzer (2008:380-386) and Viney, Johnson, Tagaro, Fanai, Linh, Kelly, Harley and Sleight (2014:14), the positive impact of could be a benefit to patient care and promote trust and understanding between the two. Fatality rates have been reduced when comparing the time of isolation, as patients were brought to the clinic and hospital in a seriously ill condition.

Another participant expressed the collaboration as follows:

B5

“Sangomas bring patients who brought to them for ‘ku thwasa’, (initiation) when they see the signs and symptoms of TB on the patient they bring them here”.



The issue of integration between biomedical health and African indigenous health practitioners was of great advantage to those in need of their services, also highlighted as a benefit to the entire community by Matsabisa, Spotose, Hoho and Javu (2009:142). According to Green, Short and Associates (2006:2), the positive impact on patients with TB is brought about through convergence between biomedical health and African indigenous health practitioners.

The following sub-categories emerged

- **Meeting**

Participants reported that they did meet the African indigenous health practitioners for the purpose of workshop and health education regarding TB, with information sharing sessions in which they educated each other for the benefit of the patients. This is what the biomedical health practitioners said about their integration:

B1

“Here at Mpumalanga they decided to call the Sangomas to give them health education about TB. Now they know the signs and symptoms of TB and they refer patients to the hospital. I think now we became one. Most of them they comply, Sangomas bring patients who brought to them for “ku thwasa”, when they see the signs and symptoms of TB on the patient they bring them here”.

B7

“There is an integration because before, many patients died due to, ----- when they have signs and symptoms of TB they tend to go to the Traditional healers saying that they are suffering from “tindzhaka”, and they were inhaling some stuff that make them to cough more and bleed more. So it went and went until the government initiated the issue of coming together, let the traditional healers come together with the medical staff to talk about TB”.



According to Matsabisa, Spotose, Hoho and Javu (2009:142), good integration involves having the same understanding of TB through teaching signs and symptoms and treatment of TB (Viney et al. 2014:14).

Participants deliberated on the issue of meeting with the African indigenous health practitioners with the aim of improving the service delivery to the patients with TB. From the participant's experience it was evident that there had been a change regarding referral of the patients by the African indigenous health practitioners and they were able to share ideas when they met with them (Ibid. 2009:142). A number of studies have been undertaken by various researchers in which they have noted the improvement of service delivery to patients with TB when they involved the African indigenous health practitioners in their care (Busia & Kasilo 2010:3).

- **Awareness campaign, health education and workshops**

Participants indicated that training the African indigenous health practitioners would help and empower them with knowledge regarding the signs and symptoms of patients with TB and referring them in time in the hospital or clinic. These are their words to support their statement:

B1

“Biomedical health practitioners give health education to African indigenous health practitioners”. “They are explaining to the Inyangas how TB is spreading to prevent TB”. “They are workshopped through media and they know how patient can be handled with TB. Workshop is effective”.

The researcher then identified that meetings and health education were being practiced by the biomedical health to empower the African indigenous health practitioners with knowledge regarding TB. T is in the meeting that they open up to everyone and discuss their matter of concern regarding their practices towards TB



condition treatment. Their meeting is used for information-sharing sessions in which they educate each other for the benefit of the patients.

Matsabisa, Spotose, Hoho and Javu (2009:142-147) indicated the importance of training African indigenous health practitioners that the awareness trainings would increase their knowledge, improve their practices and able to consult with their patients. Mngqundaniso and Peltzer (2008:386) found that biomedical health practitioners believed African indigenous health practitioners lacked knowledge and understanding of the TB, thus they need to be trained for the condition for safety precautions when handling patients. According to Mngqundaniso and Peltzer (2008:386) most African indigenous health practitioners are willing to learn and refer patients to clinics and hospitals, having lost many of their patients by not doing so because they did not know the symptoms.

3.4.2 THEME 2: Acknowledgement of establishment of Traditional Health Practitioners Act 2007, Act no 22 of 2007

Biomedical health practitioners acknowledged the Traditional Health Practitioners Act 2007, Act no 22 of 2007. Their acknowledgement was based on the integration between them and the African indigenous health practitioners with regard to the delivery of quality service to patients with TB. Some participants did not acknowledge the establishment of the Act because they did not wish to collaborate with the African indigenous health practitioners.

3.4.2.1 CATEGORY ONE: Acceptance of the Act

Some of the biomedical health practitioners were reluctant to collaborate with the African indigenous health practitioners as they believed they were illiterate, working in poor hygienic conditions and using strong unmeasured traditional medicine on patients. They had to be coerced into abiding by the Traditional Health Practitioners Act, Act no 22 of 2007, and that this was not always straightforward is reflected in the following responses:



B2

“The treatment must not mix the treatment it cannot work they must see that they use it separate. To prevent them from mixing medication we give them health education”.

Participant B4 added:

“First we have to teach the African indigenous health practitioners, explain side effects to them, they understand before treating them. The doctors explain to them why patients are not healing and explain that they use to drain the treatment in their bodies in some hospitals where they have equipment’s to do so. We educate the families the danger of herbal treatment so that if patient is discharged they must not take patient to herbalist”.

B6

“Hmm! They must be health educated that how this patients should be nursed. They should have protected clothing like mask. They should refer patients with TB immediately”.

B7

“There is an improvement really, they refer patients to medical staff. The traditional healers can say a ngeke ngi ku bemise wena you are still weak,(it means that I can’t give you medicine to smoke) go to the hospital to get blood or drip”.

Acknowledgement of the Act by the biomedical health practitioners brought good collaboration between them and African indigenous health practitioners. It demonstrated a success in reducing the risks of the African indigenous health practitioner’s practices and encouraged them to provide appropriate information through health education and workshops (Busia & Kasilo 2010:3). According to Mngqundaniso and Peltzer (2008:380-386), most biomedical health practitioners felt



that collaboration with the African indigenous health practitioners would help in many ways as the practitioners were closer to the people, and if there was proper collaboration the patient referral system could be strengthened.

The following sub-categories emerged.

- **Collaboration**

According to *Oxford Advanced Learner's Dictionary* (2010:277), collaboration is the act of working with another person or group to create or produce something. In this study it involves creating mutual understanding through sharing of ideas and patient referrals with agreement between biomedical health and African indigenous health practitioners, in accord with the Traditional Health Practitioners Act 2007, Act no 22 of 2007. The latter are well known and respected in the community and are playing an important role in providing healthcare to about 80% of South Africa's population (Hlabano 2013:31).

Despite the foreseen benefit of the patients through this collaboration, some biomedical health practitioners are reluctant to accept integration with the African indigenous health practitioners for better service delivery.

The following responses to interviews were given by some of the biomedical health practitioners who did not accept the collaboration:

B10

"Aa----h! What I have seen is that, this two don't collaborate".



B3

"I can't rely to the traditional healers really because they give this not measured treatment, they give treatment to already damaged liver. Hygiene is poor. They give overdose because they can't measure, whether is too strong to the body weight, they don't measure".

However, due to increasing problems of TB and failure of the health systems to cope with the burden of TB many sub-Saharan African countries accepted the collaboration. In a study conducted by Busia and Kasilo (2010:3), collaboration had a powerful positive impact between these two parties, together with mutual respect and awareness. It should be based on understanding of the provision through dialogue and a free exchange of information on management of the disease. Between these two parties an acknowledgement of powers is important so neither party feels inferior. They must know that both are best in their area of speciality.

- **Health education**

The African indigenous health practitioners acknowledge the teachings that they receive from the biomedical health practitioners when they meet with them at the workshops. They indicated that the health education empowered them with knowledge that would enable them to handle TB patients with confidence and independently. Such teachings enabled both parties to understand and appreciate each other's contribution in the provision of service.

3.4.2.2 CATEGORY TWO: Against the Act

Not all biomedical health practitioners agreed with the Traditional Health Practitioners Act. The following is what they have said to show that they disagree with the collaboration:



B9

"If the department can visit them and do a research to the traditional healers to see if they are doing correct thing. My neighbour is a traditional healer , I use to tell her that her patients must bath and wash their teeth in a polite manner so that she cannot be angry to me".

B10

"...they must emphasise that the African medicine should be checked if is correct and the measurement because some of them they do not go to school to do their training".

Mngqndaniso and Peltzer (2008:386) indicated that some biomedical health practitioners had mixed attitudes towards African indigenous health practitioners, mostly negative (e.g., poor hygiene, lack of training and improper dosages). The former are aware that most of the community like to consult the later when they are ill, despite any negative attitudes towards them:

B3

"In Mpumalanga "aa-----h", since is a rural place people do believe of the Traditional healers which is really disturbing because patients end up defaulting treatment unless we can find a facility where we can keep them until they complete".

B5

"At first, at first "-----"most of the patients had TB. When they are diagnosed TB, they go to Sangomas and they tell them that they have something".

From the above comments it is evident that although some do believe that African indigenous health practitioners play an important role they did not wish to say it



openly. Despite the established Traditional Health Practitioners Act they are still resisting the opportunity to work hand-in-hand with them.

- ***Unhygienic conditions***

African indigenous health practitioners are perceived as having poor hygienic standards and most participants were concerned about the unhygienic conditions in which they practiced, for instance use of the same unsterilized razor blade on patients when making incisions or not measuring their medicines:

“You know what, to me, I was amazed, in fact most of our traditional healers hygienically they are not aware of the hygiene. When you got in there their patients do not bath, here at hospital we bath them. You find that their medicine stay for long time until it has that mould on top but they still drink.”

According to Van Rooyen et al (2015:4) there is concern regarding unscientific methods of traditional medicine, such as non-use of hand washing, non-sterile equipment, and lack of measured prescription of traditional medicine according to age and weight of the patient. Patients had complications, including diarrhoea, dehydration, poisoning and sores

3.4.3 THEME 3: Empowerment of African indigenous health practitioners

Participants indicated that they did come together with the African indigenous health practitioners over treating TB patients. Because of their meetings, the risky practices were being reduced and there was a great improvement in referring patients with TB to the biomedical health practitioners. The integration was seen by biomedical health practitioners as central and crucial to effective collaboration because they shared ideas as were conforming to the government encouragement to meet and address common health-related issues. Participant B7 said:

“So it went and went until the government initiated the issue of coming together, let the traditional healers come together with the medical staff to talk about TB”.



B5

“Here at Mpumalanga they decided to call the Sangomas to give them health education about TB”.

B6

“There are workshops where “ee-----r” health team and the indigenous where they come together. They are talking about TB”.

According to Matsabisa, Spotose, Hoho and Javu (2009:142) biomedical health and African indigenous health practitioners do meet to empower each other with the required knowledge regarding the care of patients with TB.

3.4.3.1 CATEGORY ONE: Mutual respect

Biomedical health practitioners wished to meet the African indigenous health practitioners, build relationship and involve them in health education and workshops, using any opportunity to meet and share ideas on the fight against the killer disease TB condition. They indicated that this could be a platform for them to create a model of convergence and engagement for harmonious service delivery:

B9

“when we do awareness, meetings let’s include them and they say ‘Va si memile e Themba’(they have invited us at Themba).There is this traditional healer they use to call to radio Ligwalagwala they become happy. We must teach them about hygiene and importance of cleanliness and they give them certificates and that will improve our relationship”.



B10

“I think if the Traditional healers can be united and have their own place where they get together teaching each other how the medicine works and involve the government”.

According to the participants' perceptions, workshops, meetings, health education and awareness, mutual understanding, communication, love and respect and research could address the challenges both groups are facing. If the model could be created according to the concepts laid down here, integration would be possible because there would be a meeting point.

The following sub-categories emerged:

- ***Changing mind-set***

Meetings, workshops, awareness and health education enhance working relationships and make both groups understand each other. They promote trust and respect and mixed mutual attitudes of undermining and mistrust can be addressed as they work together to reach their common goal. Each role must be clear in handling the patient with TB condition to prevent conflict and promote good relationship

- ***Building relationship***

Building a relationship requires opening of a two-way communication system in which both are able to understand each other's strength and weaknesses and to learn from each other. The two-way communication between biomedical health and the African health practitioners will reduce mistrust and disrespect because they will be able to share ideas about the referral and prognosis of their patients' condition.

The concepts of meeting, workshop and health education have been covered in the Theme 2 and 4, but apply here also.



3.4.3.2 CATEGORY TWO: *Understanding each other's sector*

The tension that exists between African indigenous health practitioners and biomedical health can be resolved, an issue is crucial to the optimization of healthcare of all. According to Wamba and Groleau (2012:51), patients seek healthcare from the two sectors, though biomedical healthcare is used by only 20% of the population whereas African indigenous healthcare is widespread and their services are relatively accessible and affordable to the other 80%.

According to Van Rooyen, Pretorius, Themhani and Ten Ham (2015:5), mutual understanding between the two groups was viewed as central and crucial to effective collaboration. Participants indicated that they did meet together and teach each other about health, as well as involving each other in meetings, health education, workshop and awareness programmes.

- **Communication**

Three participants indicated that communication could have a positive impact on service delivery and if the relationship could be developed integration would be promoted:

B1

“Good personal relationship between the two healthcare practitioners is to have communication line. African indigenous health practitioners must not feel inferior because they are not educated. They must know that they are doing quality nursing care”.



B2

"I think that I can say through communication they can integrate. Even teaching our community, health education about TB signs and symptoms and compliance to medication. We must make sure if our patients are discharged from the facility we must visit, phone them about the treatment outcome".

B4

"First of all we need to communicate well with them. We need to be patient because most of them are not educated and to treat patient with love and respect".

According to Kangwa and Catron (2010:1), tension between biomedical health and African indigenous health practitioners is fuelled by lack of trust and mutual understanding, as in the case of the two health practitioners with their significant differences in world view and lack of compromise. Kangwa and Catron (2010:2) further indicated that integration as the best choice would eliminate fear, mistrust and allow for the continuity of healthcare.

On the other hand, Soai (2012:1) found that African indigenous health practitioners were looked down upon by biomedical health workers and the negative attitude contributed to fear and mistrust because they were not accepted in the arena of healthcare service. Without cooperation and collaboration, success is not possible. In opting for integration one is focusing on one goal, and this approach requires patience and understanding of the groups with their unique values and beliefs. Effective communication can foster professional relationships, strengthened as information shared enables understanding of each other's world and treatment methods (Pinkoane, Greeff & Koen 2012:16).



- **Research regarding traditional medicine**

Participants felt that in order to sustain relationships, collaboration and trust research should be conducted on the site of African indigenous medicine, discovering its efficacy and safety:

B3

“Hmm! hey! Research should be done to this traditional medicine and come out with one medicine that can really help. Traditional healers can say we are using this, let the research or laboratory done to see if is killing bacteria”.

As USAIDS (2006:26) indicated, research is urgently needed to document the nature, value and effectiveness of African indigenous medicine practices as they will be important in initiating collaboration, which Busia and Kasilo (2010:3) found has a positive impact on the two parties. Collaboration goes together with mutual respect and awareness and therefore to be successful it must be based on mutual understanding through dialogue for a free exchange of information on management of the disease. Between these two parties an acknowledgement of power is very important so that neither will feel inferior, but rather both are best in their area of speciality.

For the African indigenous health practitioners to have clear understanding regarding the use of their indigenous medicine, research should be conducted before they use it, for safety purposes. Patients should be sent for physical examination and the impact and outcome of treatment determined by comparison of pre- and post-treatment laboratory results (Busia & Kasilo 2010:4). Participants, in their interviews, indicated that results from research or laboratories about the effectiveness and safety of the use of African indigenous medicine would bring a relief to biomedical practitioners. They felt that research should be undertaken to test African indigenous medicine before it is used.



The researcher will next discuss each theme and its related categories and sub-categories as in above order. Emphasis and quotations derived from the transcribed individual interview will be used. The researcher will also make reference to previous studies on the topic and to personal experiences to highlight similarities or differences between participants in the presents study.

3.5 FOCUS GROUP INTERVIEW: AFRICAN INDIGENOUS HEALTH PRACTITIONERS

Group 2 comprised African indigenous health practitioners, profiled the tables and figures as follows.

Table 3.6: Gender of the participants

Gender	Frequency	Percentage	Cumulative Percentage
Female	13	62%	62%
Male	8	38%	100%
Total	21	100%	

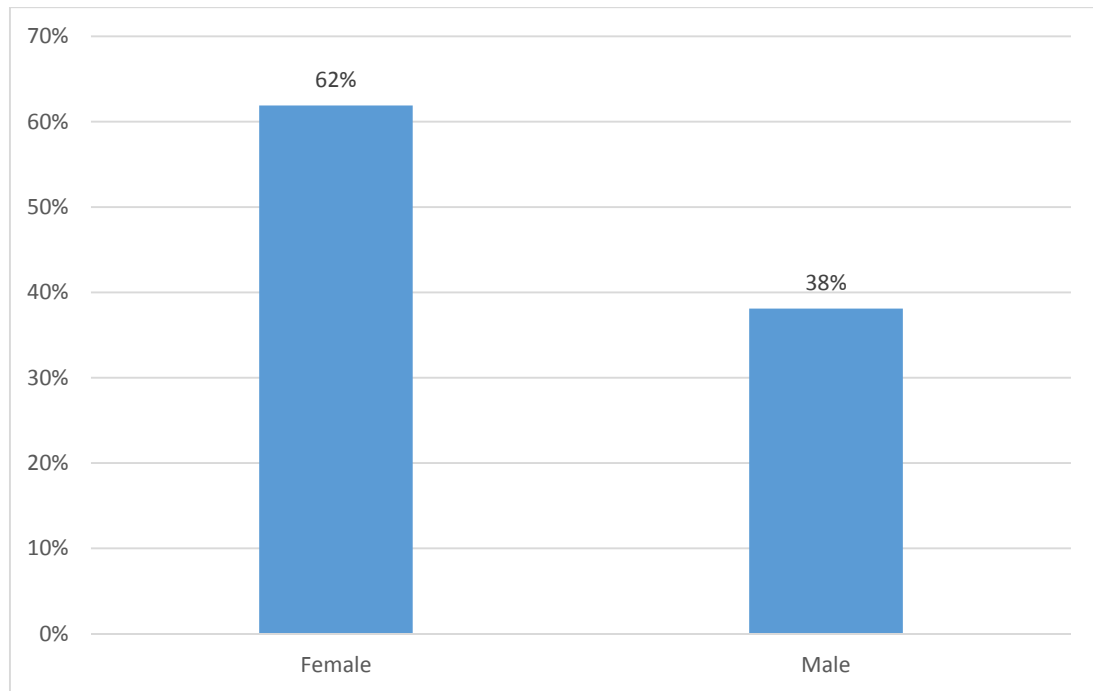


Figure 3.4: Number of participants

A sample of 21 African Indigenous health practitioners participated in this study, one of whom was the head of this group. The majority (62%) were female. All participants in this group were black.

Table 3.7: Area of the participants

Area	Frequency	Percentage	Cumulative percentage
Dwaleni (rural)	4	19%	19%
Gutshwa (rural)	10	48%	67%
Kabokweni(urban)	4	19%	86%
TV (rural)	3	14%	100%
Total	21	100%	

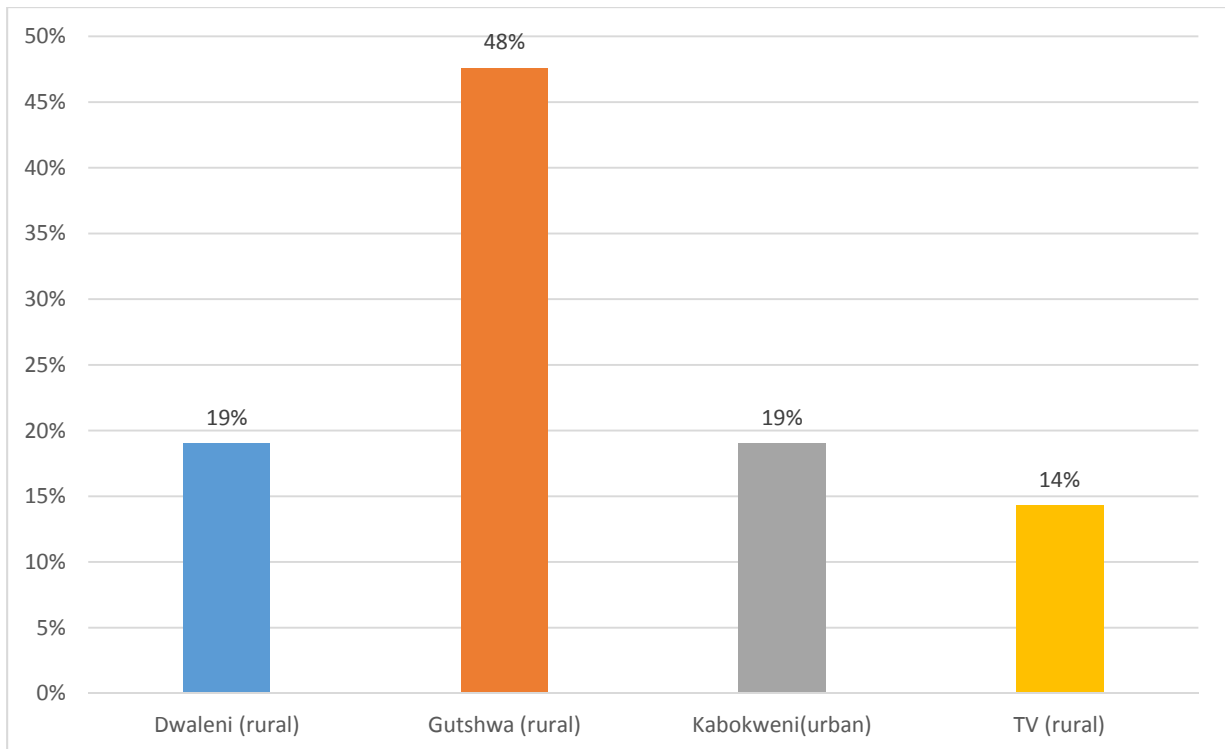


Figure 3.5: Number of participants

The participants in this group were from four different areas. Most of the Indigenous health practitioners are from Gutshwa, a rural area, followed by Dwaleni, also a rural area and Kabokweni, which is urban. Most practitioners in this group were from rural areas.



