

# **REASONS GIVEN BY CAREGIVERS FOR ADMINISTERING AFRICAN HERBAL MEDICINES TO CHILDREN AT ST RITA'S HOSPITAL IN SEKHUKHUNE DISTRICT OF LIMPOPO PROVINCE, SOUTH AFRICA**

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**Declaration:**

I, Matlagolo Mosa Moshabela, hereby declare that the work on which this research is based is original (except where acknowledgements indicate otherwise) and that neither the whole work or any part of it has been, is being or is to be submitted for another degree at this or any other University.

Signature:

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## **ABSTRACT**

The current study explores reasons provided by caregivers for the administration of African traditional medicines in children. This study seeks to understand the caregivers' knowledge, motivation, and the context for traditional medicine administration.

The study took place in the children's ward at St. Rita's Provincial Hospital in Sekhukhune District of Limpopo. An explorative qualitative design was adopted using free-attitude interviews. Purposeful sampling was used to select nine key informants.

Healthcare is sought for preventive and curative purposes, depending on mothers' cultural beliefs, from either traditional or conventional systems, or both. Contexts of health care include home, traditional, faith and conventional. Perception and differentiation childhood illness form the basis of healthcare-seeking behaviour. Mothers show varying patterns of healthcare utilization with respect to severity of childhood illness. Identity and authority factors act as internal and external stimuli, respectively, in administration traditional medicine to children.

The mothers' patterns of seeking care in the health system suggest childcare pluralism. Since mothers advocate for their children, and defend their culture, modifying their care-seeking behaviour requires acknowledgement of their cultural practices. The collective household decision-making necessitates endorsement of holistic family-oriented

practices. Reduction of traditional medicine toxicity requires emphasis of preventive and health promotion strategies.

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## CHAPTER 1

### INTRODUCTION

**‘It is important to remember that acknowledging a practice does not mean endorsing it’ Alan D. Woolf (2003)**

The work of medical doctors resembles that of a lifesaver working downstream, busy rescuing drowning people from a river. Cardiopulmonary resuscitation occurs on the river bank, and these victims are then sent to hospital via emergency medical care services for further care including intensive care unit and other life support services. The lifesaver never takes the time to walk upstream to investigate reasons for people to fall into the river and implement measures to prevent people from drowning. A simple intervention such as stopping the villain who may be throwing innocent people into the river is more beneficial than managing complications arising from waiting for people to drown first, and only then begin treating them. A convincing argument can be made to show that such action is not in the best interest of the victims.

A 10-day-old, previously well baby boy experienced sudden onset of feeding difficulties, cough, fever and lethargy. The parents took the baby to the local traditional healer, who treated him with a single dose of oral herbal medicine, after which the respiratory symptoms worsened. The baby was then taken to the local primary health care clinic, from where he was referred to a tertiary children’s hospital with signs of severe respiratory distress. No other medications were given, and there were no known pesticides used in the home (Wyk and Els, 2008).

The above scenario is all so common, and a reality of working in South Africa, particularly in rural areas. Many questions tend to arise, and management is not straightforward. Is this baby having simple community acquired pneumonia? Perhaps the baby is suffering from a severe pneumonitis or metabolic disturbances caused by herbal intoxication, but superimposed on simple respiratory tract infection. These are the realities of working with children exposed to herbal medicines in Africa. What then becomes the approach of a primary health care physician to the above child? Most likely, the skills of Western-trained practitioners become limited in this case. Curative medicine alone will be inadequate, and health promoting approaches become paramount.

Health promotion is a priceless measure in the improvement of health for individuals and communities at large, which is the very essence of the work performed by health workers, contrary to the curative practice of waiting in the health institutions for people to develop disease and treat them secondarily. Health was defined by the World Health Organization (WHO) in 1948 as the state of complete physical, mental and social wellbeing, and not just the absence of infirmity (Gilbert et al., 2002). Primary health care has been defined as essential health care based on scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination which forms an integral part of the country's health system, of which it is the central function and main focus and is integral to overall social and economic development (WHO/UNICEF, 1978).

Therefore, for Family Physicians, the move away from focusing predominantly on curative medicine is the point of departure.

### **1.1 Problem Statement and Motivation**

As a medical practitioner working in a rural hospital, traditional medicine intoxication became a major problem, particularly among children. The challenge faced by conventional medical practitioners is the limitation in the ability to intervene effectively. In a conventional clinical setting, the features of traditional medicine intoxication are assessed as poisoning. The type or nature of poisoning in this regard is poorly understood, if at all. The current medical training curriculum does not include African traditional practices. Furthermore, unlike other forms of poisoning, active ingredients are not easily identifiable, and antidotes do not exist. Diagnosis is therefore made based on a high index of suspicion, and admission by the patient to traditional medicine ingestion. Management of the patient is generally supportive. Considering the limitations in care, it is therefore reasoned that prevention of traditional medicines may reduce the prevalence of traditional medicine intoxication complications. Little knowledge exists about the use of African traditional medicines, especially in children. Children are particularly vulnerable due to their unpredictable in/ability to cope with poisoning, varying body surface areas, medicine dosage sensitivity, and their age-related inability to negotiate medicine use or provide informed consent.

## **1.2 Purpose Statement**

The purpose of this study was to explore reasons provided by mothers or caregivers for administering African traditional medicines in children. We seek to identify the types of traditional medicines, investigate their practice, and present reasons for these practices in children as given by caregivers. Explorative qualitative interviews were conducted on caregivers of children admitted with a history of prior traditional medicine use. The study was conducted as part of post-graduate studies in the field of Family Medicine and Primary Health Care.

## **1.3 Study Setting**

This study occurs in the context of world-wide use of Complementary and Alternative Medicine (CAM), but particularly of an even wider use of Traditional Medicines (TM) in Africa. In SA, 80% of the population use traditional medicines, predominantly in the rural areas. Post-Apartheid era (1994), the new democratic government made primary health care services freely available, and this policy change resulted in increased use of health care services. The increased demand of services resulted in poorer quality of services through shortages, burnout and brain-drain of Health staff, shortages of medicines and limitations of space in facilities. The impact of this policy change may have led to increased use of primary health services, but may have paradoxically reduced patriotism resulting in return to traditional health systems.

Half of SA's population live in rural areas, and Limpopo Province is largely a rural province. It is therefore suspected that majority of the people in this rural province will utilize traditional medicines.

This research study took place at St. Rita's Provincial Hospital, a major secondary level hospital in Sekhukhune district of Limpopo. This hospital is a 400 bed institution, serving a large district with six feeder district hospitals. The referral tertiary hospital is located 120 km away, accessed by a tarred road.

The hospital serves a large rural population predominantly of Sepedi-speaking black African community of Bapedi people found among the Northern-Sotho tribe in the northern parts of the country. The Sepedi/Ndebele-speaking people of Ndebele origin from the South-West parts of Sekhukhune district (Previously Kwa-Ndebele) are using services of this hospital.

St. Rita's hospital, even though it is a secondary level hospital, is staffed largely by non-South African general practitioners. The hospital is having high health worker vacancy rate according to the clinical manager, as is the case with many rural hospitals in South Africa.

The 60 bed colourful paediatric ward is managed by an active and competent team of doctors, nurses and assisting staff members, led by passionate sister-in-charge and specialist paediatric doctor. Special services for children are operated from the out-patient wing of the ward, and these include paediatric out-patient and HIV clinics. On average, the bed-occupancy rate in the ward is 70%.

## **1.4 Conceptual Framework**

The hallmark of Family Medicine is the patient-centred bio-psychosocial approach to patient care (McWhinney, 1997, Whittaker, 2006). Simply referred to as holistic care, a bio-psychosocial framework emphasizes that patients are more than just disease entities, and exist in the context of evolving cultural, environmental, psychological, socio-economic factors, beyond medical and biological ones (McWhinney, 1997, Whittaker, 2006).

The holistic framework was coined based on the Systems Theory of Bertalanffy, and as a reaction to reductionist approaches of biomedical practice (Gilbert et al., 2002). The scientific biomedical model has brought major advances in the understanding of disease causation and treatment of disease (Gilbert et al., 2002). The holistic model is therefore not an alternative to biomedical practice, but an essential addition and expansion to this approach. This is the reason Holistic care is considered revolutionary and superior in many spheres of health sciences (Gilbert et al., 2002).

As a theoretical framework for research study, the bio-psychosocial model has been used previously in other fields of health (Rock et al., 1996), but it was not found to have been used in exploring the practice of Traditional Medicine.

The framework is chosen here, firstly for its relevance to post-graduate studies in Family Medicine and primary health care in general, secondly for its revolutionary nature in assessing health problems, and lastly to achieve a holistic understanding of this poorly researched area. The researcher has been fully trained in the use and application of this

model to patient assessment, and therefore applying the approach to the study design and interpretation of results is not considered a limitation.

The area under study is considered to be sensitive due the nature of cultural secrecy existing in the context of this practice (Popat et al., 2001). Therefore, this approach will assist the researcher to adopt and apply a non-judgemental approach to data collection, interpretation and presentation. Post-graduate researchers are strongly advised to incorporate relevant and applicable theoretical frameworks throughout study designs (Badenhorst, 2008). Authorities in family medicine and primary health care regard very highly the use of a bio-psychosocial approach (McWhinney, 1997, Whittaker, 2006).

### **1.5 Health Care System and Policy**

Family medicine and primary health care form part of the formal health care system, the basis of which lies within the foundation and practice of Western Medicine. Since the ground-breaking discovery of microbes as causative agents of disease, leading to the “Germ Theory”, Western Medicine has since evolved into a biomedical field whereby illness in a person is reduced to disease, and further reduced to a single microbiological causative agent (Gilbert et al., 2002). It was postulated that eradication of the causative agent will cure illness in a person (Gilbert et al., 2002).

Biomedical model grew tremendously in the Western world, became highly institutionalized, highly regulated and formed the basis of health care (Hillier, 1986). Furthermore, it forms the foundation of formal medical training all over the world including South Africa (Whittaker in Mash, 2006). However, medicine was later

challenged for its social control, and its failure to explain many diseases of lifestyle and diseases where no causative agents were found (Hillier, 1986). Since uncertainty was considered failure or incompetence, where diagnosis is not found patients were abandoned, and specialties dealing with incurable and chronic diseases not amenable to cure became unpopular (Hillier, 1986). These challenges led to the growth of general practice, and the incorporation of holistic approaches to health care. Primary health care was promoted by the WHO/UNICEF particularly due to these challenges (WHO/UNICEF, 1978). The Declaration of Alma Ata addresses these challenges, and promotes comprehensive interventions.

Along with the growth of holistic practices in the formal health sector was the growth in non-formal complementary and alternative therapies (CAM). One may argue that they have always existed, just not openly spoken about within the formal health systems. There is evidence to show that CAM existed from ancient history (WHO, 2002). This argument holds true particularly for continents like Africa, where western medicine is known to have been introduced in the recent centuries during colonization by the West (Freeman and Motsei, 1992).

With Western practice as a recent phenomenon in Africa, it comes as no surprise that majority of people in Africa, especially the indigenous groups, still practice traditional ways of health care (Popat et al., 2001).

The traditional health care system in South Africa is popular, such that Government is making efforts to regulate the sector (DOH, 2007). Therefore, South Africa operates with two known and strong health care systems.

The Draft National Policy on African Traditional Medicine in South Africa is designed to provide a framework for the institutionalisation of African Traditional Medicine in the South African healthcare system. The World Health Organisation (WHO), The African Union (AU) as well as Southern African Development Community (SADC) have all passed resolutions, which urge member states to implement national policies and regulations on Traditional Medicine. At the Lusaka Summit of Heads of State, the African Union adopted a Plan of Action on the decade for African Traditional Medicine (2001 – 2010). The primary objective of the Plan of Action is the institutionalisation of African Traditional Medicine in the public health systems of member states by 2010.

## **1.6 Child Health and Conclusion**

Child health is a major indicator of health profile in any given country in the world, and a measure of health performance. One of the most important indicators of health for any developing country is the number of children who die within the first year of life (Health et al., 2007). Also, children grow to become economically active in the society, and social capital of communities where they originate rests on their shoulders, including rural areas. Rural areas are generally impoverished and under-served, and development becomes a major priority on their long list of needs. Ensuring survival and healthy development of these children is a crucial factor in promoting the health of African people. We know that many mothers will protect and advocate for the health and well-being of their children. Since herbal intoxication can end the dreams of these mothers and the future of many children, as Family Physicians, the jury is out and we seek to understand the practice of traditional medicine within the context of primary health care. One fact remains, prevention is better than cure.

## CHAPTER 2

### LITERATURE REVIEW

The current study, motivated by traditional medicine intoxication in children, seeks to understand the context, reasons and knowledge pertaining to the use of African traditional medicines in rural South Africa. This vital information is necessary to influence the approach of health workers to children with traditional medicine ingestion, so as to reduce morbidity and mortality from traditional medicine use.

The study is timely and relevant, because of the paucity of data with regard to African Traditional medicine practices. Most of the available literature is based on complementary and alternative medicine (CAM) practices in developed countries, and the scanty reports on African Traditional Medicine (ATM), where in South Africa emphasis is placed on toxicity.

The review addresses, firstly, concepts used in the practice of Traditional medicine (TM) to set the stage for further discussion. Issues relating to practices, toxicity and safety, effectiveness and efficacy, access, and regulation are discussed. This review will touch on important generic aspects in the use of CAM and TM, but attention will be drawn to children and caregivers.

Before going any further, it is imperative that we acknowledge and affirm the essential role of conventional medicine with its capability to respond completely in the care of acute disease and trauma (Chez and Jonas, 1997). Its technical innovations in diagnosis and treatment and the escalating clinical applications of basic science discoveries need to

be recognized and appreciated. However, it is in the areas of comprehensive care and the management of chronic disease conditions that the more reductionistic, mechanistic, and organ-specific approach of conventional medicine can be lacking (Chez and Jonas, 1997).

## **2.1 Key concepts in Traditional Medicine and CAM**

Traditional medicine is a comprehensive term used to refer both to TM systems such as traditional Chinese medicine, Indian Ayurveda and Arabic Unani medicine, and to various forms of indigenous medicine (WHO, 2002). TM therapies include medication therapies —if they involve use of herbal medicines, animal parts and/or minerals — and non-medication therapies — if they are carried out primarily without the use of medication, as in the case of acupuncture, manual therapies and spiritual therapies (WHO, 2002).

In countries where the dominant health care system is based on conventional medicine, or where Traditional Medicine has not been incorporated into the national health care system, Traditional Medicine is often termed “complementary”, “alternative” or “non-conventional” medicine (WHO, 2002).

The WHO Traditional Medicines Strategy *2002–2005* reviews the status of TM/CAM globally, and outlines WHO’s own role and activities in TM/CAM. But more importantly it provides a framework for action for WHO and its partners, aimed at enabling TM/CAM to play a far greater role in reducing excess mortality and morbidity, especially among impoverished populations (WHO, 2002).

Traditional medicine may be codified, regulated, taught openly and practiced widely and systematically, and benefit from thousands of years of experience (WHO, 2002).

Conversely, it may be highly secretive, mystical and extremely localized, with knowledge of its practices passed on orally (WHO, 2002). It may be based on salient physical symptoms or perceived supernatural forces (Popat et al., 2001).

Clearly, at global level, traditional medicine eludes precise definition or description, containing as it does diverse and sometimes conflicting characteristics and viewpoints. But a working definition is nevertheless useful. For the WHO such a definition must of necessity be comprehensive and inclusive.

**WHO therefore defines traditional medicine as including diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness (WHO, 2002).**

According to the South African Traditional Health Practitioners Act no. 22 of 2007 (DOH, 2007), traditional medicine means an object or substance used in traditional health practice for—

(a) The diagnosis, treatment or prevention of a physical or mental illness; or

(b) Any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings, but does not include a dependence-producing or dangerous substance or drug.

Traditional health practitioner means a person registered under this Act in one or more of the categories of traditional health practitioners.

Traditional philosophy means indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and uses of traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not, and which are generally used in traditional health practice.

This study investigates African herbal medicine utilization in children. African Herbal Medicines (ATM) are specifically identified as herbal medicines originating and used in Africa by the indigenous African people. The practice of herbal medicine use in Africa, particularly SA, is based on the concept of Ubuntu, translated into English as the spirit of togetherness, humanity and solidarity achieved through living with other people (DOH, 2008). It is said here that one of the causal factors considered in African traditional medicines is the type of relations existing between the particular individual and other human beings, both the living, and those who have passed away (DOH, 2008). Nature is regarded as a living force, with personality, protocol and will of her own.

This practice uses a holistic approach to diagnosing and treating illness (Kubukeli, 2000). Illness or health is explained, not only in terms of its physical cause and presentation, but also as the interaction and relationship between nature, the cosmos, and human beings (DOH, 2008). Holistic approaches refer to those approaches caring beyond the physical,

incorporating emotions, spirit, mind, and body and affecting the individual or the family as a whole (Kemper, 2000). These approaches tend to lead to integrative care, whereby interventions are not only biomedical, but consider a broad range of therapies and select those with the best evidence for safety and effectiveness in the context of holistic care, including complementary and/or alternative forms (Gaudet, 1998).

Complementary care is better understood in terms of concurrent use of different health care forms, primarily where biomedical care is combined with non-conventional approaches in treating illnesses (Loman, 2003). Alternative care, on the other hand, simply means non-conventional services are preferred over biomedical type services (Loman, 2003). The two concepts, alternative and complementary, are difficult to distinguish from each other, and for this reason they are often used together to describe non-conventional care as complementary and alternative medicine (CAM). CAM is certainly a broader form of non-conventional therapies, including both medication, such as herbal medicine, and non-medication, such as chiropractics, homeopathy, naturopathy, hypnosis, manual therapies, therapeutic exercises, acupuncture etc.

As noted, herbal medicines are only a part of CAM, and not all there is to it.

All regions of the world have some form of TM/CAM or another currently under use (WHO, 2001). There is a widespread and increasing appreciation of the role of traditional medicine. This is so because traditional medicine is used by a large part of the world's population, who considers it more affordable and in line with their ideologies (WHO, 2001).

Leading TM/CAM use is found in Asian, African, Native American and Arabic regions, as part of their culture and tradition, while TM/CAM use is escalating in North American and European countries (WHO, 2001). In Africa, up to 80% of the population use traditional medicine to help meet their health care needs. In China, traditional medicine accounts for around 40% of all health care delivered. The percentage of the population which has used CAM at least once is 48% in Australia, 70% in Canada, 42% in USA, 38% in Belgium and 75% in France (WHO, 2002).

Expenditure on TM/CAM is significant and growing rapidly, for example, Malaysia spends more on TM/CAM than conventional medicine care (WHO, 2002). It has been noted in Northern Europe, United States and Australia, that expenditure on CAM increased sharply in the recent years. In most developed countries, over USD 2 billion is spent annually on TM/CAM (WHO, 2002).

## **2.2 TM/CAM Globally**

The increasing pattern of TM/CAM use is significantly noted in the Western Countries, where the primary and original form of health care is Conventional medicine, also referred to as Allopathic or Western (WHO, 2002, Wahlberg, 2007). TM/CAM practice, in the developed world, certainly became prominent after Conventional Medicine had been reigning for many years, but people are shown to be turning to TM/CAM despite this practice having been shunned off by the formal health care system (Wahlberg, 2007).

Literature suggests that TM/CAM use is gaining recognition for a number of reasons. In developing countries, popularity is attributable to TM/CAM affordability and

accessibility, and the fact that it is firmly embedded within the wider belief systems. Furthermore, traditional medicine is sometimes the only source of health care for the world's poorest population (WHO, 2002). While in developed countries popularity is fuelled by adverse effects of chemical drugs, questioning of approaches and assumptions of conventional medicine, longer life-expectancy and chronic illnesses, and greater public access to information (WHO, 2002).

Traditional medicine is based on the needs of individuals. Different people may receive different treatments even if, according to modern medicine, they suffer from the same disease. Traditional medicine is based on a belief that each individual has his or her own constitution and social circumstances which result in different reactions to causes of disease and treatment (WHO, 2002).

TM/CAM therapies are used to treat children (Pitetti et al., 2001). Most parents who use TM/CAM therapies to treat their children use such therapies themselves (Pitetti et al., 2001). Families of children with chronic medical conditions may be more likely to pursue herbal remedies as part of their treatment regimen (Woolf, 2003). Studies show that older children are using TM/CAM more than the younger ones. College education in caregivers was found to be associated with herbal products use in North America (Lanski et al., 2003).

Most caregivers prefer to use TM/CAM complementary to conventional therapies, such that a large proportion of children found to use TM/CAM also use prescription or over-the-counter medications concurrently (Pitetti et al., 2001). However, they tend not to disclose CAM use information to their physicians or primary health care provider of the

child (Lanski et al., 2003). Caregivers report limited knowledge of TM/CAM medications used, with respect to interactions and side effects (Lanski et al., 2003). The majority of caregivers obtained their information about herbal products from their friends and relatives (Lanski et al., 2003). The form of TM/CAM used varies from country to country, and even within country depending on cultural differences. Even the common names of plants and herbal remedies can be archaic and variable depending on the geographic region (Woolf, 2003).

People are likely frustrated with Conventional medicine, especially because most TM/CAM users suffer chronic illnesses (Busch and Visser, 2004). Most people prefer TM/CAM for its holistic approach to illness (Busch and Visser, 2004). TM/CAM therapies are considered superior because they are natural and safe (Lanski et al., 2003). Caregivers did not believe that herbal products they use had any side effects or potential medication interactions (Lanski et al., 2003).

Studies on the effectiveness of TM/CAM are limited, and those available have not been designed in a rigorous manner (Woolf, 2003). Many pharmaceuticals used today were originally derived from plant sources, suggesting that some herbs may prove to be effective remedies for treating medical diseases (Woolf, 2003). TM/CAM studies conducted in the laboratory, for example essential oils demonstrating antimicrobial activity, are showing promising results (Woolf, 2003).

Some herbal teas seemed to have a favourable effect on infantile colic (Weizman et al., 1993). Randomised Controlled Trials have been conducted on Acupuncture. St John's Wort, *Hypericum perforatum*, was subjected to a randomized controlled trial for its

benefits observed on depression, but the study showed no effect on major depressive disorder in adults (Group, 2002). There remains a dearth of knowledge concerning how children are affected by taking herbal remedies (Woolf, 2003).

Safety of TM/CAM has not been established. There are problems with manufacture, registration, labelling, purity, and concentration of these remedies, mainly because there is no government regulation on such activities as yet (Woolf, 2003). Efficacy studies, interactions with conventional drugs, toxicity prevention, contamination and quality, and therapeutic monitoring are among those matters in need of resolution.

