

## **Biomedical health practitioners' views regarding the practices and health care delivery methods of the African indigenous health practitioners' in Mpumalanga province, South Africa**

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**Abstract:** Approval of the Traditional Health practitioners Act 22 of 2007 caused great concern among biomedical health practitioners because it was believed that African indigenous practitioners use African medicine that is detrimental to the health of the community. They were treated as illiterate and unscientific, and believed to be practicing in unclean conditions. It was expected that the establishment of the legislation would promote collaboration between the biomedical and African indigenous health practitioners, however the former are still reluctant to integrate with the latter. The aim of this article is to explore the views of the latter regarding the practices and healthcare delivery methods of their African counterparts in Mpumalanga Province, South Africa. A purposive sampling method was used to select 10 knowledgeable participants on the phenomenon, using structured in-depth interviews. Whilst they believed African indigenous health practitioners should be empowered in order to change their practices and healthcare delivery methods it is also recommended that the biomedical ones conduct meetings, workshops, health education and awareness for the benefit of the indigenous practitioners and those in need of their service.

**Keywords:** African indigenous health practitioners/Biomedical; healthcare delivery methods; Mpumalanga province; Views

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### **I. Introduction**

The marginalisation of African indigenous health practices will remain an impediment to healing and fighting diseases on the continent if integration of biomedical practices is not improved. The former predate the latter by centuries or more, but are perceived as being carried out by illiterate, unscientific practitioners in unclean conditions and with the use of witchcraft and traditional medicine that is strong and unmeasured [1]<sup>1</sup>.

For centuries the two types of health practitioner were operating in parallel but in secret, with more than 80% of the population consulting the African indigenous ones [2]. Patients were consulting indigenous health practitioners before they sought biomedical help [3] so rather than being cured many were becoming worse or even dying. Reliance of most blacks on indigenous health practitioners and the apparent failure to reduce the number of fatal illnesses has led the government to consider collaboration with the biomedical fraternity, notably by the World Health Organisation (WHO) at the Alma Alta Conference on Primary care in 1978 [4].

This paper explores biomedical health practitioners' views regarding the practices and healthcare delivery methods of the African indigenous health practitioners in Mpumalanga Province, South Africa. It is intended to contribute to empowerment of the latter through knowledge acquisition, such that their work will be respected and properly understood by the former.

In 2007 the South African government passed the Traditional Health Practitioners Act to close the gap and address a concern surrounding integration of traditional and modern medicine. The incorporation of the two disciplines had an impact on local communities in accessing their rights as vested in the Constitution [20], however, despite the WHO's recommendation and the Act, marginalisation persists [5, 6, 7], with concerns expressed that the biomedical group were being forced to collaborate with their African counterparts for the sake of reducing the spread of diseases among the community and preventing abandonment of biomedical treatment. Authors [7] [2] and [8] have argued that integration is the cornerstone of any effective health system, essential to sharing views regarding the care and treatment of diseases and giving all involved a similar understanding.

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<sup>1</sup>Numbers in square parentheses refer to works listed numerically in the bibliography.

## II. Methods

The researcher used purposive sampling to select knowledgeable participants about the phenomenon to include in the research project [9], and ones able to share their views regarding practices and healthcare delivery methods following the Traditional Health practitioners Act of 2007 (Act no. 22 of 2007). Permission to conduct the study was requested from the sister in-charge (manager) of the selected hospital. Based on agreement and permission being granted to conduct the research in the facility the registered and enrolled nurses were requested to participate, with reasons for the study explained and consent obtained for the individual interviews. Formal appointments with date, time and secure venue for the interview were made. A total of 10 females participated, (eight registered and two enrolled nurses), but no males. One male registered nurse did not participate because he was on night duty and the two male doctors were taking ward rounds. Interviews were conducted in the month of April 2014 and participation was voluntary.

The setting encompassed physical, social and cultural contexts, namely the geographical area of the selected district of Mpumalanga province. Data was collected at the workplace of the participants, which was the office and ward. A qualitative research design was used to collect data, including participant observation [10] and structured in-depth, individual interviews conducted in English. A voice-recorder was used with the participants' permission and field notes taken. Data saturation was reached with the tenth participant.

## III. Data analysis

Voice-recorded data was transcribed verbatim and notes carefully read and checked by the researcher as she conducted the interviews. Organisation, reduction and giving meaning to data followed Tesch's method, as described by [11].

## IV. Ethical considerations

The Ethics Committee of the University of Pretoria provided approval and permission to conduct the study was obtained from the Mpumalanga Provincial Department of Health and at the District department. Consent was also obtained from the participants prior to their participation after being informed about the purpose of the study and its methodology, including clarification when requested [12]. The participants were informed that participation was voluntary and that confidentiality would be ensured [13]. They were free to withdraw from an interview at any time without penalty. The researcher made every effort to protect participants from discomfort and harm, whether physical, emotional, spiritual, economic, social or legal [10]. Permission was obtained from them to voice-record the interviews, which lasted from 30 to 45 minutes.