Table 3.8: Age of the participants

Age	Frequency	Age	Frequency
30-36	1	40-45	2
30-37	1	40-50	1
33-35	1	40-55	1
34-37	1	42-55	1
35-40	3	45-55	1
36-40	1	55-60	1
37-40	1	60-65	1
37-42	1	65-70	1
38-42	1		
38-45	1	Total	21

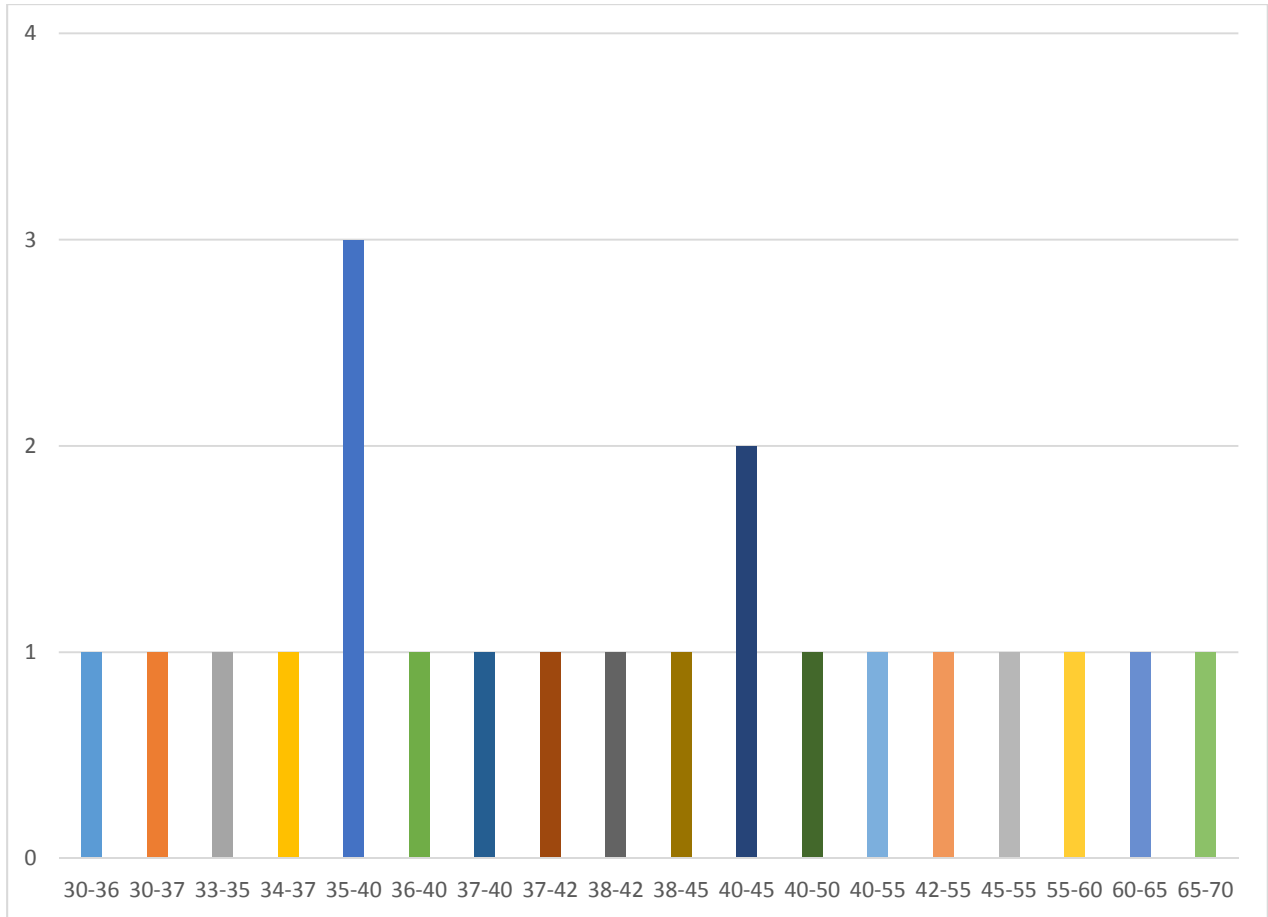


Figure 3.6: Age of participants

The age of participants ranged from 30 to 70 years. Age groups 35-40 and 40-45 were the only ones containing more than one practitioner



Table 3.9: Years of experience as African indigenous health practitioners

Years of Experience	Frequency	Percentage	Cumulative Percentage
3yrs	1	5%	5%
4yrs	4	19%	24%
5yrs	3	14%	38%
6yrs	3	14%	52%
7yrs	1	5%	57%
8yrs	1	5%	62%
10yrs	1	5%	67%
11yrs	1	5%	71%
12yrs	1	5%	76%
16yrs	1	5%	81%
18yrs	1	5%	86%
20yrs	1	5%	90%
28yrs	1	5%	95%
38 yrs	1	5%	100%
Total	21	100%	

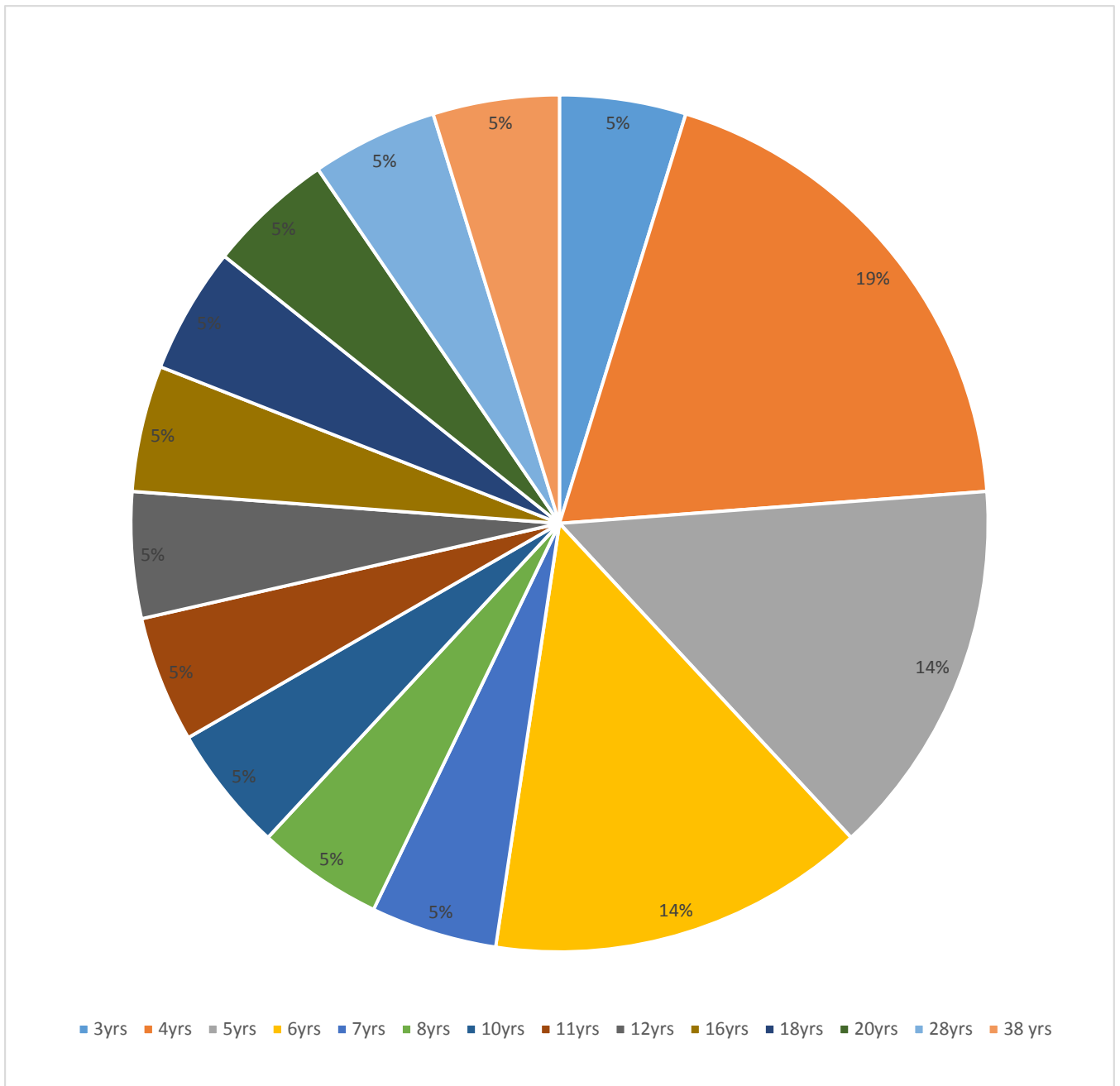


Figure 3.7: Chart title

Just over 50% of the participants in this group had work experience of between four to six years. The head of the health practitioners had 38 years of experience. 40% of the participants had more than 10 years' experience as African Indigenous health practitioners. The average years of experience was 13 years, with a minimum of 3 years and a maximum of 38 years.



Table 3.10: Highest qualification

Highest Qualification	Frequency	Percentage	Cumulative Percentage
Standard 5	1	5%	5%
Standard 6	1	5%	10%
Grade 10	4	19%	29%
Grade 11	2	10%	38%
Grade 12	10	48%	86%
Grade 8	1	5%	90%
Grade 9	1	5%	95%
Diploma	1	5%	100%
Total	21	100%	

Figure-38: Number-of-participants

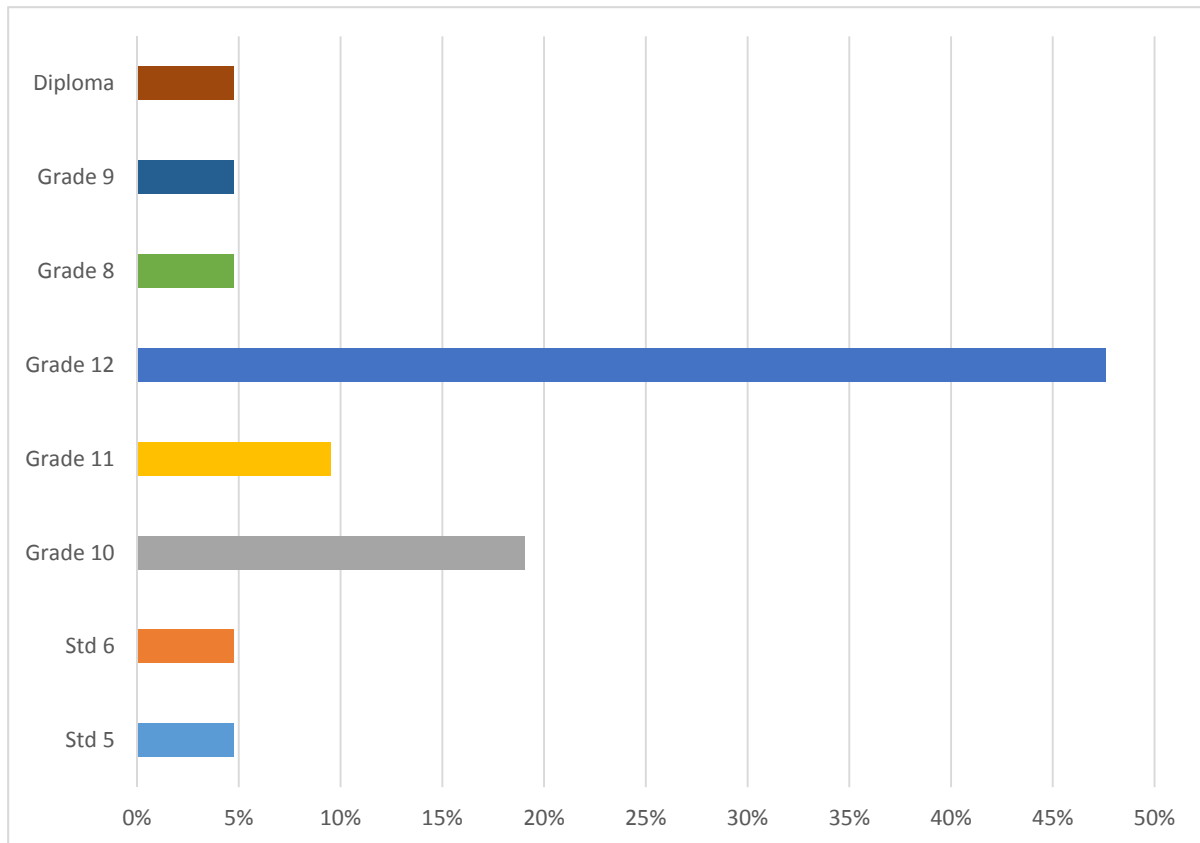


Figure-38: Number-of-participants

48% of the African Indigenous health practitioners in this study had grade 12. None had a diploma and two had standard 5 and 6 respectively. Diviners are the most important intermediaries between humans and the so-called supernatural. No one can become a diviner by personal choice (Pretorius 2011:251 & Mokgobi 2012:20) but rather the ancestors call them (more usually a woman) and they regard themselves as servants of the ancestors. Diviners concentrate on diagnosing the unexplainable, analysing the causes of specific events and interpreting the messages of the ancestors. They use divination objects and explain the unknown by means of their particular mediumistic powers (Portfolio Committee 1998:251).

Focus group interviews were conducted with three groups of African indigenous health practitioners at their homes. The first and second groups were in their homes and the third group was gathered at the president of the African indigenous health practitioner's home. Participants were in different age groups with three males and



two females in the first group, two males and four females in the second and the three males and seven females in the third. The level of education of the participants ranged from illiterate to possessing a diploma. They had been recruited from nearby villages such as Gutshwa, Dwaleni, TV and Kabokweni under the selected district. They were from both rural and urban areas.

The interviews were conducted in SiSwati and lasted between 45 and 90 minutes, with interruptions in most cases as they were giving examples of the situation that they were discussing. All participants were diviners (who had been for initiation) and had been practicing indigenous healing for two years and more. They all spoke I siSwati. The themes that emerged from the focus group interviews held with the participants in the groups were:

- Perceptions regarding patient's consultation
- Attitudes of biomedical health practitioners
- Views to enhance integration



The themes, Categories and their sub-categories are depicted in the table below.

Table 3.11: Themes, Categories and Sub-categories from group participants: African indigenous health practitioners

Theme	Categories	Sub- Categories
1.Perceptions regarding patient’s consultation	1.1 Consult for treatment	1. Trust 2. Affordability 3. Availability
	1.2 Strong believe system	1. Socialisation 2. Client satisfaction get cured 3. Source of illness
2. Attitudes of biomedical health practitioners	2.1. Disrespect	1.Superiority complex 2.lack of acknowledgement of African indigenous and their treatment
	2.2. Scepticism about their treatment	1. One sided referral 2. Lack of collaboration 3. Act forces biomedical to work with African indigenous health practitioners
3. Views to enhance integration	3.1. Capacity building	1. Education 2. Engagement of other stakeholders 3. Awareness 4. Sharing of ideas 5. Formal training of African indigenous health practitioners

Discussions will relate to the perceptions regarding patients’ consultation as role players in the healthcare delivery continuum in the selected district of Mpumalanga Province. Themes reflected the attitudes of biomedical health practitioners regarding their relationship with the biomedical health practitioners about TB condition treatment prior to the legislation of the Traditional Health Practitioners Act, situation



after the legislation as well as their viewpoints on their practices and views to enhance integration.

3.5.1. THEME 1. Perceptions regarding patient's consultation

Regarding the treatment of TB condition the participants indicated that they did not give treatment to a patient presenting with a history of influenza and cough prior to being investigated, and TB being excluded by the biomedical health practitioners. This indicated that African indigenous health practitioners considered their working relationship with the biomedical health practitioners by referring patients to them and acknowledge that they did not know everything, so they should work hand-in-hand for the benefit of the patients. However, some indicated the one-sided referral of patients. African indigenous health practitioners said the following to emphasise that they did not treat patients with TB:

Participant AG1:

“Let me say, We African indigenous health practitioners when a person come with the history of having flu, we send the person to the clinic. We meet with the nurses. There was a client from Delmas was given an appointment letter to prove that he does not have TB so that he can be treated for other things. We all do that, we do not give treatment without knowing whether the patient is having Asthma or TB, we do not treat TB”.

Participants AG2 and AG3 supported the above statement:

“We don't, we don't treat. We don't. Here at home we don't treat TB. We are not used to treat TB. There is a disease which is similar to TB called 'Mafulatsa' but when you come to me I send you to Gutshwa clinic to be checked TB. I f they say you do not have TB treat you”.



AG3

“We don’t treat TB, We African Indigenous health practitioners. We refer the patients to the clinic where they examine the patient. They give the patient treatment and advise me on how to give this patient the treatment”.

All participants indicated that they did not treat TB, but referred patients with a history of coughing to hospital or a clinic. African indigenous health practitioners took referral as an important factor and the essence of the collaboration, a sign for working together with the biomedical health practitioners. There is no literature on the issue of African indigenous health practitioners treating the TB condition.

3.5.1.1 CATEGORY ONE: Consult for treatment

Today, up to 80% of the African population rely on traditional medicine (Al-Rowais, Al-Faris, Mohammad, Al-Rukban & Abdulghani 2010:199). In South Africa, Rautenbach (2005:1) and Ross (2010:46-48) estimated that 70-80% of the population consulted 250,000 indigenous health practitioners, but only 28,000 medical doctors. Summerton (2006:15) indicated that the strength of the traditional healing system lay in its sharing of worldview and belief system of its users, it being an alternative to an inefficient Western healthcare system, privacy and absence of limitations in consultation, treating patients psychologically, and scientifically unexplained physiological relief of the symptoms of specific illness.

It was also estimated that between 60% and 80% of sub-Saharan African community members utilized traditional healers. These authors argue that traditional medicine is part of the culture and heritage of Africa, supported by Viney et al (2014:2), who emphasised the accessibility of African indigenous health practitioners in that traditional healers are usually consulted first as they are typically local, familiar, affordable, dispense medication for symptoms, and provide locally comprehensible and culturally appropriate explanations of disease causation.



It was well known and the literature confirmed that African community believed in culture that they have inherited from their forefathers or elders. They consulted African indigenous health practitioner when they were sick before consulting biomedical health practitioners or they rather seek self-treatment when they had no money to go to the African indigenous health practitioners. They had strong belief in cultural issues.

The following sub-categories emerged:

- ***Trust***

African indigenous health practitioners did not trust the biomedical health practitioners as they perceived them as exploitative on their part, intent on stealing their traditional medicine knowledge for their own gain. To emphasise the mistrust between the two health practitioners, one of the participants said:

“We treat at our own way but I cannot tell you how we mix our treatment. We once met with a white man from skukuza and asking us types of medicine we use and he wanted to know how we mix it but we did not tell him”.

According to Kangwa and Catron (2010:2), tension between African indigenous health and biomedical health practitioners is based on a lack of trust and mutual understanding, as the latter believe the practices of the former are unscientific. In turn, the latter feel that they are exploited because their knowledge about traditional medicine is needed but they are not told about the mixture of the treatment used by the former (Mokgobi 2012:54).

- ***Affordability and availability***

In sub-Saharan Africa, people rely on indigenous health because of their accessibility with the ratio of indigenous health practitioners to population approximately 1:500, while biomedical health practitioners have a 1:40,000 ratio, such that the former outnumber the latter (Health & Democracy 2001:204; Wamba & Groleau 2012:51). Regarding the ratios, African indigenous health practitioners are



easily accessible and can keep costs lower as they are being consulted in numbers (Wamba & Groleau 2012:51).

Communities may only consider using modern health facilities when they realise that the indigenous medicines have failed. In some communities patients first seek advice from a traditional health practitioner, who in turn prescribes herbal remedies or treatment based on the traditional system of thinking and belief (Oeser et al 2005:571-575; Bateman 2010:1). Only when there is no sign of improvement will the patient consult a hospital or clinics, by which time it may pose a serious challenge to life. Summerton (2006:16) found that the high utilisation rate of traditional medicine may be attributed to accessibility and affordability in the comparison to Western medicine, and it being firmly embedded within wider belief systems.

In support of the above information about the payments, one of the African indigenous health practitioners said:

AG2

“What happen is that I always preserve life, you have to understand that we preserve life. When you arrive even if you have fifty rand we treat you but in hospital they cannot”.

“We ask the person to pay fifty rand and will bring a thousand rand when is healed”.

Serbulea (2005:1) indicated that in terms of accessibility, since the ending of apartheid and introduction of universal suffrage, Western medicines are still not used by many of the healthcare users of the South African population. This may be attributable to several factors, on one hand the high cost which make it difficult for the relatively poor black majority to access, on the other the continued popularity of the more holistic approach followed by African indigenous health practitioners (Rautenbach 2005:2; Madamombe 2006:10).



The community treated the African indigenous health as the cheapest practitioners. When they got sick were treated free when they don't have money to pay for the service and asked to pay later. African indigenous health practitioners were preferred by the majority because of their availability. The participants indicated that the visit to the indigenous practitioners was not costing, it was a walking distance as they were staying in the same community. They visit the African indigenous health practitioners at any time without time restrictions unlike the biomedical practitioners where they have opening and closing time.

3.5.1.2 CATEGORY TWO: Strong believe system

South Africans perceive TB differently, for instance, differing beliefs and worldviews have an impact on understanding and meaning of concepts such as disease, illness and wellness. The condition of TB and indigenous medicine is perceived differently in various communities, with some believing it to be caused by 'witchcraft', and others that it is the result of cleansing rituals not having been carried out and so to be treated by indigenous medicine.

One of the participants emphasise a belief in traditional issues:

DG2

"When we visit them we find traditional medicine and they said their grannies were using traditional medicine so they cannot leave it".

In a study by Gqaleni et al (2010:296), 80% of South Africans utilise and rely on indigenous medicine for their healthcare needs, as other patients are resistant to leave indigenous medicines because of their condition and take both simultaneously or stop Western treatment. Such an attitude shows that they are dependant and rely on indigenous medicine. Summerton (2006:15) found that in South Africa an estimated 70-85% of the population use African indigenous medicines to help meet their healthcare needs. The high rate may be attributed to its accessibility and affordability, as Gqaleni et al (2007:178) indicated that African indigenous health practitioners are estimated between 150,000 and 200 000 in the country.



South African has strong belief in indigenous medicine. Their attitude led the government to negotiate for collaboration with the biomedical health practitioners to improve the healing of TB because they were fighting a losing battle.

The following sub-categories emerged.

- ***Socialisation***

African indigenous health practitioners are part of the community and share its socio-cultural values, including beliefs about the origins, significance and treatment of ill-health. The African indigenous health practitioners are recognised by the community in which they live as competent to provide healthcare, whether by using vegetables, animal or mineral substances. They invoke their social, cultural and religious background, as well as knowledge, attitudes and beliefs prevalent in the community, to address disease and disability, both physical and mental (Sandlana & Mtetwa 2008:119-131). They are well known, respected, trusted and culturally accepted within their communities.

- ***Client satisfaction in being cured***

African indigenous health practitioners' healing models are holistic and treat the "whole" person, employing interventions targeted at all forces responsible for ill-health. Both symptoms and causes are addressed in order to ensure health or wellbeing and harmony in human functioning (Comas-Diaz, Edwards & Holdstock 2010:284). This comprehensive approach was concerned with illness prevention, health promotion and/or cure (Gumede & Staugard in Bujuwoye & Sodi 2010:285).

According to Jali (2009:42), African indigenous health practitioners are popular due to the approach to health, being holistic in approach to illness treating and the spiritual and physical wellbeing of patients whilst allowing for the interdependence of the body, mind and environment, while the biomedical health practitioners approach to health focuses only on the body and excludes the mind. It does not address the root cause of the problem so the patients with TB achieve satisfaction about the healing system of the African indigenous health practitioners.



- **Source of illness**

African communities believe that illnesses come through witchcraft and sorcery, and when they become ill most sufferers seek diviners to throw bones and tell them the cause of the illness before they take a step of treating the disease. Jali (2009:35) states that witches cause illness by making the environment dangerous and thus disturbing the balance between it and the individual. This may occur because of an unhealthy relationship among members of a community.

It is believed that these evil spirits among the community are placed in the environment and can be picked up through inhalation or through contact when the sorcerer smears harmful substances on objects that the victim is likely to touch or by stepping over. In this study, the community believe most in *Mafulatsa*, which happens when a person has not undergone cleansing rituals after a death in the family. The signs and symptoms of *mafulatsa* are similar to those of TB so the biomedical health and African indigenous health practitioners, through their convergence and engagement, will both investigate the cause of the illness in their own ways and come up with the results before they give treatment to the patient with the condition.

3.5.2 THEME 2: .Attitudes of biomedical health practitioners

Participants expressed their feelings regarding the treatment that they received from the biomedical health practitioners which made them uncomfortable:

AG2

"It is not happening, I was having a learner who has TB and I referred her to Mantangaleni clinic and I followed their instructions but when we asked them not to inject the patient because of other diseases they did not listen to us, they inject our patients and after that we experienced difficulty to treat that patient"



Participant AG1 added:

“My sister, according to us we are very happy for the government to make the togetherness with nurses, doctors and Christians but they do not like us, but the Zion (ZCC) are right, they accept us”.

Participants further expressed their unhappiness regarding the treatment they received from the government:

AG2

“Even Motsaledi took a person to represent me, what is it that going to talk on my behalf while is not a traditional healer. Now we need a council like nurses because they have their council. We need it so that when we are not paid for work done we must know where to go and report. When Traditional health practitioner treat a patient and write a letter to the employer they don't recognise our sick note. The government told us that we are allowed to write our patient's sick notes but it does not work. When a person bring sick note from a nurse they accept it”

Soai (2012:2) found the main cause of the problem to be poor regulation over the African indigenous health practitioners, which made it impossible for health authorities to closely monitor African indigenous health practitioners systems and establish a set of practices and standards. Despite pre-traditional healing legislation having been enacted in a number of countries, indigenous healing is still unregulated. A lack of regulation and development has had a negative effect on African indigenous health practitioners and their patients due to the absence of precedents to follow. They find themselves being undermined because of their unregulated legislation and their practices (actions) are not monitored, with no rule to follow unlike the biomedical health practitioners that need to follow certain rules or practice within certain parameters (scope of practice).



AG3 participant further expressed his feelings that indicate mistreatment by the biomedical health practitioners:

“Before the Traditional Health Practitioners Act, the nurses were not accepting us saying that we cannot treat. If there was a fly machine that could spread poison to traditional healers and herbalists we should have been dead. Before, when taking patient to hospital we use to bath them red treatment that applied on their heads because they would not accept us in that situation. Christian nurses were not accepting us but others they do accept us. Another doctor said to me ‘if you don’t have money you don’t have, but if you have money here is the treatment two hundred rand. I drank the treatment but the taste was like (ligalagala) traditional medicine”.

3.5.2.1 CATEGORY ONE: Disrespect

African indigenous health practitioners feel disrespected when treated by the biomedical health practitioners, looked down upon and not considered as health practitioners who can bring change to the treatment of patients with TB. According to Hlabano (2013:45), biomedical health practitioners do not believe that other cultures have anything special to offer in the medical field and only recognise medical doctors, specialists, dentists, veterinary surgeons, and professors of medicine from various medical faculties across South Africa or abroad who demonstrate sound science in the medical profession.

The following sub-categories emerged:

- ***Superiority complex and lack of acknowledgement of African indigenous and their treatment***

Participants perceive that the biomedical health practitioners did not respect them because they did not allow them to visit their patients when admitted to the hospital as the doctors did. The African indigenous health practitioners wished to be free when visiting their patients in the hospital so as to monitor their conditions.



Participant AG2 displayed his anger:

“If they can allow us to go to the clinic to check our patients, they must give us permission because we all meet because of the patients because I do not give them anything to smoke I have come to check my patient only. (An example of the situation to reinforce an understanding to the colleagues.) Maybe a patient is having a wound and when I go to see and attend to my patient they don’t allow me to check my patient. I promise to hit some because they undermine us”.

The participant continued talking about the promised piece of land that was to be given to them in order to plant their indigenous trees for use when treating their patients:

AG2

“The trees (for traditional medicine) will not work for us because they won’t allow us to go at any time to use our trees because they will lock their gates. We need our piece of land because that one in Phaphamani is for the community. I may find that they have removed seven trees, what will I say? We want a piece of land where we can be able to control. We want our place”.

3.5.2.2 CATEGORY TWO: Scepticism about their treatment

Participants indicated their concern regarding the unscientific methods of traditional medicine, such as poor hygienic environment, not washing hands, non-sterile equipment, and the lack of measured prescription of traditional medicine according to the age and weight of the patient.

The following sub-categories emerged:

- **One-sided referral**

Participants stated that they did refer patients to the biomedical health practitioners but they did not reciprocate because they were regarded as illiterate:



AG2

“We African Indigenous Health Practitioners try our level best but nurses took us otherwise. If a person come to us and find that the person is having TB we send the person to the clinic but nurses do not refer the person to us. Nurses believe that we African Indigenous Health Practitioners are illiterate”.

Participant AG1 elaborated on the issue of referral:

“We meet and come to an agreement, then they ask if we refer our patient to the clinic or hospital (the participant elaborated the situation as he was not home for three days and has just arrived), I have just arrived and found that there was a person who ill and they took her to the hospital, I suggested to take the person to the clinic to be checked before we treat her. What I’m trying to say is that we do not treat the patient before they diagnose at the clinic”.