The actual dose of active ingredients being consumed is often variable, unpredictable, or simply unknown (Woolf, 2003). For these reasons, children may be particularly susceptible to such variations, when compared to adults, by virtue of their smaller size and different capacity for detoxifying chemicals. Children differ from adults in their absorption, distribution, metabolism, and excretion of some substances. Infants and younger children are physiologically more vulnerable to certain adverse effects of herbs (Woolf, 2003).

The duration of use is another consideration, with longer courses of herbal therapy exposing the patient to a higher risk of adverse effects (Woolf, 2003). There may be subpopulations of children who are more susceptible than other children to the adverse effects of herbs. The safety of herbal products may be related to the mixtures of active chemicals, interactions with other drugs and herbs, contaminants or adulterants, and their inherent toxicity. Foragers seeking herbal remedies, for example, may mistakenly collect

one plant confusing it for another (Woolf, 2003, Stewart et al., 1998). More rigorous research and regulation are necessary to ensure safety in the use of TM/CAM therapies.

Physicians routinely balance risks and benefits in decision-making. The advent of TM/CAM therapies challenges physicians to deal responsibly with paradigms of healing that fall outside the boundaries of conventional medical practice and to make decisions in the unfamiliar realms, often in the absence of evidence (Adams et al., 2002).

In one study, only one-third of parents reported discussing TM/CAM use in children with their physicians (Sibinga et al., 2004). TM/CAM therapies were used in infants as young as one month old without discussing it with the paediatrician. The researchers also showed that up to 53% of parents expressed the desire to discuss TM/CAM use with their paediatrician (Sibinga et al., 2004).

However, even physicians who are willing to consider TM/CAM treatments in some circumstances find it difficult to know how to responsibly and ethically advise patients in this unfamiliar domain of medicine. They feel uninformed about TM/CAM therapies and ill-equipped to judge the quality of TM/CAM providers (Adams et al., 2002).

### **2.3 TM/CAM in Africa**

Many forms of CAM are practiced in different parts of Africa. There are those originating within Africa, and those adopted from other parts of the world. Although these practices will not be discussed in any detail, it should be noted that forms of CAM such as Chiropractics, Homeopathy, Spirituality, Healing Exercises (Yoga, Shiatsu) and others are practiced in Africa.

African Traditional Medicine practice is based on traditional knowledge, transferred orally from one generation to the next (Kubukeli, 2000). Three-quarters of current therapeutic drugs in use today have been found by following herbal practice leads (Witwatersrand, 2005). Practitioners are trained formally and informally (Peltzer and Mngqundaniso, 2008). Traditional healers are specialist botanists who, with their own form of training, possess incredible knowledge of the chemistry, nutritional and medicinal value of hundreds of medicinal herbs (Witwatersrand, 2005).

Practitioners include herbalists, diviners, traditional healers, and bone-setters. It is further noted that, within Africa, traditional surgeons and birth attendants are found, forming a wider sector of African Traditional Health System. Some countries like Tanzania have taken advantage of these groups to alleviate deficiencies in their Formal Health care system (DOH, 2008). A study conducted in the South African tribe of BaTswana, reports that traditional herbs are not restricted to traditional healers and herbalists only, but churches do at times support or even provide herbal teas (Kooi and Theobald, 2006).

In South Africa, it is estimated that between 60% and 85% of black population use traditional medicines, and usually in combinations (Popat et al., 2001, WHO, 2002). Between 70% and 80% of the black population is said to visit traditional healers regularly (Witwatersrand, 2005).

In a study of South African hospital outpatients, 16.7% black patients had visited a traditional healer for their presenting ailment prior to seeking conventional western medicine (Muwonge, 2002), while Wamono found this figure to be 48% among patients attending General Practitioners (Wamono, 2001).

In one South African urban study, patients consulting traditional healers were found to be predominantly female (80%), and majority had achieved Grade 9 and higher (81%) of schooling (Peltzer and Mngqundaniso, 2008).

In children, majority of users are younger more than older, and the prognosis is poorer. The records of 50 children admitted to King Edward VIII hospital between 1969 and 1977, whose post-mortem findings suggested compatibility with Impila poisoning, were analyzed. In this study, the age distribution in years (0-3 54%, 3-6 24%, 6-9 14% and 9-12 8%) showed that younger children were frequently poisoned (Watson et al., 1979). A retrospective study was conducted in the Transkei on children admitted with herbal intoxication for the years 1998-2001 inclusive (Tindimwebwa and Dambisya, 2003). It was shown here that 97.4% of the admitted children were below 5 years, and moreover, 90.4% of the children were under one year of age.

The rigour in these studies is under question, since diagnosis of traditional medicine use and poisoning may be under-estimated (Wittenburg, 2002). Detection of traditional medicine poisoning is complicated by the lack of analytical techniques to make a confident diagnosis. Diagnostic tools are either limited or currently non-existent. The plant component of the remedy or concoction responsible for toxicity often cannot be identified. The culprit plant has in some cases been identified through questioning even though people are in general very reluctant to admit the use of herbal medicines (Wittenburg, 2002). This reluctance occurs often because health workers tend to hold a negative view towards traditional medicines, but also because of the cultural secrecy around use of these medicines.

In a study conducted by Peltzer et al, patients were asked about their illness presentation reasons, and findings suggest a complex array of factors (Peltzer and Mngqundaniso, 2008). Major self-reported reasons for consulting the traditional health practitioner (THP) included a complex of supernatural problems (bad luck, reverse bad luck, magic poisoning) or psychosocial problems (depression, anxiety, sexual dysfunction), chronic conditions (chronic pain in joints/arthritis, hypertension, diabetes, cancer), acute conditions, generalized pain, HIV and other sexually transmitted infections. Almost half of the patients (45%) patients indicated that they had been for the current illness episode to a different health care agent prior to coming to the current THP.

Clients were further asked for which type of problems they had been previously consulting a THP. Similar to the current illness episode, clients reported the following five problem areas, in order of frequency (Peltzer and Mngqundaniso, 2008):

- 1) A complex of supernatural or psychosocial problems (reverse bad luck, bad luck, magic poisoning by stepping over something, being poisoned by food purposely, ancestral problem, spirit illness, mental problems),
- 2) Generalized pain (headache, sharp pains),
- 3) Acute conditions (stomach problems, sores/shingles),
- 4) HIV and other STIs, and
- 5) Chronic conditions (arthritis, high blood pressure/heart problems, diabetes mellitus, cancer).

Studies showing effectiveness of African Traditional Medicine (ATM) are scarce. When measured against popularity in use, there is an implied and overwhelming sense of greater value for users of ATM (DOH, 2008). Laboratory efficacious test are currently underway, and results are promising to date (Light et al., 2005).

In South African studies, more than safety, emphasis has been placed on toxicity. Poisoning studies have shown that many cases occur as a result of herbal intoxication, and children are mostly affected (Joubert, 1982). A South African study analyzed cases of acute poisoning among patients admitted to Ga-Rankuwa Hospital (Now named Dr George Mukhari) in Pretoria over a five-year period (1981-1985). Overall, poisoning with traditional medicine resulted in the highest mortality, accounting for 51.7% of all deaths due to poisoning (Venter and Joubert, 1988). Majority of victims were found to be children aged 1-5 years old. Traditional healers were the main source of the medicines, but in some instances medicines were purchased from herbal shops. Majority of poisonings were found to be accidental in this study, and only 4% of all the poisoning cases were deliberate. Mortality was found to be high among those with herbal intoxication in another study, estimated to be at 51.7% to 62% (Joubert, 1990).

By analyzing the Johannesburg Forensic database over five years (1991-1995), Stewart et al found that African traditional medicines were involved in 43% of cases (Stewart et al., 1999). Diagnostic tools are limited, active ingredients are not known, antidotes are unavailable, and management remains supportive. A record review of autopsies done at Mthatha showed an increase in the cases of poisoning from 2.5% in 1993 to 13.7% in

2005 (Meel, 2007). Since most deaths from poisoning are generally associated with traditional medicine use, the study suggests that traditional medicine use may be on the rise in rural South Africa, and calls for improved ways of managing herbal intoxication (Meel, 2007). Cases of acute poisoning from traditional medicine are not uncommon, many of which have resulted in significant morbidity and mortality. Mortality is estimated to be as high as 10 000- 20 000 per annum (Popat et al., 2001). Impila toxicity has been relatively better studied for its contribution to liver toxicity in children (Wittenburg, 2002, Popat et al., 2001).

Among western-trained physicians, there exist divisions in the way ATM is perceived. Some find it appalling, while others are acknowledging. The scepticism is founded on the negative aspects of ATM including toxicity, fragmentation, non-scientific basis etc, as well as the burden and difficulties these challenges create for conventional practitioners. Enthusiasm lies mainly in the belief that Traditional Health Practice has a lot to offer, and for their great majority, their cooperation and contribution is likely to relieve the burden on the current health system. Currently, conventional doctors are very unlikely to ever refer a patient to Traditional Health Practitioners (Mngqundaniso and Peltzer, 2008).

Traditional Health Practitioners themselves are very cautious, since they are aware of the attitude presented to them by the conventional practitioners. They also worry about their wisdom being stolen from them. They desire recognition, but hold many reservations with regard to freeing their knowledge. These factors make the idea of integrating them into conventional services very complex (Summerton, 2006).

Many of them have been trained in some basic conventional care services, in an attempt to improve the quality of their practices, and in line with the current challenges faced by the health fraternity (Peltzer and Mngqundaniso, 2008).

## **2.4 TM/CAM Regulation**

The WHO conducted a comparative study to assess the legal status of traditional medicine and complementary/alternative care in different countries (WHO, 2001). With respect to the legal status of traditional medicine, key countries can be divided into the following categories (WHO, 2001):

Firstly, in Argentina, Cuba, Italy, Japan, Germany and Spain traditional medicine has become popular but allowed to be used or practiced by allopathic doctors.

Secondly, in Austria, France, Malaysia, Nigeria, Switzerland, and the United States of America traditional medicine is illegal but tolerated by law.

Thirdly, in Chile, Mexico, Peru, Phillipines, South Africa and Zimbabwe traditional medicine is being actively promoted with the aim of making it part of the national health care system.

Lastly, in China, Germany, Ghana, India, Indonesia, Pakistan, Mali, Myanmar, Republic of Korea, Thailand, United Kingdom of Great Britain and Vietnam, traditional medicine is already an integral part of the national health care system.

The WHO provides a framework for action aimed at enabling TM/CAM to play a far greater role in reducing excess mortality and morbidity, especially among impoverished populations (WHO, 2002). The strategy incorporates four objectives, namely policy, access, rational use, and safety, efficacy and quality.

Firstly, policy is aimed at integrating TM/CAM with national health care system, as appropriate, by developing and implementing national TM/CAM policies and programmes.

Secondly, promote the safety, efficacy and quality of TM/CAM by expanding the knowledge-base on TM/CAM, and by providing guidance on regulatory and quality assurance standards.

Thirdly, increase the availability and affordability of TM/CAM, as appropriate, with an emphasis on access for poor populations.

Lastly, promote therapeutically sound use of appropriate TM/CAM by providers and consumers.

With the growing use, demand has grown for evidence on the safety, efficacy and quality of TM/CAM products and practices. Increased use has not been accompanied by an increase in the quantity, quality and accessibility of clinical evidence to support TM/CAM claims (WHO, 2002).

Although many TM/CAM have promising potential, and are increasingly used, many are untested and their use not monitored. As a result, knowledge of their potential side-

effects is limited. If TM/CAM is to be promoted as a source of health care, efforts to promote its rational use and identification of the safest and most effective therapies will be crucial (WHO, 2002).

The WHO calls for quantitative research to ascertain levels of existing access, and qualitative research to clarify constraints to extend such access. Research priority areas are broad including social research into motivation of patients seeking TM/CAM and usage patterns of TM/CAM (WHO, 2002).

At the Lusaka Summit of Heads of State and Government in June 2006, the African Union adopted a Plan of Action on the Decade for African Traditional Medicine (2001-2010). The main objective of the Plan of Action is the recognition, acceptance, development, and institutionalization of African Traditional Medicine by all Member States into the public health care system in the region by 2010.

The South African government has taken steps towards the official recognition and institutionalization of African traditional medicine, including establishing a Directorate of traditional medicine in 2006 (DOH, 2008). The Directorate co-ordinates and manages initiatives regarding African traditional medicine within the Department of Health as well as enacting the Traditional Health Practitioners Act No. 22 of 2007 which established the Traditional Health Practitioners Counsel. The Government has also provided funding for research and the development of African traditional medicine (ATM) to manage and control diseases (DOH, 2008).

The presidential Task Team on African traditional medicine was appointed in 2006 to make recommendations with regard to a national policy and an appropriate regulatory and legal framework for the institutionalization of African traditional in South Africa. The Task team after consultation with some stakeholders completed the Draft National Policy on African Traditional Medicine in South Africa (DOH, 2008).

The South African draft national policy on African traditional medicine is aimed at the institutionalization of African traditional medicine and not its integration with allopathic medicine. The intention is for the two systems to function side by side within the health care system.

To provide an enabling environment for African traditional medicines, the following legislation needs to be enacted (DOH, 2008):

- Regulation of African Traditional Medicine in South Africa (ATMSA).
- Inclusion of African Traditional Medicine in the National Health System.
- Resource mobilization (financial, human and structural) for ATMSA.
- Harnessing of best practices of ATMSA through the establishment of an Institute for African Traditional Medicine, setting up of Education & Training, Research & Development and other regulatory structures;
- Registration and regulation of African Traditional Medicines and Medicinal Products in South Africa.
- The establishment of a national pharmacopoeia.
- Production and/or conservation and/or cultivation of African Indigenous Medicinal Plants.

- Protection of African Traditional Medicine Knowledge and Intellectual Property Rights.
- Protection of the rights of persons involved in the discipline of ATMSA.

## **2.5 Summary**

The above literature review addresses key concepts in traditional medicine and complementary and alternative medicine. The discussion alludes to practices, toxicity and safety, effectiveness and efficacy, access, and regulation both locally and internationally. Traditional medicine is based on the belief that each individual has his or her own constitution and social circumstances which result in different reactions to causes of disease and treatment.

Most people prefer TM/CAM for its holistic approaches. However, they tend not to disclose use of TM/CAM to their physicians or primary health care providers of the children. Studies on the effectiveness of TM/CAM are limited, and those available have not been designed in a rigorous manner. Safety of TM/CAM has not been established.

In South Africa, it is estimated that between 60% and 85% of black population use traditional medicines, and usually in combinations. Some self-reported reasons for adults to consult the traditional health practitioner included supernatural problems, psychosocial problems, chronic conditions, acute conditions and generalized pains.

Poisoning studies have shown that many cases occur as a result of herbal intoxication, and children are mostly affected. In African children, majority of users are younger more than older, and the prognosis is poorer. However, older western children are ones involved in increased CAM use.

The WHO provides a framework for action aimed at enabling TM/CAM to play a far greater role in reducing excess mortality and morbidity, especially among impoverished populations.

The South African draft national policy on African traditional medicine is aimed at the institutionalization of African traditional medicine, and not its integration with allopathic medicine.

## CHAPTER 3

### METHODOLOGY

The reasons for caregivers to administer traditional medicines to children are poorly understood, and therefore, explorative approaches to better understand these reasons were necessary (Bowling, 2002, Britten et al., 1995).

#### **3.1 Study Setting**

This research study took place in the Children's ward at St. Rita's Provincial Hospital, a major secondary level hospital in Sekhukhune district of Limpopo. The hospital is a 400 bed institution, serving a large district with six feeder district hospitals. The hospital serves a large rural population predominantly of Sepedi-speaking black African community. The Children's ward achieves on average 70% occupancy of its 60 beds.

Of note is that only caregivers of younger children generally less than 2 years and sick older ones are allowed to stay as lodger mothers. Other caregivers would visit children during general hospital visiting hours. No records of males staying overnight as lodger caregivers exist in the ward.

#### **3.2 Study Design**

A qualitative study method was chosen for this investigation. Explorative free attitude interviews (FAI) were conducted, whereby an opening question is posed to the participant, followed largely by reflective summaries and clarifying questions (Meulenberg-Buskens, 1998).

The advantages of this approach include allowing the participant to speak as freely as possible without unnecessary interruption, minimizing leading questions, and confirming the information provided with the participant through reflective summaries and clarifications (Meulenberg-Buskens, 1998).

The main disadvantage may be that the interviewer is not able to raise new questions of interest to the research project if they were not brought up by the participant. It may also be difficult to probe a participant who does not say many words. The method may be challenging to carry out in the hands of inexperienced interviewer (Meulenberg-Buskens, 1998).

### **3.3 Study Population**

Information was requested from the people providing care to the child most of the time, and ideally present and having participated in one way or another in the administration of traditional medicines to the child. Caregivers, and not necessarily mothers, of children admitted to the paediatric ward were invited to take part as key informants.

#### **3.3.1 Inclusion Criteria**

- Caregivers, who are 18 years and older, to 12 years old children or younger with traditional medicine administration
- Informed consent granted
- Fluent in English and/or Sepedi
- Willingness to discuss details around the traditional medicine administration process
- Participated in the administration process in any way

### 3.3.2 Exclusion Criteria

- Denial of involvement in administration process
- Language barriers
- Informed consent not granted
- Reluctance to discuss process details
- Significant distress rendering the subject unable to sit for an interview
- Caregiver less than 18 years of age

### **3.4 Sampling**

Purposive sampling method was used (Patton, 1987). The paediatric ward was used for recruitment of participants. Purposeful sampling was used to select only those respondents who have had an experience or are knowledgeable about the phenomenon under investigation, hence information-rich (Patton, 1987).

The sample size was eight to ten informants, but final sample size was determined by data saturation- when no new information is emerging from the interviews, also known as the emergence of regularities (Hoepfl, 1997).

#### 3.4.1 Invitation to participate

Nurses working in the ward were requested by the researcher through a consultative process to identify caregivers admitting to using herbal medicines during admission procedures in the ward. The purpose and methods of the study were explained to them. The sister-in-charge of the paediatric ward offered to coordinate the process. The

researcher would regularly check the list of caregivers identified by the nurses, and interview the caregivers. But, two problems arose.

Firstly, the nurses were unable to identify qualifying caregivers for a period of more than two months. Non-disclosure to traditional medicine use was suggested to be the main barrier in identifying participants. However, children were admitted to the ward with suspected herbal intoxication.

Secondly, some caregivers reported use of herbal or church tea in children for therapeutic purposes, but both nurses and caregivers did not regard this as traditional medicine. Their understanding of traditional medicines included only African Traditional medicines offered by the traditional healers.

The above information was elicited by the researcher in a meeting with the ward nursing staff, in attempt to resolve the recruitment problem.

The solution was for the researcher to invite the caregivers individually, mainly because literature suggests cultural secrecy around the use of traditional medicines (Popat et al., 2001). Furthermore, the identification of caregivers who have administered traditional medicines to children by the nursing staff may compromise the care of their children, a perspective initially overlooked.

#### 3.4.2 Recruitment

The researcher discussed the new recruitment strategy with the nursing staff, and arrangements were made. Caregivers were addressed in groups by the investigator, and

provided with information on the purpose of the study. They were given the opportunity to ask questions.

They were invited to individually hold discussions with the investigator, whether or not they had any experience in using herbal medicines. They were reassured that a decision not to speak with the investigator will not jeopardize the care of their children. It was also emphasized to them that they have a right not to attend the recruitment interview, and to withdraw at any stage during the recruitment or interview process. The individual recruitment interviews were held in a private room.

In order to protect identity of caregivers, no information was disclosed to nursing staff.

The challenge of defining herbal medicines was resolved. Any use of non-western or non-conventional medicines intended for therapy or as medicine in a child was regarded as qualifying for the inclusion.

### 3.4.3 Participant selection

The consent form was read and explained to the caregivers thoroughly, and they were allowed to ask questions. They were reminded that their participation is completely voluntary and must feel free to refuse participation or withdraw from the interview process at any stage if they chose to do so. It was emphasized to them that non-participation will not affect care of their children in any way. They were requested to report adverse effects experienced as a result of participating in the study. They were informed that no physical harm will be experienced directly from the study, and a counsellor is available if they needed counselling as a result of the study during or after

the interview. They were also reassured of the confidential nature of the information they provide, and that their identity will not be revealed. Although the results of the study will be disseminated and published, the identity of participants will remain anonymous, and their identity will be protected by the investigator as required by the Research and Ethics committee. Those providing consent for the study were interviewed.

#### 3.4.4 Sample Size

The approved protocol for the study required 8-10 participants to be interviewed. The maximum number of interviews depended on the degree of data saturation.

Of the 25 caregivers invited to participate, 12 had no past history of administering non-conventional therapy to their children, mostly because they did not believe in the use of non-conventional medicines.

A total of 12 caregivers offered their children non-conventional therapy when they are ill, but only 9 had done so in the recent past.

Saturation of data was identified by the investigator through ongoing analysis concurrent with data collection. A total of 9 interviews were conducted to ensure completeness and confirm saturation. At interview number 9, no new data was emerging, and therefore, the investigator made a decision to stop further data collection.

### **3.5 Data Collection**

Data was collected through free attitude interviews over a period of three weeks. All caregivers meeting the criteria for inclusion agreed to be interviewed, and to have their

voices recorded. The demographic form was filled, and was found to be helpful to the researcher in building rapport with the caregiver. Caregivers were allocated study numbers aimed at protecting their identity (McLellan et al., 2003). These study numbers were linked anonymously to the consent form they signed, demographic form, interview voice recording and field notes documented by the investigator.

The voice-recorder was activated and the opening question was posed to all participants.

**What are all the reasons that lead you to offer the child herbal medicines or non-conventional therapies?**

**Sepedi version: Mpotse mabaka kamoka ao a dirilego gore o nne ngwana meriana ya Sesotho?**

All the interviews were conducted in Sepedi. After the first two interviews, the investigator made a list of important points and areas requiring further exploration emerging from the study. These points were explored in detail as the data collection process continued.

Duration of the interview process for the selected participants ranged from 30 to 50 minutes, while the recorded parts of the interview lasted between 11 and 24 minutes. Time was recorded when the participant arrived in the room, actual interview commenced, interview ended, and when the participant leave the room. The voice recorder automatically registered the duration of all voice-recorded parts of the interviews.

### **3.6 Data Management**

Written and electronic data collected were securely stored. Written data that includes the signed consent forms, demographic forms and filed notes were stored in the investigator's file kept in a secure lockable cupboard with restricted access (Mclellan et al., 2003). Besides the consent forms, no other records were available linking the participants study numbers to their identity.

The voice recordings were conducted using an Olympus digital voice recorder. Data was transferred from the voice recorder onto a computer using the supplied software. This transfer allowed for a secure password-protected electronic storage of raw data (Mclellan et al., 2003). The transcribed and translated data, along with outputs from analysis, were also stored on a back-up disc in case of any unintended and unforeseeable damage or loss of electronic data on the computer occurred (Mclellan et al., 2003).