## V. Trustworthiness

Trustworthiness measures the truth value of a study and is indexed by measures to enhance credibility, dependability and conformability. Credibility was achieved through prolonged engagement with the participants and establishing rapport. Dependability was ensured by the voice-recorder and the transcripts which were available for the use of verification if necessary. Confirmability was ensured by conducting individual interviews until data saturation was attained and taking of field notes by the researcher during the interviews, the voice-recordings of the proceedings during the individual interviews and the verbatim transcripts.

## VI. Findings

### 6.1 Demographic characteristics of the biomedical health practitioners

Of the 10 biomedical health practitioners, the eight registered and two enrolled nurses were interviewed individually. They were all female and their ages ranged between 35 and 60. Findings are discussed per participant.

**Table 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%
Total	10	100%	

## 6.2 Themes and Sub-themes

Two main themes and sub-themes were identified which give clear views of the biomedical health practitioners regarding the practices and healthcare delivery methods of the African indigenous health practitioners in Mpumalanga province.

**Table 3:** The themes and sub-themes

Themes	Sub-themes
1. Unacceptance of the African indigenous health practitioners' practices and healthcare delivery methods by the biomedical health practitioners	1. Strong unmeasured African medicine 2. Unhygienic conditions 3. Defaulting of treatment 4. Delays in referral
2. Group interaction was suggested between these two types of health practitioner to enhance understanding	1. Health education 2. Changing mind-set 3. Understanding each other's sector 4. Communication 5. Research regarding traditional medicine

### 6.2.1 Theme One: Unacceptance of the African indigenous health practitioners' practices and healthcare delivery methods by the biomedical health practitioners

Biomedical health practitioners expressed their feelings regarding the practices and healthcare delivery methods by the African indigenous health practitioners. They indicated that their negative attitudes had developed when the latter delayed referring patients to hospital, giving strong unmeasured medicine and the patients defaulting to biomedical treatment focusing on indigenous medicine.

The sub-themes identified are outlined as follows:

#### 6.2.1.1 Sub-theme One: Strong unmeasured African medicine

Some of the biomedical health practitioners were reluctant to collaborate with the African indigenous health practitioners in the belief that they were illiterate and used unscientific methods, giving strong unmeasured indigenous medicine to the patients which resulted in damaging their internal organs, such as the liver. However, some acknowledged the establishment of the Act and were ready to work with them, albeit a barrier identified in that the African indigenous health practitioners lacked policies to cover their practices [21].

#### 6.2.1.2 Sub-theme Two: Unhygienic conditions

Biomedical health practitioners were labelling African indigenous health practitioners as having poor hygienic standards, not bathing, washing their hands or working in clean environments: *"You know what, to me, I was amazed, in fact most of our traditional healers are not aware of the hygiene. Their patients do not bath while here at the hospital we bath them. You find that their medicine stay for a long time until it has that mould on top but they still give patients to drink. They use one razor blade to every patient coming to them, I suggest that the department can check one traditional healer if is doing correct."*

#### 6.2.1.3 Sub-theme Three: Defaulting of treatment

Biomedical health practitioners were concerned about the default of the treatment by patients after discharge from the hospital, as they returned to the African indigenous health practitioners to start from where they had left off with the indigenous medicine. This attitude put more communities at risk of contracting and spreading infectious diseases, and even death: *"In Mpumalanga, a--h, people believe in traditional healers which is really disturbing because patients default treatment. I suggest if we can find a facility where we can keep the patients until they complete their treatment after discharge'.*

#### 6.2.1.4 Sub-theme Four: Delays in referring patients to the clinic or hospital

Biomedical health practitioners were concerned about the delay of referring patients to them, indicating that African indigenous health practitioners referred patients only when they had failed and a patient's condition was at an advanced stage.

### 6.2.2 Theme Two: Group interaction between types of health practitioner to enhance understanding

Biomedical health practitioners were availing themselves to meet their African counterparts at workshops and run an awareness campaign to share ideas, understand different types of conditions and how they

weremanaged for the improvement of service delivery.Theyadded that the outcome of their meetings reduced risky practices and there would be a great improvement in referring patients to them.Their integration was seen as central to effective collaboration.

#### **6.2.2.1 Sub-theme one: Health education**

Biomedical health practitioners indicated that they werewilling to providehealth education regarding the different types of disease. They also showed willingness to meet during the workshops in order to empower the indigenous practitioners with knowledge that wouldenable them to handle patients with confidence. Such teaching could enable both groups to understand and appreciate each other's contributionstothe provision of service for the benefit of the patients. Biomedical health practitioners felt honoured and superior to be facilitators of health education: *"Let the traditional healers come together with the medical staff to talk about diseases."* *"Here at Mpumalanga they decided to call the sangomas in workshop to give them health education aboutdiseases."*

Biomedical health practitioners considered the establishment of the Traditional Health Act as the foundation for discussing their meetings: *"At least they are recognised now with their Act."* *"First we have to teach the African indigenous health practitioners, explain side effects of traditional medicine to patients, they should understand before treating them. The doctors explained to them why patients are not healing. We educate thefamilies the danger of herbal treatment so that if the patient is discharged they must not take patient to herbalist."*

The acceptance of the Traditional healers Act by the biomedical health practitioners brought good collaboration between both practitioners and demonstrated a success in reducing the risks of the African indigenous health practitioners' practices to patients [14].