Wamba and Groleau (2012:56-57) found that prophets referred patients to African indigenous health practitioner whilst biomedical health referred them to other biomedical clinicians rather than non-biomedical practitioners. Priests referred patients to other reverends and hospitals. The literature emphasises the one-sided referral by the African indigenous health practitioners to biomedical health practitioners. Kangwa and Catron (2010:1) regarded the one-sided referral of patients to the biomedical practitioner by African indigenous health practitioners as due to lack of trust and mutual understanding between them. Most participants viewed it as a way of undermining them as they were treated as illiterate. According to Soai (2012:1), biomedical health practitioners have looked down upon African indigenous health practitioners and viewed them with scepticism and disdain.

- ***Lack of collaboration***

The relationship between the two groups was one-sided because the African indigenous health practitioners show their integration by referring patients to the biomedical health practitioners but not vice-versa. This attitude was reported as follows:



AG2

“We meet but it does not help. Maybe is just because they get salaries and we do not. Even Motsoaledi took a person to represent me, what is it that is going to talk on my behalf while is not a traditional healer? Now we need a council like nurses because they have their council. We need it so that when we are not paid after work done we must know where to go and report”.

There are various factors that hinder the effective collaboration, including the African practices being labelled as “primitive and savage” and their traditional medicines perceived as posing a danger to the health of their patients (Summerton 2006:17; Wamba & Groleau 2012:50). As the African practices are not monitored and there is unregulated legislation, whatever they are doing is not taken into consideration by other health practitioners. They are taken as harmful practitioners and their treatment as detrimental to their patients.

African indigenous health practitioners were concerned about the treatment that they receive from the biomedical health practitioners. The referral of patients was one way not two way as they have agreed during their meetings. The negative attitude by the biomedical towards them was still observed. When the refer patients they were not getting feedback.

- ***Act forces biomedical to work with African indigenous health practitioners***

Participants acknowledged the establishment of the Traditional Health Practitioners Act 2007, Act no 22 of 2007 and indicated that they appreciated the effort that the government had made to collaborate these two health practitioners, although nurses, doctors and some Christians did not like them. According to the participants, the establishment of the Act was of no significance to them because the situation remained the same. Biomedical health practitioners were being forced by the Act to meet with them.



3.5.3 THEME 3: Views to enhance integration

Some participants acknowledged the integration between them and the biomedical health practitioners regarding the service that they were rendering to the community, but others were not happy because they were still experiencing hardships when working with the biomedical health practitioners.

Positive words from the participants to support their integration with the biomedical health practitioners were as follows:

AG1

“The nurses and traditional healers must work together and respect each other. Nurses nurse patient with Mafulatsa unaware thinking that is TB. Mafulatsa is when there is a death in the family and someone who touched the corpse cook for the people, those people get sick and also a person who slept with a man. Tindzhaka is when a person is coughing and is chick. When the person sleep adopt a lithotomy position. When you sleep with a widow you get tindzhaka because the blood of her dead husband is still in her blood”.

One participant supported the statement that they worked hand-in hand with the biomedical health practitioners and also advised their patients and colleagues that when they are sick they must seek help from the hospital:

AG3

“Today I told someone to go to the clinic for investigations and she told me that will go tomorrow”.

3.5.3.1 CATEGORY ONE: Capacity building

African Indigenous health practitioners indicated that their collaboration with the biomedical health practitioners could be strengthened through, meetings, workshop, health education, mutual understanding and respect. They should overcome mutual differences and work together harmoniously. They also indicated that they were being educated about TB and HIV/AIDS:



AG1

"We traditional healers meet with the nurses, they give health education on the care of patient with TB. We try our level best to follow their instructions by referring any patient coming to us complaining of anything related to cough before we give traditional medicine".

The above shows that the African indigenous health practitioners have their own rules in their industry to discipline their members when committed an offence.

Participant AG3 said:

"What can integrate us is the government? Government can integrate us and become one thing. The government must be told that the traditional healers are happy to meet with the nurses. We can meet for learning with nurses and police".

The participant added that the government promised to build them (tindhumba) houses in which they could consult their patient:

AG3

"I remember when they call us and tell us that the government will build us (tindhumba) ancestor's houses to work in and phones because I'm also a doctor. Government took money and give to people and they drank liquor now I hire a transport to transport my patient to hospital. We want to have our office where we can meet each other. We use suggestion box because it helps but not well. We ask you to tell them that people are suffering in the hands of nurses. Please help us with gloves because we use razors to cut the patients. They must give us as they are doing to condoms".



Their final concern was:

AG3

“Nurses’ integration with traditional healers. If we can get a building where we meet with them to treat and to talk about the treatment of different diseases. If there are traditional healers to meet with the nurses, there should be a person who will gather all the nurses and traditional healers at the meeting point. Like now as you see this people, I phoned them all. If we can have a meeting point we could be more than this. If the government can build us a house we would hire a person to guard the place where we would meet”.

On this theme the participants were elaborating on the factors that would help in creating a model of convergence and engagement, showing that learning and integration were occurring between them, the biomedical health practitioners and other departments, including involvement with the police in the workshop. It is clear that African Indigenous health practitioners were aware that collaboration meant knowledge, good relationship and mutual respect between the two groups in order to render a quality service to patients with TB.

The following sub-categories emerged.

- ***Education, awareness and workshop***

African indigenous health practitioners indicated that they did meet with the biomedical health practitioners for empowerment on the knowledge of TB, HIV/AIDS and cleanliness:

AG1

“There is Gutshwa clinic where I send people to them and we attend classes and we get certificates. During this classes we cook food and we meet with nurses and police. Sometime we learn about TB, HIV because AIDS they mean when you are ill. HIV is when you are like me. We learn about TB, HIV, AIDS and cleanliness of the traditional healers house (ndhumba) (is a house which they use to store their



traditional medicine and also practicing their service), and how to handle the learners. When you ill-treat a learners and be reported to me (the head). I keep the learner with me until the supervisor of the learner come and fetch the learner. If the supervisor does not come to fetch the learner I send the learner to the police station. If may happen that the supervisor's case is defeated he or she loses the learner and the money".

- **Engagement of other stakeholders: Ward councillor, traditional healers and the nurses**

Participants expressed an interest in involving the councillors as the people to instruct and urge the African indigenous health practitioners not to treat patients with any illness related to cough before being investigated for TB.

They also acknowledged the importance of meeting of the councillors, nurses and traditional healers to discuss TB:

DG2

"I suggest that a councillor should be involved to intervene and instruct the traditional healers to refer TB patients to the hospital. TB treatment and traditional medicine is not taken simultaneously, is better we tell them to alternate".

DG3

"The councillors, nurses, doctors and traditional healers should work together and encourage patients to take TB treatment. TB kills and most here in Mpumalanga".

- **Sharing of ideas**

Most of the African indigenous health practitioners were receiving training in biomedical approaches to establish a collaborative relationship and improve patient care, which would help to improve communication between patients. Both groups of healers would understand the different forms of health treatment and be able to



provide respectful guidance and coordination between the systems. They would then be able to participate in informed discussion with patients about alternative medicinal options and allow them to seek alternatives, thus opening communication between the patient and the practitioners (Mark & Chamberlain 2012:102)

- ***Formal training of African indigenous health practitioners***

According to the participants, African indigenous health practitioners gave patients treatment to induce vomiting and smoke inhalers, which contradicts general biomedical TB treatment. They stated that they should be empowered with knowledge regarding signs and symptoms of TB and TB treatment so that patients would receive quality care.

DG3

“I think if they can call traditional healers and teach them that they must refer patients to the hospital. Traditional healers must be fair and taught about TB. Nurses, doctors and traditional healers should meet and discuss about TB. I think people can be healed”.

According to Gqaleni et al. (2010:295), African indigenous health practitioners receive learning to empower and promote their understanding so that patients can consult freely and receive health information from them. The knowledge will allay myths and misconceptions in the minds of the patients regarding TB treatment.

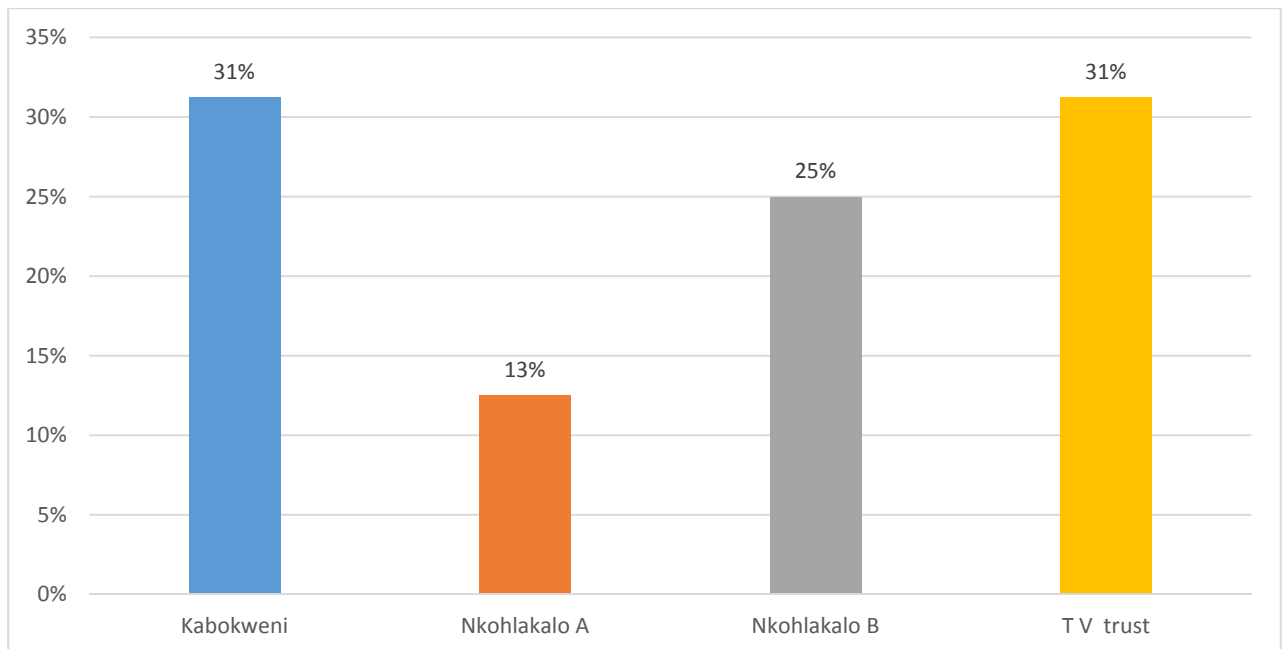
3.6 GROUP 3: DOT SUPPORTERS SUPERVISING PATIENTS WITH TB

Representation of the group in terms of residential area, number and gender was ensured, as summarised in the profile of the participants in Table 3.12 below.

There were 16 participants in this group, all female and one the leader of all the groups.

Table 3.12: Residential area

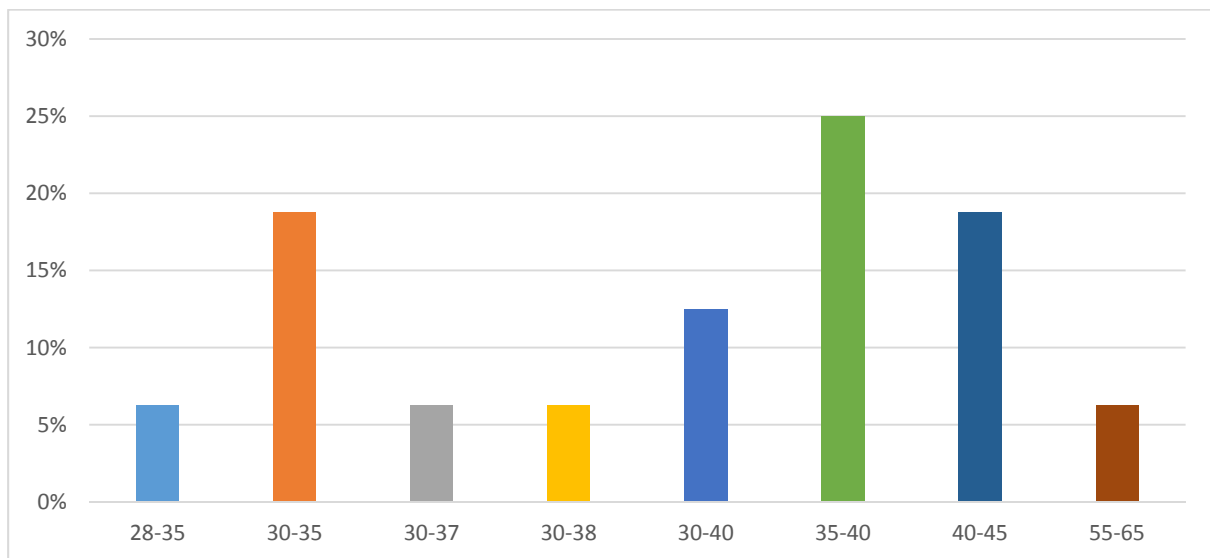
Residential Area	Frequency	Percentage	Cumulative Percentage
Kabokweni	5	31%	31%
Nkohlakalo A	2	13%	44%
Nkohlakalo B	4	25%	69%
T V trust	5	31%	100%
Total	16	100%	

**Figure 3.9:** Number of participants

31% of the participants were from Kabokweni and 31% from T V trust. The least participants were from Nkohlakalo A.

Table 3.13: Age of the participants

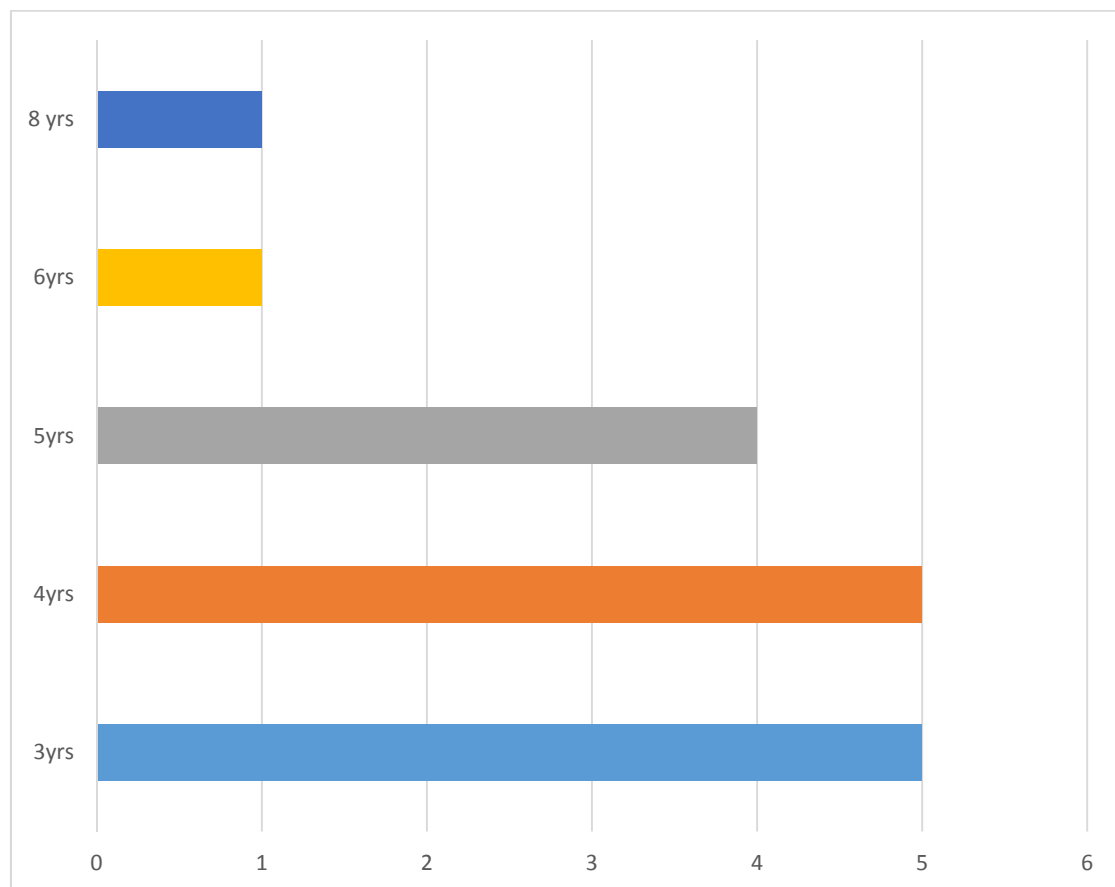
Age	Frequency	Percentage	Cumulative Percentage
28-35	1	6%	6%
30-35	3	19%	25%
30-37	1	6%	31%
30-38	1	6%	38%
30-40	2	13%	50%
35-40	4	25%	75%
40-45	3	19%	94%
55-65	1	6%	100%
Total	16	100%	

**Figure 3.10:** Age of the participants

10 participants were between the ages of 30 and 45 years.

Table 3.14: Years of work experience

Work Experience	Frequency	Percentage	Cumulative Percentage
3yrs	5	31%	31%
4yrs	5	31%	63%
5yrs	4	25%	88%
6yrs	1	6%	94%
8 yrs	1	6%	100%
Grand Total	16	100%	

**Figure 3.11:** Number of participants

14 of the 16 (88%) participants in this group had work experience of between three and five years. The average work experience of the participants was 5.2 years.



Table 3.15: Highest qualification

Highest Qualification	Frequency	Percentage	Cumulative Percentage
Grade 8	3	19%	19%
Grade 10	3	19%	38%
Grade 11	2	13%	50%
Grade 12	8	50%	100%
Total	16	100%	

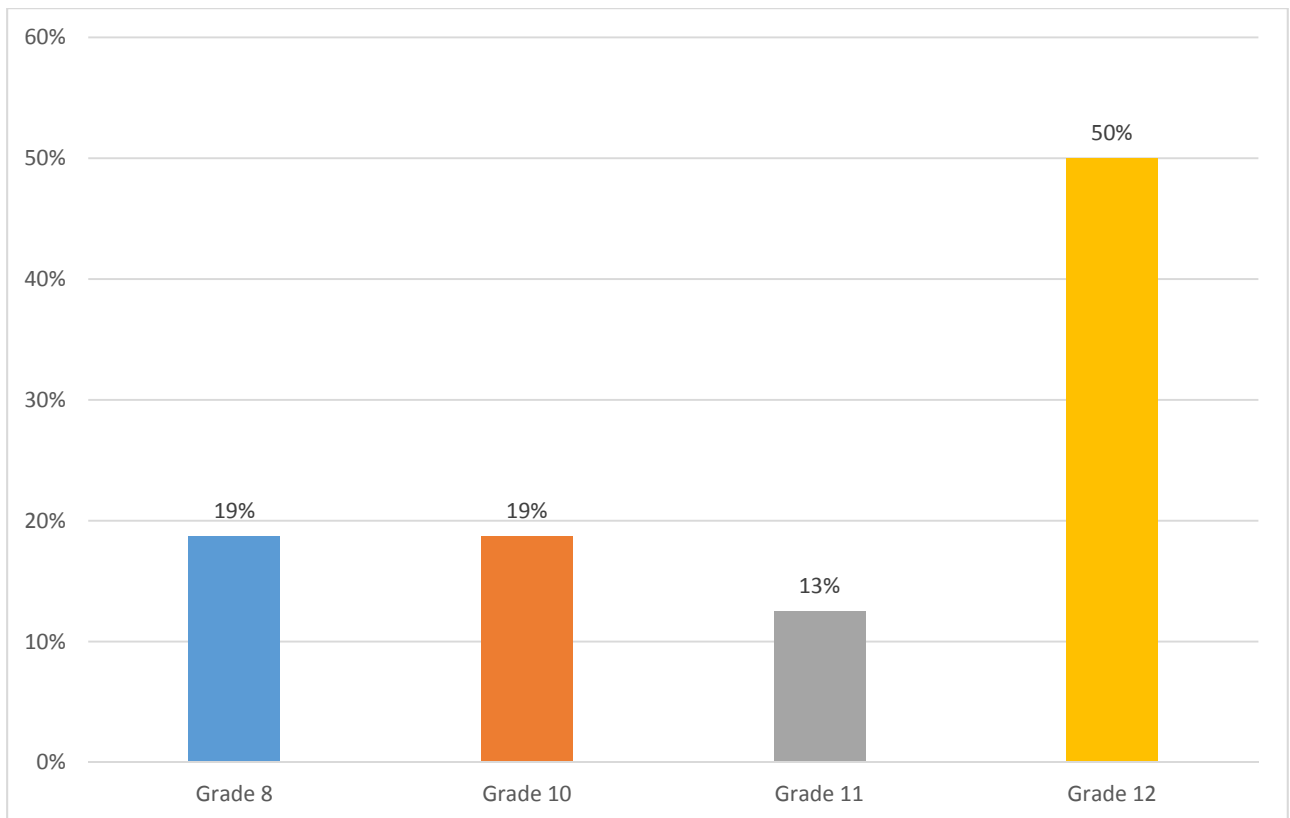


Figure 3.12: Number of participants

50% of these participants had Grade 12 as the highest qualification while 19% and another 19% of participants had Grades 8 and 10 respectively.

The themes, categories and their sub-categories are depicted in the table below.

Table: 3.16: The identified theme, categories and sub-categories relating to Group 3: DOT Supporters

THEMES	CATEGORY	SUB-CATEGORY
1. Challenges during supervision of patients with TB	1. Experiences during supervision	<ul style="list-style-type: none">• Lack of food during the period of treatment• Misconception of treatment by the patients• Default of treatment and referral to hospital• Resistance on leaving traditional medicine when on TB treatment

In this study, the participants were selected through purposive sampling, which involves personal judgement in selecting the participants who were representative of the topic being studied as professional practitioners in their respective fields. The interviews were conducted in Swazi and lasted between 45 and 60 minutes.

The themes that emerged from the focus group interviews held with the participants in the groups were as follows.

3.6.1 THEME 1: Challenges during supervision of patients with TB

Participants were faced with many challenges when rendering care to patients with TB that hindered them from eradicating TB from the community.



3.6.1.1 CATEGORY ONE: Experiences during supervision

DOT supporters reported various challenges that they come across when supervising patients with TB on taking their treatment. Patients had many complaints about hunger, their cultural beliefs and misconceptions regarding TB treatment. The following sub-categories are narrating the challenges.

- **Lack of food during the period of treatment**

Participants experiencing difficulties when supervising patient with TB to take their treatment. They reported that patients were suffering and lack of food led to termination of treatment before the completion of the course. This attitude resulted in defaulters and more MDR.

“They take treatment but they do not take it accordingly because they do not have food”.

Another participant added:

“What causes people to default treatment is lack of food”.

“First challenge, first challenge patients take treatment at different times and some want to take treatment after meals while it should be taken before food. Some are crying of hunger. They want grant to be able to buy food, fruits and vegetables”.

In support of the above statement Fiseha and Meaza (2015:6) indicated that most patients with TB were very poor and less educated. This type of situation in the families lead to default because they could not take treatment in an empty stomach.



- ***Patients' misconceptions about treatment***

Some patients do not have knowledge of TB and that if hungry any treatment may result in side-effects. Participants indicated that patients defaulted on treatment because they felt dizzy with swelling of the lower limbs following hunger:

"They take treatment but they do not take it accordingly because they do not have food. They say when they take treatment they feel dizzy and their lower limbs become swollen".

- ***Defaulting on treatment and referral to hospital***

Lack of food led to defaulters and in turn to MDR, which requires a long period of hospitalisation with expensive treatment. Some participants stated that patients defaulted on treatment because of hunger, with little knowledge about treatment, whilst others did not take their treatment seriously because they did not want their pension to be cut off:

"They do not know how to count the months and they discharge themselves before they complete the full prescribed months. Some are doing this because they receive pension and do not want to be healed because their pension will be cut off. They want their pension to be renewed. Some they do not take treatment accordingly because they default when they are drunk but they tick."

"When we find that the patient is not taking treatment we inform our supervisor to intervene by referring them to Bongani. They say they do not want to take treatment. Some they drink their wives ARV treatment. Men are problematic. Brother Ralph and Phillip work together with us, when we have patient's problems we ask them to intervene".

"They give us defaulters and we trace them, and they become less. We do



home visits to detect those who has TB to be treated earlier”.

The participants indicated that some patients default treatment because of their beliefs, they believe that *Mafulatsa* or *Tindzhaka* is to be treated with indigenous medicine.

One of the participants highlighted the issue:

“We blacks we believe in traditional healers because when they become ill they go to the traditional healers and they tell them that they has Mafulatsa not TB and traditional healers give them treatment to inhale and treatment that cause vomiting and the treatment does not work. Some patients mix alcohol and treatment and it does not work in that way”.

Summerton (2006:16) found that a large proportion of South Africans hold strong traditional cultural beliefs and practices, which influence their reactions to illness.

- ***Resistance on discontinuing traditional medicine when on TB treatment***

It was also reported that some patients were resisting discontinuation of indigenous medicine when taking TB treatment because of their culture and their elderly were using indigenous medicine before the Western counterparts had been introduced:

DG2

“When we visit them we find traditional medicine and they say their grannies were using traditional medicine so they cannot leave it”.

Gqaleni et al (2010:296) indicate that 80% of South Africans utilise and rely on indigenous medicine for their healthcare needs, as other patients are refusing to leave indigenous medicines because of their condition. They either take both medicines simultaneously or stop Western treatment, an attitude that shows their



dependence and reliance on indigenous medicine. Summerton (2006:15) further indicated that in South Africa an estimated 70-85% of the population use African indigenous medicines to help meet their healthcare needs. The high utilisation rate of indigenous medicine may be attributed to its accessibility and affordability, as Gqaleni et al (2007:178) indicated, with African indigenous health practitioners estimated at 150,000 to 200,000 in the country.

3.7 SUMMARY

This chapter has provided the data analysis in relation to the research questions. Data was grouped into themes and sub-themes and the themes that emerged were described and discussed. Literature was incorporated either to support or to refute the research findings. The next chapter will provide a description of concept analysis.

CHAPTER 4

CONCEPT ANALYSIS

4.1 INTRODUCTION

Having described the findings of this study in the previous chapter, the purpose of this one is to analyse the main concepts that emerged from the data that would enable the researcher and readers to understand their meanings. The theoretical meaning of the concepts is analysed following the process suggested by Walker and Avant (2011:57), as the basis of any theory, depends on identification and explication of concepts. It allows one to classify experiences in a meaningful way, both to oneself and to others.