#### **3.6.1 Data Transcription**

Voice-recorded information was transcribed verbatim (Mclellan et al., 2003). Certain actions conducted during the interview were preserved during transcription, such as laughter, pointing, demonstrating etc. Data transcription took large amounts of time for certain voice clips, ranging between two to six hours (Mclellan et al., 2003). The process proved to be very useful in terms of immersion with the data, allowing the investigator to become more familiar with the contents and intimate with emerging themes. Transcribing data became a concrete way of reflecting and debriefing on the interviews conducted (Mclellan et al., 2003).

### 3.6.2 Data Translation

Transcribed data was translated from Sepedi to English. Rather than emphasizing word for word translation, the investigator focused on preserving the meaning of statements made by both the interviewer and participant. The investigator speaks fluently the languages used during the interviews, transcriptions and translations. There was no third party involved in the data transcription and translation process.

Translated data rendered the process of data analysis easier to conduct.

### **3.7 Data Analysis**

Analysis began at the onset of data collection (Hoepfl, 1997). The investigator, using thematic analysis, began to identify emerging themes and sub-themes. These themes allowed the investigator to identify areas requiring further exploration, which were addressed as data collection progressed (Ryan and Berhard, 2003).

Emerging themes, thoughts and other observations were written down immediately after interviews in the field notes journal (Ryan and Berhard, 2003).

The investigator listened to the voice clips repeatedly for immersion and familiarization with the data collected. Field notes were also read several times during data collection and analysis (Markovic, 2006).

The translated data was coded and re-coded several times through content analysis (Skinner, 2007), and emerging themes were written on the margin of the documents (Markovic, 2006).

Themes were compared, contrasted and aligned following multiple shifting and re-shuffling activities. Once data was grouped into themes and sub-themes, the immersion cycle was repeated. Where data did not support or opposed certain themes, these themes either altered or additional themes. Once themes were clearly outlined, the investigator adopted a different strategy to look in the data for these specific themes, and this process was also repeated several times to the satisfaction of the investigator (Ryan and Berhard, 2003).

### 3.7.1 Data Validity and Reliability

All available caregivers were invited by the investigator. Caregivers not meeting the criteria were interviewed briefly and informally, but their reports were not used for analysis. All those selected for the study agreed to participate. Data saturation was reached and two additional interviews were still conducted to ascertain this point.

However, the investigator acknowledges that other ways of increasing trustworthiness in qualitative data collection exists (Skinner, 2007). These methods may include follow-up interviews and member-checking of the data collected. Follow-up interviews were not intended firstly as part of the protocol, but also due to budgetary limitations, and risk of compromising identity of participants. Instead, the concurrent processes of data collection and analysis allowed the investigator to explore issues arising from the earlier interviews as the data collection continued. Member-checking was also not conducted partly due to reasons already mentioned, and the potential difficulty in tracking and tracing participants living in the described wide rural setting.

### 3.7.2 Bias

An attempt was made to minimize bias. Interviewer bias may have occurred on the basis of the researcher being a medical doctor (Skinner, 2007). The researcher was not introduced as a doctor, and did not work at the hospital where the study was conducted (Ogunbanjo, 2001).

Recall bias is likely present since some participants presented events that happened a few months before the children were admitted to hospital (Ogunbanjo, 2001). Sampling bias is a common problem experienced with purposeful sampling, and the smaller sample size expected in explorative studies.

Reporting bias may have occurred due to the cultural secrecy that exists with the phenomenon under study. Also, there may have been fears of nurses finding out about their experiences through the investigator (Ogunbanjo, 2001). Bias may have occurred in the interpretation of the results, due to the subjectivity involved in qualitative analysis.

### **3.8 Limitations of the study**

The investigator recognizes that the study setting may act as a limiting factor, because other children may be using non-conventional therapies and recovering, and therefore not requiring hospitalization. Experiences of their caregivers may be somewhat different from those admitted in the hospital. However, the interviews conducted were not centred on the current hospital admission of the child, but rather explored general experiences of caregivers with non-conventional therapies. In addition, views expressed by the caregivers interviewed seem to represent general views of caregivers based on findings

from interviewing those caregivers whose children used alternative therapies long before the current hospital admission.

The researcher further recognizes the limitations of interviewing caregivers lodging in the ward as per protocol, since these caregivers were more likely to be providing care to younger and sicker children as per ward rules or guidelines. Only mothers with younger and older, but sicker children were permitted to stay as lodger mothers.

Language is singled out as an important limitation in the study. Although no communication barriers were experienced during data collection, translation of data from Sepedi to English may have compromised the authenticity of data provided by the participants. Efforts were made to preserve the original meaning of statements, and word by word translation was not made a priority.

Lastly, the initial recruitment strategy is acknowledged as a limitation to the study, and the corrective methods were sufficient and necessary for the validity of the study.

### **3.9 Ethical Considerations**

The necessary approval letters were obtained sequentially from the different levels and bodies of authority. The protocol was first approved by the department of Family Medicine, and then reviewed by the Ethics Committee. The feedback from this committee required a full review of the protocol, allowing six months for this process. The re-submission was further delayed by required modifications and some organizational factors for another 3 months. Finally, the study was approved in June 2007 without any restrictions (MCREC/05/2007).

Applications for permission to conduct the study were also submitted to the Department of Health Provincial office, St Rita's hospital, and hospital paediatric ward. Permission by the Provincial office required ethics letter from the institution first, and the process of approval took 6 months. Permission by the hospital took two months despite the provincial approval letter.

Informed consent was also obtained from every participant interviewed for the study.

Verbal consent was obtained from the caregivers who were interviewed during recruitment, and prior to selection to participate in the study.

## **CHAPTER 4**

### **RESULTS**

The results of this explorative study to understand mothers' reasons to administer traditional medicines to their children are presented in five parts. Firstly, results of content and thematic analysis of individual key informants are presented. Secondly, outputs from combined thematic and content analysis results are presented. Sources of health care and determinants of health care utilization are outlined under the Pathways of care section. Lastly, the legends of childhood conditions and their therapies as identified by mothers are tabulated.

#### **4.1 Analysis of Individual Interviews**

Thematic and content analysis of the nine interviews conducted for this study is presented below. For every interview, a profile is presented with a pseudonym for the participant, a summary of findings, themes, and sub-themes.

## **4.1.1 Interview 1**

### **Anna**

#### **4.1.1.1 Profile**

Anna is a 24-year old woman living with her partner. Their 2-month old baby boy was admitted to hospital for gastro-enteritis. She is unemployed and her highest level of education is Grade 11. She lives in a household of 5 people and her aunt is the elder in the family. The church, hospital and clinic are the sources of health care for her son whenever he is ill.

#### **4.1.1.2 Summary**

Anna took her son to church for a problem of 'Hlogo'. The baby fell ill, thereby prompting a consultation with a pastor. The decision to consult with any health service is made at home, in consultation with an elder. The decision depends on whether the baby suffers from a traditional or western type of illness. Culture, tradition, faith and personal experiences influence the use of church therapies. Women are not allowed to prepare church teas, but male members and pastors do. During therapeutic procedures, women are not allowed to enter the treatment room, and only the pastor is allowed. If the baby does not improve with church therapies, he will be taken to a hospital. The child is also taken to the hospital if he suffers from non-church relevant conditions. Decisions are made at home in the context of the family.

#### 4.1.1.3 Reasons for using Faith-based Medicine

##### Ill health

The decision to consult the church was triggered by a traditional type of childhood illness called ‘Hlogo’, known to present with excessive crying and neck pulling.

##### Tradition

Consulting the church is considered a tradition in the family. *“From long we work through the church. In my family, we do our things through the church.”*

#### 4.1.1.4 Classification of illness

##### Home Diagnosis

Anna lacked knowledge regarding the illness, but she was taught by her aunt about it.

The initial diagnosis is made at home prior to any consultation, and this diagnosis guides the family about the type of health service relevant for consultation.

##### Illness Differentiation

The child was not taken to church because there are specific conditions that are taken to church, and those that are taken to the hospital. *“What will he be doing at church when he is vomiting? There are those conditions that are supposed to go to church, and those that do not.” “You find that when he is vomiting he runs short of water, and the hospital will put water inside him.”*

#### 4.1.1.5 Consultative decision-making

##### Shared Beliefs

Anna, her partner and her aunt are all members of the same church. Shared worldview allows for an easier process of collective decision-making in the household.

##### Role of family elder

The aunt is the elder in the family, gifted with the ability to identify health problems, and she possesses the wisdom to advise the family on the necessary steps. *“My aunt decides where the baby should go, but we all agree.” “I do not know the baby’s illnesses. She is the one who sees them.”*

#### 4.1.1.6 Using church health services

##### Regulations

The baby’s mother is not allowed to enter the treatment room while the pastor is performing the therapeutic procedure. Unfortunately, the mother is left without any knowledge on the procedures performed. *“I do not know what they do to treat him. I did not enter.”*

The tea is prepared by men only and generally by the pastors themselves, such that if Anna wanted some more tea for the baby, she would have to invite the pastor to her house to prepare and bless the tea. Women are prohibited from making church tea,

indicating gender-bias. *“As women we do not make these teas. Only men handle the tea, and women do not.”*

### Faith

Anna expressed comfort in letting the pastor take the baby into the treatment room, and she had no fears of any harm being brought to the child as a result of therapy. Her confidence stems from her own personal experience, and recognition of the process as a long-standing cultural practice. She also had faith in the abilities of the pastors. *“We ourselves are now grown-ups, and we were never harmed. I trust them.”* Anna believes that church therapy cannot cause adverse events.

### Purposeful Interventions

Anna feels that church teas cannot be combined with conventional medicines. The baby is generally initiated on therapy aimed at a specific condition, and for this reason medicine administration is usually illness-dependent and purpose-driven. The baby cannot be placed on church therapy when he suffers from illnesses requiring conventional therapy, or vice versa.

## **4.1.2 Interview 2**

### **Julia**

#### 4.1.2.1 Profile

Julia is a 28-year old woman living with her partner and their 6-month old male baby. Her highest level of education is Grade 11, and she is currently unemployed. She receives support from her mother-in-law regarding child care. General practitioner, church, hospital and the primary health care clinic are all the sources of health care for her baby.

#### 4.1.2.2 Summary

Julia identified illnesses in the child that are not treated through the conventional care services, thereby making a distinction between traditional and conventional conditions. The initial diagnosis is made in the context of their home, in consultation with her partner and most importantly an elder. The consultation extends into the church, where therapy may be instituted. Where confusion exists, the decision may swing in favour of the conventional care service for a trial of therapy, failing which the child would be taken to the church. Julia's challenge is that conventional practitioners display no knowledge of traditional type of illnesses. However, conventional practitioners become helpful with regard to non-traditional illnesses. The use of church services for health care is influenced by the culture of growing up in a church-going family. The church releases church orders which the participant find to be sacred, and feels reluctant to disclose them. However, no secrecy exists around church orders for the child. Faith strongly affects commitment to

therapy. Knowledge regarding childhood conditions and various therapies is acquired from the home, then the church, and through personal experiences.

#### 4.1.2.3 Reasons for using Faith-based Medicine

##### Ill-health

Traditional illness experienced by Julia's baby is called 'Hlogwana' / 'Lebala'. The baby presents with diarrhoea and the stools have a greenish appearance. The other possible diagnosis here was 'goreka' which means 'buying' (of teeth), and refers to teething. Teething is associated with diarrhoea in a child, and conventional therapy in the form of 'Motswako' (oral re-hydration therapy) is used for treatment. However, 'Hlogwana' requires consultation with the church pastors who would then confirm the diagnosis as was the case with Julia's baby.

Therapy involves an application of coffee mixed with Vicks to the baby's head, oral ingestion of church tea, and inhalation therapy by burning the coffee for the child to re-breathe until he sneezes. Sneezing is used as one measure of therapy success. *"Let me just say they give church tea and prick him with a church needle. Everyone knows that Zionist people are treated with needles. The child was treated the same way at the back of his head using the needle for the blood to come out."*

##### Tradition

Julia's family has always been members of the same church, and as a result she grew up learning about the church and its activities. She projected a sense of cultural belonging

regarding the church. *“I was born into a church-going family. I first heard these things at home prior to hearing them at church.”*

#### 4.1.2.4 Illness classification

##### Home Diagnosis

Members are equipped by the church to make a diagnosis in the home environment. The church provides teachings for the members regarding childhood illnesses and the necessary steps to be taken. Specific conditions and illnesses are described to members regarding whether they should be taken to the church or taken to the hospital.

##### Illness Differentiation

If the child is suspect of a traditional type of illness, Julia would visit the church first for a final diagnosis. If the church decides there is no traditional illness, then she would go to a clinic or hospital. The child may also be taken to a hospital first, but if there is no improvement he will be taken to the church.

#### 4.1.2.5 Consultative Decision-making

Julia contacts her mother-in-law telephonically to discuss with her the child's symptoms whenever he is ill. She takes advantage of these opportunities to illicit information and to learn about the problem under discussion. These discussions inform decisions regarding when and where to go for health services, depending on what the possible illness may be. *“I also ask older people like the child's granny (mother-in-law), since they would know what the child's problem is. They are the one with knowledge, so I tell them first that the*

*child is unwell. They would look at him and tell me what his illness is, and advise me as to whether to take him to church or the hospital.”*

#### 4.1.2.6 Care-seeking Behaviour

Conditions and illnesses are prioritized, services are chosen, a switch is made depending on the level of satisfaction with care and a set period of therapy trial, and alternative services are used. Every step involves processes of engaging authorities and continuous decision-making, and these decisions are continually reviewed.

#### Prioritizing

Conditions that are perceived to be life-threatening are addressed first, and the others are attended secondarily. *“The thing is ‘hlogwana’ is the scariest thing, and others like ‘diso’ are not very worrying.”*

#### Scope of Practice

These pathways are also influenced by patients’ understanding of the health service’s scope of work. Conventional health services are known not to have the capacity to deal with any of the conditions or illnesses deemed traditional. For this reason, Julia is compelled to decide beforehand in consultation with others what the likely problem could be, so that she could decide where to take the baby. However, if a baby’s condition got worse after he was taken to a particular service, a switch will then be made on the assumption that the scope of the problem is beyond that particular service. *“My understanding is that ‘hlogwana’ is not known in the hospital. I would take him to church*

*and they would treat him.” “We just need to give him ‘motswako’ only at home. If he does not get better we would take him to the hospital for a drip, because when he is having diarrhoea he is also losing water from his body.”*

### Switching Services

Referrals between services are formal, informal or patient-driven. Julia moved between services in search of a proper explanation for the child’s illness. Frustration resulting from lack of symptomatic improvement in a child is a significant risk factor for service-shopping. *“I took the child to the clinic because he had diarrhoea for the whole two weeks, and they gave him ‘Motswako’. I gave the child the solution but he was just the same! I took him back to the clinic, and when I got there they gave me the same solution again thinking that I had not prepared it properly. They prepared the solution right there at the clinic for me, but the child was just the same! They then gave me a letter of referral to the hospital. Then I thought to myself I’d rather take the child to church, and perhaps they could tell me what the problem is. When I got to church, they told me he had ‘diso’ and ‘hlogwana’. They helped me with ‘hlogwana’, but I had to bring him to hospital for ‘diso’.”*

### Faith

Julia displays a remarkable degree of reliance on the church, particularly in cases where all else have been tried and failed. Faith is a key factor determining the participant’s reliance on the church and its therapies. *“You must have faith! You must keep faith completely for the child to be healed.”*

### Self-conditioning

The mother has to condition herself prior to taking the child out for therapy, and adopt a brave attitude for the sake of the child's well-being. *"I would have already told myself by the time I leave home that, 'now I am going to church, and I want my child to get better. I want them to treat him.' you see? I allow my heart to feel free."* *"If you do not allow yourself to feel free, and begin to think that they will kill him while their busy treating him, he will not get better. You left your house knowing that you are going to such a place, and you want them to help your child."*

### Helplessness

Julia expressed a sense of complete reliance on the service provider. This feeling is felt during both traditional and conventional interventions, and it echoes a significant degree of helplessness. *"Fear will not bring me any help when I am looking for the child to be healed. It's just like here (in the hospital) when they insert a drip, they do it in front of my eyes. I want him to get better, and there is nothing I can do."*

#### 4.1.2.7 Sources of Healthcare

##### 4.1.2.7.1 Faith-based

### Church Secrecy

The church offers its members 'Ditaelo', which are essentially orders by the church regarding church practices. The term is also used to generically address therapies prepared and offered by the church. Julia expressed contempt and discomfort regarding

disclosure of information contained within these orders. The orders are considered sacred and personal, and must be kept secret especially for people not following the same church. However, children's orders are not considered confidential. *"Do you want me to reveal church orders?" "It's not like they cannot be spoken about. I just cannot tell you about 'Ditaelo' when you do not go to my church. The thing is I just don't want to reveal them."*

#### Therapy Safe Use

Church therapies do not induce an illness in a child because they are therapeutic. However, ill-health may result from a combination with either conventional medicines or African traditional ones. *"This must not be done, no, no! I must give him one thing at a time. I must observe and see, and know which one of the treatments I am giving is making him feel better. If it treats him poorly or his illness gets worse, then I give him the other one."*

The exception to the rule to never combine therapies occurs when a church member is placed by the conventional practitioners on chronic therapy. For this reason, the member is allowed to use church therapies alongside the conventional ones. *"Yes, it's like an Asthmatic person, she cannot leave her spray just because she will be drinking church coffees. They tell us that people with conditions like Asthma and High Blood Pressure must bring along their medicines to church outings and gatherings."*

#### 4.1.2.7.2 Conventional Service

#### Non-disclosure

Julia would not disclose any use of church therapies when she presents to the hospital, even if she was asked. She sees the potential value of telling the conventional practitioners, but worries about a disapproving response she may receive. *“They have never asked me, but I would tell them I never treated the child with teas. I would tell them at home we do not go to church and do not touch traditional medicines. Otherwise they would want to know why I treated the child with teas before I came to the hospital.”*

### Challenging Authority

Julia desired to challenge conventional practitioners about their knowledge and ability to deal with traditional type of illnesses. She assumes they would not know about these conditions, and as a result would not be able to help her if indeed the child was suffering from one of them. She believes the child’s condition could deteriorate while they try different therapies without any success. *“I would ask them if they are able to treat ‘Hlogwana’ because that’s what I think the child is suffering from. They must tell me whether they are able to treat it or not.” “Suppose the child had ‘hlogwana’ and I knew nothing about it. I will bring him to the hospital to die from worsening diarrhoea despite all the water they put inside him. How will they know what the problem is? Will they know? They will not know!”*

### Negative Attitudes

Julia expresses concern about the likelihood of being dismissed by conventional practitioners for her own beliefs, and resorts to non-disclosure for this reason. She acknowledges that it could be helpful to inform the conventional workers. *“You know*

*what? I do not deny you can tell them, but others do not believe in church or traditional forms of care. They will dismiss you saying the child does not have a traditional illness, or that they do not know whatever it is you would be talking about.”*

### **4.1.3 Interview 3**

#### **Kate**

##### **4.1.3.1 Profile**

Kate is a 37-year old married woman, and a mother of two. Her 10-month old female baby was admitted to the hospital for Pneumonia. She is unemployed, and her highest level of education is Grade 11. She lives with her two children and her husband who is also one of the pastors at the church she follows. Sources of health care for her child include the church, hospital and primary health care clinic.

##### **4.1.3.2 Summary**

Kate administered church tea to her child for two traditional-type illnesses. Her husband is one of the pastors at the same church she is affiliated with. Kate regards the administration of church tea as therapeutic, but not a form of African traditional medicine. The administration of medicines is influenced by her faith in the church and church therapies. The type of illness the baby is having determines whether the baby will be taken to a church healer or western health service. Lack of illness improvement while using one of these services will often lead to a switch to the other. The decision to administer the medicine was taken by her husband. However, Kate has the authority to override decisions made by pastors regarding her baby's health for advocacy reasons, as she believes to know what is best for her baby.

#### 4.1.3.3 Reasons for using Faith-based Medicine

##### Ill-health

The baby was born healthy, but developed ‘sores’ shortly after birth. The ‘sores’ are described as an eruption of rash that appeared on the face and neck, and then ‘went back inside’. The baby did not only suffer from ‘sores’, but at some stage she was believed to have ‘hlogo’. For this traditional condition, she was also taken to church for therapy.

##### Prevention of illness

Therapies are also used for preventative purposes. The objective is to prevent evil harm to the child. These therapies have to be prayed for prior to use. *“I would not just buy from a store and use a baby’s Vaseline before it is prayed for. You see, other children use traditional medicines out there, so I must protect my child for them not to ‘weaken’ and get her sick. I mix Vaseline with Vicks and apply it to her whole body. There will be no child who can weaken her, and nothing will happen to her. Even if that child was heavily smeared with traditional medicines, nothing will happen.”*

#### 4.1.3.4 Illness classification

Church members are further taught about conditions that should not be brought to the church. These conditions are usually treated at home, at the clinic or in-hospital. *“If the baby had diarrhoea, she must not take church tea. I would have to either take her to the clinic or personally prepare ‘Motswako’ for her. If these fail, then I would have to carry her to the hospital. Tea does not work!”*

The ‘sores’ were treated through the church initially, but the child was later taken to the hospital. The ‘sores’ cannot be exclusively placed in either traditional or conventional, and treatment involved faith-based therapies initially, but they were later treated conventionally.