#### **6.2.2.2 Sub-theme two: Changing mind-set**

Meetings, workshops, awareness and health education would change negative ways of thinking about the African counterparts and improve attitudes towards them. Theywould promote trust and respect between the two groups, so that they could work together to reach their common goal. Each practitioner's role must be clear in handling the patient with different conditions to prevent conflict and promote good mutual relationships.

#### **6.2.2.3 Sub-theme Three: Understanding each other's sector**

Biomedical health practitioners accepted African indigenous health practitioners on conditions that would make them understand each other regarding service delivery. They felt they should be able to work together, understand each other's strength and weaknesses and learn from each other. The two-way communication would reduce mistrust and disrespect because they wouldbe able to share ideas about the referral and prognosis of their patients'conditions.

Biomedical health practitioners accepted that they werewere fewer in numberwith less accessibility and higher costs [17]. Anoption wasto engage themselves for the benefit of the patients and the smooth running of the service.

#### **6.2.2.4 Sub-theme four: Communication**

Three participants indicated that communication wasbehind the success of every action taken to move forward: *"Good personal relationship between the two health care 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."* *"We must make sure if our patients are discharged from the facility we must visit, phone them about the treatment outcome."* *"Hmm! They must be educated on how these patients should be nursed. They should have protective clothing like mask. They should refer sick patients immediately."*

#### **6.2.2.5 Sub-theme five: Research regarding traditional medicine**

Participants felt that in order to sustain relationships, collaboration and trust research shouldbe conductedon the site of African indigenous medicine, thus to see its efficacy and safety: *"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 tests be done to see if it kills bacteria."*

## **VII. Discussion**

It has been determined that biomedical health practitioners were unlikely to collaborate with the African indigenous health practitionerswithout the Act. The latter were happy that they wouldwork together but the negative attitude of the former was a hindrance,withno interaction between them.Rather, there was a perception that they were mistrusted and looked down upon.

A model for convergence and engagement between these two health groups is imperative, considering the disease burden challenging the Mpumalanga province, and this would facilitate integration, trust, relationships, capacity and changing of negative attitudes.

The African indigenous health practitioners were seen as unhygienic by the biomedical health practitioners. This confirmed the view of [7] on the issue of untidiness, such as unscientific methods of traditional medicine, lack of hand washing, non-sterile equipment, and lack of measured prescription of traditional medicine according to age and weight of the patient. Patients consulting the African indigenous health practitioners resulted in complications such as diarrhoea, dehydration, poisoning and sores on the body. According to [16], meeting between the different practitioners could empower each with the requisite knowledge regarding the care of patients with a variety of diseases and patients would be saved from complications.

According to [15], most biomedical health practitioners saw an advantage in integration as African indigenous health practitioners were preferred by the community and it would help them access the community and strengthen their referral system.

Participants demonstrated their willingness to work with African indigenous health practitioners in order to understand each other's strengths and weaknesses and to learn from each other, thus empowering the latter with knowledge to enhance provision of quality care to patients as well as adherence to treatment. According to [7], mutual understanding between biomedical health and the African indigenous health practitioners was viewed as central and crucial to effective collaboration. To increase acceptance and understanding of their capabilities between the two types, participants indicated that they would meet together to resolve differences for the smooth running of the service.

According to [18], tension between biomedical health and African indigenous health practitioners is fuelled by lack of trust and mutual understanding. The two health practitioners had significant differences in their world view because of lack of compromise. It is clear that communication and respect between these two practitioners could take them to a better level of engagement. [18] also suggested that integration would eliminate fear and mistrust, and allow for continuity of health care.

As argued by [19], research is needed to document the nature, value and effectiveness of African indigenous medicine, important in initiating collaboration with the biomedical counterparts. For the former to have a clear understanding of the use of their indigenous medicine, research should be conducted before they use it. It should be sent for laboratory tests to establish its safety before it is used. Patients should be tested before and after the treatment, and the impact and outcome of treatment determined by comparison of pre- and post-treatment results [14].

## **VIII. Conclusions**

Through the meetings, workshops, health education and awareness campaigns held by the biomedical health and African indigenous health practitioners, it was agreed that practices and healthcare delivery methods were to be improved. Trust and relationships were rebuilt and negative attitudes challenged. The research reported in this article has provided an insight into the needs of collaboration between biomedical and African indigenous health practitioners in the field of health for the sake of saving the community from harmful practices. Furthermore, it should contribute to an understanding of sharing knowledge for the benefit of both patients and health practitioners and the development of a model for convergence and engagement to sustain their relationship throughout. Continuous in-service education is imperative to gain more knowledge and skills that will enable them to make intervention when necessary.

The study found that biomedical health practitioners have the same goal as their African counterparts, namely that of healing patients. However, there is a need to modify the practices and healthcare delivery methods through health education, workshops and awareness campaign that can empower each other with knowledge. The former were compelled to collaborate with the latter, when considering the realities of staff shortages, cultural values and norms and disease burden challenging the Mpumalanga province.

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