The aspect of the themes was analysed in chapter three from the viewpoint of biomedical health and African indigenous health practitioners, as well as DOT supporters when they deliberated on the issue of integration. The researcher was cautious to avoid personal experiences as a biomedical health practitioner from dictating the script, so focus was placed on the stories told by the participants and their underlining meanings (Lawrence 2012:116). During data analysis the researcher relied on reflective field notes and voice recorder to give insight into the meaning of the stories told whilst reflecting on the interview process. The themes and sub-themes were identified and assessed against existing literature.

The **first theme** that emerged from the interviews was that of the acknowledgement of integration with the African indigenous practitioners. Biomedical health practitioners acknowledged the step that the government had taken to integrate them with African indigenous health practitioners by establishment of the Traditional Health Practitioners Act 2007, Act no 22 of 2007. Some participants praised the collaboration between the two groups of practitioners but others felt it showed no change because they were still experiencing problems from the African indigenous health practitioners regarding patients with TB.

The **second theme** acknowledged the establishment of Traditional Health Practitioners Act 2007 (Act no 22 of 2007). Biomedical health practitioners acknowledged the Traditional health practitioners Act 2007 (Act no 22 of 2007), based on the integration between them and the African indigenous health practitioners with regard to the delivery of quality service to patients with TB. Some participants did not acknowledge the establishment of the Act because they did not wish to collaborate with the African indigenous health practitioners.

The **third theme** focused on the empowerment of African indigenous health practitioners. Participants indicated that they came together with the African indigenous health practitioners to discuss TB and as a result risky practices of the African indigenous health practitioners were declining, with a great improvement in referring of the patients with TB to the biomedical counterparts.

The integration between the two groups of practitioners was seen by biomedical health practitioners as central and crucial to effective collaboration because they could share ideas regarding the TB condition. Participants suggested that they needed to hold meetings with African indigenous health practitioners as the government was encouraging them to meet and address common health-related issues. The main concepts that summarised the collaborative effort were 'convergence' and 'engagement'.

In the first and second theme biomedical health practitioners acknowledged to work together with the African indigenous health practitioners as they were recognised by their establishment of the Traditional Health Act. African indigenous health practitioners were happy and acknowledged their acceptance by the biomedical health practitioners. However, their working together imposes conditions or antecedents that should agree on or occur before they could start working together such as meetings and sharing of ideas. The effort that they would take and the processes that they would undergo in the first and second theme will bring its consequences in them such as empowerment to both practitioners. Thus, will make

easier for them to converge and engage because they would be having same understanding about the goal to reach.

4.2 CONCEPT ANALYSIS PROCESS

According to Walker and Avant (1995:37), concept analysis “is a strategy to examine the attributes of a concept”. It is also the core activity in developing a theory and is therefore essential to create a meaning of a concept in practice, research or theory (McKenna 1997:57, cited by Pooe-Monyemore, 2007:116). A creative exercise, it allows one to identify and clarify mental images, whilst conceptual meaning is created and formed from experience. Maputle and Donavon (2013:4) ascertained that in the process of analysis the characteristics of the concepts and surrogate terms are identified and the related concepts, antecedents and consequences documented. In this study the concepts ‘convergence’ and ‘engagement’ were identified using the process of Jon (2012:2) to bring clarity so that the readers would have more understanding regarding their meanings. Walker and Avant (2005:63) detailed the process of examining the basic elements, structure and functions of a concept, with the following steps:

- Identify concepts
- Determine the purpose or aims
- Define the concept
- Identify concept uses
- Determine the defining attributes
- Construct a model case
- Identify antecedents and consequences

4.2.1 Identification of the concepts

A study of the model of convergence and engagement between biomedical health and African indigenous health practitioners regarding TB condition treatment was conducted in Mpumalanga Province, and the experiences of the health practitioners about working together in their health practices revealed the major concepts ‘convergence’ and ‘engagement’ They were holding meetings, workshops and awareness programmes, giving each other health education on TB condition in

which they came to an agreement that all patients presenting with coughing to the African indigenous health practitioners should be referred to the biomedical health practitioners for investigation before being given indigenous medicine.

The researcher identified 'convergence' and 'engagement' as core concepts because they were found to be the central concern, and all the other categories and attributes were contingent upon them (Maputle & Donavon 2013:4). Identifying the central concepts for the development of the model required the researcher to reflect on the main themes described in chapter 3 and to reason inductively to combine those from specific knowledge. This enabled the researcher to form the general concepts, convergence and engagement, that could be transferable to a broader biomedical health, African indigenous health practitioners and DOT supporters (Parahoo 2006:64).

According to Walker and Avant (2011:157), the selection of concepts is guided by the purpose and expresses the value related to it. In this study, in order to actualize the purpose, concepts were selected from the findings of the in-depth individual and focus group interviews that were conducted with African indigenous health and biomedical health practitioners giving service to patients with TB.

4.2.2 Determination of the purpose or aims of the concept analysis

The aim of concept analysis is to clarify meanings of similarity and identify multiple considerations for measuring the concept (Falan 2010, as cited by Maputle & Donovan 2013:2).

After identification of the concepts the researcher determined the aims or purposes of analysis, as follows:

- To clarify and describe the meaning of convergence and engagement between biomedical health and African indigenous health practitioners in their health practices
- To develop a theoretical definition of the concepts 'convergence' and 'engagement' that directed the data collection process and the development

and description of a model for convergence and engagement of these two health practitioners' practices into the knowledge of treatment of TB condition.

- To discuss and interpret the results for concept analysis that would assist in developing and describing the model for convergence and engagement of these two health practitioners practices
- The meaning of the concept clarified the basic elements, structure and functions of the concepts 'convergence and engagement' (Chinn & Kramer 2008:192; Ibid 2011:162-181; Walker & Avant 2005:66, cited by Ngunyulu, Mulaudzi & Peu 2012:42).

4.2.3 Definition of the concepts

The process of creating conceptual meaning is achieved by adopting a definition process for all identified concepts. Therefore, in this study, each selected concept was discussed in relation to its attributes, definition, antecedents and consequences and thereafter conceptual meaning was attached to each one. Dictionary and subjective meanings of concepts were derived to give conceptual meaning to the selected concepts. Various dictionaries were used, as well as textbooks relevant to the area under scrutiny (Mokoena 2012:118).

The two concepts that described are convergence and engagement. The first concept to be defined would be convergence.

4.2.3.1 Defining the concept: convergence

Table 4.1: Definition of convergence

Definition of convergence	Source
<ul style="list-style-type: none"> • Two or more individuals sharing information, then over time tending to converge, leading to a state of greater uniformity 	Tjale & De Villiers (2004:128)
<ul style="list-style-type: none"> • Refers to a legally process of bringing about the functioning of these two health practitioners as they made up of professionals and practitioners to work 	Pinkoane, Greeff and Koen



together under one health department in a multi-professional approach	(2012:18)
<ul style="list-style-type: none"> • Share the same aims and objectives focused at fulfilling the patients 'identified health and cultural needs. It is a two sided effort combining both treatment methods and best practices to form partnership in which each remain autonomous. 	Pinkoane, Greeff and Koen (2012:18)
<ul style="list-style-type: none"> • Move towards each other and meet at a point. 	Oxford Advanced Learner's Dictionary (2010:320)
<ul style="list-style-type: none"> • Moving together towards a common point, as occurs when the two eyes move in coordination towards fixation on the same point or object. 	Blackwell's Nursing Dictionary (2010:148)
<ul style="list-style-type: none"> • The act of converging and especially moving toward union or uniformity; especially : coordinated movement of the two eyes so that the image of a single point is formed on corresponding retinal areas • The state or property of being convergent • Independent development of similar characters • The merging of distinct technologies, industries, or devices into a unified whole 	Merriam-Webster (2014:1)

Above all definitions that were made the researcher adopted the definition by Pinkoane, Greeff and Koen (2012:18) as it is more to the phenomenon.

The synonyms for the concept of convergence were taken from the definitions of Merriam-Webster (2014:3) online.

Table 4.2: Synonyms of the concept convergence

Concept	synonym
Convergence	confluence
	convergency
	meeting
	conjunction

From various dictionaries one finds the following definition of the concept convergence:

- Confluence - meaning a place where two rivers flow together and become one (*Oxford Advanced Learner's Dictionary* 2010:304).
- a meeting – an occasion when people come together to discuss or decide on something (*Oxford Advanced Learner's Dictionary* 2010:924).

In all the above situations “together” forms a motif in providing meaning in this case.

4.2.4 Identification of uses of the concept

After identifying the concept ‘convergence’, the researcher identified its uses from a dictionary, and the impressions of colleagues and available literature on the subject, Unsworth (2000, cited by Maputle & Donovan, 2013:4) indicated that dictionary definitions were authentic and therefore useful because they conveyed accepted ways in which words are used. An extensive literature search was conducted to achieve the aims of analysis (Walker & Avant 2005:67).

The *Oxford Advanced Learner's Dictionary* (2010:320) defines uses of the concept: ‘convergence’ as: to move towards a place from different directions and meet, for example, for the event; to move towards each other and meet at a point; to fix or connect two or more things together; to combine two or more things joined or mixed together to form single unit. If ideas, policies and aims converge, they become

similar or the same. According to the description the concept means to connect or join, combine and unify, so the biomedical health and African indigenous health practitioner's practices would be united through its use so that they become partners in the service delivery. They collaborate and integrate for the rendering of quality service.

Yahia, Bellamine and Ghézala (2012:1) describe the concept as:

... to achieve their common goals by collaborating and to make that more effective and efficient. Sharing of ideas for the purpose of gaining more knowledge and collaboration regarding their convergence and their integration enhance to a better understanding of the knowledge and convergence concepts.

In this study the biomedical health and African indigenous health practitioner's practices regarding the treatment of TB condition can be incorporated and become one (Yahia, Bellamine & Ghézala (2012:1).

Similarly, Wainhouse Research (2006:2) indicated that convergence is the coming together or coming closer of two or more different entities, and elaborated that the concepts 'unify', 'integrate', 'collaborate', 'join', 'combine', 'incorporation', 'connect', 'form a junction' and 'couple' are terms used interchangeably. Steinberg, Architects and Kinser (2013:1) conclude that convergence of health information and technologies is at the heart of transformation, and the improvement of workflow, increased patient safety and better care coordination.

Based on the abovementioned uses of the concept the model of convergence between biomedical health and African indigenous health practitioners might assist in ensuring that their practices would unify, integrate, collaborate, join, combine, incorporate, connect, form a junction and couple with one another.

4.2.5 Determination of the defining attributes

The essential attributes for the concept of convergence were taken from the definitions stipulated by Webster (2014:3), based on which a definition was developed. The classification of attributes that were commonly used with the concept and that allowed the researcher to be broad-minded about it was indicated, enabling the researcher to name the occurrence of a specific phenomenon as differentiated from another similar or related one (Chinn & Kramer 2008:194; Walker & Avant 2005:68, cited by Ngunyulu, Mulaudzi & Peu 2012:45) such as connect, unify, join and combine.

4.2.6 Construction of the model case 'convergence'

A model case is a model exemplar of all antecedents and attributes (Walker & Avant, 2005, cited by Bernecker 2010:113) and can be factual, whilst Bruggerman, Wijma and Swanberg (2012:8) view it as an example of the use of the concept that demonstrates all the defining attributes of the concept. Solomon, Poggenpoel & Myburgh (2012:155) sees a model case as an amalgamation of some of the common experiences of the participants interviewed in this study and is used to illustrate the conceptualisation of the main concept. Upon the identified uses and the defining attributes cases of the concept the theoretical definition of 'convergence' might be the process of junction, juncture, linking, unification, combining, combination, coupling, consolidation, connecting and merging and integrating the African indigenous health and biomedical health practitioners in the treatment of TB condition. In this study the researcher has developed a model case of the concept, a paradigmatic example based on the uses, the defined attributes and the theoretical definition of the concept (Chinn & Kramer 2008:195; Walker & Avant 2005:69).

A 25 year old woman, daughter of a known African indigenous health practitioner in the area was suffering from a cough for three weeks with no improvement, despite the treatment that her mother was giving her to drink. She was losing appetite and weight each day of her illness and one day she decided to go to hospital for

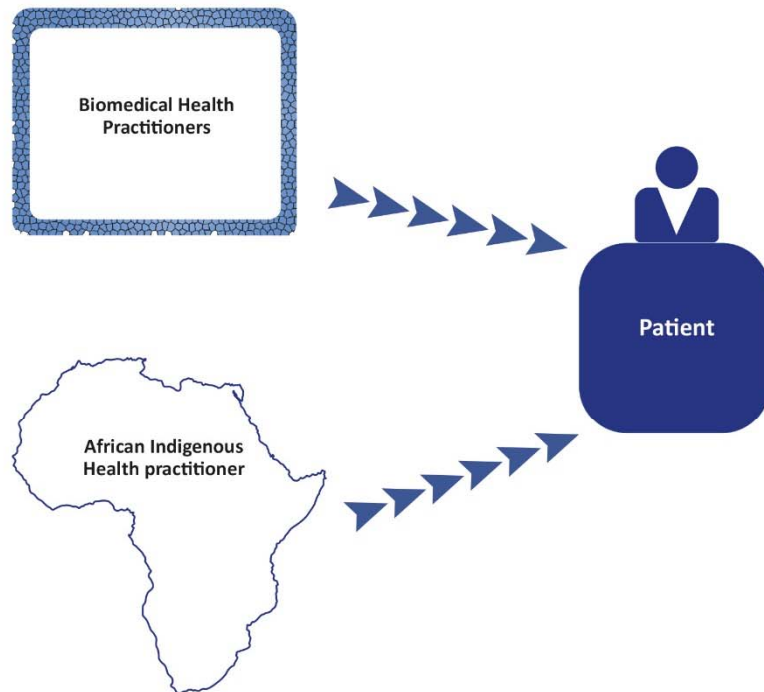
consultation on her deteriorating condition as she also started to vomit everything that she was taking orally. Her mother was not happy about her decision as she believed her daughter was suffering from *tindzhaka*, following a death a few months earlier in the family. The woman was admitted to the hospital and investigation was made prior to giving the treatment to find the cause of the illness. The entire procedure was explained to the woman to gain cooperation and promote understanding. After the positive TB results were shown to her she was encouraged to involve her family in her illness as it was infectious and required the family to be investigated. The family was told about every investigation that the patient had undergone until the conclusion of the diagnosis. Health education regarding TB was given to the family, which included causes, mode of spread, signs and symptoms and the treatment. Investigations continued into the members of the family and one was found to be infected, so treatment was initiated and healing given.

The investigations were conducted before confirming the final diagnosis. The method used to diagnose, treat and finally diagnose the patient impressed the family, and made them conscious of the similarity of conditions. Since then the family discovered that they had little knowledge of the conditions and realised that it was important to seek medical opinions before concluding lest they be misled about the signs and symptoms. The nurses who were taking care of the woman with TB were happy to see the family cooperating with them and realised the need for them to combine with the African indigenous health practitioners for the purpose of giving them health education and teaching them about the conditions that required their collaboration in treatment.

This model case study demonstrates the attributes of convergence: recognition of the need to join, combine and connect between the biomedical health and the African indigenous health practitioners in order to share ideas and teach each other, so as to enhance good relationships for excellent service delivery to the patients with TB. These two parties were practicing in isolation because they were not joined, forming a junction, linking, unifying, combining, coupling, connecting, merging or integrating, because of lack of compromise, mutual understanding and

trust of each other. Integration as the best choice would eliminate mistrust and allow for the continuity of healthcare without disrupting cultural setbacks. For them to be integrated they would empower each other through health education, meeting together, raising awareness and conducting workshops. After empowering each other the biomedical health and the African indigenous health practitioners would converge, work together, and share ideas regarding the service delivery to patients in need.

Matsabisa, Spotose, Hoho and Javu (2009:142-147) indicated that African indigenous health practitioners should be trained, hold meetings and workshops and raise awareness in order to increase their knowledge, improve their practices and be able to consult with their patients. In a study conducted by Mngqundaniso and Peltzer (2008:386), biomedical health practitioners indicated that African indigenous health practitioners lacked knowledge and understanding of the TB condition, thus they needed to be trained, especially for safety precautions when handling patients. According to Mngqundaniso and Peltzer (2008:386), most African indigenous health practitioners were willing to learn and refer patients to clinics and hospitals, expressing their willingness to train by saying that they had lost many of their patients by not referring them to the hospital because they did not know their symptoms.



The figure 4.1: Biomedical health and African indigenous health practitioners converge for the purpose of fulfilling the patient's health need

4.2.7 Identification of antecedents and consequences

According to Walker and Avant (2005:73) and Ngunyulu, Mulaudzi and Peu (2012:49), antecedents are those events or incidents that occur prior to the occurrence of the concept. Walker and Avant, in Shatell (2004:11-18) further indicated that identifying antecedents is an important step in the analysis of a concept. Walker and Avant (1995:45) related an antecedent to the concept of convergence as the cognitive ability to make choices and for abstract thought, more specifically cognitive reasoning, to be an antecedent to the concept convergence.

- **Antecedents**

Antecedents helped the researcher identify underlying assumptions about the concept of 'convergence'. In this study, 'meeting' means the action of coming together of the biomedical health and African indigenous health practitioners with the purpose of sharing ideas, giving each other health education, attending workshops and awareness when teaching is taking place to empower one another with the information regarding the treatment of TB.

Participants said that they met to discuss TB:

"There are workshops where "ee-----r" health team and the indigenous where they come together. They are talking about TB".

Prior to convergence of the biomedical health and African indigenous health practitioners the above actions of empowerment should take place in order to place everyone on the level of understanding the treatment of TB condition, signs and symptoms of TB and the care of a patient with TB, to have required knowledge about TB and to enhance quality service delivery to patients in need. 'Awareness' relates to TB and its treatment. African indigenous health practitioners should be aware of it and its treatment in order to have knowledge and ability to work independently.

They felt that they did have awareness of biomedical health when they learnt about treatment, hence the following comments:

"There is Gutshwa clinic where I send people to them and we attend classes and we get certificates. During this classes we cook food and we meet with nurses and police. Sometime we learn about TB, HIV because AIDS they mean when you are ill. HIV is when you are like me".

Awareness between the practitioners might reduce tension of mistrust and looking down on one another, and thus enhance relationships and confidence in their practices because of the knowledge that they have acquired through awareness and workshops. According to Matsabisa, Spotose, Hoho and Javu (2009:142), good

integration is influenced by having similar understanding of TB through teaching signs and symptoms and treatment of TB (Viney et al. 2014:14).

Matsabisa et al. (2009:142-147) also pointed out that the importance of training African indigenous health practitioners lay in increasing their knowledge, improving their practices and enabling them to consult their patients. In the study conducted by Mngqundaniso and Peltzer (2008:386), biomedical health practitioners indicated that African indigenous health practitioners lacked knowledge and understanding of TB, thus they needed to be trained on TB conditions for safety precautions when handling patients.

Lack of respect, mutual understanding and relationship is a feeling brought about by the African indigenous health practitioners after they had observed that the biomedical practitioners did not recognise them as partners when they referred patients with coughing but did not receive feedback regarding their condition. They felt that they were not taken into consideration or respected. According to Kangwa and Catron (2010:1), tension between the groups of practitioners is fuelled by lack of trust and mutual understanding. They had significant differences in their worldview of health because of lack of compromise and mutual understanding. Kangwa and Catron (2010:2) also indicated that integration as the best choice would eliminate fear, mistrust and allow for the continuity of healthcare.

Soai (2012:1) found that African indigenous health practitioners were looked down upon by the biomedical health practitioners and that negative attitude contributed to fear and mistrust with the African counterparts because to them it was a sign of not having been accepted in the arena of healthcare service. Without cooperation and collaboration, success is not possible.

- **Consequences**

The *Oxford Advanced Learner's Dictionary* (2010:308) defines 'consequences' as a result of what has happened. This study, after an effort was made to converge biomedical health and the African indigenous health practitioners towards the care of

a patient with TB condition and its treatment, came up with the results of empowerment, team-building and improved service delivery, whereby the African indigenous health practitioners were able to work independently through the education received from the biomedical health practitioners. Walker and Avant (1995:45) stated that consequences are the events or outcomes that take place after the event.

The *Oxford Advanced Learner's Dictionary* (2010:481) describes 'enable' as to create one's own, to do, and to make it possible for. In this study the biomedical health practitioners made the African indigenous health practitioners do or practice independently through the health education given to them. The former were empowering the latter with knowledge that would enable them to work on their own. Muller, Bezuidenhout and Jooste (2011:407) describe 'empowerment' as a dynamic process of interaction between the follower and leader during motivation, power-sharing and participative decision-making, both working in a management and leadership structure, with the aim of balancing power in the healthcare service.

The meetings, health education, awareness and workshops that the biomedical health and African indigenous health practitioner were attending was for empowering them with knowledge and skills so that they could work independently and know how to take care of patients with TB. As a result, empowerment was regarded as the consequence or outcome. The *Collins English Dictionary* (2012) defines 'empowerment' as having a sense of self-esteem or confidence, control over one's life, or power to do something (as cited in Potratz 2012:4).

African indigenous health and the biomedical health practitioners are expected to unite and share ideas in relation with the treatment of TB for the benefit of patients in need of the service. Unification of these two sectors can bring success to the healing of patients with TB as they may receive quality care from both groups when referred to both.

However, the findings revealed no integration between the two. African indigenous health practitioners reported no teamwork:

“We meet but it does not help. Maybe is just because they get salaries and we do not. Even Motsoaledi took a person to represent me, what is it that is going to talk on my behalf while is not a traditional healer”.

“The nurses and traditional healers must work together and respect each other”.

On the other hand, biomedical health practitioners emphasise that integration exists:

“Biomedical health practitioners give health education to African indigenous health practitioners”.

“They are explaining to the Inyangas how TB is spreading and to prevent TB”.

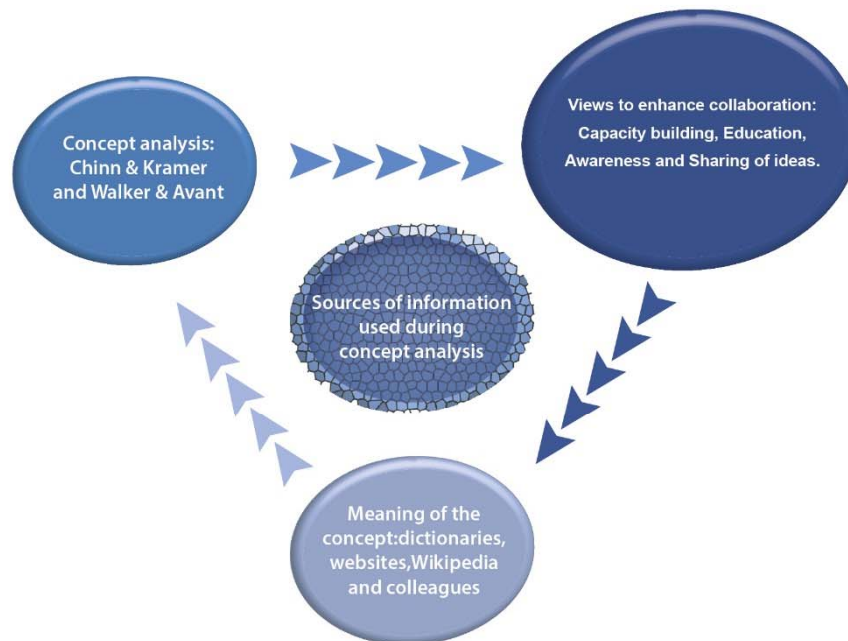
Bruning and Baghurst (2013:88) describe teamwork in healthcare as a provider of a safer patient care and further indicate that it reduces errors and increases patient satisfaction.

Through empowerment and team-building the standard of service delivery could be lifted and patients receive quality care. Both biomedical health and African indigenous health practitioners would be able to work as equal partners, independently and harmoniously, and with confidence. Transcultural nursing should be included in nursing education theory and practice for better service delivery (Leininger 2002:510). Both groups are expected to learn each other’s healthcare system for the better care of the patients.

The table below illustrate the approach used to conduct the literature review during identification of the uses of the concept convergence:

Table 4.3: Illustrated approach used to conduct literature review

Search terms	Type of article	Inclusion criteria	Author/year/country
Convergence	Cultural issues in Health and Healthcare	All research studies which deals with issues of integration, convergence including or add as part of something else	Tjale and de Villiers (2004) South Africa
Collaborate, integrate, join, combine, unify, incorporation	Collaborating with Traditional Healers for HIV Prevention and Care in sub-Saharan Africa: Suggestions for Programme Managers and Field Workers	connect, junction, coupling	USAIDS (2006) Sub-Saharan Africa



The figure 4.2: Above illustrates the conceptual framework showing the sources of information used during concept analysis:

4.3 ENGAGEMENT

Table 4.4: Definition of engagement

Definition of engagement	Source
An agreement to marry; the period during which two people are engaged.	<i>Oxford Advanced Learner's Dictionary</i> (2010:485)
<ul style="list-style-type: none"> • An arrangement to meet or be present at a specified time and place • a job or period of employment especially as a performer • something that engages : pledge • the act of engaging : the state of being engaged • emotional involvement or commitment 	<i>Merriam-Webster</i> (2014:1)

After defining the concept the researcher identified the uses of the concept 'engagement' and an extensive literature search was conducted to understand the uses of the concept (Walker & Avant 2005:67).

4.3.1 Uses of the concept

The *Oxford Advanced Learner's Dictionary* (2010:485) cites uses of the concept: "engagement" to include succeeding in attracting and keeping attention and interest, becoming involved with and trying to understand. In this study, the concept can be used to appoint, meet, deal and gather the various practices so that they become connected with their work in the service delivery. Kangwa and Catron (2010:12) argue that the best medical intervention is not segregation but integration of the two medical approaches to healing. According to Wamba and Groleau (2012:58), good engagement between the practitioners is strengthened when participants agree to adjust their relative positions after one has presented an idea and they learn to cooperate and negotiate their differences for the benefit of their patients.