‘Hlogo’ was classified as traditional from the onset, but faith-based therapies were chosen over African traditional medicines. *“For traditional ones, her father once refused adamantly saying that he does not use traditional healers. The baby was suffering from ‘hlogo’, and these other women suggested that he takes her to a traditional healer for inhalation therapy. He said no ways, he would rather take her to church, and they would use coffee for inhalation, and they would even let her drink it.”*

#### 4.1.3.5 Support Network

Kate’s husband plays a major role in decision-making on healthcare because of his religious position, in addition to his authority as a household head. *“She was fine when I got her. When the ‘sores’ came out, my husband thought they may also be inside.” “Her father is the one who decided to make the tea for her at home. He is also a pastor.”*

Church members receive support and acquire knowledge on therapies from the church. They are taught procedures regarding the use of church approaches and therapies. *“I know all these things because I am a member of the church. They talk about them at church.” “We do not necessarily go to church with the obvious intention to take the child there, but wait until they call for children to come forth for the blessing session. We do*

*not go straight to them. We have seers in the church that would just come up to you and tell you what is going on with the child.”*

#### 4.1.3.6 Sources of healthcare

##### Faith-based Services

Church members are taught by the church about illnesses necessitating church interventions, and those requiring conventional care. They have procedures they follow in order to receive healthcare from the church. The use of the church as a health resource is driven by faith and beliefs. *“Every therapy has a place for faith. It is very much like when I take the baby to a hospital, I would be having faith in that she would be cured. It is the same thing with the church tea, when they make it for her I would ensure that I trust in its power to heal her.”*

##### Conventional Services

Kate eventually decided to take the baby to the hospital due to the lack of progress with the church tea. Efforts by the western practitioners to identify and resolve the problem led to further frustrations for her as she continued to receive mixed and confusing messages. The child’s condition showed no progress. *“I saw months passing by, six months to be precise without any improvement while she continued to take the tea. I then figured I should bring her to the hospital and see if they could help her. They took X-rays and said she had ‘sores’ most likely due to Asthma, but others said it was TB. I no longer know what the real problem is. The ‘sores’ are able to come out and then go back inside. She was admitted for one week and then discharged. I had given up on the church teas, and I*

*was giving her their medicines from the clinic. They gave aqueous creams and other things to apply to her skin, and she got better, but after a while they would come back.”*

#### 4.1.3.7 Care-seeking behaviour

##### 4.1.3.7.1 Lay understanding of illness

###### Cause of illness

Despite her uncertainty about the cause of the rash, Kate nevertheless attributed this to hereditary factors. She still hoped that the ‘sores’ could be healed to relieve the baby’s suffering, or at best just stay internally and not recur. *“I do not know what causes them, but her father and I both have a lot of ‘sores’.” “My ‘sores’ do not come out, so hers must also do the same. I would prefer that they rather fool me into thinking that they are healed when they are just inside. She would just grow, and the pastors would also say she has a lot of sores but they are inside.”*

###### Symptomatic Improvement

Kate expected the rash to disappear and not recur. In her understanding, the recurrence signifies the ability of the rash to stay within the baby’s body. This recurrence was also a sign of resistance to therapy. She even consulted with the church, and the baby was confirmed to harbour a lot of ‘sores’ internally. Church tea remained the therapy of choice during this time, but the rash worsened. *“I was then told in church that the baby had a lot of ‘sores’. They said I must give her ‘thin’ (weak) tea for the sores to come out. We used the ‘thin’ tea but it failed. They made ‘cocoa’ tea for her, which is better than*

*the other one. It is a little stronger and thicker than the initial one. The 'sores' came out, but went back inside." "Whenever she took the tea they would come outside, and on the scalp they would cause some big lumps. They were never cured, but they would appear and then go back inside."*

#### 4.1.3.7.2 Switching services

When Kate's distress about the baby's health problem increased, she went back to church to consult with them again, but when they recommended a trial of church tea therapy again she opted not to cooperate with them. The lack of improvement in her baby's health problem made her to keep looking in different places for a cure. *"I was told at the church to give her tea and see what would happen. Since I had given up on the church tea, and because I do not want to mix them, I had to use only one of them. I had already tried the church teas, so I decided to stay with the western medicines. If I fail, I would change again."*

#### 4.1.3.7.3 Quality of life

Distress and frustration increased with the failing therapy and worsening rash. The ability of the rash to compromise the baby's quality of life caused anxiety for her. *"Sometimes she would be scratching to show that they are itchy. Wherever they would have appeared she would scratch, so I do not want them. When I administer or apply something to her I never want to see them again. She cries when the sores are many."*

#### 4.1.3.7.4 Advocacy

Kate has a strong role to play in deciding whether to give tea to the child or not, regardless of her husband's view or even the pastors. She discusses childcare with her husband, but when she herself decides to stop church tea, not even her husband can derail her. *"He knows when I do not want with the child. I just tell him that I am no longer giving the child tea, so he must not give her either."* *"...even if the pastor has spoken. They do say at church that I must give her tea, but I do not."*

She believes her role is to protect and advocate for the child, even when it means she must not cooperate with her husband or the other pastors. *"The baby is small and cannot speak for herself. If the therapy was intended for me, I would have to agree."*

She would not tell the pastors about conventional medicines she is administering to a child. The secrecy is aimed at protecting the child from the danger of combined therapy exposure.

#### 4.1.3.8 Using Therapies

##### Faith

Kate showed faith in the ability of the coffee to cure illness. When the rash appears on the skin, it is believed to signify a process of healing. Weak coffee is used for children, and a stronger one for adults. The weak coffee is not always effective in curing illnesses. *"It works you know. For an adult person, they make a strong coffee. After the coffee, the*

*'sores' would appear outside." "It only depends on a person's faith. If I go there with reservations, it might happen that my child ends up not getting better."*

### Gender Roles

Only pastors and male church members are the ones allowed to prepare the tea. When the tea is being offered to the child, it is prepared by the child's father, but the Kate is the one who administers it because she remains at home with the child. The tea replaces the regular intake of ordinary water.

### Sacred Nature of Therapies

The power and strength of the coffee as therapy lies in the fact that it is a church coffee. It is blessed with prayers prior to use. Its use is so sacred that Kate believes people who are not members of this particular church would not even touch it. *"You would not even attempt using the coffee if you are not a Zionist. You would never! Even when you see it lying there, you would not even come near it. It will be bought by Zionists because they know its use"* *"I will not be able to use it before it is prayed for. As long as one is a Zionist, one cannot take and use it before it is prayed for by the pastors."*

### Therapy administration

The church coffee is used therapeutically through multiple administration routes, including inhalation and oral. *"They use the ZCC coffee; burn it and re-breathe the smoke. When they are finished, then they would let her drink the coffee three times a day. She would take it frequently until she is healed."*

### Adverse Effects

Kate was uncertain as to whether church tea could induce an illness in a child or not, but wondered how tea could get a child sick when it is supposed to help. She decided that illness can be exacerbated if the child is having concurrent conditions requiring the attention of a doctor and a pastor. Moreover, the tea can be used even when there is no illness, and just like you could have any tea. *“It is the one that is supposed to help her. If she has another serious problem that requires a doctor, the yes it could make her sick. She cannot become ill from the tea if her problem is only ‘sores’.”*

If an unqualified person was to offer someone traditional medicines with the aim of helping that person, and medicines lead to the death of the one taking them, this event will be described as witchcraft. The person who acted as a therapist will be referred to as a witch.

### Therapy Combinations

The most recurrent emerging theme lies in Kate’s disapproval of combining church teas with conventional medicines for fear of therapy interactions. She considers a well child to be fit for church tea, while a child on conventional medicines must not be given tea concurrently. The church tea and traditional medicines are generally considered to be stronger than western medicines, and a combination would lead to therapy interactions. She particularly believes that church teas or traditional medicines have the ability to clear conventional medicines from the body. *“I do not want them to be given together, because I would not know which one helped her. I have no idea what would happen when these*

*two things enter her tummy and mix up. When I am using tea I only use tea. If it happens that she is ill enough to require a doctor, then I no longer give her tea.” “People say traditional medicines are more powerful, and the tablets are weaker. They oppose each other in the blood, and when they meet that disease then they fight each other. Around here it is said that when you combine traditional medicines with western ones, the traditional ones would clear the western medicines because they are stronger.”*

#### **4.1.4 Interview 4**

##### **Maria**

###### **4.1.4.1 Profile**

Maria is a 39-year old married woman, and a mother of one child. She lives with her husband and their 5-month old baby boy. Her highest qualification is Grade 11, and she remains unemployed. In their family, her husband is the household head, but she enjoys support from a particular church elder regarding child health. Sources of health care for her baby are general practitioner, primary health care clinic, hospital and the church.

###### **4.1.4.2 Summary**

Maria's baby was given church therapies for both preventive and curative reasons. On the 8<sup>th</sup> day after birth, a traditional church ritual is performed to protect the baby and allow free movement around the home. Two traditional illnesses resulted in further church therapy exposure to the baby. Maria considers the use of church therapies as a way of life, and church culture plays a major role in her process of decision-making. Decisions are also made in consultation with other family and church members, particularly the elder in the church. These decisions are further influenced by personal learning experiences and church teachings. She displays a lot of pride and faith in her church, but confessed that corruption in the church is rampant. Overall she prefers church therapies for herself and conventional care for her baby.

#### 4.1.4.3 Reasons for Faith-based Therapies

##### Illness prevention

After a baby is born and upon arrival at home from the hospital, he is kept indoors for seven days. On the 8<sup>th</sup> day, the pastor and his wife will arrive to perform a ritual that introduces the baby to the outside world. They bring along ‘taelo’ (an ordered therapy by the church), which is described as blessed water. The baby is washed using ‘taelo’, placed on the door entrance for a moment, and then taken back into the house. The baby is then allowed to get out of the house because the process of ‘taking the baby outside’ would have been completed. After 4 months, the baby is taken to church for the first time for a special welcome, whereby rituals to protect the baby from evil spirits are performed. *“He can now begin entering all the other rooms and getting outside the house. We stay for 3 months without going to church, and during the 4<sup>th</sup> month I am allowed to go to church but without the baby. This is done to protect the baby’s life. After 4 months I take the baby with me to church for an official welcome into the church.” “We give him a thin Joko tea and water that has been prayed for. Then they tie ‘Letlamo’ around his waist. These are the things we do for the baby in church.”*

##### Illness treatment

The child was also treated for ‘Letshatshaso’, described as a small sore found in the baby’s mouth. The baby presents with continuous crying, and he was diagnosed by the elder from church. Therapy involves the use of a sharp-pointed object like a needle to prick and open up the sore, and squeeze the contents out. They then rub some sugar on

the small puncture wound. The baby was healed after the same elder instituted therapy. If untreated, complications may arise.

‘Thema’ was noticed by the elder from the church, who wanted to know what the problem was with the child. It is diagnosed by a combination of symptoms and an area of redness behind the head is a pre-requisite. A church needle is used to treat it, by pricking the baby behind the head over the area of redness to release some blood. *“I told her the baby sleeps on one side, and she requested to look at him. She showed me this redness behind his head. Then he was treated, and I saw everything they did.”*

### Culture

The practice of using church therapies is in line with the church tradition, and Maria regards this culture as a way of life for her family. She recognizes the role played by the church in her life, and displayed pride in the church. Her faith in the church and its therapies influences her practices. *“Let me just say this is how we live our life in my home. Where our faith lies is where we go for help.”*

#### 4.1.4.4 Illness Classification

The decision to choose the health service is further dependent on the type of illness in the child. There are specific conditions that are known to be treated by the church, and these are usually the ones the hospitals do not know about. The other conditions are taken to the clinic, doctor or hospital. However, if a child does not improve while receiving care from on the services, the mother is at liberty switch from one service to another. *“We do not treat diarrhoea at church, for a baby this small? No! We treat neither for diarrhoea*

*nor vomiting. Even the 'sores' in a little child we will not be able to treat them. Isn't it we have to use stronger forms of therapy? So in a child they cannot be used."*

#### 4.1.4.5 Decision-making

The process of decision-making is consultative and collective, by involving members of the support network. The initiative to take the child for therapy is based on a decision made in consultation with an elder from within the church. Extraordinary support was offered to Maria by this particular elder, especially because Maria does not have a family elder near her to source support. Maria engages her husband as well on child health decisions. *"My child was seen by some elderly woman who wanted to know what the child's problem was. She is just an elder from our church." "I speak to my husband and we show each other. If I were to notice anything with the child I would tell him, and he would also do the same."*

#### 4.1.4.6 Care-Seeking Behaviour

##### Sources of Knowledge

Maria's sources of knowledge on childhood illnesses managed by the church include church teachings, personal experiences, and consultations with church elders. *"My baby is the first one, and that is why I do not know much about these illnesses." "The thing is as I already told you my child is only five months old, and I stayed a long time without a child. I saw from my sister's child, some of these things were done. My baby only had 'thema' and 'Letshatshaso', and that is why I am able to describe them in some detail."* *"I just hear them talk in church. Church members who happen to know about the*

*presenting condition like older women and other elders are able to teach. They would even show me how to identify the symptoms. Before I had my own child, I knew very little about how the children would present. My baby allowed me to actually witness these things.”*

### Fears

Fear of complications triggers the use of health services, even where there is no proof or certainty around the potential complications. *“I do not know but they say a worm develops if it is not treated. It would start off watery, but then becomes a worm. The worm can then bring madness for the child, how? I do not know.”*

### Faith

Maria shows a lot of faith in her church, and the ability of the church to help her resolve life’s problems including infertility. Her successes reinforce the church’s ability to produce results, and thereby increasing the amount of faith and generating pride in the church. *“I feel proud about the fact that I use church therapies. That is where my faith is, and I feel strong about the church. You know, for 15 years I had no children, and the baby was born into the church.”*

### Regulations

The process of illness prevention is considered church law and must be obeyed. The pastor cannot falter by not coming to perform the rituals. *“...this is law. Just like every*

*house have its laws. It is not possible for them not to come. There may not be a problem if they do not come but this is our law.”*

#### 4.1.4.7 Sources of Healthcare

##### Discretionary use of services

At her disposal, Maria has the church and the conventional health care services available to her whenever the need for health care arises. She generally prefers to take the child to conventional care, and she personally prefers to go to the church. The small size of the baby makes him vulnerable to harm, and the participant feels the obligation to advocate for the baby. Hence, she promotes the use of therapies that are specifically prepared for children. *“Some of ‘ditaelo’ are not suitable for a baby, whereas I am not prevented from using them. It’s not that there is anything with them per se, but for a little baby they become unsuitable.” “It’s also just that a child needs to be ‘searched’ sometimes.”*

##### Switching Services

The availability of healthcare options allows Maria to actively engage in a process of choosing a service, but also transition between services depending on circumstances. Most often the decision is based on specific reasons, but sometimes she changes just because the options are available and expected to be used. *“I know that both of them work, by the time I leave one form of therapy to go for another it means that I have decided. I could stop the church therapies and use the doctor’s ones, and when he is better he could return to the church ones.” “Ok look, I cannot always relish with*

*'morogo' (leafy veggies), but I must add some meat here and there. So we tend to change."*

#### Church Corruption

Maria highlights the problems with the church regarding corruption, abuse of power and greed. She depends on her spiritual guidance to protect her from corrupt members of the church. *"Corruption is all over you know. I don't even want to hide it. We have them. I just feel it in my spirit that this one is trying to mislead me." "We do nothing to punish them. We just hand them over to the Lord. God will deal with them"*

Some pastors are impostors who falsely pose as prophets, and because she is older, Maria is able to compare their work with the work of the previous pastors. The trouble is they mislead many members of the church who are vulnerable to corruption. She advises those who have been misled to repent for their own deliverance. *"A person is able to see that they have lost it. When you lose your path, you must go back to find it again. Then you embark on a way of truth." "Sometimes families are broken because of them. You find a person acting like a man of the house, and these things are not wanted." "Sometimes we think we have been given prophesying powers when we don't have all that much."*

#### 4.1.4.8 Using Therapies

##### 'Ditaelo'

'Ditaelo' is a word used by the church to refer to church orders made to members with regard to service or therapy. The term is also used generically to refer to the actual

remedies prepared and offered by the church to their members, and also therapeutic procedures that may be conducted.

#### Avoiding Therapy combinations

Therapies from the different services are never combined. If a decision is made to leave the conventional care and return to a church care, the mother will have to complete the therapy course prior to switching. *“I would not mix them, but I would use the doctor’s medicines until they are finished. Mixing them would make it difficult for me to know which ones helped him.”*

## **4.1.5 Interview 5**

### **Patience**

#### **4.1.5.1 Profile**

Patience is a 21-year old single lady and a mother to an 11-month old baby boy. She completed the first academic year of a Bachelor's degree as her highest level of education, but dropped out due to pregnancy. She is currently unemployed. She lives in a family of 8 members, and although her father is the household head, her grandfather is the elder in the family. Sources of health care for her son include general practitioner, clinic, hospital and traditional healer.

#### **4.1.5.2 Summary**

Patience visited a traditional healer to investigate a suspected medical condition in her son, after she consulted with her family members. The suspected medical condition was thought to have been caused as an unintended harmful consequence through exposure to a traditional medicinal product used for luck. Knowledge of this medical condition is generated through home and street learning, and reinforced by personal experiences. Traditional and cultural beliefs are the basis for the decision to use traditional health services for her child, and motivated by fear of child death. Specialty, expertise, competency and trust emerged as major determinants in the choice of a traditional healer.

#### 4.1.5.3 Reasons for Traditional Consultation

##### Ill-health

In this case, consultation of a traditional healer occurred, but no herbal medicines were administered. Ill-health prompted the mother to take her child to a traditional healer. *“We saw at first something known as ‘styf’. The child becomes unwell in a strange manner, and they (traditional healers) must ‘search’ him for this thing called ‘styf’.*

##### Cultural Beliefs

Cultural beliefs led Patience to suspect a certain medical condition in her child, and to act based on this suspicion. *“It is a belief. I believe in both traditional and western care. Therefore, the way we live, it is the first thing I must do to take him there so that they can ‘search’ how his health is.”* The word ‘search’ is used here Patience to describe a process of medical investigation or assessment for an illness or cause. *“It is a belief. I believe in both traditional and western care. Therefore, the way we live, it is the first thing I must do to take him there so that they can ‘search’ how his health is.”*

‘Styf’ is suspected by the mother and her family based on known culture and context-specific practices. The family would suspect ‘styf’ because of their understanding of traditional disease distribution in their environment. The word ‘styf’ is used for both traditional medical condition and product. *“To think like this is because many people from my place where I come from use ‘styf’ a lot, and that’s why we would suspect it in a child.”*

#### 4.1.5.4 Illness Classification

Health beliefs determine how medical conditions in children are classified, and subsequent actions regarding access to healthcare. ‘Styf’ is believed to bring luck to women using it. *“It is normally used by women. The women use it, I don’t know whether for luck or what they bath with it.”*

Transmission of the medical condition occurs by air through inhalation of the medicinal product, and only in babies. *“Even when the child is at home and that person is passing by in the street, you will see the child changing condition. The child would have inspired the medicine because it is carried in the air.” “The child will feel it suddenly, and as long as he sneezes it means it’s got in.” “I got into a taxi with one of the women, and there was a certain funny smell giving me a nasal blockage. Then the child began to sneeze.”*

Clinical manifestations of this condition are non-specific. *“I knew how the child presents and that it gets in when he sneezes.” “The child becomes weak and you will see the eyes rolling, and he cries also.”*

#### 4.1.5.5 Decision-making

##### Collective and Consultative

There is an emphasis on the concept of ‘we’, denoting that Patience does not reach conclusions on her own. She consults with her family members, and the ‘granny’ is usually the first one to identify the problem. The decision to take the child to a healer is

also made in consultation with the family. *“The decision for him to be ‘searched’ comes from me as a mother. I discuss it with my family first, the people I live with.”*

### Shared Beliefs

It is important for the family to have shared beliefs and practices to allow the family consultation to be more effective. *“If I believed more in the church than tradition, these two things do not mix and they would oppose each other. It would be an endless debate in the family, and you would end up nowhere with the discussion. At home we are the same, because we believe in the same thing.”*

#### 4.1.5.6 Care-seeking

### Sources of Transmission

Knowledge about ‘styf’ is not acquired through school or literature reading, but rather occurs orally from home and street environments, and by personal experience. *“I was not taught about it at school. I first heard from home when they explained that ‘styf’ is like this, and then we also heard in the street as people spoke about it. Only when your child gets it, and then you really get to know it.”*

### Unintentional harm

In the use of ‘styf’, an emphasis is made on the unintended harmful consequence in children. *“But when they apply it, they are not targeting these children. To them it is for luck, while on the other hand it kills children.” “If after bathing with it you go where*

*there are children, even though your intention is not to kill children with it, this thing is dangerous on children.”*

#### Perceived harm

The suddenness and danger perceived by mothers of children suspected to have acquired ‘styf’ leads to urgency in seeking intervention. *“When it enters the baby after inspiration, that baby dies same time!”*

#### Priority-setting

Depending on the perception of threat, decisions about accessing healthcare are prioritized. *“It is the first thing before going to western care they (traditional healers) must look for, because it is a sudden and urgent thing.” “As a tradition and belief, I search him first and take him to the hospital afterwards.”*

#### Lifestyle Modification

The beliefs people hold regarding causes of illness can influence their subsequent behaviour, and lead to modification of their lifestyle. *“We were going to town one day, and he started sneezing. I requested that they open the windows just so that we could arrive home, and this is why I do not take him with me to town anymore.”*

#### 4.1.5.7 Sources of healthcare

##### 4.1.5.7.1 Choosing a healer

The process of choosing a traditional healer for this participant appears to have been straightforward *'it did not even take us long to choose'*, but there were pre-requisites identified.

### Expertise

Firstly, there are many types of traditional healers known Patience. 'there are 'malopo', mantau', seers', and 'river' ones.' For this reason, a healer must have a recognizable and known specialty relevant to the medical problem at hand. *"They specialize in different things, differ in their approaches and do not perform the same way. According to their approaches, isn't it you know that the one healer is like this or that?"*

### Faith

Secondly, the healer must be trusted, and this trust develops because of evident ability or reputable expertise in the eyes of the mother. *"I have faith in him. I also liked something about that person."* *"It is because he saved someone in my family, and that's why we chose him."* Traditional healers do not necessarily tell their clients what they expect to hear. Diagnosis can be against the mother's expectation, but these mothers have faith and trust in the expertise of the healer, and therefore trust in their advice.

#### 4.1.5.7.2 Personalised Service

Traditional healers tend to build relationships with mothers, and as a result offer them certain privileges. Patience received special attention and a personalized service. *"Since it was someone we knew and had his telephone numbers, we called him while we are still*

*at home to inform him that we are on the way. You often find that he has a queue, and we therefore avoid waiting in the line and receive speedy assistance...as per appointment!”*

#### 4.1.5.7.3 Referral Channels

Traditional healers are taking advantage of conventional services, and they do refer their clients to hospitals. *“He checked him and inspected using his traditional bones. When he looked, he observed that the child’s problem required a hospital consultation.” “Isn’t it if it was ‘styf’ he would see it with the bones that the child has inspired ‘styf’, and if it were he would have helped the child himself.” “Yes, it was not ‘styf’. I then took the child to the hospital”*

Patience took the child to hospital without further delay, and since her fears have been alleviated, the urgency in rushing to the hospital may have emerged out of the respect for and the trusting relationship with the healer. *“He decided to send the child to hospital. I did not sit but came here (to the hospital) immediately, and abandoned a plan to go to town.”*

## **4.1.6 Interview 6**

### **Rose**

#### **4.1.6.1 Profile**

Rose is 42-year old mother to a 4-year old male child. Her highest level of education is Grade 4, and she is unemployed. She lives in household of 6 members, for which she is the head of the family. Sources of health care for her child include traditional healer, general practitioner, hospital and the primary health care clinic.

#### **4.1.6.2 Summary**

Rose took her son to a traditional healer for traditional therapy after ‘Hlogwana’ was diagnosed based on a set of symptoms. Ill-health in the child prompted the decision to consult the traditional healer. The decision was made after consultation with the elders in the family, regarding both the diagnosis and choice of a traditional healer. The consultation process by the traditional healer included history-taking, diagnosis using traditional methods, therapy administration and follow-up. The medications were given via oral, respiratory and topical routes. Rose was satisfied with the outcome of traditional therapy.

#### 4.1.6.3 Reasons for Traditional Consultation

##### Ill-health

Ill-health in the child prompted the decision to visit a traditional healer in this case. *“For taking him to the traditional healer?...it was because the child was not feeling well.”*

#### 4.1.6.4 Classification of illness

Prior to seeking medical care and in consultation with the elders, illnesses in children are broadly categorized into conventional and traditional for the purpose of decision-making regarding access to health care. *“Maybe I would take him to a clinic, just to find later that he has illnesses like ‘dihlogwana’, which are treated by traditional healers.”*

This differentiation between conventional and traditional illnesses is based on combinations of certain symptoms and signs observed in the child. Using existing knowledge, beliefs, and past experiences of the mother and elders, sets of symptoms and signs are turned into a provisional diagnosis. *“He was also having some diarrhoea, and we thought it could be due ‘hlogwana’.”*

#### 4.1.6.5 Decision-making

The complex nature of reaching a possible home-based medical diagnosis may leave the mother feeling unqualified to make relevant decisions, and as a result Rose tends to consult elders in the family for assistance and guidance. *“We looked at him with the elders, and they said when you see him like this, it could be ‘hlogo’.”*

#### 4.1.6.6 Care-seeking behaviour

##### Provisional diagnosis

When the child is not well, Rose attempts to understand what the problem could be before seeking medical help from a health service. The understanding of the possible medical diagnosis helps her to decide on the type of health service she needs to utilize. *“I must have an idea of what could be wrong with the child, so that I don’t take him to a hospital whereas his medical problems are not suitable for the hospital.”*

##### Knowledge Transmission

The household consultation process serves as teaching and learning experiences for the mother, beyond guidance and assistance. The consultation process appears to be most valuable in transmitting and imparting knowledge from the older to younger generations. *“Isn’t it we go to the grannies to ask about the child, and say to them the child is like this, what can the problem be? Since we are younger, they would then suggest that it could be ‘hlogwana’, and recommend that we take the child to a traditional healer.” “It is because we are young and we know very little.”*

##### Choosing a healer

The role of consulting elders in the family is not only confined to a provisional diagnosis and the required type of health service, but they are able to recommend a particular traditional healer on the possible diagnosis and expertise or reputation of the healer. *“Isn’t it the elder will tell me that she knows someone who can treat it. So, take the child*

*to this person. I will then leave and take the child to that particular person the elder would have told me about.”*

### Concurrent Use of Services

In cases where a clear differentiation cannot be achieved between traditional and conventional, or both types of medical problems exist at any given time, both types of health care are utilized concurrently or sequentially and with or without the knowledge of the health providers. *“Now, when he finishes treating him for ‘Hlogo’, I will take him to the western side for examination, to see whether he has enough water or blood, you see! That’s how it works.”*

### Non-disclosure

With concurrent or sequential use of traditional and conventional forms of health care, Rose maintains that she would never tell the hospital providers about traditional medicines. *“No! No, no, no! I would never tell them about the traditional medicines. No! If they asked I would tell them I did not take him for herbal treatment, I just came straight to the hospital. No, no!”*

The culture of secrecy around traditional medicine utilization showed a learned pattern by younger from older generations. Rose observed that elders hid this information from health workers, and hence she has also sworn not to speak of it. *“No, it is forbidden! I would just tell them I came here straight. It is just like when you are pregnant, and having to come to the hospital for delivery. The older women will take their tools and hit the mountain while you call for the ambulance. When I say call the ambulance to come*

*and take me to the hospital, she will take her tools and hit the mountain. She then prepares the traditional medicine, and gives me to drink. When we all arrive at the hospital, and they are asked about herbs, even though she gave me, she would say I know nothing about any herbs! I never made her drink anything. When they ask if she did not give me anything she would insist no! Nothing!” “You do not speak about it. They say ‘we are giving you to drink, but you do not speak!’ so even for the child, when you give him to drink, you do not say anything at the hospital.”*

#### 4.1.6.7 Sources of Healthcare

##### Competence and Expertise

Rose believes that it would be an error of judgement to take what could be a traditional type of medical problem to a conventional practitioner, or present a conventional type of a medical problem to a traditional healer. *“The clinic can tell me (something about the medical problem), but not about ‘hlogo’. No! Not ‘hlogo’. ‘Hlogo’? Not at all! They would not touch anything about it. Yes, they will treat those other conditions (conventional), but ‘hlogo’, no no no! They will not tell me anything about it.”* The patterns suggested here indicate concurrent, sequential and alternative use of services. *“So if I take him to a traditional healer, he will look at him and treat whatever it is he finds. For the western type problems, the traditional healer will not be able to cure them. No! He will cure what he is able to. He will not be able to cure the western problems.”*

### Usefulness of services

Rose is able to recognize the usefulness of conventional health care services, *“They are able to see what the state of the body is, while our traditional doctors just offer medicines to drink.”* However, she seems to appreciate the hospitality and unbiased approaches by traditional health providers, *“You actually spend the whole day with him when the person is too ill. He can even take the patient and bring him to the hospital. He gets them to help him see what the problem could be, and they (conventional providers) also look.”*

### Satisfaction with care

This mother presents a sense of feeling supported, reassured and satisfied with the care offered to her child by the traditional healer, particularly at follow-up. *“When the medicine is finished I go back to him, and tell him the medicine is now finished. He then takes his traditional bones and look again. Then he confirms that the child was suffering from ‘Hlogo’, and now he is cured according to what he sees from the bones. Then all is well traditionally.”*

#### 4.1.6.8 Using Therapies

### Combining therapies

Rose did not perceive any problem in combining traditional and conventional forms of medicines. *“You can mix them...the way I see there is no serious opposition. In fact if I spoke strictly, there is no opposition...you continue to take the western medicines.”*

### Safety

She also believes that traditional medicines cannot be harmful to the child. According to her, *“They (traditional medicines) cannot have a negative effect.”* However, she recognizes that harm could arise if conventional care is not used at all. *“Negative effects can only occur in situations where you just concentrate exclusively on them without taking time to have a western examination. You can use them, but you need to a visit to the western service where they are to examine the child’s body thoroughly.”*

### Administration

Traditional healers provide therapies for children through oral and respiratory routes, but also topical application. *“He just took his medicines and made the child re-breathe the smoke, and smeared some medicines on the head the way he knows how. He gave him some to drink, and some more to give him at home.”*

### Dosage Limitations

The limitation of not quantifying medicines or adhering to dosage specification was singled out by Rose, although it did not seem to be a problem for her. *“With traditional medicines, you do not measure. You just prepare the medicine, pour it into a bottle, and give him to drink.”*

## **4.1.7 Interview 7**

### **Sara**

#### **4.1.7.1 Profile**

Sara is 20-year old single mother to a 2 months old female baby, admitted to hospital for gastro-enteritis. Grade 11 is her highest level of qualification, and she is unemployed. She lives with her parents in family of 9 members, wherein her mother is the household head. She consults with traditional healers, the hospital and primary health care clinic when her baby is ill.

#### **4.1.7.2 Summary**

African traditional medicines were offered to Sara's daughter. The decision to administer traditional medicines was prompted by ill-health in the baby. The symptoms observed pointed to three traditional illnesses as suggested by Sara's mother, that the child was suffering from 'Lebala', 'Hlogwana', and 'Kokwana'. Sara had to further consult with her boyfriend's family regarding the baby's ill-health, and they also concurred with her mother's suspicions. A decision was therefore taken to find a traditional healer who can treat the baby's conditions. The first healer was not helpful to them, and the second healer managed to assist them. He essentially confirmed the diagnosis of the three traditional illnesses, and instituted therapy. The therapy was helpful because the baby's symptoms disappeared, but they later re-emerged. Sara returned to the same traditional healer who then decided that the child was dehydrated and referred her to the hospital. The baby was admitted to the hospital as a result.

#### 4.1.7.3 Reasons for traditional consultation

Ill-health influenced by traditional beliefs led to the child receiving traditional medicines.

It is Sara's practice to take a child to a traditional healer whenever the child is ill.

#### 4.1.7.4 Illness Classification

When the child is ill in the home, an elder in the family is able to notice symptoms and signs suggesting certain traditional illnesses in order to make an initial diagnosis within the home. Sara does not have this expertise because she has no knowledge and experience of traditional illnesses. *"The child was ill from 'kokwana', 'hlogwana', and 'lebala'."* The role of an elder is instrumental in establishing a home diagnosis and differentiation of illnesses. *"An elder in the home notices these illnesses, so my mother did. She also decided that the baby must receive therapy."*

#### 4.1.7.5 Decision-making

A collective and consultative decision-making process unfolds within the home and between family members, leading to a firmer diagnosis and a decision to seek help. *"I took her to my partner's place, and told them I was not impressed by the baby's state of health. They also saw how she was."*

#### 4.1.7.6 Care-seeking

#### Authority

The elders are able to command authority in the decisions around the presence and treatment of these illnesses because of their knowledge and experience.

### Choosing a healer

Once a decision has been made to seek a traditional healer, the choice of a healer hinges upon his reputation, expertise, specialty and competence. They found the first healer, whom they declared incompetent, and went further to look for another healer. *“The following day they looked for a traditional healer, and this person failed to help the child. Then they went and looked for another one who was competent. The she was treated.”* *“The first healer said he did not have medicines for ‘Hlogwana’ and ‘Kokwana’, and he only had inhalation therapy. We went to the one who had them.”*

### Limitations of Knowledge

Sara did not have a detailed knowledge of the illnesses, but she was able to offer some descriptions. This limitation makes it possible for elders to have power in influencing decisions. *“I do not know how they differ. A baby with ‘Kokwana’ passes green stools, and you see ‘Lebala’ at the back of the baby’s neck. A baby with ‘Hlogwana’ passes green stools as well.”*

### Secrecy

Sara went with the family to visit a traditional healer, but she did not join them during therapy procedures. She was not allowed to sit-in, but she also acknowledged that she was afraid to observe and the child was crying. Sara was not told what actually happened during therapeutic procedures, but she knew generally what the actual procedures were.

*“I was not told what was done, because they do not tell.” “I do not know what they did, but I only saw what was applied to her head.”*

### Fears

It bothered Sara that the baby cried, and the procedure was frightening to her, but she trusted that no injuries could be caused by therapy. She knew neither the instrument used nor medicines inserted for the rectal therapy. *“I do not know what they used. They do it while the mother is not present. The mother is not supposed to be present” “I knew that they stir the rectum, but I trusted that she would get better.”*

### Satisfaction with care

Sara was not forced to have the baby treated, and she took her to a healer with an understanding and confidence that the baby would receive the help she needed. Sara was satisfied with the outcome of therapy. *“She was helped. Her state had changed for the better. She was much better than at the beginning.”*

### Referral to other services

The baby was cured after taking traditional medicines, but she began to vomit. As a result of this vomiting, and due to her normal practice of visiting a traditional healer when the baby is ill, Sara went to see a healer. The child was said to be dehydrated, and was referred to a hospital. The main purpose of this referral was for the hospital staff to rehydrate the child. Sara did not think that the dehydration could have been caused by the traditional medicines that the baby took. *“I brought her here because she did not have*

*enough water in her body. The shortage of water was caused by the vomiting, that's what caused the shortage of water." "She had finished taking traditional medicines when she started vomiting, and they (the healer) said the baby did not have enough water. They said we must come to the hospital, because her skin was dry and shrunken."*

#### 4.1.7.7 Using Therapies

##### Administration

Sara was given medicines to administer to the baby at home. Some medicines were intended for oral ingestion, and others were to be used for bathing the baby. She believed that medicines would cure her baby, even though she had no knowledge of the contents. These medicines were in powder form, and Sara had to first prepare these medicines. She estimated the amount of water by herself, and used her own bottles. The baby did not experience any adverse effects while on therapy. *"I gave her two teaspoons three times a day to swallow. Before that I had to prepare the medicine myself. I had to boil water, and then allow cooling. I then added two teaspoons of the medicine and mixed thoroughly. I then poured some of this mixture to a little numbered bottle, from which I gave to the baby."*

##### Stoppage

The decision to stop medicine administration to the baby was also dependent on the mother. Sara had to determine whether the baby was well enough for her to stop the medicine or not. She felt at liberty to visit the traditional for follow-up in cases where the

baby did not show progress. *“I stop when she is cured. If she does not improve I would not stop.” “If she does not improve I can go and ask the healer what the problem is.”*

### Therapy Combinations

Although the healer referred her to the hospital, she would never combine traditional with western medicines. She also believed that traditional medicines should not be brought into the hospital setting. *“They do not allow traditional medicines here (hospital), because they are afraid that the medicines would weaken (supernaturally) other children in the hospital.”*

## **4.1.8 Interview 8**

### **Sophy**

#### **4.1.8.1 Profile**

Sophy is a 23-year old single mother of an 8-month old baby girl. Although she has matriculated, she remains unemployed. She lives in a household of 9 members, for which her mother is the household head. Sources of health care for her baby during ill-health are traditional healer, hospital and primary health care clinic.

#### **4.1.8.2 Summary**

Sophy's baby was exposed to African traditional medicines on two occasions. In both cases the baby was not suffering from any obvious physical ill-health. Immediately after the baby was born and brought home from hospital, a decision was made by Sophy's mother to offer the child traditional medicines upon arrival. This ritual was said to be a traditional practice that will prevent the baby from being supernaturally weakened by exposure to children harbouring other forms of traditional medicines. The practice is performed on a newborn immediately after birth for preventive and protective purposes, and thereby saving the baby from an avoidable childhood death. The baby was later treated for 'Thema', after Sophy's mother noticed it at the back of the child's neck even though the child was physically well. Sophy was then sent to a traditional healer for therapy, after which the baby was cured without any further problems. The baby was later admitted to hospital for a diarrhoeal illness. A traditional healer was not consulted for this problem, because Sophy believes traditional healers do not treat diarrhoea. An elder in

the family seems to influence strongly the observation and decisions to treat children traditionally. Sophy cooperated with the procedures mainly because she was told by her mother that she herself was also brought up through the same practices. It was enlightening to observe that African traditional medicines are not only herbal, but uses animal products as well.

#### 4.1.8.3 Reasons for Traditional use

##### Illness Prevention

‘Go-Tshubelwa’ is a Sepedi word meaning ‘to burn for’. This also describes the process of protecting a child from supernatural or evil powers that she may encounter after birth. Sophy was told by her own mother that the baby required ‘Go-Tshubelwa’ upon arrival from the hospital immediately after birth, or else the baby may die young. This ritual is performed for preventative purposes, and therefore generally on a healthy and well child without any physical illnesses. *“I was told by my mother that when a child is born, she must undergo ‘Go-Tshubelwa’ so that other people must not ‘weigh heavy’ on her. They must not ‘weaken’ her. Other children carry ‘ditupa’ on their waists, so my baby could die because of that.” “Right after birth when I got home. The moment I arrived home they immediately started with ‘Tshubela’ for her.”*

The baby was further exposed to African traditional therapy during treatment for ‘thema’, a traditional condition said to cause death in many children. Once again, Sophy’s mother noticed physical signs in the child suggestive of ‘thema’, but the child was not sick.

*“There was another one known for clogging-up of blood behind the neck called ‘thema’.*

*It is also known to be a killer.” “I was just told by my mother that the baby is suffering from ‘thema’, and that we should go to someone who is known to cure it.” “She was not ill. My mom just showed me how she was behind her neck, and told me it was called ‘thema’ known to be a killer of many children.”*

### Tradition

Sophy allowed her mother to perform the rituals because it was part of their culture, and her mother said it was the way Sophy was also brought up. *“I did not refuse because they said it is tradition, and this was how we were also brought up.” “In fact I just agreed because they were telling me that we were also raised like this.”*

#### 4.1.8.4 Illness Classification

The baby ended up in hospital because of diarrhoea, and a traditional healer was not consulted for this problem. Traditional healers do not treat diarrhoea and its consequences in a child. The decision to consult either the hospital or traditional healer depends on the type of illness the child is having, and this decision is made at home prior to any consultation. *“I do not know about a traditional healer who treats diarrhoea. When she runs short of water, would he be able to give her a drip? It is only the hospital where they are able to give her water.” “It depends on the illness. A diarrhoeal illness that causes shortage of water is brought to the hospital. I have never heard traditional healers say they can treat diarrhoeal illnesses in children. The thing is traditional healers treat illnesses that are not treated at the hospital.”*

#### 4.1.8.5 Care-seeking behaviour

##### Role of an elder

The ritual was performed by the Sophy's mother, although she is not considered a traditional healer but just an elder in the family. This elder was the one who made the decision to have the baby treated, and she also went to buy the necessary traditional medicines. She prepared the traditional medicines herself, and performed the rituals. *“My mother is the one who performed the procedure at home. She decided that the child should receive therapy, because I did not know these therapies.” “I just saw her give the baby some inhalation therapy. The baby would re-breathe it and pass some urine”*

Sophy was further advised by her mother to take the child to a particular traditional healer. She did not state the reasons for her mother to recommend the traditional healer, other than he was known to cure it. The traditional healer's reputation appears to have led Sophy's mother to recommend him. Sophy was prepared by her mother beforehand that the traditional healer is going to make cuts behind the baby's neck and apply traditional medicines. *“My mother is the one who decided that I must go to a healer, and she just told me whom to go to.” “I took her to the traditional healer for the treatment.”*

##### Knowledge

Sophy admitted to her own lack of knowledge regarding the rituals and the medicines used, but she was allowed to sit in and observe all that her mother was doing. Her mother kept explaining to her the steps and reasons as she went along. Although this process clearly allows oral transmission of knowledge and information from one generation to the

next, Sophy did not regard it as a training process. *“I was there watching what they were doing, but I was not under training.”*

Despite her declared lack of knowledge, Sophy displayed a good understanding of what the ritual entailed. She was able to describe the process, along with some indicators of therapeutic success. *“They just burn some animal skins, cover the baby, and tilt her over for her to pass urine. You sometimes find them saying a small baby is unable to pass urine, so they give her these medicines for her to do so.”* *“They put some hot ash in a bowl, place the hair from the animal skin on the hot ash, and then cover the baby to allow inhalation. They use a blanket, but allow some air because she is still small. You’ll even hear her sneeze, and she passes urine.”*

She further showed some knowledge regarding the medicines used for therapy, including reasons for their use. It was clear that the therapy is a family-initiated intervention. It was further evident that the ritual did not only protect the child from supernatural weakening, but also from certain known illnesses. *“These are animal skins. They go to people who sell them, inquire about the ones they are looking for, and buy them.”* *“One from a hare to prevent dizziness in a child, and the other one was from a monkey so that a baby does not suffer from seizures. These are the ones I remember, the others I forgot them.”*

#### Negative Perception

Her perception of the medicines was found to be negative despite her practices and newly-acquired knowledge. She did not like the use of these medicines, but believed that they are therapeutic, only because it is traditional practice. *“I just don’t like those*

*(Animal skins). Of course they help, but I just don't like them. I believe so just because I was told this was how we were also brought up." "I understand that the meats of these animals are not edible, but they make the baby to inhale the smoke. She just suffocates from the smoke when their meats are not for eating."*

### Faith

Sophy was content with the outcome of therapy, and the baby did not experience any adverse effects. Sophy remarkably noted that success of therapy hinges upon the faith one may have in the therapy itself. She also embraced the therapy process as a traditional practice. *"I noticed that the problem disappeared. The 'thema' was cured, and the medicines never made her ill." "I just believe that they helped. At home they tell me that we were also brought up with the medicines, and I also believe. I just think healing is a belief. It is when I trust that she would really be cured that she improves. I do not believe, and then it means she would not get better."*

#### 4.1.8.6 Using Therapies

### Consultation

Sophy took the child to a healer by herself, after she was given clear instructions by her mother. The healer looked at the child and made a diagnosis. He also explained the treatment procedure to Sophy. There were some pre-requisites for the procedure to be conducted. *"I said that I was told the baby has 'thema', and he looked at her. He confirmed that it was indeed 'thema'. He saw a reddish discoloration at the back of her neck." "He wanted to wait until the sun was up. He raises her against the sun so that*

*more blood can collect around the reddish area, and then he cuts with a razor blade.”*

*“He makes many small cuts. He takes traditional medicine and rubs with it. He is then finished, and he wants money.”*

### Instructions

Sophy was offered traditional medicines to give to the baby at home. The traditional healer’s instructions to the regarding the administration of these medicines remained non-specific, and as a result much was left to subjective interpretation. The challenges of estimating the amount of medicines to be administered did not seem to be bothersome for Sophy as she expressed confidence in the use of these medicines. *“There was this other black one that he said we must put in the baby’s porridge. We put just a little because I needed to just sprinkle a bit. He said to take a small pinch, mix with the porridge, and feed the child.” “It is just like one would know how much salt to put in the meat. Likewise one would be able to estimate the medicine.”*

### Duration

The decisions about the length of medicine administration and stoppage were left to the mother to make. These decisions seem to depend largely on the mother’s satisfaction with the process. *“I just give her to drink and when I feel satisfied I just stop. It depends on me because he did not tell me when to stop. I just let her drink and when I feel like it I just stop.”*

### Therapy Combinations

Sophy was agreeable to the use of traditional medicines in her baby, and she did not think traditional medicines could cause any problems in a child. She was also of the opinion that traditional medicines should not be combined with conventional medicines. *“I would not mix them. I suspect they may not work. If I had been giving her traditional medicines, and then realized that I needed to take her to the hospital, I would stop the traditional ones and trust the hospital ones. If they fail then I would go to the traditional ones.”*

### Therapy Safety

She indicated that conventional medicines are tested and tried before they are used, while traditional medicines are used on trial and error basis. It does appear as though Sophy regards conventional medicines as superior to traditional medicines, but this perception does not explain her continued use and faith in traditional medicines. *“I understand that the hospital ones get checked isn't it? They are checked as to whether they would cause illness or not, and whether they are suitable for a child or not. I do not think traditional medicines are checked. They just find someone getting better when they try one the medicines, and then decide that the medicine is helpful.”*

## **4.1.9 Interview 9**

### **Susan**

#### **4.1.9.1 Profile**

Susan is a 19-year old mother to a 4 months old male baby. She is a single Grade 11 scholar currently living in a household of 9 people, in which her father who is also a traditional healer is the household head. Sources of health care for her baby include primary health care clinic, hospital, and traditional healers.