The essential attributes of the concept of engagement were taken from the definitions stipulated by Webster (2014:1), the aim being to show the classification of attributes that were commonly used with the concept, and allowed the researcher to have a wider perspective (Walker & Avant 1995:38, cited by Nuopponen 2010:10). The classification of the attributes enabled the researcher to name the occurrence of a specific phenomenon as differentiated from another similar or related one (Chinn & Kramer 2008:194; Walker & Avant 2005:68, cited by Ngunyulu, Mulaudzi & Peu 2012:45), such as appointment and gathering. The aim of this study is to promote understanding between the two parties regarding the treatment of TB condition so that they can work together.

According to Nuopponen (2010:9), a model begins with selecting a concept to be analysed, and Walker and Avant (1995) recommended that it be interesting to the researcher and associated with or her work. Bruggeman, Wijma and Swanberg (2012:8) view a model case as an example of the use of the concept that demonstrates all the defining attributes of the concept. Based on the identified

cases, the defining attributes cases of the concept, the theoretical definition of the concept 'engagement' might be the process of "appointment, conclave, deal and gathering" the African indigenous health and biomedical health practitioners into the treatment of TB condition. In this study the researcher has developed a model, with paradigmatic example based on the uses, the defined attributes and the theoretical definition of the concept (Chinn & Kramer 2008:195; Walker & Avant 2005:69).

4.3.2 Construction of the model case 'engagement'

On 4 July 2014 an African indigenous health practitioner brought her learner to the clinic because she was not feeling well. On her arrival she found that there was a workshop hosted by the facility manager at the selected healthcare centre. As she was there she was invited to attend as it was planned for the biomedical health, African indigenous health practitioners and DOT supporters to teach them about TB. The theme for the day was referral of TB patients to the hospital and clinic. The biomedical field addresses participant engagement as a means of fostering stakeholder empowerment and orienting participant-directed policies. The participants felt happy and free to ask questions regarding the challenges they faced. The answers were given and opened for discussion to enhance understanding of the issue concerned. Engagement is considered a valuable resource to shape collaborative care strategies and health promotion interventions and is conceived as a marketing concept that may guarantee high-quality intervention delivery, using terms such as 'empowerment', 'policy', 'community' and 'collaboration'.

In this study, the focus is on the community and the social contexts in which African indigenous health practitioners are involved, considered as crucial drivers for engaging patients in the health industry as they are cultural believers. In addition to the potential for achieving greater efficiencies in seeing more patients, encouraging African indigenous health practitioners to engage with their care and to take more control and vigilant on assessing and referring patients with TB coming to them for consultation has the potential to be an effective tool for improving public health.

According to Ross (2010:46) there are 250,000 to 400,000 traditional healers in South Africa and 28,000 medical doctors, so it is imperative to engage the African indigenous health practitioners in the health system. Eight in 10 South African are believed to rely on traditional medicine alone or in combination with Western medicine. Because of pluralism in society, their engagement in the National Healthcare System will bring down the number of TB infections if they fight the disease together. On the other hand, Pinkoane, Greeff and Koen (2008:4) indicated that policies passed initiated the recognition of the existence of traditional healers but failed to address the important aspect of incorporating the traditional healers in the National Healthcare Delivery System.

4.3.3 Identification of antecedents and consequences

The antecedents and consequences are defined and discussed in this section, page 118 and 120.

- **Antecedents**

Antecedents helped the researcher to identify underlying assumptions about concept 'engagement'. In this study, the researcher identified the following antecedents:

- **Appointment**

The *Oxford Advanced Learner's Dictionary* (2010:59) defines 'appointment' as a formal arrangement to meet or visit at a particular time, especially a reason connected to their work. In this study an appointment means an arrangement made prior to a meeting, and coming together to discuss work-related issues. Biomedical health and African indigenous health practitioners meet with the purpose of sharing ideas regarding the treatment of TB condition.

Participants indicated that they met to discuss TB:

"We meet and come to an agreement, then they ask if we refer our patient to the clinic or hospital".

- **Gathering**

Gathering means a meeting of people for a particular purpose (*Oxford Advanced Learner's Dictionary* 2010:619). In this study it means coming together of the health practitioners with the purpose of discussing issues regarding treatment of TB and handling the patients. As an appointment and gathering having similar definitions the response from both is applied.

- **consequences**

Walker and Avant (2005, cited by Brush, Kirk, Gultekin & Baiardi 2011:168) describe consequences as those events or incidents that occur as a result of the occurrence of a concept and that stimulate new ideas or avenues for research pertaining to certain concepts. In this study the appointment and gathering resulted in the empowerment and commitment of African indigenous health practitioners to their work. The gathering is participatory and open in that participants are encouraged to share their experiences. This has further promoted understanding between African indigenous health and biomedical health practitioners. Patients can freely consult African indigenous health practitioners and receive health information from them in their own language and, when necessary, be referred to clinics to access services not rendered by African indigenous health practitioners.

- **Knowledge**

African indigenous health practitioners should be confident to assess the patients with TB and able to work independently with the knowledge that imparted to them through health education awareness, workshops and discussions. Through the knowledge they have acquired relationships will be enhanced, based on sound principles and belief in the ability to become a model for partnership in this district.

The model aims to contribute to the development of African indigenous healthcare knowledge without compromising intellectual property rights of the African indigenous health practitioners (Gqaleni et al. 2010:297).

The table below illustrate the approach used to conduct the literature review during identification of the uses of the concept engagement

Table 4.5: Approach used to conduct the literature review

Search terms	Type of article	Inclusion criteria	Author/year/country
Engagement	The Politics of Health: Community Engagement in South African HIV Vaccine Trial Sites	All research studies which deals with issues of collaboration including or add as part of something else.	Upton (2011) United Kingdom

4.4 SUMMARY

In this chapter a theoretical and empirical analysis of the concepts ‘convergence’ and ‘engagement’ was presented, following the concept analysis by Walker and Avant (2005:213). The uses and characteristics of the concepts were determined. The researcher also identified and described the antecedents and consequences of the concept. The empirical perspective was based on the convergence and engagement between African indigenous health and biomedical health practitioners regarding treatment of TB. The concepts were identified and defined, the essential and related criteria listed and the related as indicated by Dickoff et al. (1968) classified. The concepts convergence and engagement supported by the illustrated diagram in figure 4.1. These will form the foundation for the model description in chapter 5.



CHAPTER 5

DEVELOPMENT AND DESCRIPTION OF A MODEL FOR CONVERGENCE AND ENGAGEMENT BETWEEN BIOMEDICAL HEALTH AND AFRICAN INDIGENOUS HEALTH PRACTITIONERS REGARDING TREATMENT OF TB CONDITION

5.1 INTRODUCTION

Chapter four dealt with the concept analysis. The concepts ‘convergence’ and ‘engagement’ were analysed to enable the researcher and the participants to understand their meaning for both biomedical health and African indigenous health practitioners. Their views and those of DOT supporters were grounded and the analysis and interpretation of their experiences explored.

The findings were discussed together with the literature control in chapter three. The purpose of this chapter is to provide the construction of a model for convergence and engagement between biomedical health and African indigenous health practitioners regarding treatment of TB. A description of the model will be provided.

The findings for phase one and two will provide the framework of the model. The similarities and interactions between the themes, concept analysis by Walker and Avant (2005:28) and six aspects of Dickoff et al (1968:422) form the basis for development and description of a model for convergence and engagement between biomedical health and African indigenous health practitioners regarding treatment of TB condition presented in this chapter.



5.2 MODEL DEVELOPMENT

The model was developed by utilising the steps proposed by Dickoff, James and Weidenbach (1968: 422) and was developed in three phases.

- **Phase one**

The purpose of this phase was to explore and describe the views and experiences of biomedical health, African indigenous health practitioners and DOT supporters regarding the treatment of TB condition. A qualitative, exploratory, descriptive and contextual was followed.

- **Phase Two**

In this phase concept analysis defined by Walker and Avant (2005:28) was used to clarify the concept 'convergence' and 'engagement' as it relates to relationship between biomedical health and African indigenous health practitioners regarding treatment of TB. The findings revealed the antecedents that should occur before the convergence and engagement and its consequences or outcomes. Understanding the meaning of convergence and engagement during data collection in phase one during the in-depth individual and focus group interviews made the process of concept analysis easier for the researcher and also gave direction in following the six steps of Dickoff, James and Wiedenbach (1968:422).

- **Phase Three**

The purpose of phase three was to construct a model from the themes that emerged from the interviews with the participants, the observations made, field notes as well as the literature which was used to support the data. The researcher has chosen the six steps by Dickoff et al (1968:423) as the conceptual framework that guides the development and description of a model for convergence and engagement between the biomedical health and African indigenous health practitioners regarding treatment of TB condition,



the model was developed based on the findings for phase one, two as conceptualised and the six aspects of Dickoff et al (1968:423) as follows:

- **The agent:** who or what performs the activity? The agents in this model play a fundamental role in enhancing convergence and engagement among themselves, and they are the African indigenous health, biomedical health practitioners including DOT supporters in the healthcare service delivery. The agents should therefore use the model to show the connectedness to improve convergence and engagement as a team, to provide cultural congruent care to patients with TB condition as the recipients.
- **The recipient:** is the person who receives the activity. In this study, the patients with TB as the recipient of the agent's actions. Recipients depend on agents for help.
- **The context:** is the situation in which the activity takes place, and comprises human, environment, professional, and organisational facilities (George 1995:183, cited by Pooe-Monyemore 2007:147). Biomedical health practitioners see their patients with TB at the hospitals and clinics whilst African indigenous health counterparts see patients in their natural environment, their homes. The DOT supporters make house-to-house visits to patients with TB to provide healthcare service.
- **The process / procedure:** comprises the protocol and devices through which the agent is enabled to attain a set goal (George 1995:183). The procedures are the steps in which the agents engage to enhance convergence and engagement to improve healthcare service delivery to patients with TB. The biomedical health practitioners should support the African indigenous health practitioners and the DOT supporters to adapt in the environment, thus, maintenance of the relationship would be sustained to enable them to work independently.



- **The dynamic:** is the energy or power source for the activity. Dickoff et al (1968:446) explain that dynamics would explore power sources, which may be physical, biological, psychological or chemical for the agents and recipients (collaboration; interactive service delivery).
- **The purpose/terminus:** is the desired outcome the agent wishes to attain through the procedures, or the end result or goal to be attained by the agent's action (Dickoff et al 1968:441; George 1995:184). Terminus is therefore the biomedical health, African indigenous health practitioners and the DOT supporters that were empowered with knowledge and skills that will enable them to work independently through awareness, workshops and meetings to enhance quality service delivery in the treatment of the TB condition.



Figure 5.1 Above displays the three phases of the study which served as a guide during development and description of a model of convergence and engagement between the biomedical health and African indigenous health practitioners regarding treatment of TB condition.

Dickoff, James and Wiedenbach's six steps are as follows:

The agent

An agent is described by Dickoff, et al (1968:425) cited by Ngunyulu, Mulaudzi & Peu (2012:133) as a person who performs an activity towards a goal, and who produces an effect and takes active part, or does the actual work. The agents in this model play a fundamental role in enhancing quality service delivery to patients with TB, and they are biomedical health (doctors, registered nurses and enrolled nurses), African indigenous health practitioners (diviners) and DOT supporters, as they are



involved in provision, planning, organisation, management, monitoring and evaluation of care to patients with TB. The health professional as an agent should therefore use the model to produce an effect of improving the care or service that they are rendering to patients with TB as a recipient (Pooe-Monyemore 2007:146).

According to Dickoff et al (1968:439), the internal and external resources of the agents should be determined. The internal resources include the health practitioner's skills, knowledge as well as commitment and policies on TB available to or through the health practitioners (Dickoff et al 1968:439; Pooe-Monyemore 2007:147). The health practitioner's external resources include those resources other than the health practitioners or agent, that are available for maintaining, supporting, developing, protecting or extending the agent's capacity, power, or flexibility.

The recipient

According to Ngunyulu, Mulaudzi & Peu (2012:133), a recipient is the person who receives the activity. In this study, the patients with TB are the recipient of the health service from health practitioners and DOT supporter's actions (Dickoff et al 1968:440). Wiedenbach (1970:1059) stated that the patients with TB as the recipient are vulnerable, depends on others for help. The health practitioners as the agent should thus be supportive of the person with TB as the recipient.

The diagram below depicts the findings for phase one to phase three:

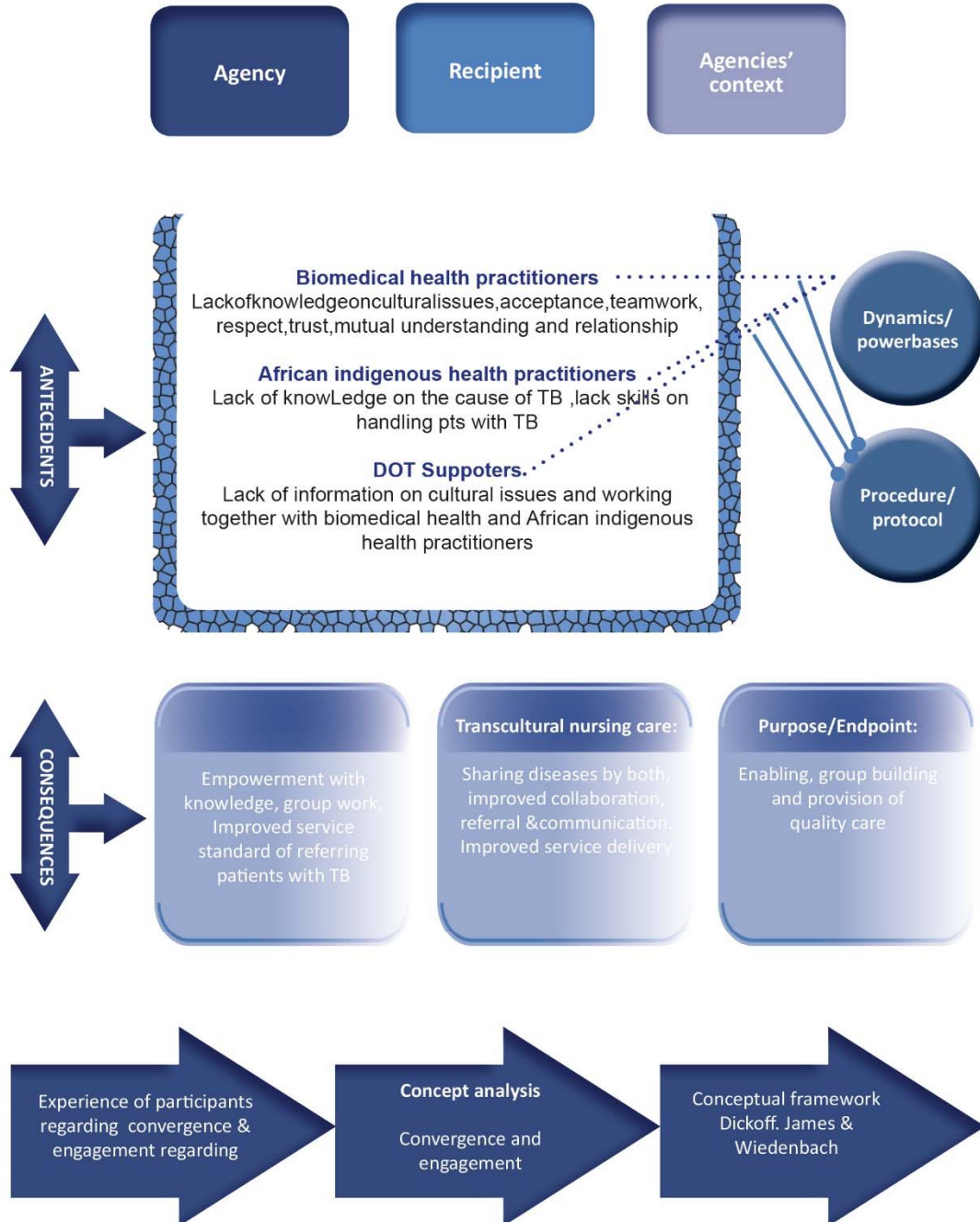


Figure 5.2: Relationship, merging and the interaction of the findings for Phases One to three

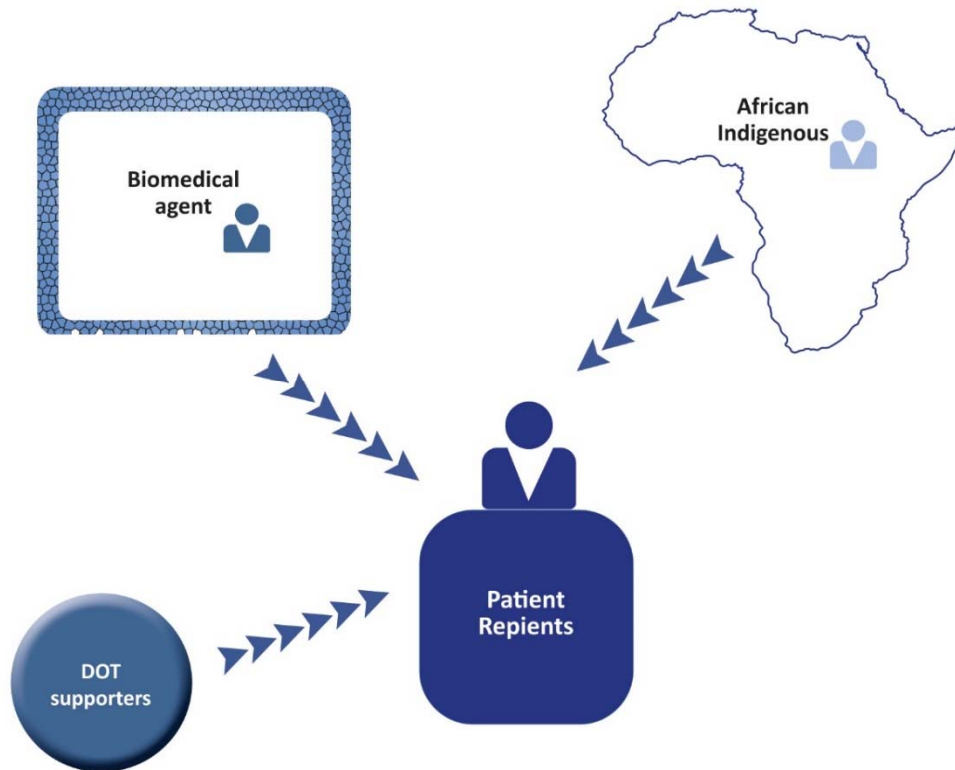


Figure 5.3: Agency and recipients of TB care

The context

The context is the situation in which the activity takes place, and comprises human, environment, practitioners, and organisational facilities (Pooe-Monyemore 2007:147).

In the third aspect, an activity is produced by the agent and receive by the patient. In this study, the convergence and engagement between the biomedical and African indigenous health practitioners may be performed in the hospital / clinic, home of African indigenous practitioner and in the community context by the DOT supporters.

Dickoff et al (1968:441) and Wiedenbach (1970:1061) refer to the context as a framework, and indicate that to view an activity from the aspect of the framework is to do so with the matrix of that activity or total context. The context of this model is the natural environment of the biomedical health, African indigenous health practitioners and DOT supporters in urban and semi-urban areas of the Mpumalanga province, South Africa.

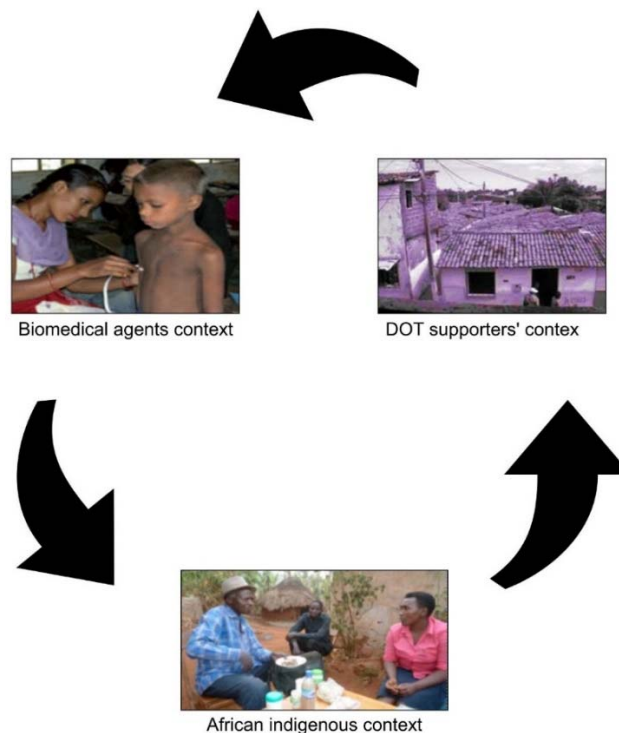


Figure 5.4: Agency and recipients for the treatment of TB condition in their working context

The dynamic

The dynamics are the energy or power sources for the activity. Dickoff et al (1968:431) cited by Ngunyulu, Mulaudzi & Peu (2012:136) explain that dynamics would explore power sources which may be chemical, physical, biological or psychological that can drive the activity towards the attainment of a goal. The

dynamics also involves reflection and feedback on the use of the model. Reflection will allow the health practitioners to deal with previous experience and use the opportunity to adapt to the changes. Feedback will allow the health practitioners to determine the value of using the model in practice.

In this study the dynamics are as follows and also displayed in figure 5.5 (below):

- Person's knowledge to perform the activity independently
- Show respect, mutual understanding and trusting relationship
- Attitudinal changes towards acceptance of each other
- Empowered through awareness, workshop and health education

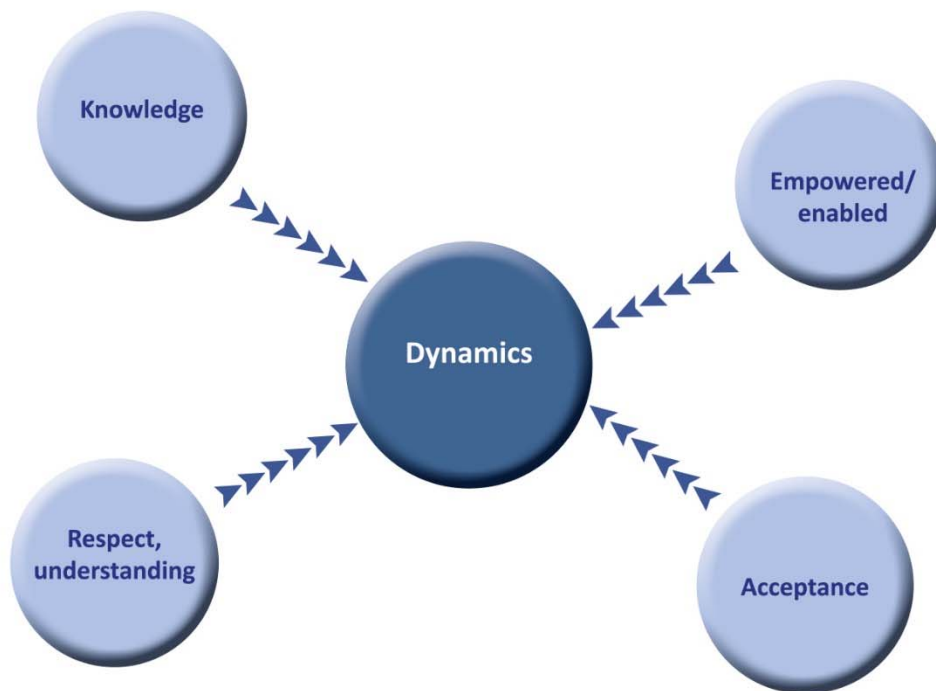


Figure:5.5: Dynamic

The process/procedure

The procedure comprises the protocol and devices through which the agent is enabled to attain a set goal (Pooe-Monyemore 2007:147). According to Dickoff et al (1968:444), procedure emphasises the path, steps or pattern to perform an activity. Dickoff et al (1968:444) point out further that procedure does not stress the outcome or the particularising features of the activity. The procedure is the fifth aspect, which should be to involve the stakeholders responsible for rendering service to patients with TB. The stakeholders will include biomedical health practitioners, African indigenous health practitioners and the DOT supporters. The Traditional Health Act 2007, Act no. 22 of 2007 will be the point of departure in converging the biomedical health and African indigenous health practitioners who are aiming to reach the common goal, which is to alleviate TB condition among the community.

The following factors will be included in the process to enhance convergence and engagement between the two health practitioners: workshops, meetings, awareness campaigns and team-building between biomedical health and African indigenous health practitioners, and the DOT supporters to discuss their concern, challenges and recommendations

The procedure will empower the two groups of practitioners and DOT supporters with knowledge regarding TB and feel confident to work independently with patients with TB.