#### **4.1.9.2 Summary**

Susan administered African traditional medicines to her child. The main reason for the administration of the medicines was to treat a traditional illness known as ‘lebala’. The condition was diagnosed by her father who is also a traditional healer. The baby is reported to have fallen ill and taken to the nearby hospital for the illness. While in the hospital, the baby’s condition did not improve, and a decision to institute traditional therapy was made by the family. Susan was assisted to obtain a temporary release from the hospital so that she could go home and have the baby treated. Therapy was offered at home by her father, but the baby complicated during therapy, and it was stopped. She then returned to the hospital, where the baby continued to vomit including at discharge. She was then advised by her family to take the baby to a different hospital, where the baby was again admitted. At this stage, the baby recovered and the vomiting ceased. Susan seemed happy with her son’s progress.

#### 4.1.9.3 Reasons for Traditional Consultation

##### Ill-health

She gave birth to a healthy and chubby son, who later fell ill. The baby began to vomit, and then he lost weight, and became weak. The mother took him to the hospital, where he was admitted. His condition did not improve, and the family declared a traditional illness known as 'Lebala'. For this reason, the baby needed to be treated by a healer at home in a traditional manner. *"I took this child to a hospital last month, and he was not getting better. I was told to take him to a healer for the treatment of 'Lebala'."*

##### Authority

Susan's father is a traditional healer himself. He is the one who decided the child needed traditional therapy, went to find traditional medicines, prepared them, and offered them to the baby and his mother. *"My father decided that the baby gets treated for 'Lebala', and he is able to treat. He is a traditional healer."* *"I do not know where he got the medicines, but probably from his own traditional healer and he brought them home with him."*

#### 4.1.9.4 Illness classification

Medical conditions are treated according to the category under which they fall.

Traditional conditions are managed by traditional healers, even when they are diagnosed in the context of conventional care. *"I was told to take him to a healer for the treatment*

*of 'Lebala', and then come back to them. He was treated for 'Lebala', and then I went back to them”*

#### 4.1.9.5 Decision-making

##### Unshared beliefs

It was striking to see a person growing up in a family that practices traditional therapies refusing to allow use of these medicines in her baby. Her experiences led Susan to believe that traditional medicines could be harmful, and to lose faith in them. It was also refreshing to note that education offered by health workers can influence attitudes in some of their clients. *“We were told at the hospital not give children traditional medicines. They showed us one child who vomited black stuff, and said it was due to traditional medicines. That’s when I realized that traditional medicines are dangerous. I refused because I saw the child.”* However, this case confirms that health decisions are not made individually, but as a household. The demands of those who have more authority will surpass of those who are junior members in the family, even though the decision pertains to the junior member’s own child. Therefore, the baby was treated.

##### Role of Authority

The father used his authority as a parent and household head to coerce Susan into consenting to traditional medicine administration to the baby. Susan was initially reluctant to administer traditional medicines to her son. *“Initially I was refusing, but they complained that I was being disrespectful. I told them just because they said I was disrespectful, and then they could go ahead and make him drink the medicines.”*

#### 4.1.9.6 Care-seeking

##### 4.1.9.6.1 Dealing with Authority

###### Conventional care

Once this decision was made, getting out of hospital became a challenge for Susan because the hospital staff refused to let her take an ill-looking child home. Remarkably, a relative of hers working at the same hospital interceded for her. From the manner in which Susan tells her story, it appears as though she assumed what she was told by her relative represented the view of the hospital as a whole. It is noted here how the relative negotiates on Susan's behalf, and give her the permission to leave and return to the hospital after traditional therapy has been completed. In her view, Susan resolved that the hospital allowed her to treat the child for the traditional illness, and further requested her to return to the hospital. *"I requested a relative of mine who works at the hospital, and he suggested that I take the child for traditional therapy. He even requested the hospital people on my behalf to release me, since they were refusing to let me go."*

###### Traditional

Susan father adopted multiple roles that made it extremely difficult for Susan to negotiate with him. In addition to being a parent, he was also a household head and traditional healer. The power play favoured the father more than Susan, and she was unable to stand up to him. Her lack of cooperation was considered disrespectful, thereby rendering her helpless.

#### 4.1.9.6.2 Switching services

Back at home, the baby continued to vomit and he was looking sick. The family was supportive in exploring alternatives for the baby, and they advised that Susan returns to the hospital, except this time she had to visit a different hospital. It appears the family placed the quality of care at their nearby hospital under question. *“I gave him ‘Motswako’, but he still did not improve. My family suggested that I change a hospital, and bring him here. When I got here he was treated, and he began to improve. Now he is fine, and the vomiting got better and better until now.” “I had to start afresh and take the baby back to the hospital.”*

#### 4.1.9.6.3 Symptomatic improvement

Susan returned to the hospital with the baby. The strange spasms ceased, but the vomiting persisted. She seemed dissatisfied with the outcome of therapy at the time of leaving the hospital because the baby was still ill. *“The child continued to vomit, but they discharged us. I was told to give the child ‘Motswako’ (oral re-hydration solution).” “Ever since I came back from there (traditional therapy), I could see that he was better because the pulling stopped. Only the vomiting persisted.” “Now he is improving, and he is much better than the time I had just arrived here. When I got here he was so weak and short of water, but now he is able to turn and play.”*

#### 4.1.9.6.4 Changing attitudes

Susan’s attitude towards traditional medicines seemed to have been significantly altered. Her faith shifted from traditional medicines towards conventional care. In her

retrospective reflection, Susan seemed to even doubt the validity of the initial traditional diagnosis of 'Lebala'. *"Traditional medicines wasted my time, but the Western ones have now helped. I gave him traditional medicines, but I could not see any improvement. They kept saying it was 'Lebala', but there was no improvement."* *"I realized that traditional medicines are dangerous, and western ones are better."*

#### 4.1.9.7 Using Therapies

##### Administration

The therapeutic procedure required for the traditional healer to make small cuts at the back of the baby's neck, and apply traditional medicines to these cuts. The baby also received inhalation therapy. Both Susan and her son were given cooked herbs for them to ingest. *"They held the baby down and made multiple small cuts on the back of his neck to release blood. They applied some medicines in the mouth and on the head. He also received inhalation therapy, and they cooked some herbs for us to take."* *"They prepared those (cooked herbs) for both of us. The baby had his, and I had my own."* *"I did not know how I was supposed to give him, but he (my father) said I must give him two teaspoons three times a day."*

##### Adverse effects

Unfortunately, during therapy the baby developed some strange muscle spasms, stiffening his body and pulling his head towards his back. This unintended consequence troubled the Susan tremendously, and she was not seeing any improvement. Susan went to the extent of putting pressure on her family to discontinue the traditional medicines.

*“From the time my son started taking herbal medicines, his neck was pulled backwards. I wanted to know what it was that made the baby to have pulling of his neck when he was taking traditional medicines and my father said he did not know.” “The thing is that they (my family) saw how the baby’s neck was pulled backwards, and he cried day and night. That’s when he (my father) decided to stop.” “He (my father) also realized that he was basically throwing money into the water when the baby was not getting better. Then he gave up and stopped giving the baby medicines.”*

### Therapy Combinations

Susan used traditional medicines without any knowledge of the contents. Her child developed adverse effects, but she herself did not. Although she moved back and forth between hospitals and introduced traditional medicines in the process, she was of the opinion that traditional and conventional medicines should not be combined. This was another classical example of the Susan’s receptiveness to health education. *“At the clinic they taught us about the dangers of traditional medicines, that they should not be combined with Western medicines because the contents of traditional medicines are not known. The Western ones have their contents written.” “They would cause a problem because the western health workers are no longer able to treat a child. The traditional medicines would have penetrated into the child’s body. They prevent the Western medicines from working well.”*

### Harmful use

Susan gives an example of how harmful traditional medicines can be based on her own family experience. She also notes the role of health workers in emphasizing the dangers of traditional medicines once again. *“For some children they would cause problems, while for other they may not cause any problems. Certain children may not respond well to traditional medicines. When he was growing up my little brother was given traditional medicines whereas he was also taking western medicines for a heart problem. My family was told that he must not take traditional medicines even during initiation school, and he must not stop taking his heart treatment. When the child got to the initiation school, he was given traditional medicines. We were surprised when he got back because he was not looking well. The day he died, something came out looking like some meat mixed with traditional medicines, and I still do not know what it was. When the ambulance service people (Paramedics) came, they told us that those things were traditional medicines.”*

## **4.2 COMBINED RESULTS**

### **4.2.1 Reasons for the administration of Traditional Medicines**

Caregivers administer traditional medicines to children for two broad reasons. Firstly, traditional medicines are given to children in reaction to ill-health, and secondly, children without any illnesses are given traditional medicines to prevent illness. The two situations may co-exist, whereby a child with an illness is also declared to be at risk of a preventable future harm. The co-existence of the two situations may lead to concurrent use of curative and preventive therapies.

#### **4.2.1.1 Reaction to illness**

Often times, children fall sick. Since the mother's duty is to ensure the well-being of the child, she responds by seeking help and eventually administering prescribed medicines to the child. *“(Rose) For taking him to the traditional healer?...it was because the child was not feeling well.”* The natural response upon noticing symptoms is to first observe the child. If there is no improvement, medicines that are immediately available in the home are used to relieve symptoms.

These symptoms are also discussed with family members and other allies in the search for advice. The decision to seek help is then made if the child's condition does not stabilize. The source of health care is selected based on the suspected medical problem, and expected therapeutic assistance. *“(Rose) I must have an idea of what could be wrong with the child, so that I don't take him to a hospital whereas his medical problems are not suitable for the hospital.”*

The decision about the suspected medical problem depends on the mother's beliefs, culture and knowledge. *“(Sophy) it depends on the illness. A diarrhoeal illness that causes shortage of water is brought to the hospital. I have never heard traditional healers say they can treat diarrhoeal illnesses in children. The thing is traditional healers treat illnesses that are not treated at the hospital.”* The knowledge, beliefs and culture of the people advising the mother contributes significantly to this decision.

The use of traditional medicines arises from two scenarios. Firstly, if the suspected medical problem is classified under traditional as opposed to conventional, then traditional medicine therapy will be the first option. Secondly, if there is uncertainty or the initial suspicion suggests a conventional problem, but the use of conventional therapy does not prove to be effective, then traditional medicines are used. *“(Susan) I took this child to a hospital last month, and he was not getting better. I was then told to take him to a healer for the treatment of ‘Lebala’.”*

#### 4.2.1.2 Prevention of illness

The culture of every group carries with it certain beliefs and practices. Among the people who believe in the use of traditional medicine, there are existing traditional practices that promote the use of these medicines to prevent ill-health and death in children from supernatural forces and identified threats. *“(Kate) you see, other children use traditional medicines out there, so I must protect my child for them not to ‘weaken’ and get her sick. I mix Vaseline with Vicks and apply it to her whole body. There will be no child who can weaken her, and nothing will happen to her. Even if that child was heavily smeared with traditional medicines, nothing will happen.”*

The fear of consequences prompts performance of rituals to curb any potential harm that may descend on the child. *“(Sophy) she was not ill. My mom just showed me how she was behind her neck, and told me it was called ‘thema’ known to be a killer of many children.”*

Depending on the particular cultural practice, the ritual may or may not include ingestion of traditional medicine therapy. The practitioners and believers of these practices harbour a firm reliance and confidence in the effectiveness of these rituals to prevent harm. Their faith in the rituals contributes significantly in the passing on of the practices from generation to generation, even without proof of effectiveness.

The observations of conviction made by younger generations on the older ones lead them to trust and believe in these practices. They adopt the same fear of potential consequences, and build a strong sense of faith in the practices. These practices are then incorporated into the culture of their times, and they are also passed to newer generation. The transmission is purely oral and learned by observation. In other instances, it is maintained by regarding it as law, which then makes its violation to possibly carry consequences. *“(Maria) we give him a thin Joko tea and water that has been prayed for. Then they tie ‘Letlamo’ around his waist. These are the things we do for the baby in church.” “...this is law. Just like every house have its laws.”*

## **4.2.2 Factors influencing traditional medicine administration**

The reasons to administer traditional medicines are influenced by three key interacting factors, namely:

1. Expression of Identity
2. Exertion of Authority
3. Role of Balancing

The differences between the above categories are theoretical and tailored to this presentation. Identity is an internal stimulus, authority is an external stimulus, and the caregiver's role is to react to both these stimuli through a complex process the product of which is manifested in her behaviour.

### 4.2.2.1 Expression of Identity

Every mother, like any other person, identifies with certain beliefs, culture and tradition. These factors contribute significantly towards an inherent sense of self and belonging for the mother, and as a result influence her decision-making process including decisions regarding child health.

#### 4.2.2.1.1 Beliefs

Personal experiences in life make it possible for mothers to acquire knowledge and skills. Knowledge may be acquired through formal or informal teaching, and may be transmitted orally. For these mothers, they have learned about the African way of living throughout their lives, and the basis of which forms the foundation of their self-identity.

They harbour within themselves strong views about what they know and believe. This knowledge has been passed onto them by people they trust, and on who they largely depend. Their interactions with varying forms of information relays may have significantly shaped their views. *“(Julia) My understanding is that ‘hlogwana’ is not known in the hospital. I would take him to church and they would treat him.”* *“(Sophy) I do not know about a traditional healer who treats diarrhoea. When she runs short of water, would he be able to give her a drip? It is only the hospital where they are able to give her water.”*

Their behaviours tend to express the strong views they hold. *“(Sara) I brought her here because she did not have enough water in her body. The shortage of water was caused by the vomiting, that’s what caused the shortage of water!”*

These views and behaviours influence their decisions regarding child health. They rely on and respond to their instinctive feelings and understanding regarding the children’s conditions and health status. *“(Maria) we lead spiritual lives. You find some members trying to take chances hoping to scare me, and I just feel it in my spirit that this one is lying to me.”*

They also use these beliefs to measure the trustworthiness of the things they are told by peers and authorities. The knowledge and beliefs they hold about illnesses and therapies for children tend to determine how they react. *“(Patience) to think like this is because many people from my place where I come from use ‘styf’ a lot, and that’s why we would suspect it in a child.”* *“(Patience) when it enters the baby after inhalation, that baby dies same time!”*

These mothers have been conditioned to place trust and hold faith in their knowledge and beliefs, even where proof cannot be provided. *“(Sophy) I just believe that they helped. I just think healing is a belief. It is when I trust that she would really be cured that she improves. I do not believe, and then it means she would not get better.”*

They prioritize according to their beliefs. *“(Julia) the thing is ‘hlogwana’ is the scariest thing, and others like ‘diso’ are not very worrying.”*

#### 4.2.2.1.2 Culture

For any group of people living together, be it a family or a community, they tend to hold similar views. Certain behaviours and attitudes will characterize the particular group.

Culture is shared in the context of people they love and respect, and those that may significantly depend on. Their shared cultural beliefs and practices affect the care of children. *“(Maria) Let me just say this is how we live our life in my home. Where our faith lies is where we go for help.”* *“(Patience) it is a belief. I believe in both traditional and western care. Therefore, the way we live, it is the first thing I must do to take him there so that they can ‘search’ how his health is.”*

The common views held by mothers and those around them are instrumental in ensuring that there is consensus on debates breaking out in relation to the health of their children. Shared beliefs allow a smooth process of decision-making in the family. However, where views differ, decisions are hard to make, and reliance is placed on other influencing factors. *“(Patience) if I believed more in the church than tradition, these two things do not mix and they would oppose each other. It would be an endless debate in the family,*

*and you would end up nowhere with the discussion. At home we are the same, because we believe in the same thing.”*

Mothers identify strongly with their culture, even when they themselves do not necessarily agree with the cultural practices. *“(Sophy) I just don’t like those (Animal skins). Of course they help, but I just don’t like them. I believe so just because I was told this was how we were also brought up.”*

#### 4.2.2.1.3 Tradition

Shared cultural beliefs are passed down from one generation to the next through oral transmission of information. *“(Sophy) I did not refuse because they said it is tradition, and this was how we were also brought up.”* *“(Sophy) At home they tell me that we were also brought up with the medicines, and I also believe.”*

Mothers perceive their family’s approaches to childhood illnesses as historical and therefore binding on them. *“(Sophy) I was told by my mother that when a child is born, she must undergo ‘Go-Tshubelwa’ so that other people must not ‘weigh heavy’ on her. They must not ‘weaken’ her. Other children carry ‘ditupa’ on their waists, so my baby could die because of that.”*

They have no authority to question or challenge it. They are sent into submission from any reservations they may hold by the mention of the word tradition. The realization that they themselves were raised the same way renders them defenceless and unsuccessful attempts to project objections. Some mothers express sense of trust, belonging and pride in their tradition. *“(Anna) from long we work through the church. In my family, we do*

*our things through the church.” “(Anna) we ourselves are now grown-ups and we were never harmed. I trust them.”*

#### 4.2.2.2 Exertion of Authority

The external environment commands tremendous power to influence decisions, and therefore offers a major contribution towards the mothers’ use of traditional medicine in their children. The determinants of this power to influence are categorized into knowledge, experience and status.

##### 4.2.2.2.1 Information

The mother’s context carries with it immense information in the form of hearsay, facts, stories and witnessed events in relation to childhood illnesses and care. The possessors and expressers of this vast information have the ability to channel certain thoughts, actions or reactions by the caregiver. This information comes in the form of beliefs and education imposed on the mother by other people. These people may include her family members, friends, fellow church members, and health practitioners. The mother faces a constant challenge of reviewing this information and deciding which parts of it to believe and accept. The information may be overwhelming especially when it comes at the time where she is most vulnerable trying to rescue a sick child. Sometimes the information sends through contrasting messages and the mother has to decide what to adopt. It is better for the mother to receive more information than she needs, rather than not receiving any information. These messages are delivered in the context of a supportive

atmosphere. This information influences the mother's decisions about child care, and it may also modify her behaviour.

*“(Kate) for traditional ones, her father once refused adamantly saying that he does not use traditional healers. The baby was suffering from ‘hlogo’, and these other women suggested that he takes her to a traditional healer for inhalation therapy. He said no ways, he would rather take her to church, and they would use coffee for inhalation, and they would even let her drink it.”*

*“(Maria) I just hear them talk in church. Church members who happen to know about the presenting condition like older women and other elders are able to teach. They would even show me how to identify the symptoms. Before I had my own child, I knew very little about how the children would present. My baby allowed me to actually witness these things.”*

*“(Susan) we were told at the hospital not give children traditional medicines. They showed us one child who vomited black stuff, and said it was due to traditional medicines. That's when I realized that traditional medicines are dangerous. I refused (to allow use of traditional medicines in my baby) because I saw the child.”*

*“(Susan) at the clinic they taught us about the dangers of traditional medicines, that they should not be combined with Western medicines because the contents of traditional medicines are not known. The Western ones have their contents written.”*

*“(Patience) we were going to town one day, and he started sneezing. I requested that they open the windows just so that we could arrive home, and this is why I do not take him with me to town anymore.”*

*“(Patience) I was not taught about it at school. I first heard from home when they explained that ‘styf’ is like this, and then we also heard in the street as people spoke about it. Only when your child gets it, and then you really get to know it.”*

#### 4.2.2.2.2 Experience

Repeatedly, mothers emphasize the importance of living experiences wherein their own children allowed them to learn more about the childhood illnesses. During this period when their children are sick, mothers are more receptive information from those who are more experienced than the mothers are. Mothers acknowledge their inexperience, and therefore allow more knowledgeable and experienced elders to guide them through the necessary processes. Mothers constantly consult with elders when their children are ill, in search of advice. At the end of therapeutic procedures, they come out with new knowledge and personal experiences, thereby empowering them with some expertise. Young mothers may also learn from experiences of those around them, whose children may succumb to illnesses. Mothers may be able to participate in the care of that child, and in the process learn from experiences of other mothers.

*“(Maria) The thing is as I already told you my baby is only five months old, and I stayed a long time without a child. I saw from my sister’s child, some of these things were done.*

*My baby only had 'thema' and 'Letshatshaso', and that is why I am able to describe them in some detail."*

*"(Julia) I also ask older people like the child's granny (mother-in-law), since they would know what the child's problem is. They are the one with knowledge, so I tell them first that the child is unwell. They would look at him and tell me what his illness is, and advise me as to whether to take him to church or the hospital."*

*"(Rose) it is because we are young and we know very little."*

#### 4.2.2.2.3 Status

In as much as women have the responsibility to make decisions pertaining to their children's health, this right is superseded by the authority commanded by the household members. The emphasis on collective decision-making, as opposed to individualistic, disempowers the mother to a great extent, and allows the support network to greatly regulate decisions made about the health of these children. The power to influence these decisions comes with the status attached to the roles played by the different cadres within the mother's support network. The elders in the family hold precious positions to influence the outcomes of child care discussions, by virtue of their knowledge and experience.

*"(Patience) The decision for him to be 'searched' comes from me as a mother. I discuss it with my family first, the people I live with."*

*"(Rose) we looked at him with the elders, and they said when you see him like this, it could be 'hlogo'."*

The household head, usually the father, is also allowed significant stake in decision-making. However, females are generally the ones with a major say on child health issues. The exception to this rule is observed in situation where the male household head is also experienced in health care, for example Susan's father is both the household head and a traditional healer, and Kate's husband is also a church pastor. *“(Susan) My father decided that the baby gets treated for ‘Lebala’, and he is able to treat. He is a traditional healer.”*

The healers are respected in the community for their role. They are classified according to their specialties, and rated by their competence and expertise. They gain further respect, status and authority by proving their competence. They may also lose their status by failing to show competence. *“(Patience) they specialize in different things, differ in their approaches and do not perform the same way. According to their approaches, isn't it you know that the one healer is like this or that?”*

*“(Patience) it is because he saved someone in my family, and that's why we chose him.”*

*“(Sara) the following day they looked for a traditional healer and this person failed to help the child. Then they went and looked for another one who was competent. The she was treated.”*

The conventional system is found to be superior with regards to scientific rigour. The conventional practitioners are valued for their ability to insert intravenous lines and introduce fluids like water and blood directly into persons' bodies. However, they are unable to address traditional illness. Their attitudes towards traditional illnesses make mothers not to disclose information, and some mothers like Julia feel so aggravated to the

point of desiring to challenge these authorities. *“(Sophy) I understand that the hospital medicines get checked isn’t it? They are checked as to whether they would cause illness or not, and whether they are suitable for a child or not. I do not think traditional medicines are checked.”*

*“(Rose) I will take him to the western side for examination, to see whether he has enough water or blood, you see!”*

*“(Julia) I would ask them if they are able to treat ‘Hlogwana’ because that’s what I think the child is suffering from. They must tell me whether they are able to treat it or not.”*

#### 4.2.2.3 Balancing Role

The mother finds herself in a state of constantly balancing the needs of the child, her own needs and those of the world surrounding them. She therefore adopts three roles in response to identity and authority, namely Advocacy, Defence and Compliance.