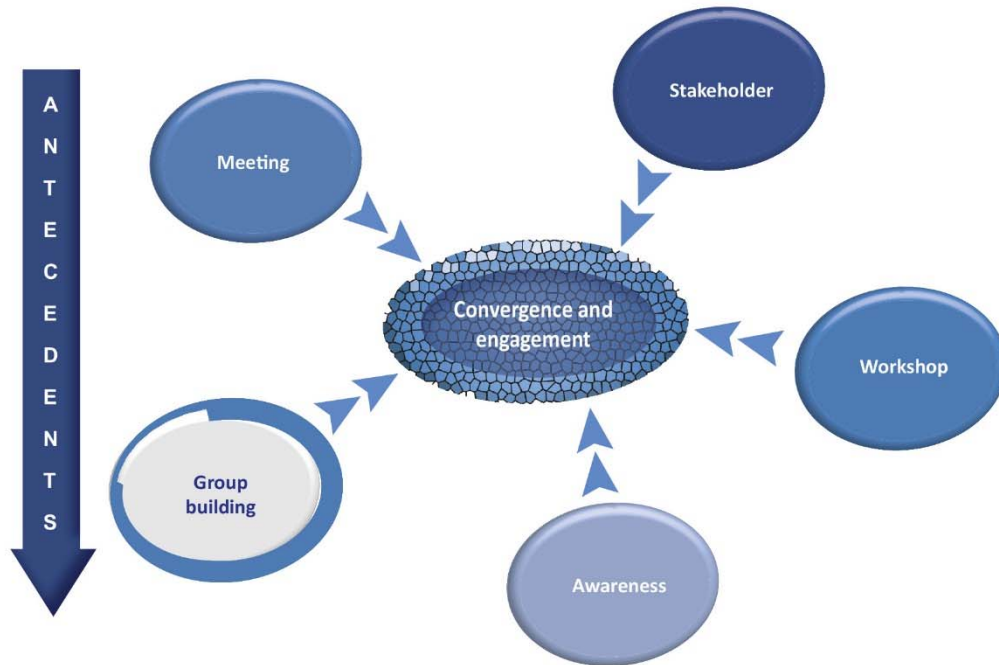


Figure 5.6 Above display the procedure to be followed during development of a model

The purpose/ Terminus

The terminus is the desired outcome the agent wishes to attain through the procedures or the end result or goal to be attained by the agent's action (Dickoff et al 1968:441). In this study, the intended outcome is the convergence and engagement between biomedical health and African indigenous health practitioners regarding treatment of TB which results in attainment of knowledge and skills, teamwork, mutual understanding, trust relationship, transcultural nursing care and quality service delivery.

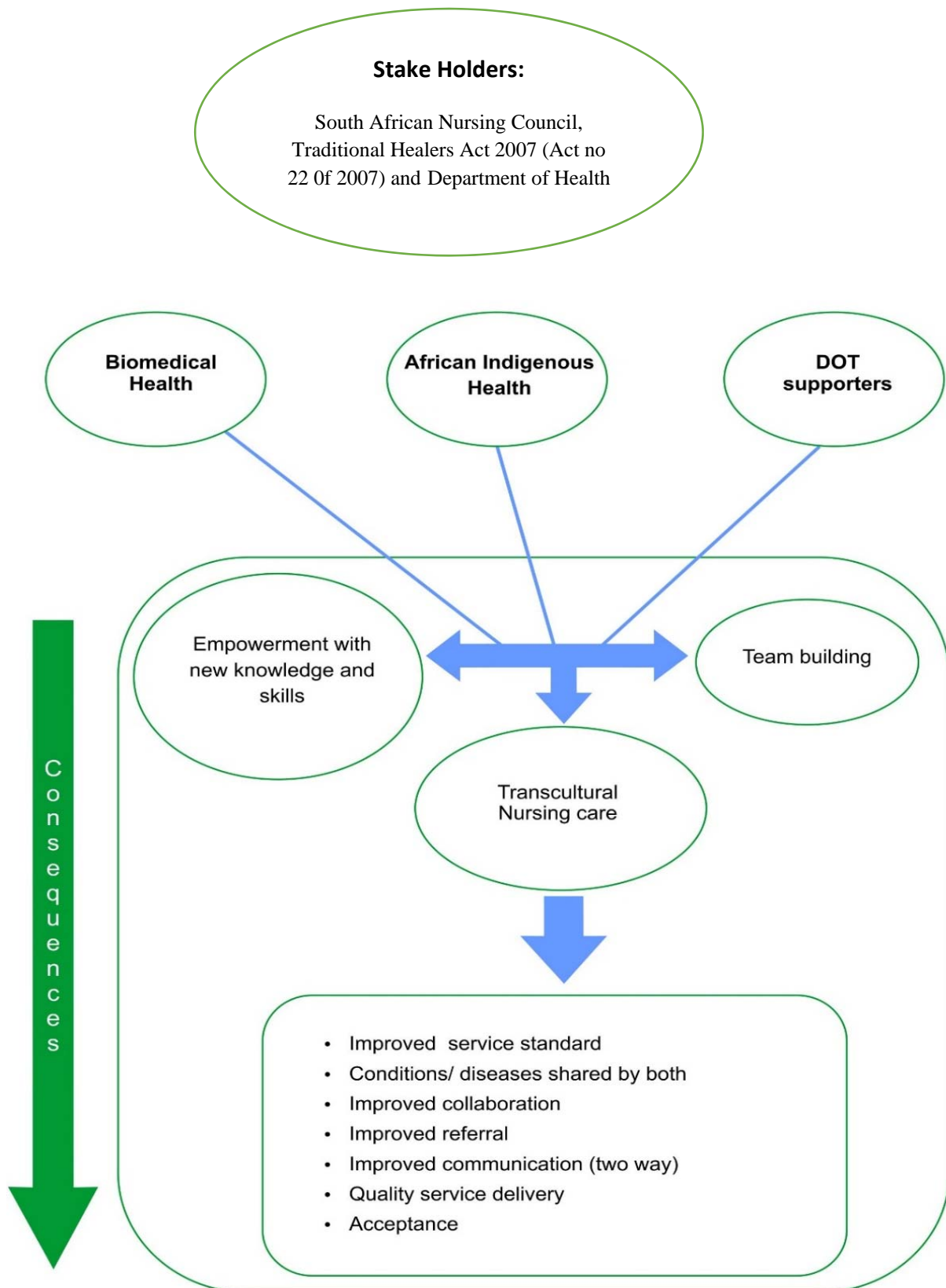


Figure 5.7: Terminus or endpoint of the activity.

Schematic representation of the model

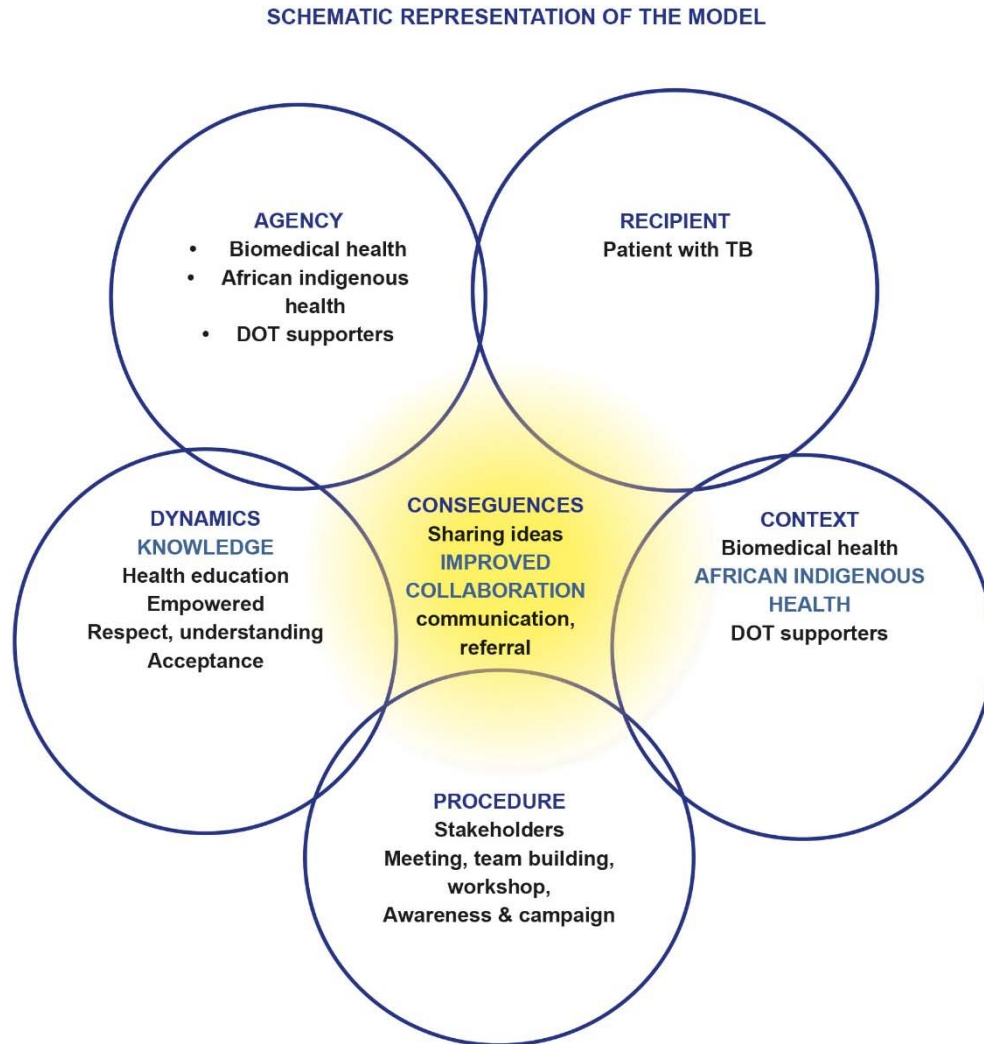


Figure 5.8 Model for convergence and engagement between biomedical health and African indigenous health practitioners regarding treatment of TB condition.

5.3 MODEL DESCRIPTION AND PROCESS

The convergence and engagement between the biomedical health and African indigenous health practitioners into the treatment of TB condition is the main purpose of this model in order to improve standard of service delivery between them through the provision of transcultural nursing care whereby the concepts of the model in



relation to agent, recipient, context, dynamics, procedure and terminus was classified according to Dickoff et al (1968:422) survey list.

In this study the main concepts were classified to facilitate future prescription to use the model. The researcher used Dickoff et al (1968:431, cited by Poee-Monyemore 2007:195) survey list to classify the concepts of the model into agents, recipients, context, procedures, dynamics and terminus. In this model, the biomedical health, African indigenous health practitioners and DOT supporters are regarded as the agents to deliver the service to the patient with TB.

The patient with TB is the recipient who benefits from the action of the biomedical health, African indigenous health practitioners and the DOT supporters. They are involved in the process of convergence and engagement and comprised the psychological power bases for the achievement of the expected goals. The procedures to be followed during the process of convergence and engagement between biomedical health and African indigenous health practitioners involve recognition of each other, mutual understanding and valuing of their inputs among themselves as they are the pillars of service delivery to patients with TB.

The dynamics or power bases are the energy source for the activity. The agents are expected to have capabilities, knowledge and skills to perform the activity. There should be workshop, awareness, mutual understanding and respect and trusting relationships for them to be able to work together and to provide quality care to patients with TB.

Terminus or consequences are the outcomes of the model. The consequences of convergence and engagement, include empowerment among the agents, teamwork, knowledge and skills, transcultural nursing, improved service standard, improved referral, improved collaboration (two-way), quality service delivery, acceptance of each other and confidence to work independently.



5.3.1 The components of the model

The National Health Act, 61 of 2003 provides a framework for a single health system for South Africa. The South African Nursing Council (SANC) is a regulating body that govern the practices of the nurses (Regulation 2598) whereby it mandates them to execute care to the patients and the Traditional Health Act 2007, Act no 22 of 2007 and gives permission to African indigenous health practitioners to carry on their practices. The identified bodies are involved in the convergence and engagement between the two health's practitioners regarding treatment of TB condition.

The government has launched the National Strategic Plan for TB for 2012-2016 for the integration and shored up by a provincial implementation programme. The plan seeks to address the social structural drivers of TB care, prevention and support; to prevent new infections; to sustain health and wellness and to protect human rights and access to justice of sufferers (WHO's factsheet on tuberculosis).

5.3.2 Framework and contexts for the convergence and engagement

Various context constitute the framework for convergence and engagement

5.3.2.1 Biomedical health practitioner's context

A biomedical health system is defined as “formally taught, learned and transmitted professional care, health, illness, wellness and related knowledge and practice skills that prevail in professional institutions, usually with multidisciplinary personnel to serve consumers” (Leininger 2002:492). A biomedical health context sees patients with TB being consulted, investigated about their condition and treated before they are discharged. The convergence and engagement between biomedical health and African indigenous health system might empower the biomedical health practitioners with new knowledge and skills regarding the provision of care, bearing in mind that patients have their own cultural beliefs that need to be considered during their care and explained thoroughly how it should include in their care.



5.3.2.2 African indigenous health practitioner's context

African indigenous health context consult patients complaining of coughs and other similar signs and symptoms of TB. Patients were given strong and unmeasured indigenous medicine. The convergence and engagement between biomedical health and African indigenous health system might empower the African indigenous health practitioners with new knowledge and skills through the health education, workshops and awareness campaign in order to be able to take care of patients with TB.

5.3.2.3 DOT supporter's context

The DOT supporter's context is one in which the DOT supporters are going out to the community to assist on the care of patients with TB after discharged from the hospital/clinic. DOT supporters face various challenges during the care of the patients with TB because of different perceptions regarding treatment of TB condition. The convergence and engagement of the biomedical health and African indigenous health system might empower the DOT supporters with new knowledge and skills on how to take care of patients with TB and know what to be done and not to, during their course of treatment.

5.3.2.4 Agents for performing the activity

- **Biomedical health practitioners**

Biomedical health practitioners play an important role on the care of the patients with TB. They monitor patients' condition, progress and behaviour twenty four hours around the clock. Biomedical health practitioners make investigations about the condition and give treatment based of the findings. Biomedical health practitioners acknowledged that they need to be empowered with cultural knowledge so that they can be able to render quality service to their patients. They suggested to converge



and engage with the African indigenous health practitioners for the benefit of the patients.

- **African indigenous health practitioners**

African indigenous health practitioners are the most recognised practitioners that provide service to more than 80% of the Africans because of their availability, accessibility and low cost(Viney et al (2014:2).They are in the mission of integrating with the biomedical health practitioners to learn more from them that will lead to reduction of pandemic TB condition. African indigenous health practitioners are ready to be empowered through health education and workshop in order to share ideas with the biomedical health practitioners

DOT supporters

DOT supporters are the home based carers. They visit patients who need assistance in their daily activities. DOT supporters bath, feed and give treatment to the weak or critical ill patients, and even collecting treatment from the hospital/clinic for the sick.DOT supporters experience a lot of challenges during their service delivery. Patients default treatment complaining of hunger and some want to take indigenous medicine because of their cultural beliefs.DOT supporters recommended collaboration with the African indigenous health and biomedical health practitioners for the sharing of ideas which will lead to improvement of service delivery

5.3.2.5 The recipient of the activity

- **Patient with TB**

Patients with TB are the recipients of care from the biomedical health, African indigenous health practitioners and the Dot supporters. The regulating body (SANC) oversees that nurses abide by their scope of practice (Regulation 2598) to execute care to the patients with TB in the way it is expected and the Traditional Health Act 2007, Act no 22 of 2007, limits the unqualified African indigenous health practitioners



to take care of patients with TB because of their limited experience in the field of healing. The DOT supporters take instructions from the biomedical health practitioners on how to take care of patients with TB and bring feedback on the progress of the patients and the challenges they experience during the course of their supervision.

5.3.3 Procedure to serve as a guide during convergence and engagement

The following procedure was suggested to serve as a guide during the convergence and engagement.

- **Involvement of relevant stakeholders and the legislation**

Biomedical health, African indigenous health practitioners and the DOT supporters should take a lead to strengthen their convergence and engagement through participation in sharing of ideas, health education and awareness. The South African Nursing Council, Traditional Health Practitioners Act 2007, Act no 22 of 2007 and Department of health should interlock in order to reach the goal.

To ensure successful convergence and engagement, the legislation governing the nurses and the Traditional Health Practitioners Act 2007, Act no 22 of 2007 that controls the African indigenous health practitioners practice should be a point of departure. The SANC, Nursing Act 2005 (Act no 33 of 2005) is responsible for the nurses and their practice, the constitution (i.e. government, Department of Health), (WHO's factsheet on tuberculosis).

- **Meetings**

Information obtained from Group 1 and 2 participants indicated that meetings were convened by the biomedical health and African indigenous health practitioners to discuss health issues in order to empower each other regarding the treatment of TB and on how to take care of patients with TB and to tackle the challenges that they experience during the care of the TB patients. Holding meetings on regular basis as the best choice might assist to eliminate fear, mistrust and also to improve mutual



understanding and relationship to allow for the continuity of healthcare (Kangwa & Catron 2010:1).

- **Group building**

In group building, biomedical health, African indigenous health practitioners and DOT supporters work together as a team. Teamwork is the cornerstone in ensuring quality patient care, as the team will have common purpose, share ideas, support each other and monitor the results of the service delivered.

- **Awareness, campaigns and workshop**

The biomedical health practitioners are not aware of the indigenous practices that are employed by the African indigenous health practitioners during care of the patients with TB. On the other hand the African indigenous health practitioners are not aware of the biomedical practices during the care of patients with TB because they are practicing in isolation and do not communicate. Awareness campaigns, workshops and health education is a prerequisite to convergence and engagement for the health practitioners to gain new knowledge and skills regarding treatment of TB (Matsabisa, Spotose, Hoho & Javu 2009:142-147).

- **Recognition of African indigenous health practitioners by the government**

The World Health Organisation (WHO) fostered collaboration between African indigenous health and biomedical health practitioners so as to achieve the goals of the primary healthcare initiatives. This is geared towards integration of African indigenous health system into the National Health Service system which is most dominated by the biomedical system

The African indigenous health practitioners are recognised by the government as a result of the establishment of the Traditional Health Practitioners Act 2007, Act no 22



of 2007 despite of their denial by the biomedical health practitioners as they are called illiterate and unhygienically, however, through the meetings, workshop and awareness that they held together, the mutual understanding and trust relationship was reinforced among them Kangwa and Catron (2010:1) and Soai (2012:1). Now their existence is accepted as part of the team members. Recognition of African indigenous health practitioners emerged as an important strategy in the convergence and engagement.

The presentation of theoretical framework in figure 5.8 (above) includes cultural care and social structures dimensions that are influenced by multiple factors. The other factors included the following (Leininger 1991; cited by Pooe-Monyemore 2007:18)

- **Cultural values**

Culture is a concept that has been applied to diverse situations, particularly in a situation in which African indigenous health practitioners and biomedical health practitioners have to converge. It is a multilevel and multidimensional concept that addresses social behavioural as well as political and interpersonal related matters. Though transcultural nursing is a point of departure in nursing it still has some shortcomings such as traditional healers being the ones who fully acknowledge the idea of cultural beliefs, values and norms of each individual client (Bereda 2002:19).

5.4 DYNAMICS AND POWER BASES

The dynamics are the energy or power sources for the activity. Dickoff et al (1968:446) explain dynamics as chemical, physical, biological or psychological power sources that can drive the activity towards the attainment of a goal. The dynamics to enhance convergence and engagement between biomedical health and African indigenous health through knowledge and skills to perform the activity, acceptance of each other in a team, empowerment, respect and understanding and



awareness campaigns to ensure transcultural nursing care which will improve quality service delivery.

Consideration of a number of dynamics and power bases is important for the model of convergence and engagement and are discussed below:

- **Knowledge**

Knowledge is power, without which there is nothing to achieve. Biomedical health, African indigenous health practitioners and DOT supporters should converge and engage in the treatment of TB condition utilising their pre-knowledge and the strategies that were taken to improve their knowledge and skills through training (Wreford 2005:30).

- **Enabling, respect and understanding**

Enabling is the results of the measures taken to transmit information for future use. For the successful convergence and engagement might result in empowerment of the biomedical health, African indigenous health practitioners and DOT supporters with new knowledge and skills through, health education, awareness and workshops. After such empowerment the participants might have sufficient knowledge to able them to work with confidence utilising the knowledge that was achieved during training. The knowledge achieved will reduce tension between these health practitioners, improve standard of service delivery and enhance mutual understanding and trust relationship. Patients will receive quality nursing care and their cultural beliefs will be taken into consideration during the course of their treatment as transcultural nursing will be practiced. Patients might be safe because they would be taken care by the trained agents who will be able to identify their problems and refer them appropriately (Wreford 2005:23).



- **Acceptance of each other**

Acceptance is one of the principles of primary healthcare. Compliance is essential for the agents for the convergence and engagement to be effective. The findings revealed that the African indigenous health practitioners and DOT supporters were willing to work together as a team with the biomedical health practitioners, and that they needed the support of biomedical health practitioners during the provision of care to patients with TB. The biomedical health practitioners are willing to accept the African indigenous health practitioners if they can be workshopped and acquire the required knowledge regarding TB condition. It was confirmed that for successful convergence and engagement the biomedical health practitioners should accept the African indigenous health practitioners and initiate mutual understanding and trusting relationship so that they can work together as a team (Wreford 2005:14).

5.5 TERMINUS OR OUTCOMES OF CONVERGENCE AND ENGAGEMENT (CONSEQUENCES)

There are several factors relating to end of the process of convergence and engagement:

- **Sharing ideas and Group work**

Bruning and Baghurst (2013:88) describe group work in healthcare as a provider for a safer patient care and further indicated that also reduces errors and increases patient satisfaction. Group work was identified as a consequence of convergence and engagement. African indigenous health and the biomedical health practitioners are expected to unite and share ideas in relation with the treatment of TB for the benefit of patients in need of the service. Unification of these two health practitioners can be a success in the healing of patients with TB as they may receive quality care. However, the findings revealed that there is no integration between the two health practitioners.



- **Improved service standard of referring patients with TB**

Improved service standard was identified as a consequence of convergence and engagement during concept analysis (Walker & Avant 2005:29), and during data analysis of the experiences of the biomedical health, African indigenous health practitioners and DOT supporters regarding the convergence and engagement between biomedical health, African indigenous health practitioners regarding the treatment of TB condition and as a terminus or endpoint in the six aspects of activity by Dickoff et al (1968:422). Through empowerment and teamwork the standard of service delivery could be lifted and patients receive quality care. Both biomedical health and African indigenous health practitioners would be able to work independently and harmoniously with confidence.

- **Quality service delivery**

Quality service delivery was identified as a consequence of convergence and engagement and led to standard of care whereby patients are assessed and referred appropriately. African indigenous health practitioners would be able to abide and implement the knowledge that they have achieved during their training by assessing patients correctly and refer them to the biomedical health practitioners if there is a need. The biomedical health practitioners would be able to create a therapeutic environment, showing positive attitudes towards patients of different cultures and also to the African indigenous health practitioners to show their acknowledgement of the referral of the patients.

- **Reduced spread of TB condition among the communities**

Biomedical health practitioners would witness and experience reduced statistics of TB condition through teamwork and fighting together to alleviate TB. This would be a benefit to the entire community of Ehlanzeni district because there would be reduced mortality rates and the government (Department of Health) would benefit from less expenditure on TB treatment as patients would be less.



5.6 SUMMARY

Chapter five has focused on development and description of a model for convergence and engagement between biomedical health and African indigenous health practitioners regarding the treatment of TB condition. From the data gathered and the analysis made it has become clear that biomedical health practitioners should collaborate with African indigenous health practitioners for the benefit to the community. It is necessary for the transcultural nursing to be included in the nursing curriculum so that the biomedical health practitioners should have knowledge regarding cultural differences. Model development was based on the findings of phase one (concept analysis by Walker & Avant 2008:30), phase two and phase three (conceptual framework by Dickoff, et al 1968:422). The next chapter will provide the conclusions drawn from the study, the recommendations made based on the findings, as well as the limitations encountered during the process of the study. These are done against the background of the aims and objectives of the study.



CHAPTER 6

OVERVIEW OF RESEARCH FINDINGS, RECOMMENDATIONS, IMPLICATIONS, LIMITATIONS AND CONCLUSIONS

6.1 INTRODUCTION

This chapter provides an opportunity for the researcher to illustrate to the reader whether the purpose of undertaking this study has been fulfilled and objectives as stated in chapter one attained. After exploring the development and description of a model for convergence and engagement between biomedical health and African indigenous health practitioners regarding treatment of TB condition, the researcher will therefore discuss the findings, recommendations, implications, limitations of the study and conclusions and suggest areas for further research as emerged from the findings.

6.2 OVERVIEW OF RESEARCH FINDINGS

6.2.1 Phase One – Empirical perspective

In this phase the purpose was to explore and describe the experiences of biomedical health and African indigenous health practitioners and DOT supporters regarding the treatment of TB. A qualitative, exploratory, descriptive and contextual approach was used to achieve this objectives. Eight themes were identified from different population groups, with categories and sub-categories identified to substantiate each theme and be compared to relevant literature. African indigenous health practitioners indicated their dissatisfaction about the treatment that they are receiving from the biomedical health practitioners when they are taking patients to them: lack of respect, mutual understanding, trusting relationship and acceptance between the biomedical health and African indigenous health practitioners.

African indigenous health practitioners indicated that they were looked down and treated as illiterate by the biomedical health practitioners. When African indigenous health practitioners refer patients to biomedical health practitioners they do not receive report from them regarding the condition of the patient or the referral to them. The referral seems to be one-way instead of two-way.



The biomedical health practitioners seemed to resist their integration with the African indigenous health practitioners. This attitude is motivated by fear and mistrust of traditional methods of treatment.

6.2.2 Phase Two – Concept analysis

Phase Two was designed to analyse the concept “convergence and engagement”, which helped the researcher understand the meaning of convergence and engagement between the biomedical and African indigenous health practitioners regarding treatment of TB condition. To achieve this objective, concept analysis was carried out, following the process of Walker and Avant (2005:49), after which the following findings emerged: theoretical definition, antecedents and consequences of the concepts “convergence and engagement”.

Upon the identified uses, defining attributes and model cases of the concept, the theoretical definition of the concept might be the process of unifying, integrating, collaborating, joining, combining, incorporating, connecting, junction and coupling, and converging the biomedical and African indigenous health practitioners, with the aim of improving the standard of care to patients with TB condition.

Chinn and Kramer (2008:195) and Walker and Avant (2005:73) describe antecedents as events or incidents that should occur prior to the occurrence of the concept. In this study, before convergence and engagement between biomedical and African indigenous health practitioners, the following events should occur: campaigns, workshop, awareness, meeting acceptance of each other to promote mutual understanding and trust relationship between them.

According to Chinn and Kramer (2008:95) and Walker and Avant (2005:73) consequences are the events or incidents that occur as a result of the concept. In this study teamwork, sharing of ideas, empowerment, knowledge to both practitioners and skills, Quality service delivery, and improved referral (two-way) were perceived as the possible consequences of convergence and engagement:



6.2.3 Phase three – Model development

Phase Three was intended to develop and describe a model for convergence and engagement between African indigenous health practitioners and biomedical health practitioners regarding the treatment of TB condition. Model development was based on the findings for Phase One, Phase Two and Phase three.

6.3 RECOMMENDATIONS

Upon the purpose of the developed model, the convergence and engagement between African indigenous health practitioners and biomedical health practitioners regarding the treatment of TB condition, the following were recommended:

- Inclusion of the African indigenous health practitioners and biomedical health practitioners should be considered because the more gap each discipline creates between itself and the other, the more patients with TB exposed to harm.
- It is necessary for the biomedical health practitioners to be taught anthropology and how culture affects people's daily lives, decision-making and freedom of choice about their health.
- There should be policies that indicate clearly the working parameters of the African indigenous health practitioners as it is indicated to the biomedical health practitioners for the control and monitoring of their service delivery.
- Transcultural nursing care should be included in the curricula of all health professionals (training) as it may help to improve the standard of care.
- Integration between African indigenous health and biomedical health practitioners should be ensured by the South African Nursing Council (SANC) to improve the standard of care to patients with TB. The SANC should also compile rules and regulations to guide and inform policies regarding the convergence and engagement between the African indigenous health and biomedical health practitioners regarding the treatment of TB condition.
- They should initiate in-service training for biomedical health practitioners regarding cultural competency.
- African indigenous health practitioners on the other hand should be taught personal and environmental hygiene, including the use of clean equipment and the correct measurement of traditional medicine.



- TB programmes should capitalise on the popularity of African indigenous health practitioners amongst community members by clearly defining mutually beneficial collaborative programs where African indigenous health practitioners play a major role in case finding/identification of TB suspects and referring them to health facilities for proper diagnostics and treatment.
- African indigenous health practitioners' roles should include that of treatment support to improve adherence to treatment (DOTS). By so doing convergence and engagement can be strengthened and sustained.
- About cases for referrals to the hospital or clinic. e.g., TB.
- The government must enact policies to guide and regulate the practice of traditional medicine whereby some degree of self-regulation and professionalism amongst African indigenous health practitioners is provided for.
- The government should consider the legislation that controls the qualification and registration of African indigenous health practitioners.

6.4 RECOMMENDATIONS FOR FURTHER RESEARCH

Research should be conducted into the following areas:

- The attitude of these two health practitioners towards each other during their integration
- Development of guidelines for implementation of the Traditional Health Practitioners Act 2007, Act no 22 of 2007.
- Monitoring of the implementation of the model for convergence and engagement between the African indigenous health and biomedical health practitioners regarding treatment of TB condition.
- Involvement of African indigenous health practitioners when doing research on issues related to TB condition and treatment. This is necessary because they will be able to know the condition and treatment in details and will enhance integration and quality service delivery.
- Another study could cover participant observation on the daily execution of the African indigenous health practitioners' skills during their disease intervention processes.

- It is also a necessity for the biomedical health practitioners to form partnership and investigate with African indigenous health practitioners different herbs, regarding their origin, effectiveness, side effects, how they are preserved and their uses on different illnesses and diseases.

6.5 IMPLICATIONS

Biomedical health practitioners are reluctant to accommodate African indigenous health practitioners in healthcare service because of inadequate knowledge and skills on western system. This attitude results in demarcation of health service delivery between African indigenous health and biomedical health practitioners due to lack of knowledge on the service that is being delivered in the other discipline. They need to work together, open to each other and have knowledge of what is being done in both disciplines. Transcultural nursing in the nurses' curriculum should be included to upgrade the standard of quality service delivery and also will benefit the community.

The African indigenous health practitioners were complaining of the convergence that is being preached but is not functional because of the attitudes that the biomedical health practitioners show towards the African indigenous health practitioners when they accompany their patients for consultation. Patients with TB still get insult when they indicate about their visit to the African indigenous health practitioners. African indigenous health practitioners still experience problems of acceptance by the biomedical health practitioners. According to the African indigenous health practitioners, the working together of both health practitioners is not working.

African indigenous health practitioners suggested an infrastructure such as buildings within the hospital facility which will serve the purpose of meeting with the biomedical health practitioners, consulting the patients and easy referral of patients. They also indicated the issue of the transport for the need of the patients. They need gloves to protect themselves and razor blades. African indigenous health practitioners indicated that even if they raised their voices they were not heard because they did not receive any support from the government.

African indigenous health practitioners are the repository of the indigenous medicines and are willing to teach the biomedical health practitioners if they are ready to



exchange information regarding the treatment through training, workshops and health education to be able to take care of patients with TB under the supervision of the biomedical health practitioners to alleviate the mortality rate.

They elaborated on legalisation of instruments that they can be supplied of to use on the implementation of the service to show that they are part of the healthcare system.

6.5.1 for the South African Nursing Council

South African Nursing Council rules and regulations should emphasise the importance of culture in nursing by including it in the curricula to create awareness of socio-cultural factors and to ensure that the cultural needs of the patients are met (Ngunyulu, Mulaudzi & Peu 2012:165)..

6.5.2 for the Department of Health

Awareness, workshop and training should be monitored to make sure that it take place between the biomedical health and African indigenous health practitioners to ensure the provision of culturally congruent care to multicultural South Africans (Ngunyulu, Mulaudzi & Peu 2012:166).The health policies should accommodate the “indigenous” practices and it should be stated clearly the extent in which they should practice.

6.6 CONTRIBUTION TO THE BODY OF KNOWLEDGE

A model for convergence and engagement between African indigenous health and biomedical health practitioners regarding treatment of TB condition might contribute to the body of knowledge in both practitioners because training, awareness and workshops might be carried out from both practitioners points of view, and as a result transcultural nursing and skills through nursing curriculum, leading to improvement of service delivery through provision of culturally congruent care will take place. The African indigenous health practitioners will be able to work independently with the knowledge that achieved through training, workshops and health education and the involvement in research.

6.7 LIMITATIONS

According to Ngunyulu, Mulaudzi & Peu (2012:167), limitations are those trades-offs that remind a researcher what the study was and was not, and how its boundaries and results may and may not contribute to understanding



Mokoena (2012:148) explains limitations as there is no study, irrespective of the method used, that can provide findings that are universally transferrable. The following limitations are relevant to this study:

Limitations might occur during the process of convergence and engagement because some conditions will not require the active involvement of the African indigenous health practitioners as the biomedical health practitioners might be reluctant to involve the other party as they take them as illiterate. In order to recognise the importance of culture in the provision of nursing care the researcher should be knowledgeable regarding culturally congruent care and display to others that irrespective of illiteracy by the African indigenous health practitioners there are conditions in which they are more knowledgeable than the biomedical health practitioners, so it needs perseverance and understanding in order to accommodate each other and work together to overcome the differences.

6.8 CONCLUSION

Out of the data gathered and the analysis so far it is evident that if something is not done to bring this difference between African indigenous health and biomedical health practitioners, healthcare consumers will be continually mistreated. It is through this qualitative research that clarity has been made.

This study has highlighted that African indigenous health and biomedical health practitioners have the same goal that of healing patient although to some health practitioners there was no interaction between them, rather they mistrusted and looked down upon each other and displayed a mutually negative attitude.

Creating a model for convergence and engagement between African indigenous health and biomedical health practitioners is imperative, considering the realities of staff shortages, cultural values and norms and disease burden challenging the Mpumalanga province. The researcher succeeded in creating a model for convergence and engagement which would facilitate the integration between the African indigenous health and biomedical health practitioners, building trust, relationship, capacity and changing their negative attitude.

REFERENCES

- Adjei, B.2013. Utilization of Traditional Herbal Medicine and its role in Healthcare delivery in Ghana: The case of Wassa Amenfi West District
- Al-Rowais, N., Al-Faris E. Mohammad, A.G., Al-Rukban, M. & Abdulghani, H.M.2010.Traditional Healers in Riyadh Region: Reasons and Health Problems for Seeking Their Advice. A Household survey. *The Journal of Alternative and Complimentary Medicine*, 16 (pt. 2), 199-204
- Ashforth, A. 2001. AIDS, Witchcraft, and the Problem of Power in Post-Apartheid South Africa, no 10
- Babbie, E. 2010.The Practice of Social Research.12th ed. Chapman University.
- Bateman, C.2010.Bridging the divide- anthropologist/sangoma challenges delegates.SAMJ, S.Afr.med.j, 100 (2), 1.
- Bernecker, T. 2010.Invulnerability: A Concept Analysis. *Global Journal of Health Science Vol. 2, No. 1; April 2010*
- Bereda, J. E. 2002. Traditional Healing as a Healthcare delivery system in a transcultural society, University of South Africa, Pretoria
- Blackwell's Nursing Dictionary.2010 Juta 2nded.
- Bojuwoye, O. & Sodi, T. 2010. Challenges and opportunities to integrating traditional healing into counselling and psychotherapy. *Counselling Psychology Quarterly*, 23(pt. 3), 283-296.
- Busia, K & Kasilo, O.M.J.2010. Collaboration between traditional health practitioners and conventional health practitioners: Some country experiences. West African Health Organisation. WHO Regional Office for Africa

- Botma, Y., Greef, M., Mulaudzi, F.M. & Wright, S.C.D.2010.Research in Health Sciences. Cape Town, Nozuko Makhuvha
- Bruggerman, A.J., Wijma, B. & Swanberg, K.2012. Abuse in healthcare: A concept analysis
- Bruning, P & Baghurst. 2013. The relationship between teamwork and empowerment to patient satisfaction in orthopaedic settings: an exploratory study.*American Journal of Health Research*, 2013; 1(3): 86-94
- Brunner, L.S. & Suddarth, D.S. 2004. Medical Surgical Nursing.11thed. Philadelphia, Lippincott Williams & Wilkins.
- Brush, B.L., Kirk, K., Gultekin, L and Baiardi, J.M.2011. Overcoming: A concept Analysis. *Nurs Forum*. Jul 2011; 46(3):160-168
- Burns, N & Grove, S.K. 2009. The practice of Nursing Research. 6th ed. St Louis. Philadelphia. Saunders Elsevier
- Burns, N. & Grove, S.K.2007. Understanding Nursing Research. Building an Evidence – Based Practice.4th Edition. Saunders Elsevier, st Louis
- Burns, N. & Grove, S.K. 2005. The Practice of Nursing Research.5thed.Philadelphia, Saunders
- Chinn, P.L & Kramer, M.K.2011. Integrated Theory and Knowledge Development in Nursing.8th edition. Elsevier – Mosby, 162-181
- Chinn, P.L. & Kramer, M .K. 2008. Integrated knowledge development in nursing .7th Ed. St. Louis, MO: Elsevier-Mosby.
- Chinn, PL & Kramer, MK. 1995. Theory and nursing: a systematic approach. 4th edition. St Louis: Mosby.

- Comas-Diaz, L., Edwards, M & Holdstock, R.2010. *Latinas: Celebrating the psychological Strength and Resilience of Latina women and girls*, San Antonio, TX 2010, 284
- Collins English Dictionary – Complete & Unabridged. 2012. Digital Edition. Collins.
- Creswell, J.W.2013. *Research Design: Qualitative, Quantitative, and Mixed Methods Approached*. 4th edition
- Creswell, J.W.2003. *Research Design: Qualitative, Quantitative, and Mixed Methods Approached*. 2nd edition. University of Nebraska, Lincoln. Sage Publications. *International Educational and Professional Publisher*. Thousand Oaks. London. New Delhi
- Daniels & Nicoll, L.2012. *Contemporary Medical-Surgical Nursing*. Second edition.
- De Vos, A.S., Strydom, H., Fouche, C.B & Delport, C.S.L.2011.*Research at Grassroots. For the social sciences and Human service Profession*, 4th edition
- De Vos, A.S., Strydom, H., Fouche, C.B. & Delport, C.S.L.2006. *Research at Grassroots*. 2nd ed. Pretoria, Van Schaik. 345-347.
- De Vos, A.S. ed.1998. *Research at Grassroots- a Primer for the caring profession*. Pretoria, Van Schaik. 343-344.
- Department of Health.2009. Mpumalanga Health to commemorate world TB day. Available from [http://www.mpumalanga.gov.za/healthsocserve/news/media-Releases/2009/2009031\[2009.12.17\]](http://www.mpumalanga.gov.za/healthsocserve/news/media-Releases/2009/2009031[2009.12.17])
- South Africa.2007. *Traditional Health Practitioners Act 2007 (Act no.22 of 2007)*, Cape Town. Government Gazette

- Dickoff, J, James, P & Wiedenbach, E. 1968. Theory in a practice discipline. Part 1: Practice oriented theory. *American Journal of Nursing* 7(5):415-435.
- Edmunds, M.W & Scudder, L.E.2009. How to make sense of Qualitative research findings.*AORN*.2009; 90: 543-554
- Elo, S., Kaariainen, M., Kanste, O., Polkki, T., Utriainen, K & Kyngas, H.2014. Qualitative Content Analysis. A focus on Trustworthiness. Sage journals
- Falan, S.2010. Concept Analysis of Similarities Applied to Nursing Diagnosis: Implication for Educators. Volume 21, issue 4, Pg. 144-155
- Fiseha, D & Meaza, D. 2015. Assessment of Directly Observed Therapy (DOT) following tuberculosis regimen change in Addis Ababa, Ethiopia: a qualitative study.*BMC Infect Dis*. 2015; 15:405
- Gray, D.E. 2009. *Doing Research in the Real World*.2nded. SAGE Publications, London
- George, J.B.1995.*Nursing theories: the base for professional practice*.2nd edition. Englewood Cliffs: Prentice-Hall
- Green, E.C., Short & Associates.2006. Can collaborative programs between Biomedical and Indigenous Health Practitioners succeed? Available from <http://www.sharing.org>. Retrieved 2014/08/0
- Gqaleni,N.,Mbatha,N.,Mkhize,T.,Naidoo,S., Makhathini,M., Buthelezi., David and Moodley,I.2010.Education and Development of Traditional Health Practitioners in isiZulu to Promote their Collaboration with Public Healthcare Workers. *Alternation* 17, 1(2010)295-311 ISSN 1023-1757
- Gqaleni, N., Moodley, I., Kruger, H., Ntuli, A & Mcleod, H.2007.Traditional and Complementary Medicine. Available at <http://www.mrc.ac.za/Tramed3/>

- Hall, L.2010.Ethnicity and Sociolinguistic variation in San Francisco. Language & Linguistics Compass, 4(7):458-472
- Health & Democracy.2001. Traditional and alternative healthcare. Section 27.org.za.dedi47.cpt1.host-h.net/wp-content/-/chapter7.pdf, 208.
- Hlabano, B.2013. Perceptions of traditional healers on collaborating with biomedical health professionals in uMkhanyakude district of KwaZulu-Natal
- Jali, M.N. 2009. Collaboration of indigenous African and Western European Medicine: Policy Guidelines
- Jon.2012. Application of concept Analysis to Clinical Practice.2011 All free Papers.comGoogle,1-4
- King, Balaba, Kaboru, Kabetesi, Pharris & Homsy. 2004. The Role of Traditional Healers in comprehensive HIV/AIDS prevention and care, 1723-1724.
- Klinikleri, T. 2011.Epidemiology of Tuberculosis in the world and in Turkey. Turkey klinikleri J Pulm Med-Special Topics, 4(2), 1-6.
- Kozier, B., Erb, G., Berman, A. & Snyder, S.2004. Fundamentals of Nursing concepts, process and practice. 7th Ed. New Jersey.
- Krieg, D.2009.Traditional Medicine and Healers in South Africa. Available from http://www.emwa.org/JournalArticles/JA_V7_I1_Krige.1pdf, 6
- Kangwa, C & Catron, R.2010. Traditional Healing and Western Medicine: Segregation or Integration?
- Lamsal, D.K., Lewis, O.D., Smith, S & Jha, N.2009.Factors related to defaulters and treatment. Failure of Tuberculosis patients in the DOTS. Program in the Sunsari District of Eastern Nepal.SAARC J TUBER.LUNG DIS.HIV/AIDS 2009 VI (1)25-30

- Lawrence, H.A.2012.A model as a framework of reference to facilitate wholeness among therapy radiographer
- Leininger, M.M.1991. Culture care diversity and Universality: A theory of Nursing. New York: *National league for Nursing Press*
- Leininger, M.M.2002. Culture care Theory: A major contribution to Advance Transcultural Nursing knowledge and practices. *J Transcult Nurs.* 13,189.
- Lincoln, Y.S & Guba, E.G. 1985. *Naturalistic inquiry*. London: Sage.
- Macleod, D.2016.Engage for success. <http://engageforsuccess.org/what> is employee engagement [Accessed 24 February 2016]
- McKenna, H. 1997. *Nursing theories and models*. London: TJ Press.
- McMillan, J.H. & Schumacher, S.2010.*Research in Education. Evidence Based inquiry.* 7thed, 338-339.
- Madamombe, I.2006.Traditional healers boost primary healthcare. *Reaching patients missed by modern medicine*
- Mark, G & Chamberlain, K.2012. Maori healers' perspectives on cooperation with biomedicine
- Maputle, M.S & Donavon, H.2013. Woman-centred care in childbirth: A concept analysis. *Curationis* 36(1). Available at <http://dx.doi.org/10.4102/curationis.v36i1.49>
- Matebesi, Z., Neulemans, H & Timmerman, C.2005. Healthcare-seekers behaviour among clinic-based tuberculosis patients. *Acta Academica, Suppl 1*, S154-172.
- Matsabisa, M.G., Spotose, T., Hoho, D & Javu, M.2009.Traditionalhealth practitioners 'awareness training programme on TB, HIV and AIDS: a pilot project for the

- Khayelitsha area in Cape Town, South Africa. *Journal of Medical Plants Research* Vol.3 (3), pp.142-147
- Meyers, A.B. & Sylvester, B.A.2006.The role of Qualitative Research Methods in Evidence – Based Practice. *NASP Communique*, Vol.34 (5)
- Mngqundaniso, N & Peltzer, k.2008.Traditional Healers and Nurses: A qualitative study on their role on sexually transmitted infectious including HIV and AIDS in Kwazulu-Natal, South Africa. *Afr J Tradit Complement Altern Med*.2008; 5(4):380-386
- Mokoena, J.D. 2012.Construction of a model for human rights education in the health professions [dissertation].University of Limpopo.
- Muller, M.E., Bezuidenhout, M.C and Jooste, K.2011.Healthcare Service Management. Second edition. Juta and Co.Ltd, 2011. Cape Town, South Africa ISBN 978-0-702-18867-1
- Mokgobi, M.G.2012.Views on traditional healing: Implications for integration of traditional healing and western medicine in South Africa
- Mpinga, E.K., Kandolo, T., Verloo, H., Bukonda, N.K.Z., Kandala, N & Chastonay, P.2013. Traditional/ alternative medicines and the right to health: Key elements for a convention on global health. *Health and Human Rights*. Volume 15, Issue 1
- Annual progress report.2014/15.Provincial Strategic Plan 2012-2016. Mpumalanga Provincial AIDS Council, 6-9
- Napolitano, D.A. 2007. An overview of current knowledge of the Social Determinants of Indigenous Health, 7-20

- Nelspruit News.2013. Drug resistant strains of Tuberculosis (TB) are causing concern in Mpumalanga, where cases have increased by an alarming 39% over the past two years
- Neuman, W.L.2000.Social Research Methods. Qualitative and Quantitative Approaches. Allyn and Bacon: Boston
- Ngunyulu, R.N., Mulaudzi, F.M & Peu, M.D.2012. A model for incorporating “indigenous” postnatal care practices into the midwifery healthcare system in Mopani district, Limpopo Province, South Africa
- Nuopponen, A.2010. Methods of concept analysis- a comparative study. *LSP Journal*, Vol.1, NO 1 (2010)/<http://lsp.cbs.dk>
- Oeser, C.C., Escombe, A.R., Gilman, R.H., Friedland, J.S., Evans, C.A.W. & Moore, D.A.J .2005. Does Traditional Medicine use hamper efforts at, Tuberculosis control in urban Peru? *Am.J.Trop. Med. Hyg*, 73 (3), 571-575
- Oxford Advanced learner’s Dictionary.2010. Eighth edition. Oxford. University press
- Livingstone, C.ed.2008. Oxford mini Dictionary and Thesaurus.2008. *Supplement. Oxford University Press*
- Oxford English Mini Dictionary.2007.seventh edition. Oxford: Oxford University Press
- Park, Y.2000. The challenge of cross-cultural psychology. The role of the indigenous psychologies. Chung-Ang University, Korea.
- Parahoo, K. 2006. Nursing Research principles, process and Issues. 2nd ed. McMillan.
- Pinkoane, M.G., Greeff, M. & Koen, M.P. 2012. A model for the incorporation of the traditional healers into the national healthcare delivery system of South Africa. *Pinkoane et al., Afr J Tradit Complement Altern Med. (2012) 9(3S):12-18*

- Pinkoane, M.G., Greeff, M. & Koen, M.P.2008. Policy makers' perceptions and attitudes regarding incorporation of traditional healers into the national health care delivery system
- Plowden, K.O. & Wenger, A.F.2001.Journal of transcultural nursing. Transcultural nursing society, 12(1), 34-39
- Pooe-Monyemore, M.B.J.2007. A model for enhancement of self-concept of people with albinism.
- Polit, D.F. & Beck, C.T.2008. Nursing Research. Generating and Assessing Evidence for Nursing practice. 8th ed. Lippincott Williams & Wilkins.
- Pretorius, L. & Small, L.2007. Trans-cultural nursing: exploring the experience of international students visiting Namibia, 1
- Pretorius, E.2011. Traditional Healers – Health Systems Trust. University of the Orange Free State
- Potratz, E. 2012.Transforming Care at the Bedside: A Model to Promote Staff Nurse Empowerment and Engagement
- Portfolio Committee on Health. 1998. Personal communication. Regulation of African traditional healthcare
- Provincial Strategic Plan.2012 – 2016.Annual Progress Report 2014/15. Mpumalanga Provincial AIDS Council, 9.
- Rautenbach, C.2005.The inaccessibility of western healing, the high cost attribute to it and more. Available from <http://www.greekconference.com.au/papers/2005/rautenbach.html>
- Ritchie.J and Lewis.J.2003. A Guide for Social Science Students and Researchers. SAGE. London, New Delhi. Thousand Oak, 52-155.