##### 4.2.2.3.1 Child Advocacy

The mother advocates for the well-being and the best interests of the child. The vulnerable nature of children and the motherly instincts compels the mother to ensure protection of the child. She will defy identity and authority to protect the child if deemed necessary. She would lie and hold back information if the child’s well-being is threatened by disclosure. She may also expose secrets if child’s life may be preserved by openness. Maria is aware of existing corruption within a system that she relies on for child health care, and she allows her intuition to warn her against any trouble. Susan brought in her

relative to help her deal with conventional practitioners who were denying her leave to go and treat the child traditionally. Mothers advocate for their children.

*“(Kate) He (Child’s father) knows when I do not want with the child. I just tell him that I am no longer giving the child tea, so he must not give her either.” “...even if the pastor has spoken. They do say at church that I must give her tea, but I do not.” “The baby is small and cannot speak for herself. If the therapy was intended for me, I would have to agree.”*

*“(Maria) Corruption is all over you know. I don’t even want to hide it. We have them. I just feel it in my spirit that this one is trying to mislead me.”*

*“(Julia) suppose the child had ‘hlogwana’ and I knew nothing about it. I will bring him to the hospital to die from worsening diarrhoea despite all the water they put inside him. How will they know what the problem is? Will they know? They will not know!”*

*“(Sophy) I understand that the meats of these animals are not edible, but they make the baby to inhale the smoke. She just suffocates from the smoke when their meats are not for eating.”*

*“(Susan) I requested a relative of mine who works at the hospital, and he suggested that I take the child for traditional therapy. He even requested the hospital people on my behalf to release me, since they were refusing to let me go.”*

#### 4.2.2.3.2 Culture Defence

There is a prevailing trend towards cultural confidentiality. Mothers are often not willing to disclose details of their cultural beliefs or practices to people who do not share their culture. These people may not be worthy of this information due to their negative attitudes, or the sacred nature of the cultural practices may have to be protected. It is also a learned practice from elders to maintain cultural protection. The cultural practices may become vulnerable to distortion if exposed to the outside world. The mother's beliefs may also be challenged by people who hold different perspectives, and therefore influence the mother's decisions negatively and in contrast with her cultural norms. The cultural preservation maintains balance within the mother, and the faith she holds in her tradition. Identity remains protected. Julia and Kate provide views that suggest that cultural practices will also be protected from being contaminated by combining them with other practices. However, the defence of culture and identity has to be balanced with advocacy for the child. The mother has to balance her identity protection with the best interest of the child. Therefore, a switch may be made from using cultural practices in favour of conventional therapies or otherwise, as may be deemed appropriate based on authority factors.

*“(Julia) it's not like they cannot be spoken about. I just cannot tell you about 'Ditaelo' when you do not go to my church. The thing is I just don't want to reveal them.”*

*“(Rose) you do not speak about it. They say 'we are giving you to drink, but you do not speak!' so even for the child, when you give him to drink, you do not say anything at the hospital.”*

*“(Julia) they have never asked me, but I would tell them I never treated the child with teas. I would tell them at home we do not go to church and do not touch traditional medicines. Otherwise they would want to know why I treated the child with teas before I came to the hospital.”*

*“(Kate) I was told at the church to give her tea and see what would happen. Since I had given up on the church tea, and because I do not want to mix them, I had to use only one of them. I had already tried the church teas, so I decided to stay with the western medicines. If I fail, I would change again.”*

#### 4.2.2.3.3 Compliance

The ultimate product of the mother’s balancing exercise is a decision about compliance. The mothers display a picture tainted with helplessness, confidence, faith, bravery and submission. The interaction between identity and authority factors may not always work in their favour, and they have to come to terms with the outcome for the sake of their baby. The power of authority may render them helpless and drive them into submission.

*“(Sophy) My mother is the one who decided that I must go to a healer, and she just told me whom to go to.”* *“(Susan) Initially I was refusing, but they complained that I was being disrespectful. I told them just because they said I was disrespectful, and then they could go ahead and make him drink the medicines.”*

However, their faith carries them through difficult moment like withstanding insertion of instruments into the baby’s rectum. *“(Sara) I knew that they stir the rectum, but I trusted that she would get better.”*

Their newly acquired knowledge and ability to fulfil instructions build their confidence in child care, and will allow them to also transmit the knowledge to younger generations.

“(Sara) I gave her two teaspoons three times a day to swallow. Before that I had to prepare the medicine myself. I had to boil water, and then allow cooling. I then added two teaspoons of the medicine and mixed thoroughly. I then poured some of this mixture into a little numbered bottle, from which I gave to the baby.”

They find themselves having to rise to the occasion for the sake of the child. “(Julia) Fear will not bring me any help when I am looking for the child to be healed. It’s just like here (in the hospital) when they insert a drip, they do it in front of my eyes. I want him to get better, and there is nothing I can do.

### **4.3 PATHWAYS OF CARE**

The pathways that mothers follow in response to a sick child can be complex and challenging to predict. However, three broad areas are discussed below to illustrate the components and determinants of these pathways, namely:

1. Sources of health care
2. Determinants of pathways
3. Health care utilization patterns

#### **4.3.1 Sources of Healthcare**

##### **4.3.1.1 Home Care**

The immediate source of health care for a child is found within the home. Members of both the nuclear and the extended family participate directly or indirectly in the provision of home care to the child. Therapies that are known to the mother, or within her support system are be used to relieve suffering in the sick child. Leftover medicines from previous ailments may also be used at this stage. Upon return from other service points, children are further cared for by the caregivers in their homes.

##### **4.3.1.2 Conventional Out-patients**

Children are also taken to a general practitioner or a primary health care clinic where they are seen as out-patients. They may be examined, tested and offered medicines immediately, and some to take at home. Instructions are given to the mother with regards to the care of the baby at home.

#### 4.3.1.3 Conventional In-patients

The hospital is also a popular source of health care for sicker children, where they are treated as in-patients. Children are admitted to the ward with or without their caregivers depending on the sickness or age. Medicines are given to the child in the ward until they are stable enough for discharge. Therapy may be continued at home.

#### 4.3.1.4 African traditional care

Traditional health care systems are used in cases where the medical problem is believed to require the attention of a traditional healer. The traditional healer would either confirm or dispute the suspicions of the family, and he may either treat the child or refer to another health service point.

#### 4.3.1.5 Faith-based Care

Faith-based health care services are also used by those mothers who have the church as a source of health care for children. The use of these services is directed by faith in the church and the church medicines. Faith-based interventions are not considered traditional, as opposed to African traditional practices, although the illnesses treated are described and referred to with the same names. Therapeutic procedures are also similar, but the ingredients differ.

## 4.3.2 **Determinants of Pathways**

### 4.3.2.1 State of health

At the time of declaring the child to be in need of therapy, it is important to identify whether the child is ill or not. A well child is generally managed in the home, where traditional or faith-based therapies may be instituted, but some of them may be treated by the traditional healer or church pastor. A sick child is categorized into stable or seriously ill. There is lack of urgency in treating a stable child, such that the child may first be observed and given home remedies prior to seeking help outside the home- be it traditional, faith-based or conventional. A seriously ill child is taken to a health service outside the home early in the illness. A well child may also be rushed to an outside source health care in cases where the perceived threat is considered ominous.

### 4.3.2.2 Sources of support

The decisions regarding the urgency in sourcing health care may well depend on the available support to the mother. The conduct of home therapies is also dependent on the type of support available. There is a standard pattern for mothers to acknowledge that they are younger, and therefore lack the necessary knowledge to make informed health decisions for their children. As a result, mothers consult with family members, particularly those considered to be elders in the family. This is also where the importance of shared beliefs and culture prove to influence the health decisions about the child. Problems arise in cases where the elder and the mother carry opposing views about what is best for the child. However, the authority commanded by senior members of the family

tends to play a major role in final decisions made regarding the health of the child. Sources of support may extend beyond the family and spill into friendships, neighbourhoods and church members. These sources of support may not always reinforce decisions in a positive manner, but they may also trigger a rebellious-type of reaction from the mother in attempt to protect the well-being of the child.

#### 4.3.2.3 Classification of illness

Mothers have to classify with the help of their sources of support the type of illness the child is suffering from. There are generally two broad categories, namely traditional (faith-based) and conventional. This classification determines the source of health care to be used by the mother. Depending on the set of symptoms, culture and the views of the support system, the child's condition is classified so that a decision about the source of health care can be made. Mothers find it unacceptable to take a traditional illness into a conventional facility or a conventional illness to a traditional system, because the best interest of the child will be violated. The child is unlikely to receive the care that is required.

#### 4.3.2.4 Symptomatic improvement

Every mother desires to see improvement in the condition of the child, and where this is not realized frustration emerges. When the mother loses patience, she is likely to switch from one service point to another. If a child is receiving care in a conventional system without any improvement, a conclusion may be reached asserting that the child's illness is inappropriate for the conventional system. Therefore, a decision is made to take the

child out of the conventional system into a traditional one. Once again, these decisions are made in consultation with the support system. Lack of symptomatic improvement is destructive to the mother's faith in that system, particularly in cases where a child is retained in the same system despite the lack of progress. However, alternative explanations and referral to other systems tend to preserve the mother's faith and hope, thereby ensuring continued healthy interactions with that system.

#### 4.3.2.5 Therapeutic outcomes

The mother's expectation is for the ailment to be healed. The mother's understanding of a favourable outcome may differ from that of a health care provider. Her own satisfaction or lack thereof determines whether further care will be obtained or not. For a mother who believes that symptomatic relief of the medical problem does not cure the problem, but only internalizes it, then may continue to seek help for the same medical problem elsewhere. This situation may be exacerbated in cases where the medical problem is recurrent in its nature, yet the mother wants the problem to completely disappear to alleviate the suffering experienced by the child. Poor communication between the health care provider and the mother tends to worsen the situation. The health care provider is not treating only the child, but the mother and her support system as well.

### 4.3.3 **Healthcare Utilization Patterns**

#### 4.3.3.1 Well Child

Typically, a well child may be subjected to a ritual to prevent future illnesses as a standard practice, or certain signs may be identified on the child's body despite lack of

symptoms, pointing towards a high risk to suffer ill-health in the future. The major determinant for action in these children is the fear of harmful consequences, usually death. The child is mainly treated at home, by an experienced elder, in-house healer or a visiting healer. However, the child may also be taken urgently to a healer for therapy, especially in cases where the potential harm is death. Therapy will be continued at home.

#### 4.3.3.2 Sick but Stable Child

For a sick but stable child, the approach is to first do nothing. The child is observed at home by the mother to watch for symptomatic progression. Where the mother is uncertain, she would consult with the family elders regarding the medical problem while in the process of waiting. She may also make use of available therapies in the home such as left-over medicines from previous ailments. She may also accept advice from her support system, and carry out their home care recommendations. In cases where there is no improvement, the child's problem would be classified as traditional or conventional. Conventional problems in this situation are taken to either a primary health care clinic or general practitioner as out-patients. Immediate therapy may be offered, but medicines to use at home are also given. Traditional illnesses are taken to either the church if the mother is religious, or to a traditional healer. Immediate therapy is usually given, as well as medicines to use at home. Follow-up may also be arranged. If there is no improvement, the mother usually returns to the health care provider, and the child is likely to be referred. If therapy is continued without progress, the mother is likely to switch services by herself and in consultation with her support system.

#### 4.3.3.3 Sick Child

Sick children are urgently taken to the family elder for consultation, and the classification of illness happens early in the illness. The decision to source help from an outside provider is also made early on. The conventional service point of choice is the hospital, wherein the child may be admitted. However, the child may also be rushed to a primary health care clinic or general practitioner, and the child may be referred immediately to the hospital. The traditional service point is dependent on the culture, and the traditional healers are used for African traditional illnesses, while church healers are used for church followers.

The conventional service does not refer to traditional services, but traditional service healers tend to refer children to the conventional care system. If the healers find that only traditional illnesses are present, the child would be given immediate therapies and some medicines are offered for use at home. However, if the healers find a combination of traditional and conventional therapies, they would treat the traditional ones and refer to the hospital for the conventional problem. Also, if the healer finds only conventional problem, they immediately refer the child to the hospital.

If the child does not improve while admitted to hospital, and the mother decides the child is suffering from traditional illness, she requests a pass out or a discharge from the hospital to take the child to a healer. This is because mothers believe conventional providers are not able to identify, diagnose or treat traditional illnesses. The mother may also decide to switch between two hospitals if she believes the quality of care is inadequate in the first hospital. If the child does not improve while under the care of a

healer, the mother returns to the same healer to report the lack of progress, and the healer is likely to refer the child to hospital. A good explanation to the satisfaction of the mother is usually offered. The children will complete the course of therapy in their homes.

Due to the interaction between multiple factors, it is difficult to predict the mother's behaviour, but behaviour can be explained using these patterns. (it may also be possible to use the knowledge of these patterns to negotiate with the mother.)

#### **4.4 LEGENDS OF CHILDHOOD CONDITIONS AS PRESENTED BY MOTHERS**

The table below outlines the different childhood conditions identified and presented by mothers during the study. Original names have been preserved, but also translated and defined where applicable. Some clinical features and therapeutic options are also presented under certain conditions.

<p><b>4.4.1 Diso</b>  (‘sores’)  <i>Traditional and Conventional</i></p>	<p>The word means ‘sores’ to describe the presence of an internal disease usually an acute infection. However, a chronic internal disease maybe be referred to as ‘sores’. A chronically chesty child may be diagnosed with ‘sores’. There is a relationship between internal and external ‘sores’, and the skin manifestation of rash is understood to be a positive sign that indicates healing of internal ‘sores’, but it may also be described as an indication that internal ‘sores’ exist. Therapy involves both topical when the rash is present, and oral ingestion to cure the internal ‘sores’</p>
<p><b>4.4.2 Hlogwana</b>  <b>Hlogo</b>  (dihlogo/  dihlogwana in plural)</p>	<p>‘Hlogo’ literally means head. It is used to refer to an illness that affects the baby’s head when they are still small. If it is not treated the baby may die. The baby passes green stools, cries excessively, and develops pulling of the neck towards the back. The baby may also have pulsations on the fontanelle, and present with weakness. Therapy involves application of medicines topically over the fontanelle area. Also, inhalation therapy is offered to the child. Some medicines are also given for the child to take at home.</p>

<i>Traditional</i>	
<b>4.4.3 Kokwana</b>  <i>Traditional</i>	<p>The baby is ill presenting with green stools and weakness. Untreated, the child may die. The diagnosis is made through symptoms and signs, prophecy, and examination using traditional healer’s bones.</p> <p>Therapeutic procedure warrants that the baby receives an enema, and described by the mothers as a procedure to stir the rectum of the baby using either African traditional medicines or church tea or coffee. The procedure is safe, and does not result in trauma for the child. The baby will also receive some medicines to take at home.</p>
<b>4.4.4 Lebala</b>  <b>Thema</b>  <i>Traditional</i>	<p>The word means colour, and it’s used to refer to a condition that is found in both well and sick children. The presence of a reddish discolouration at the back of the baby’s neck around the hairline area is a pre-requisite. The baby may or may not have symptoms. The objective of therapy is to bleed the baby from the same area. Therefore, the healer uses a razor blade to make multiple small cuts over the reddish area for blood to come out. Traditional medicines are then applied to the small wounds. Church healers use a church needle to prick the baby over the reddish area, and rub the area with church coffee. Medicines for the baby to take at home are also offered.</p>
<b>4.4.5</b>  <b>Letshatshaso</b>  <i>Traditional</i>	<p>It is described as a small sore found in the baby’s mouth. The baby presents with continuous crying. It is identified and diagnosed by the church. Therapy involves the use of a sharp-pointed object such as a</p>

<p><i>(Faith-based-specific)</i></p>	<p>needle to prick and open the sore, and squeeze out the contents. The healer rubs some sugar on the small puncture wound, and the baby is healed. If untreated, a worm develops in the sore. It starts off being watery, and then grows into a worm. The worm will bring madness for the child.</p>
<p><b>4.4.6 Sejeso</b>  (fed poison)  <i>Traditional</i></p>	<p>Means to be ‘fed with poison’ or any substance that may be harmful enough to make one ill or threaten one’s life. This condition is not common in children, but mothers mentioned it.</p>
<p><b>4.4.7 Tupa</b>  <b>Styf</b>  (ditupa is plural)  <i>Traditional</i></p>	<p>This is a feared deadly condition. The children acquire this condition by inhaling bad spirits or effects of traditional medicines used by other people. The users of these medicines do not use them with the intention to harm children, but the harm results as adverse effect. The child becomes weak and may roll the eyes.</p> <p>Therapy is in two parts: Firstly, preventive therapy is offered to small babies to prevent acquisition of this illness when they come across it. Rituals are performed by both the church and traditional healers to protect children. Secondly, a child who is already sick is treated by the healers using traditional medicines. For the church followers, church healers use their therapies to treat the condition. The treatment of this condition is very urgent. When the mother suspects ‘Tupa’, she visits a healer immediately.</p>

<p><b>4.4.8 Letlamo</b></p> <p>(‘String’)</p> <p><i>Traditional</i></p> <p>(Faith-based-specific)</p>	<p>This is a string used by the church to help protect the child from evil powers. A baby is taken to church at 4 months of age for an official welcoming coupled with a ritual to prevent evil powers from affecting the child. Part of the ritual is to tie a string around the child’s waist.</p> <p><i>“We give him a thin (weak) Joko tea and water that has been prayed for. Then they tie ‘Letlamo’ around his waist. These are the things we do for the baby in church.”</i></p>
<p><b>4.4.9 Go-reka</b></p> <p>(Teething)</p> <p><i>Conventional</i></p>	<p>This word literally means to buy, and it is used to describe a baby’s teething stage (to buy teeth). Although teething is a natural process, it is associated with a period of diarrhoea in a child. The diarrhoea resulting from teething is treated with ‘Motswako’ (oral re-hydration solution) prepared at home or collected from the primary health care clinic.</p>
<p><b>4.4.10 Go-tshubelwa</b></p> <p>(‘burn for’)</p> <p><i>Traditional</i></p>	<p>The word means ‘to burn for’. It refers to the traditional ritual performed to protect the baby from supernatural or evil forces that may be encountered after birth. The ritual is performed upon arrival from the hospital immediately after birth, or else the baby may die young.</p> <p>This ritual is performed for preventive purposes, and therefore generally on a healthy and well baby without any physical illness.</p>
<p><b>4.4. 11 Go-ntsha ngwana</b></p> <p>(‘To take the</p>	<p>Maria explains the process as follows: After a baby is born and upon arrival at home from the hospital, he is kept in door for seven days. On the 8<sup>th</sup> day, the pastor and his wife will arrive to perform a ritual that introduces the baby to the out door world. They bring along ‘taelo’</p>

<p>baby outside the house’)</p> <p><i>Traditional</i></p> <p><i>(Faith-based-specific)</i></p>	<p>(ordered therapy by the church), which is described as blessed water.</p> <p>The baby is washed using ‘taelo’, placed on the door entrance for a moment, and then taken back into the house. The baby is then allowed to get out of the house because the process of ‘<i>taking the baby outside</i>’ would have been completed. After 4 months, the baby is taken to church for the first time for a special welcome, whereby rituals to protect the baby from evil spirits are performed.</p>
<p><b>4.4.12</b></p> <p><b>Vicks/Vaseline</b></p> <p><i>Traditional</i></p> <p><i>(Faith-based-specific)</i></p>	<p>These products are found and sold in the ordinary stores, and used by anyone. Petroleum jelly and VapoRub (mentholated topical cream) can be used by the church to protect children from evil forces. However, for the church member to use these products, they must be prayed for so they can be trusted for the adopted role they will be used for. Kate did not hesitate to reveal how much faith she has in the power of the mixture to repel all evil.</p>
<p><b>4.4.13 Ditaelo</b></p> <p>(Taelo is singular)</p> <p><i>Traditional</i></p> <p><i>(Faith-based-specific)</i></p>	<p>‘Ditaelo’ is a word used by the church to refer to church orders made to members with regard to service or therapy. The term is also used generically to refer to the actual remedies prepared and offered by the church to their members, and also therapeutic procedures that may be conducted. Maria respects the church orders, but believes caution must be exercised when they are used for children. “<i>Some of these ‘ditaelo’ are not suitable for a baby, whereas I am not prevented from using them. It’s not that there is anything wrong with them per se, but for a little baby they become unsuitable.</i>”</p>

<p><b>4.4.14 Joko Tea</b> <i>Traditional (Faith-based)</i></p>	<p>Church tea is very popular with the members, and it's used for regular intake, but it is also used therapeutically. Coffee ingestion is not encouraged in children, but it may be used topically. The requirement is for the tea to be made weak for suitable use in children. The tea is prepared only by men, but administered mainly by women. The power to function as remedy lies in the fact that it is prepared for that purpose and blessed by the church. Testimonies of its value have also been witnessed by these mothers. <i>"He got better after treatment." "We take 'taelo' using Joko tea and Coffee, but we do not use coffee for children because it is too strong. Coffee is not good because it 'spoils human blood', and even in adults we use it for specific reasons."</i></p>
<p><b>4.4.15 Motswako</b> (Oral re-hydration therapy) <i>Conventional</i></p>	<p>This is a popular form of intervention used for vomiting and diarrhoeal illnesses. The mothers have been taught at the clinics how to prepare the oral re-hydration solution by themselves while at home whenever the child develops diarrhoea.</p> <p>They may also collect sachets from the primary health care clinic to mix with water and administer to the child. The mothers expect the diarrhoea to stop with the use of this solution.</p>
<p><b>4.4.16 Short of Water</b> (Dehydration)</p>	<p>When the child has been vomiting or having diarrhoea for a while, these are said to run short of water. These children are taken to the hospital for care, with an expectation of intravenous line insertion ('drip'). It is believed by mothers that traditional healers are not able to</p>

<p><i>Conventional</i></p>	<p>help such children. Sara took her child to hospital for dehydration.</p> <p><i>“She had finished taking traditional medicines when she started vomiting, and they (the traditional healer) said the baby did not have enough water. They said we must come to the hospital, because her skin was dry and shrunken.”</i></p>
<p><b>4.4.17 Short of Blood</b>  (Anemia)  <i>Conventional</i></p>	<p>It is also believed by mothers that people who are short of blood cannot be assisted by traditional healers, presumably because such people may require blood transfusions. Below is Rose’s opinion. <i>“He (traditional healer) can cure problems like ‘dihlogwana’, but will not be able to see whether the child he is treating is having enough water (dehydration) or blood (Anemia). He will not know there.”</i></p>

## **CHAPTER 5: DISCUSSION**

Toxicity of traditional medicines in children has proven to be a challenge to manage (Wittenburg, 2002, Wyk and Els, 2008). Therapies to reverse or treat traditional medicine intoxication are not immediately available, and in most cases the offending substance is unknown. Under these circumstances, it stands to reason to strengthen preventive measures of toxicity. Ideally, preventing exposure to traditional medicines would ensure safety of children. The purpose of this study was to investigate reasons given by caregivers for administering traditional medicines. All the nine caregivers interviewed are biological mothers to their children. The children are all but one under the age of 12 months.

### **5.1 Seeking Health Care for the Child**

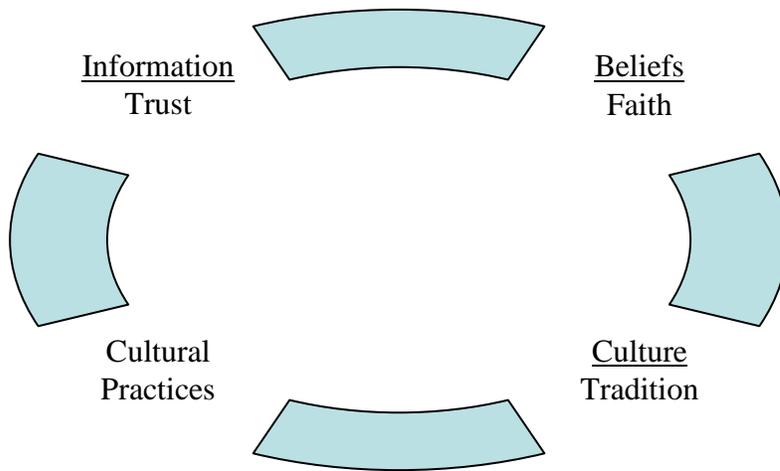
The reasons for mothers to administer traditional medicine in the study are based on their perceptions of the health care system, and determined by their health care seeking behaviours. Kleinman identified three overlapping sectors of health care: popular sector (family, friends and neighbours), folk sector (non-conventional community-based healing), and professional sector (Kleinman, 1980). The three sectors and their interactions with each other are collectively explained by a concept referred to as Medical Pluralism, formally defined as the co-existence and availability of different ways of perceiving, explaining and treating illness (Cant and Sharma, 1999). The utilization of health systems by the mothers in the study show typical patterns of medical pluralism. The traditional health care system is therefore classified as the folk sector.

While the conventional practitioners understand the first point of contact with health care to be the primary health care level, for mothers the first level of care is housed within the popular sector. The decision to consult either the folk or professional sector is dependent on how the child's illness is classified by the popular sector. Depending on cultural beliefs, illness behaviour, and illness progression, mothers may switch between the use of folk and professional sector. If a child does not improve while receiving care in one sector, the child may be taken to the alternative sector.

Identity and authority factors were found to influence the health care seeking decisions made by mothers in this study. The mother's role is to balance the scale between the two factors, bearing in mind the need to advocate for the child. Once a certain level of balance is achieved, the decision will be made whether to comply or not. Cultural tradition determines the mother's identity, and health care seeking behaviour for childhood illnesses has been associated with cultural practices in other studies (McNee et al., 1995, Agyepong and Manderson, 1994).

Experiences of the mothers in this study indicate that the passing down of traditional knowledge from one generation to the next occurs in the context of close family ties. Information is passed to the women by their own mothers or grandmothers, people that they trust. For this reason, women tend to believe the information they are given and follow the practices without questioning their validity. They then develop faith in these practices, and themselves pass the information down to their own children. It appears almost impossible for an outsider to attempt breaking the circle in one doctor-patient encounter. Authority factors include information received by the mother from the support

networks, folk sector and the conventional professionals. Where authority factors agree with identity, the decisions are generally easy for the mother. However, where the identity factors contrast with authority, or authority factors contrast with each other, the mother is often caught in the middle. Decisions about health care become challenging for her, and she solicits the help of people she trusts to partake in decision-making. Other studies have shown the involvement of others in decision-making to seek health care for the child (McNee et al., 1995).



Mothers advocate for their children because ‘he is small and cannot speak for himself’. These mothers bear no malicious intentions when they make decisions to use traditional medicines. Where traditional therapies are not helpful, mothers stop using them, and seek help elsewhere. Likewise, when conventional therapies are not helping the child, they stop using them. Mothers do not combine the use of traditional medicines with conventional ones, in order to avoid interactions and adverse effects. This finding is in contrast with previous conclusions that patients mix conventional and traditional medicines, with the potential to hamper assessment and intervention when complications

occur (Kooi and Theobald, 2006). Mothers believe that conventional practitioners have no knowledge of traditional therapies, and traditional healers cannot help them with conventional approaches such as intravenous fluids and blood transfusions. Therefore, mothers see the benefits of both these systems, and they rationalize the patterns of using them based on their understanding of childhood illnesses.

## **5.2 Multiple Health Care Systems**

The introduction of the Western-oriented medicine and systems during the colonial era did not eliminate the well-established systems of traditional medicine, and many Africans learnt how to use both depending on the availability of medicine or the nature of the illness (Freeman and Motsei, 1992).

Contrary to the general understanding of the conventional health system being the official, formal, dominant, or superior form of health care (Whittaker, 2006), mothers find the traditional health system to be just as important to them. The current view of a formal conventional health system as superior (Summerton, 2006), and traditional health system as complementary &/or alternative held by the medical fraternity is not shared by these mothers. In the social world of these mothers two important health systems exist, the relative importance of which is dependent on the medical problem at hand.

The two health systems work parallel to each other but not in competition. The conventional health system has its own illness jurisdiction that is not catered for by the traditional health system. Conditions classified by mothers as traditional cannot be treated by the conventional practitioners, and as a result consultations with traditional healers

occur. This lay classification of childhood illnesses has been described in African and non-African studies (McNee et al., 1995, Hill et al., 2003). A study conducted in Ghana found that many of the care-seeking barriers identified revolved around the local classification system of childhood illnesses (Hill et al., 2003).

### 5.2.1 Traditional Health Care System

Mothers' utilization of traditional health care is triggered by preventive and curative needs of the children, in cases where the health and illness behaviours respectively are explained by traditional factors.

Two prominent sectors within the traditional health care systems are identified in this study. Traditional-type illnesses are treated by either the African traditional healers or Faith-based healers depending on whether the mother follows the African or Religious tradition respectively. However, mothers did not consider the faith-based therapies to be a form of traditional medicine, although these therapies are used to treat the same conditions treated by African traditional healers.

In this study, no participants were found to combine African with Religious traditions. For the purposes of this discussion, both the African and Religious traditions will be considered under the traditional health care system, because they are both rooted in the sources of faith and cultures of these mothers.

Traditional illness implies a social, spiritual and physical imbalance that requires a traditional remedy, and traditional medicine is perceived as protective against harm from evil spirits as described in other studies (Kooi and Theobald, 2006). Mothers believe that

‘traditional medicines are supposed to cure the child’s illness, and therefore cannot cause any harm’. The practice of traditional health care is influenced by the mother’s self-identity and pervasive traditional cultural beliefs. Their health-seeking behaviour hinges upon these traditional beliefs, as was found in Zimbabwe (Rukobo, 1992). The recurring theme of faith in the traditional health care system expressed by these mothers is an indication that their firm reliance on traditional medicines does not require any proof on efficacy. Furthermore, success stories experienced by these mothers and their trusted allies reinforce the effectiveness of traditional medicines, thereby serving as adequate proof.

The healers are based in the same communities as the mothers, thereby sharing the same socio-cultural values and lifestyles. For the mothers, the ability to positively identify socially with the healers allows for acceptance and common understanding. These healers have a shared worldview and traditional theories of disease causation as their patients.

The holistic approach used in the traditional health care system to deal with both medical and psychosocial aspects of disease has shown to be appealing to 60-80% of South Africans (Pretorius, 1999). The medication given by a traditional healer may not alleviate the symptoms of illness, but the re-assurance and the psychological effect on the patient might play a vital role in restoring the patient’s overall wellness (Abdool Karim, 1994).

The proximity and familiarity between the healers and the mothers allow easier access and utilization of their services. Furthermore, these healers command authority in their respective communities, and they are trusted by the mothers. Other reports confirm that the historic accessibility of these community-based healers explains the high utilization rates (WHO, 2002). The holistic and socialized traditional health care system functions

differently from the highly institutionalized and biomedical conventional health care system.

In this study, the traditional healers consult, counsel, and sometimes treat the family as a whole. Childhood illnesses are not only explained exclusively by a medical diagnosis, but the root cause is also sort and removed e.g. a curse. Traditional healers try to explain who or what caused the disease and why the person is affected at that particular time (Abdool Karim, 1994). These healers are also prudent in recognizing and referring conditions that are not of traditional origin. A qualitative study conducted on the role of traditional healers and nurses showed that traditional healers were willing to learn and refer patients to clinics and hospitals, while this was not true for the nurses (Mngqundaniso and Peltzer, 2008). Testimony to traditional healers' interests in the best outcome for the children is seen by the mothers by healers' reluctance to pursue the use of traditional medicines where it is deemed unnecessary.

#### 5.2.2 Conventional Health Care System

The conventional practitioners do not support the use of traditional medicine on the question of scientific rigour. Clinical trials have not been conducted to prove the efficacy of traditional medicines (WHO, 2002), and even though the mothers expressed knowledge of this fact, they still overwhelmingly continue to use traditional health care systems. To these mothers, the practice of traditional medicine does not require a scientific basis.

The elevation, power and social control of medicine in the 20<sup>th</sup> century led to the current problems of competence gap between the practitioners and the patients within the conventional health care system (Hillier, 1986).

Mothers encounter difficulties negotiating child care with the conventional practitioners, to the point of taking leave from the hospital despite disapproval by the hospital authorities. Communication between the conventional practitioners and the patients is impaired to the extent that mothers do not disclose important information about the use of traditional therapies. This phenomenon has been labelled cultural secrecy (Popat et al., 2001), but the findings of this study suggest that mothers perceive lack of cultural understanding and traditional illness knowledge by conventional practitioners.

These mothers protect their African identity, culture and tradition of using traditional health care system from those who are likely to question, challenge and reduce it while they have poor insight into the practice. Therefore, this phenomenon is described better by cultural defence rather than secrecy.

Furthermore, if conventional practitioners did not display such negative attitudes towards traditional illnesses and therapies, as suggested by these mothers and described elsewhere (Summerton, 2006), such lack of disclosure would be at its minimum today. These attitudes exacerbate the already-wide competence gap between the mothers and the conventional practitioners, in favour of the traditional health care system. The competence gap is founded on the scientific and technical basis of the largely biomedical western-type system, making the medical language and explanations difficult for the

mothers to understand. By so doing, the window of opportunity available for conventional practitioners to influence traditional medicine practice is diminished.

The statement made by Kooi and Theobald that the ‘simply forbid’ the use of traditional medicine approach is unlikely to work remains appropriate to the views expressed by these mothers (Kooi and Theobald, 2006). The argument of lack or limited scientific rigour in the practice of medicine will not prevent exposure to traditional medicines, and the conventional practitioners’ negative attitudes towards traditional medicine practice can only exacerbate the situation.

### **5.3 Decision-making in the Home**

Decisions on the health care of the children are not made by mothers in isolation. The consultation process involved in the care of children provides the mothers’ support systems with adequate authority to influence their patterns of health-seeking behaviour. Kleinman considers this level of care the popular sector (Kleinman, 1980). By virtue of experience and status, these authorities have a stronger voice over that of the mother.

In one South African study, it was shown all participants agreed that their grandmothers or mothers make decisions about traditional medicine use (Kooi and Theobald, 2006).

The consultative household decision-making approach has been described as a collectivist approach, as opposed to individualistic approach (Gilbert et al., 2002).

Similar results were found in a Boholan study in the Philippines, where mothers indicated that some other family member or neighbour was involved in their decision to seek assistance outside the home (McNee et al., 1995). The concept of household decision-

making in childhood illnesses has been studied elsewhere, and the process that unfolds afterwards was found to depend mainly on the perception of illness (Pokhrel and Sauerborn, 2004), and to lead to delay in healthcare seeking (Agyepong and Manderson, 1994, McNee et al., 1995).

A conceptual construct on household decision-making by Pokhrel and Sauerborn suggests that perception of illness is followed in a stepwise manner by decisions about seeking care, choosing a provider and health expenditure (Pokhrel and Sauerborn, 2004). In this study, the first three steps were found to apply to the decision-making process, but health expenditure or cost was not found to be a factor.

#### **5.4 Policy Implications**

A Plan of Action on the Decade of Traditional Medicine 2001-2010, has been passed at the Lusaka Summit, and member states are required to institutionalize African Traditional Medicine in the public health systems by 2010 (DOH, 2008). The department of health has already published enacted the Traditional Healers' Act, and recently passed the draft national policy on African Traditional Medicine (DOH, 2008).

South Africa's plan to institutionalize, but not integrate the traditional health system into the conventional system resonate with the findings of this study. Mothers believe that traditional medicine cannot be practised in the context of a conventional health care system, and this is because traditional medicines used by children can 'supernaturally weaken' others. The current tension between the two health systems will have to be resolved for them to work side-by-side. The conventional practitioners' lack of trust in

the practice of traditional medicine can only aggravate the situation. There is a need for the country to ameliorate the tensions that currently exist by fostering a collaborative approach between the two health care systems. For this to happen, the training curriculum of conventional practitioners needs to include introduction to traditional medicine practice, and meetings between the practitioners of the two systems have to be held in order to generate common understanding and combined efforts.

However, the department of health faces a challenge in the actual process of institutionalizing the traditional health system. This study suggests that the current structure of community and home-based practice of traditional medicine offers the system strength, and therefore, it will be an error to house traditional practitioners in hospital-like setups. The mothers prefer to choose their healers, and therefore, licensing of a limited number of practitioners will lead to illegal practices. Further research into the different approaches to implementing the institutionalization of traditional medicine is required. The healers' instructions to mothers regarding therapy are guided by ancestral messages, and therefore, regulating dosages will remain a challenge. The regulation of treatment dosages may be the single most important step to reduce traditional medicine toxicity. Furthermore, the ingredients and names of traditional medicines may also depend on ancestral messages and cultural origins. In light of the multiple African cultures and sub-cultures practiced in South Africa, the mission to regulate traditional medicine will be a mammoth task for many years to come. Caution has to be practised by the department of health in addressing this matter, or else the already concerning traditional practice may be turned into a dangerous illegal market.

There is a further need for the department to promote recognition of danger signs in sick children by mothers, family elders and traditional practitioners alike, so as to prevent delayed presentation to hospital. Other studies have already shown that this delay may increase childhood morbidity and mortality (Hill et al. 2003, Agyepong and Manderson 1994). Addition of traditional medicines may not help the situation when the child is severely sick, and fortunately, healers have shown willingness and initiative to refer children to hospitals.

### **5.5 Conclusion**

The constraints of the biomedical model and its reductionist approach limit the scope of conventional health care in practices influenced largely by pervasive socio-cultural factors evident in traditional medicine exposure to children. Mothers are likely to continue exposing children to traditional medicines, and using the relatively more comprehensive approach of the traditional health care system. To minimise morbidity and mortality in children caused by traditional medicine toxicity, the health care system requires emphasis on prevention and health promotion. The holistic theories and approaches of health promotion may reduce the extent of the problem. The discipline of family medicine is well-placed to deal with such problems because of its principles, and holistic patient-centred approaches (McWhinney, 1997). The psycho-socio-environmental model is gaining popularity, complementary to the biomedical one, so as to improve health outcomes (Gilbert et al., 2002). Further research is necessary to quantify the distribution of traditional medicine toxicity and utilization, and to explore the safety and practice of traditional medicines by different sub-cultures in South Africa.

Also, there is a research need to measure the degree of interaction between the traditional and conventional health care systems. Effective interventions will require cooperation between conventional and traditional health care systems.

## **CHAPTER 6: RECOMMENDATIONS**

1. Provide holistic care for children and their mothers to meet non-medical needs.  
Identify and deal with concerns mothers have at consultation, otherwise alternate use of traditional medicines is encouraged.
2. Identify and meet with the elders supporting the mother with child care to make a positive impact.
3. Embrace traditional medicine practice to influence use of traditional medicines in children.
4. Medical practitioners need to be aware that most often than not traditional medicine use will not be disclosed to them, and a non-judgemental attitude is necessary to elicit this information.
5. Understand that users of traditional medicine do not question its scientific rigour, and hold faith in it.
6. Medical practitioners must recognize that traditional medicines include both animal and plant substances.
7. Recognize that church therapies including herbal teas and coffee use in children are not considered traditional medicines by their users.
8. Traditional medicine practice and interactions with conventional practice must be incorporated into the training of medical students and family physicians.
9. Medical practitioners have to recognize traditional healers as important, respected and valuable resource for mothers with respect to health care.

10. Medical practitioners must recognize that the practice of traditional medicine by mothers is not a mere uninformed belief, but finds its roots within the realm of a strong cultural identity, and the influence of powerful authorities around them.
11. Mothers advocate for their children, and their use of traditional medicines does not represent careless decisions on their part.
12. Recognize children with lack of clinical improvement, address mothers' concerns, and refer early to a higher level. Otherwise, a child will be taken to a healer for therapy.
13. Households and community-based healers need to be trained in recognition of danger signs in a sick child, to promote early access to care.
14. Not to integrate traditional health care into the conventional institution, and preserve the home-based and community-based practice approach of traditional medicine.
15. Avoid the temptation to suggest that conventional health care system is superior, and refrain from belittling the traditional health care practice, particularly in the presence of those who have faith in it.

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***REASONS GIVEN BY CAREGIVERS FOR ADMINISTERING AFRICAN  
HERBAL MEDICINES TO CHILDREN AT ST RITA'S HOSPITAL IN  
SEKHUKHUNE DISTRICT OF LIMPOPO PROVINCE, SOUTH AFRICA.***

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**UNIVERSITY OF LIMPOPO (Medunsa Campus) CONSENT FORM**

**Statement concerning participation in a Research Project.**

Name of Study

REASONS GIVEN BY CAREGIVERS FOR ADMINISTERING AFRICAN HERBAL MEDICINES TO CHILDREN AT ST RITAS HOSPITAL IN SEKHUKHUNE DISTRICT OF LIMPOPO PROVINCE, SOUTH AFRICA. ....

I have heard the information on the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I understand that participation in this Study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for the child's condition; neither will it influence the care that received from the regular doctor.

I have also been informed that the interviews will be audio-recorded; I agree to have the interview audio-taped. I have been assured confidentiality and anonymity.

I know that this Study has been approved by the Research, Ethics and Publications Committee of Faculty of Medicine, University of Limpopo (Medunsa Campus). I am fully aware that the results of this Study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this Study.

.....  
Name of caregiver

.....  
Signature/thumbprint of caregiver

.....  
Place.

.....  
Date

.....  
Witness

**Statement by the Researcher**

I provided verbal information regarding this Study.  
I agree to answer any future questions concerning the Study as best as I am able.

I will adhere to the approved protocol.

**APPENDIX 2**

**Tokologo go tšea karolo nyakollo-tsebong**

**Boikano ka mohlokamedi wa ngwana**

Leina la nyakollo-tsebo

**Mabaka ao a fago ke bahlokamedi go neela bana dihlare tša Sesotho mo bookelong bja St Rita’s ga-Sekhukhune, Limpopo, Afrika Borwa.....**

Ke kwele ditaba mabapi le mabaka le maikemišetšo a nyakollo-tsebo ye, gape ke filwe sebaka sa go botšiša dipotšišo le nako e lekanego go ka naganišiša taba ye. Mabaka le maikemišetšo a nyakollo-tsebo a kwagala mo go nna. Gago tsela yeo ke gapeletšwago go ka tšea karolo.

Ke kwešiša gore go tšea karolo mo nyakollong ye ke kgetho yaka, le gore nka ntšha hlogo nako efe kapa efe ntle lego fa mabaka. E ka se ame kalafo ya bolwetši bja ngwana, gape le hlokomelo yeo e hwetšwago ngakeng ya ka mehla.

Ke hlaloseditšwe gore dipoledišano di tla gatišwa go se gatiša-mantšo; ke dumelelana le go gatišwa ga mantšo. Ke tshephišitšwe gore ditaba tše e tla sephiri, le go fihlwa ga leina laka.

Ke ya tseba gore nyakollo-tsebo ye filwe tumelelo ke ba Research, Ethics and Publications Committee (komiti ya tsa resetšhe) go ba lefapha la tša maphelo, unibesithing ya Limpopo (medunsa). Ke tseba ka botlalo gore dipoelo tša nyakollo-tsebo ye di tla šomišwa mabakeng a saense, le go ka ngwalwa matlakaleng a tša maphelo. Ke dumela ka tshephišo ya gore ke tla bolokega.

Ke lokologa go tšea karolo no nyakollo-tsebong.

.....

Leina la mohlokamedi

Tshaeno ya/monwana wa mohlokamedi

.....

Naga

.....

Letšatši

.....

Hlatse

**Boikano ka monyakolla-tsebo**

Ke hlalošitše ditaba ka molomo mabapi le nyakollo-tsebo

Ke dumela go araba dipotšišo mabapi le nyakollo-tsebo ka mo nka kgonago ka gona

Ke dumela gape go latela lenaneo la nyakollo-tsebo

Po box 222

Medunsa

0204

.....

Leina la monyakolla-tsebo

.....

Tshaeno

.....

Letšatši

Naga

**APPENDIX 3**  
**Demographic Data**

Informant number:.....

Identity number:.....

Age:.....

Marital status: S.....M.....D.....W.....Cohabitation.....

Gender:.....

Highest qualification:.....

Religion:.....

Occupation:.....

Place of residence:.....

Household members:.....

.....

.....

.....

.....

.....

Sources of health care:.....

.....

.....

.....



## Department of Sport, Arts and Culture- Limpopo - (Greater Sekhukhune)

### Alignment of Service Boundary Survey Results 2006

- Legend**
- ▲ Assets
  - ▲ Courts
  - ▲ Police Stations
  - ▲ Schools
  - ▲ Health Facilities
  - ▲ Main Place
  - Provinces
  - Current Magisterial Districts
  - Local / Metro Municipalities
  - Traditional Authorities
  - District Management Areas
  - Current SAPS Station Boundaries
  - Parent Farms
  - Rivers
  - Railways
  - National Roads
  - Main Roads

Data supplied by:  
 Statistics South Africa  
 Department: Water Affairs & Forestry  
 Department: Provincial & Local Government  
 Department: Health  
 Department: Safety & Security  
 Department: Education  
 Department: Transport



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