- Ross, E.2010. Inaugural lecture: African spirituality, ethics and traditional healing- Implications for indigenous South African social work education and practice, 3(1),
- Sandlana, N. & Mthetwa, D.2008. African traditional and religious faith practices and the provision of psychological well-being among Amaxhosa people.
- Serbulea, M.2005.Old meets new in West Africa's medicine mix. Science and Development Network, 21 (2), 231-234.
- Simmons, D. S. 2009. Healer's understandings of Indigenous names for HIV/AIDS in Harare, Zimbabwe. AIDS Care, 231-234.
- Shatell, M.2004.Risk: A Concept analysis. Nursing forum, 39(2), 11-18
- Shenton, A.K.2004. Strategies for ensuring trustworthiness in qualitative research projects. Education for information 22, 63-75.
- Soai, M.2012. Medical practitioner versus traditional healers: Implications for HIV & AIDS policy. Website by Red Swallow Creations | Joomla templates by SG web hosting
- South African Nursing Council regulations relating to the Scope of Practice of person who registered or enrolled under the nursing Act 2005, Act no 33 of 2005
- Solomon, E.M., Poggenpoel, M & Myburgh, CPH.2014. The development of a model to facilitate success when establishing a homeopathic practice in South Africa. University of Johannesburg
- Statistics South Africa. 2013. Mortality and causes of death in South Africa, 2013: Findings from death notification. Pretoria. info@statssa.gov.za
- Steinberg,S., Architects, R & Kinser, D.E.2013.The power of convergence: Technology informed healthcare planning and design

- Summerton, J.2006. The incorporation of Africa traditional health practitioners into the South Africa healthcare system. *Acta Academia*, 38(1), 143-169.
- Summerton, J.V.2006. Western health practitioners' view about African traditional health practitioner's treatment and care of people living with HIV/AIDS. *Curationis*, 29(3): 15-23.
- Tjale, A. & de Villiers, L. 2004.Cultural Issues in Health and Healthcare.1st ed
- Unite for Sight.2000-2013.Integrative Medicine-Incorporating Traditional healers into Public Health Delivery. Available from <http://www.uniteforsight.org/global-health-university/certificate-program-delivery> [2013.05.06]
- Unsworth, J.2000. Practice development: A concept analysis. Onlinelibrary.wiley.com. Vol 8, issue 6. *Journal of Nursing Management*. Volume 8, issue 6, 317-326
- Upton, M.2011. The politics of Health: Community Engagement in South African HIV Vaccine Trial sites. PhD thesis The Open University
- USAID.2006.Collaborating with traditional healers for HIV prevention and care in Sub-Saharan Africa: Suggestions for programme managers and field workers.
- Van Rooyen, D., Pretorius, B., Tembani, N.M & Ten Ham, W.2015. Allopathic and Traditional Health Practitioners 'collaboration, *Curationis* 38 (2), Hart. #1495
- Viney,K.A.,Johnson,P.,Tagaro,M.,Fanai,S.,Linh,N.N.,Kelly,P.,Harley,D and Sleigh,A.2014.Tuberculosis patients 'knowledge and beliefs about tuberculosis: a mixed methods study from the Pacific Island nation of Vanuatu.*BMC Public Health*.2014;14:467.
- Wainhouse Research.2006. Converged Collaboration & Conferencing Services

- Walker, L.O. & Avant, K.C. 2011. Strategies for Theory Construction in Nursing. Boston: Prentice Hall,157-167.
- Walker, L.O & Avant, K.C.2005. Strategies for Theory construction in Nursing. 4th ed.CT: Appleton & Lange Norwalk
- Walker, L.O & Avant, K.C. 1995. Strategies for theory construction in nursing. 3rd edition. Connecticut: Appleton & Lange.
- Wamba, A & Groleau, D.2012. Constructing Collaborative Processes between Traditional, Religious, and Biomedical Health Practitioners in Cameroon. *Nordic Journal of African Studies* 21(2):49-74 (2012)
- Webster, M. 2014. An encyclopaedia. Britannica Company. m-w.com
- Wehbe-Alamah, H., McFarland. Macklin. & Riggs, N.2011. The lived experiences of African American Women receiving care from Nurse Practitioners in an urban nurse-managed clinic. Volume 1 (1), 19-240.
- Wiedenbach. E. 1970. Nurse's wisdom in nursing theory. *American Journal of Nursing* (70):1059
- World Health Organisation. 2014. Global Tuberculosis Report 2014.
<http://www.who.int/mediacentre/factsheets/fs104/en/>
- Wilkinson, D., Gcabashe, M. & Lurie, M.1999. Traditional Healers as Tuberculosis treatment supervisors: Precedent and Potential 5 (4) 27.
- Wreford, J.O.2005. Negotiating relationships between biomedicine and sangoma: Fundamental misunderstandings, avoidable mistakes. CSSR Working, No. 138.
- Yahia, N.B., Bellamine, N & Ghezala, H.B. On the Convergence of Collaboration and Knowledge Management. (nesrine.benyahia, narjes.bellamine)@ensi.rnu.tn



Zimmermann, K.A.2015.Livescience. What is Culture? /Definition of Culture. Www-livescience.com/21478-what-is-culture-definition-of-culture.html

ANNEXURE A

ETHICAL APPROVAL



ANNEXURE A.1

UNIVERSITY OF PRETORIA



ANNEXURE A.2

DEPARTMENT OF HEALTH
MPUMALANGA PROVINCE



ANNEXURE B

PARTICIPANT LEAFLET AND CONSENT



ANNEXURE B.1

PARTICIPATION INFORMATION LEAFLET AND
INFORMED CONSENT
BIOMEDICAL HEALTH PRACTITIONERS



ANNEXURE B.2

PERMISSION LETTER FROM DEPARTMENT OF
HEALTH
EHLANZENI DISTRICT
BIOMEDICAL HEALTH PRACTITIONERS



ANNEXURE B.3

PARTICIPATION INFORMATION LEAFLET AND
INFORMED CONSENT
AFRICAN INDIGENOUS HEALTH PRACTITIONERS



ANNEXURE B.4

PERMISSION LETTER TO THE CHIEF
KABOKWENI VILLAGE



ANNEXURE B.5

PERMISSION LETTER TO
THE HEAD OF TRADITIONAL HEALERS
EHLANZENI DISTRICT, MBOMBELA



ANNEXURE B.6

PARTICIPATION INFORMATION LEAFLET AND
INFORMED CONSENT
DOT SUPPORTERS



ANNEXURE B.7

PERMISSION LETTER TO THE
HEAD OF DOT SUPPORTERS
EHLANZENI DISTRICT, MBOMBELA



ANNEXURE B.8

ACCEPTANCE LETTER FROM THE
HEAD OF DOT SUPPORTERS
EHLANZENI DISTRICT, MBOMBELA



ANNEXURE B.9

PERMISSION LETTER TO THE
MATRON / SISTER IN CHARGE
BONGANI TB HOSPITAL



ANNEXURE C

INTERVIEW GUIDE FOR THE
BIOMEDICAL HEALTH
AFRICAN INDIGENOUS HEALTH PRACTITIONERS &
DOT SUPPORTERS



ANNEXURE D

LETTER FROM THE EDITOR





The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 13/04/2011 and Expires 13/04/2014.

Faculty of Health Sciences Research Ethics Committee

6/01/2014

Approval Certificate
New Application

Ethics Reference No.: 470/2013

Title Creating a model of convergence and engagement between African indigenous health and biomedical health regarding tuberculosis (TB) treatment.

Dear Ms TINYIKO ENNETH NKHWASHU

The **New Application** as supported by documents specified in your cover letter for your research received on the 13/11/2013, was approved by the Faculty of Health Sciences Research Ethics Committee on the 20/11/2013.

Please note the following about your ethics approval:

- Ethics Approval is valid for 4 years Start date : 2012 End date: 2015
- Please remember to use your protocol number (**470/2013**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:

- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed.
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

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09 December 2013

Ms. Tinyiko Nkhwashu
P O Box 333
MATSULU
1203

Dear Ms. Tinyiko Nkhwashu

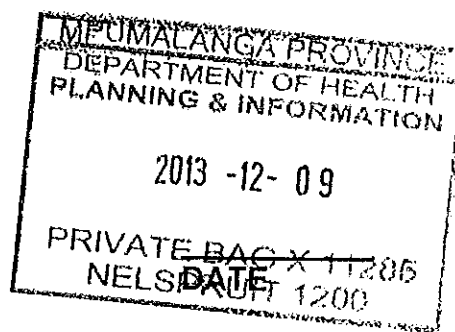
APPLICATION FOR RESEARCH & ETHICS APPROVAL: CREATING A MODEL OF CONVERGENCE AND ENGAGEMENT BETWEEN AFRICAN INDIGENOUS HEALTH AND BIOMEDICAL SYSTEM REGARDING TUBERCULOSIS (TB) TREATMENT

The Provincial Research and Ethics Committee has approved your research proposal in the latest format that you sent.

Kindly ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards


DR. WILLIAM R.M. MAPHANGA
CHAIRPERSON: PHREC



PARTICIPATION INFORMATION LEAFLET AND INFORMED CONSENT

To be completed by the biomedical health practitioners

TITLE OF THE STUDY

Creating a model of convergence and engagement between African indigenous health and biomedical system regarding tuberculosis (TB) treatment.

Researcher's name: Nkhwashu Tinyiko Enneth

Student number : 21244350

Supervisor : Prof F.M Mulaudzi

Co-Supervisor : Prof M.A Masoga

1. INTRODUCTION

You are invited to take part in this research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the researcher. You should not agree to take part unless you completely happy about all the procedures involved.

2. WHAT IS THE PURPOSE OF THIS STUDY?

The aim of this study is to explore and describe the nature of the collaboration that exists between African indigenous and biomedical health, with the intention of creating a model of convergence and engagement between the two in the treatment of the TB condition, and so enhance quality service delivery to the patients in need of it in the Mpumalanga Province.

3. WHAT IS EXPECTED OF YOU DURING THIS STUDY?

You will be requested to sign forms giving consent for the interviewer to interview you. This is done for ethical reasons. The interview will be **conducted in a private room (offices)** at the hospital, at the local clinic. The interview will be **an in-depth interview (one to one) and a voice recorder** will be used with your permission to avoid miscodes. You will be asked some questions about collaboration between African indigenous and biomedical health regarding the treatment of TB condition in the Mpumalanga Province.

You will be expected to talk while the tape recorder is recording the conversation between you and the researcher. The researcher will also take field notes and observational notes.

These will be used as references during data analysis. All the information that will be recorded will be used only for the purpose of the study. As soon as the data is analysed, the recorded information will be deleted or destroyed

4. MAY ANY OF THESE STUDY PROCEDURES RESULT IN ANY DISCOMFORT AND RISKS?

There will be no risks involved in the study. Since the study needs the views regarding collaboration between African indigenous and biomedical health regarding the treatment of TB condition, you may experience mild discomfort. Therefore you are requested to report any uneasy feelings so that they can be handled as soon as possible. The study will not include any experiments.

5. WHAT ARE THE BENEFITS OF THE STUDY?

The study will not be of immediate benefit to you, but the results of the study will enable the TB patients to get quality of service in future. The challenges that you are encountering will be taken into consideration as they will be known to the researcher and other stakeholders.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary and you are free to refuse to participate or stop the interview at any time without stating any reason. Your withdrawal will not affect you in anyway.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

The study is still to be submitted to the Research Ethics Committee of the University of Pretoria, faculty of Health Science.

8. INFORMATION AND CONTACT PERSON

Should you have any questions regarding this study, please do not hesitate to contact the researcher

Researcher : Ms. T.E Nkhwashu: 082 674 5304

Supervisor : Prof F.M Mulaudzi: 082 563 4758

Co-Supervisor: Prof M.A Masoga: 083 758 0321

9. COMPENSATION

Your participation is voluntary. No compensation or contribution towards your transport as the researcher will go around and visit the participants to their working places.

10. CONFIDENTIALITY

All information obtained during the course of this study is strictly confidential. Data that may be reported in journals will not include any information, which may identify you as a participant in this study.

CONSENT TO PARTICIPATE IN THIS STUDY

I _____ hereby confirm that I have been informed by the researcher, Ms T.E Nkhwashu about the nature, process, benefits, discomforts and risks of the study. I have also received, read and understood the participant information leaflet regarding the study.

I am aware that the results of the study, including personal details will be anonymously processed into the research reports.

I may, at any stage without prejudice, withdraw my consent and participation in this study. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in this study.

Participant's name _____ (Please print)

Participant's signature: _____ Date _____

Investigator's name _____ (Please print)

Investigator's signature _____ Date _____

Witness's Name _____ (Please print)

Witness's signature _____ Date _____

VERBAL INFORMED CONSENT

I, _____ the undersigned, have read and have fully explained the participant information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the participant whom I have asked to participate in the study.

The participant indicates that s/he understands that the results of the study, including personal details regarding the interview will be anonymously processed into a research report. The participant indicates that s/he has had time to ask questions and has no objection to participate in the interview. S/he understands that there is no penalty should s/he wish to discontinue with the study and his/her withdrawal will not affect any treatment / access to _____ in any way. I hereby certify that the client has agreed to participate in this study.

Participant's Name _____ (Please print)

Person seeking consent _____ (Please print)

Signature _____ Date _____

Witness's name _____ (Please print)

Signature _____ Date _____



MPUMALANGA PROVINCIAL GOVERNMENT

66 Anderson Street
 Nelspruit
 1200
 Republic of South Africa



Private Bag X 11278
 Nelspruit 1200
 Tel: 013 755 5100
 int: +27 13 755 5100
 Fax: 013 752 7498
 int: -27 13 752 7498

Department of Health Ehlanzeni District

Litiko Letemphilo

Umyango Wezamaphilo

Departement van Gesondheid

Enq: NS Mayimele
 Tel: 0733199697/0137555142

06 February 2014

MS TE Nkhwashu
 P.O Box 333
MATSULU
 1203

Dear Ms Nkhwashu

PEMISSION FOR RESEARCH STUDY PURPOSES

It is a pleasure to inform you that an application to conduct a research study at Ehlanzeni district health facilities is approved. Theme: **Creating a model of convergence and engagement between African indigenous health and biomedical health regarding (TB) tuberculosis treatment.**

Yours sincerely

MR. D. MDULI
CHIEF DIRECTOR: EHLANZENI DISTRICT

06/02/2014
DATE



PARTICIPATION INFORMATION LEAFLET AND INFORMED CONSENT

To be completed by the African indigenous health practitioners

TITLE OF THE STUDY

Creating a model of convergence and engagement between African indigenous health and biomedical system regarding tuberculosis (TB) treatment.

Researcher's name: Nkhwashu Tinyiko Enneth

Student number : 21244350

Supervisor : Prof F.M Mulaudzi

Co-Supervisor : Prof M.A Masoga

1. INTRODUCTION

You are invited to take part in this research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the researcher. You should not agree to take part unless you completely happy about all the procedures involved.

2. WHAT IS THE PURPOSE OF THIS STUDY?

The aim of this study is to look at the nature of the relationship that exists between traditional healers and medical doctors, with the intention of creating a common understanding between the two in the treatment of the TB condition, which will enhance quality service delivery to TB patients in in the Mpumalanga Province.

3. WHAT IS EXPECTED OF YOU DURING THIS STUDY?

You will be requested to sign forms giving consent for the interviewer to interview you. This is done to ensure your protection against dangerous acts. The interview will be conducted in a private room (offices) at the hospital, or at the local clinic. The interview will be on one to one basis and a voice recorder will be used with your permission to record the interviews. You will be asked some questions about integrating traditional healing and medical practice in the treatment of TB condition in the Mpumalanga Province.

You will be expected to talk while the **voice recorder** is recording the conversation between you and the researcher. The researcher will also take some notes.

These will be used as references during data analysis. All the information that will be recorded will be used only for the purpose of the study. As soon as the data is analysed, the recorded information will be deleted or destroyed

4. MAY ANY OF THESE STUDY PROCEDURES RESULT IN ANY DISCOMFORT AND RISKS?

There will be no risks involved in the study. Since the study needs the views regarding collaboration (team work) between traditional and western medicines regarding the treatment of TB. You are requested to report any uneasy feelings so that they can be handled as soon as possible.

5. WHAT ARE THE BENEFITS OF THE STUDY?

The study will not be of immediate benefit to you, but the results of the study will enable the TB patients to get quality of service in future. The challenges that you are encountering will be taken into consideration as they will be known to the research team and other stakeholders.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary and you are free to refuse to participate or stop the interview at any time without stating any reason. Your withdrawal will not affect you in anyway.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

The study is still to be submitted to the Research Ethics Committee of the University of Pretoria, faculty of Health Science.

8. INFORMATION AND CONTACT PERSON

Should you have any questions regarding this study, please do not hesitate to contact the research team

Researcher : Ms. T.E Nkhwashu: 082 674 5304

Supervisor : Prof F.M Mulaudzi: 082 563 4758

Co-Supervisor: Prof M.A Masoga: 083 758 0321

9. COMPENSATION

Your participation is voluntary. No compensation or reward will be offered.

10. CONFIDENTIALITY

All information obtained during the course of this study won't be shared with any person except the research team. Data that may be reported in journals will not include any information, which may identify you as a participant in this study.

CONSENT TO PARTICIPATE IN THIS STUDY

I _____ hereby confirm that I have been informed by the researcher, Ms T.E Nkhwashu about the nature, process, benefits, discomforts and risks of the study. I have also received, read and understood the participant information leaflet regarding the study.

I am aware that the results of the study, including personal details will be anonymously processed into the research reports.

I may, at any stage without penalty, withdraw my consent and participation in this study. I have had sufficient opportunity to ask questions and declare myself prepared to participate in this study.

Participant's name _____ (Please print)

Participant's signature: _____ Date _____

Investigator's name _____ (Please print)

Investigator's signature _____ Date _____

Witness's Name _____ (Please print)

Witness's signature _____ Date _____

VERBAL INFORMED CONSENT

I, _____ the undersigned, have read and have fully explained the participant information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the participant whom I have asked to participate in the study.

The participant indicates that s/he understands that the results of the study, including personal details regarding the interview will be anonymously processed into a research report. The participant indicates that s/he has had time to ask questions and has no objection to participate in the interview. S/he understands that there is no penalty should s/he wish to discontinue with the study and his/her withdrawal will not affect any treatment / access to _____ in any way. I hereby certify that the client has agreed to participate in this study.

Participant's Name _____ (Please print)

Person seeking consent _____ (Please print)

Signature _____ Date _____

Witness's name _____ (Please print)

Signature _____ Date _____

P.O Box 333

Matsulu

1203

04 July 2014

The Chief

Kabokweni Village

Ehlanzeni District

Mpumalanga Province

re: PERMISSION FOR RESEARCH STUDY PURPOSE

I hereby request permission to access the African indigenous practitioners who will be selected from Kabokweni village for a research project. I would like to conduct a research project at Kaboweni village as a requirement for my Doctoral degree with the University of Pretoria.

The aim of this study is to explore and describe the nature of the relationship between African indigenous and biomedical health regarding the treatment of TB condition in Ehlanzeni district in Mpumalanga province.

This will contribute to create a model of convergence and engagement in the treatment of TB condition to promote quality care delivery.

This study will be voluntary and anyone who does not want to participate will not be forced to do so, the interview will be used as a data collection method and a tape recorder will be used by participant's permission.

Information will be strictly confidential and findings will be communicated to the relevant authority.

Cell no: 082 674 5304

Yours truly



T.E. NKHWASHU

P.O Box 333

Matsulu

1203

23 March 2014

The Head of Traditional Healers

Ehlanzeni District

Mbombela

Mpumalanga Province

re: PERMISSION FOR RESEARCH STUDY PURPOSE

I hereby request permission to conduct a research study at Kabokweni village as a requirement for my Doctoral degree with the University of Pretoria.

The aim of this study is to explore and describe the nature of the relationship between African indigenous, biomedical health and DOT Supporters regarding the treatment of TB condition in Ehlanzeni district in Mpumalanga province.

This will contribute to create a model of convergence and engagement in the treatment of TB condition to promote quality care delivery.

This study will be voluntary and anyone who does not want to participate will not be forced to do so, the interview will be used as a data collection method and a tape recorder will be used by participant's permission.

Information will be strictly confidential and findings will be communicated to the relevant authority.

Cell no: 082 674 5304

Yours truly


T.E. NKHWASHU

PARTICIPATION INFORMATION LEAFLET AND INFORMED CONSENT

To be completed by the DOT Supporters

TITLE OF THE STUDY

Creating a model of convergence and engagement between African indigenous health and biomedical system regarding tuberculosis (TB) treatment.

Researcher's name: Nkhwashu Tinyiko Enneth

Student number : 21244350

Supervisor : Prof F.M Mulaudzi

Co-Supervisor : Prof M.A Masoga

1. INTRODUCTION

You are invited to take part in this research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the researcher. You should not agree to take part unless you completely happy about all the procedures involved.

2. WHAT IS THE PURPOSE OF THIS STUDY?

The aim of this study is to describe the experiences that the DOT supporters have on working with TB patients, with the intention of creating a common understanding that will help the doctors, nurses and the traditional healers to work together in the treatment of TB. This could improve the care of TB patients in the Mpumalanga Province.

3. WHAT IS EXPECTED OF YOU DURING THIS STUDY?

You will be requested to sign forms giving consent for the interviewer to interview you. **This is done according to the law. You will be requested to form groups of 6-10 participants each during the interview. You will be interviewed at your meeting place using your language.**

The interview will be recorded with your permission. You will be asked some questions about your **experience that you have when working with TB patients regarding the treatment of this condition** in the Mpumalanga Province.

You will be expected to talk while the **voice recorder** is recording the conversation between you and the researcher. The researcher will also take some notes. These will be used as references during data analysis. All the information that will be recorded will be used only for the purpose of the study. As soon as the data is analysed, the recorded information will be deleted or destroyed.

4. MAY ANY OF THESE STUDY PROCEDURES RESULT IN ANY DISCOMFORT AND RISKS?

There will be no risks involved in the study. Since the study needs the views regarding your experiences on working with TB patients regarding their treatment. You are requested to report any uneasy feelings so that they can be handled as soon as possible. The study will not include any experiments.

5. WHAT ARE THE BENEFITS OF THE STUDY?

The study will not be of immediate benefit to you, but the results of the study will enable the TB patients to get quality of service in future. The challenges that you are encountering will be taken into consideration as they will be known to the researcher and other stakeholders.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary and you are free to refuse to participate or stop the interview at any time without stating any reason. Your withdrawal will not affect you in anyway.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

The study is still to be submitted to the Research Ethics Committee of the University of Pretoria, faculty of Health Science.

8. INFORMATION AND CONTACT PERSON

Should you have any questions regarding this study, please do not hesitate to contact the research team

Researcher : Ms. T.E Nkhwashu: 082 674 5304

Supervisor : Prof F.M Mulaudzi: 082 563 4758

Co-Supervisor: Prof M.A Masoga: 083 758 0321

9. COMPENSATION

Your participation is voluntary. No compensation or reward will be offered.

10. CONFIDENTIALITY

All information obtained during the course of this study won't be shared with any person except the research team. Data that may be reported in journals will not include any information, which may identify you as a participant in this study.

CONSENT TO PARTICIPATE IN THIS STUDY

I _____ hereby confirm that I have been informed by the researcher, Ms T.E Nkhwashu about the nature, process, benefits, discomforts and risks of the study. I have also received, read and understood the participant information leaflet regarding the study.

I am aware that the results of the study, including personal details will be anonymously processed into the research reports.

I may, at any stage without penalty, withdraw my consent and participation in this study. I have had sufficient opportunity to ask questions and declare myself prepared to participate in this study.

Participant's name _____ (Please print)

Participant's signature: _____ Date _____

Investigator's name _____ (Please print)

Investigator's signature _____ Date _____

Witness's Name _____ (Please print)

Witness's signature _____ Date _____

VERBAL INFORMED CONSENT

I, _____ the undersigned, have read and have fully explained the participant information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the participant whom I have asked to participate in the study.

The participant indicates that s/he understands that the results of the study, including personal details regarding the interview will be anonymously processed into a research report. The participant indicates that s/he has had time to ask questions and has no objection to participate in the interview. S/he understands that there is no penalty should s/he wish to discontinue with the study and his/her withdrawal will not

affect any treatment / access to _____ in any way. I hereby certify that the client has agreed to participate in this study.

Participant's Name _____ (Please print)

Person seeking consent _____ (Please print)

Signature _____ Date _____

Witness's name _____ (Please print)

Signature _____ Date _____

P.O Box 333

Matsulu

1203

23 March 2014

The Head of DOT supporters

Ehlanzeni District

Mbombela

Mpumalanga Province

re: PERMISSION FOR RESEARCH STUDY PURPOSE

I hereby request permission to conduct a research study at Kabokweni village as a requirement for my Doctoral degree with the University of Pretoria.

The aim of this study is to explore and describe the nature of the relationship between African indigenous, biomedical health and DOT Supporters regarding the treatment of TB condition in Ehlanzeni district in Mpumalanga province.

This will contribute to create a model of convergence and engagement in the treatment of TB condition to promote quality care delivery.

This study will be voluntary and anyone who does not want to participate will not be forced to do so, the interview will be used as a data collection method and a tape recorder will be used by participant's permission.

Information will be strictly confidential and findings will be communicated to the relevant authority.

Cell no: 082 674 5304

Yours truly



T.E. NKHWASHU



|Phaphamani HBC | 006-664 NPO| 2805 Kabokweni Ridge| Box 3277
Kabokweni1245 |013 796 9122|phapahamanihbc@gmail

07/07/2014

Ms. Tinyiko Nkhwashu

POBOX 333

MATSULU

1203

DEAR MS. Tinyiko Nkhwashu

Application to conduct a research to the (DOT) supporters.

Kindly be notified that your request to conduct a research study has been approved

Kind regards?

Operations Manager

C. Mtetwa



P.O Box 333

Matsulu

1203

26 March 2014

The Matron/Sister in charge

Bongani TB Hospital

Ehlanzeni District

Mpumalanga Province

re: PERMISSION FOR RESEARCH STUDY PURPOSE

I hereby request permission to access the biomedical health practitioners who will be selected from your hospital for a research project. I would like to conduct a research project at Bongani Hospital as a requirement for my Doctoral degree with the University of Pretoria.

The aim of this study is to explore and describe the nature of the relationship between biomedical and African indigenous health practitioners regarding the treatment of TB condition in Ehlanzeni district in Mpumalanga province.

This will contribute to create a model of convergence and engagement in the treatment of TB condition to promote quality care delivery.

This study will be voluntary and anyone who does not want to participate will not be forced to do so, the interview will be used as a data collection method and a tape recorder will be used by participant's permission.

Information will be strictly confidential and findings will be communicated to the relevant authority.

The study is approved by Mpumalanga Provincial Ethics Committee.

Cell no: 082 674 5304

E-mail: tinyikoenneth@gmail.com and enneth@vodamail.co.za

Yours truly

T.E. NKHWASHU (Ms)

INTERVIEW GUIDE

Biomedical health and African indigenous health practitioners

The following research question gave direction to the study:

- What are the viewpoints of African indigenous and biomedical health practitioners regarding convergence and engagement after the promulgation of the Traditional Health Practitioners Act 2007 (*Act. 22 of 2007*) regarding their practices and healthcare delivery?
- What is the model of convergence and engagement between African indigenous and biomedical health practitioners regarding the treatment of TB condition in a selected district in Mpumalanga province?
- How can a model of convergence and engagement between African indigenous and biomedical health practitioners be created?

DOT supporters

- What are the viewpoints of DOT supporters regarding convergence and engagement after the promulgation of the Traditional Health Practitioners Act 2007 (*Act. 22 of 2007*) regarding the practices and healthcare delivery between the biomedical health and African indigenous health practitioners?
- What is the model of convergence and engagement between African indigenous and biomedical health practitioners regarding the treatment of TB condition in a selected district in Mpumalanga province?
- How can a model of convergence and engagement between African indigenous and biomedical health practitioners be created?

Acknowledgment of Language Editing

Date: Friday, 13 May 2016

This is to certify that I have conducted Language Editing on the following:

*Creating a model of convergence and engagement between African
indigenous health and biomedical system regarding tuberculosis (TB)
treatment*

by

TINYIKO ENNETH NKHWASHU

Algraham

Andrew Graham (BA, MA dist., PhD, University of Keele, UK)*



Telephone: 011 475 6724

Email: happy4andrew@hotmail.com

*Former Tutor in Postgraduate Writing Centre and Managing Editor of ISI Accredited Journal

Acknowledgment of Language Editing

Date: Thursday, 02 June 2016

This is to certify that I have conducted language editing on a revision of
chapter 4 of the following:

*Creating a model of convergence and engagement between African
indigenous health and biomedical system regarding tuberculosis (TB)
treatment*

by

TINYIKO ENNETH NKHWASHU

Algraham

Andrew Graham (BA, MA dist., PhD, University of Keele, UK)*



Telephone: 011 475 6724

Email: happy4andrew@hotmail.com

*Former Tutor in Postgraduate Writing Centre and Managing Editor of ISI Accredited Journal