Research Board Report Series

Facilitating Collaboration Between Traditional Healers and the Western Trained Health Care Workers in the Management of Illnesses in Swaziland

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ABSTRACT

The study was a qualitative participatory action research which utilized the principles of an Action Sciences Enquiry. There were two phases of this study. Phase one was analysis of the problem of collaboration and phase two was the implementation of the strategy one and two. Phase one will be presented in this paper. The methodology utilized was adapted from Stringers (1996) principles of an action research format. Data was collected through individual interviews, meetings, observations and clinical measurements. Audio-taped and field notes were transcribed, carefully studied and analyzed. The results of phase one was a descriptive profile of traditional healers, illnesses handled by traditional healers and the way traditional healers and western trained health care workers approach the management of hypertension and diabetes. Barriers and enhancers of collaboration between the two systems were identified. Strategies for facilitating collaboration were jointly established by participants. The consequences of a successful collaborative process were identified and a traditional collaborative model was compared with an existing western collaborative model.

INTRODUCTION

In 1978 the World Health Organization adopted a resolution to launch a worldwide promotion of traditional medicine. The plan formulated at that time attempted to deal with the problem of collaboration between different therapeutic systems (Hogle and Prins, 1991).

According to Namec (1980) two thirds of the people in the world at that time depended on the healing methods of their ancestors and in some areas these were the only methods they were comfortable with. In South Africa, Simon (1997) reported that more than 80% of the population consult traditional healers before, after or in place of a clinic or western medical practitioner. In Swaziland more than 85% consulted traditional healers in the 1980’s and the ratio of traditional healer to the population served was 1:1000 (Green and Makhubu, 1983). These statistical figures show that traditional healers and traditional medicine form a very important system of the peoples traditional health care service. In most cases this system of health care delivery form part of the values of the African people and is embedded in their cultural practices.

Unfortunately, most authors recognized that the policies on traditional healers and traditional medicines were still ambiguous if not absent (Green and Makhubu, 1983). According to Kalanzi (1990) traditional medicine is an aspect of health in developing countries that has not been readily acknowledged, whereas this system has a lot of advantages in the developing countries. This has led to the lack of collaboration between the western trained health care workers and the traditional healers. Such collaboration need to be facilitated if health care delivery is aimed at serving the clients at an acceptable and effective level.

The focus concerning the facilitation of collaboration between these two systems of health care delivery was on chronic illnesses, mainly diabetes and hypertension. These illnesses are an international health care problem. In the United Kingdom two thirds of all people over 45 years of age have a chronic health problem. Gort (1987) stated that traditional healers in Swaziland treated more chronic illnesses than they did acute illnesses. Traditional healers approach to illnesses is more holistic, that is they care for the physical, mental, social and spiritual aspects of the individual.

In 1987, a total of 2727 deaths were recorded from hypertension in the United Kingdom (Manship, 1994). In South Africa it was estimated that in the year 2000, 2 million people will be affected by diabetes and that 50% of the patients will also develop or have hypertension (van Dellen, 1993). Hypertension and diabetes were chosen as a focus of this study since these illnesses are well understood and have a clear process of how they are managed in the western health care system. This made it easier in this research to compare the western and traditional approaches to these illnesses.

Ideally, these two system should collaborate and learn from each other in order for the clients to benefit. This calls for a meaningful collaboration between the two systems as seen by Jingfeng (1988). Shai-Mohoko (1996) states that the situation demands that health care workers cooperate with indigenous healers in providing health care services. Collaboration among health care workers improves patient outcome, reduces patient cost and results in improved quality care of the patient. Kyle (1995) mentions that given the explosion of knowledge and expansion of health care technologies, it is more difficult for one person to be an expert in all areas. Collaboration has the potential to involve the client, energize the profession, expand professional practice and integrate the health care systems.

PURPOSE

The purpose of the study was to analyze the process of facilitating collaboration between traditional healers and western trained health care workers in the management of chronic illnesses by using a participatory action research, action science enquiry approach. The clients suffering from diabetes and hypertension, traditional healers and western trained health care workers, doctors and nurses, became the participants in this study.
RESEARCH OBJECTIVES

a) To identify the profile of traditional healers who manage chronic illnesses

b) To define and analyze the problem of collaboration as exemplified by the management of diabetes and hypertension by traditional healers, western trained health care workers and the clients suffering from diabetes and hypertension. This included the following:

i) The nature of current interaction between traditional healers and western trained health care workers,

ii) perceived barriers of collaboration between the two systems of health care delivery and perceived ways by which collaboration can be promoted.

iii) and perceived enhancers of collaboration

c) To develop strategies for collaboration between the two systems through joint meetings

d) To compare the traditional theoretical essence of these strategies with other established and documented collaborative models and approaches of collaboration.

e) To implement strategies crucial for the facilitation of collaboration between the two systems

LITERATURE REVIEW

INTRODUCTION

The World Health Organization in 1977 resolved to promote traditional medicine by urging member states to give adequate importance to the utilization of their traditional systems of medicine, with appropriate regulations suited to their national health systems (Hogle and Prins, 1991). Following this resolution some countries, organizations and individuals were motivated to carry out research. They also initiated certain projects and programmes concerning the incorporation of traditional healers into the national health care system. These projects were conducted from 1978 to about 1988. After this there was a decline in projects and research being done in the field of traditional healers and traditional medicine. Currently, traditional practice and medicine is gaining interest and this is brought by the increase in chronic illnesses and terminal illnesses like cancer and HIV/AIDS.

Policies Governing Traditional Healers

According to Alhuwalia and Mechlin (1980), in most countries the laws governing traditional healers’ practices were very ambiguous and not clear, despite the fact that WHO in 1978 made a resolution that governments worldwide should give adequate importance to the utilization of their traditional systems of medicine, with appropriate regulations suited to their national health care systems.

Green and Makhubu (1983) stated that the Ministry of Health in Swaziland had an ambiguous policy or no policy towards traditional healers. In 1945-6 there was an attempt made by the colonial powers to pass legislation that would provide for the registration of traditional healers and would attempt to control their practice. Prior to that time and dating back to 1894, all ‘witch-doctoring’ was considered illegal in Swaziland. This led to the introduction of the Witchcraft Act in 1905 forbidding the practice of traditional healers. There was strong opposition to the proposed legislation of 1945-6 by the then director of medical services. Thus, the law was never passed. King Sobhuza II was supportive of traditional healers and their practices. He envisioned the development of a health care system that combined the best aspects of both traditional and modern medicines. He believed that a scientific study of traditional healing should be undertaken before attempting to restrict or alter practices.

In 1954, the King issued an executive ‘Order-in-Council’ which represented the further development of the earlier proposed legislation. The order dealt with registration, fees, payment, referral of patients to clinics by traditional healers, misconduct and malpractice. Taxation and registration of healers began that same year and records were kept by the Swazi National Council, a traditional body under the King. The King in 1979 and 1981 called a meeting of the nation and traditional healers to discuss the formation of a new structure to guide traditional medicine. These meetings were followed by a directive to the Ministry of Health to look into ways of organizing healers. The Ministry of Health appointed a commission which dealt with the issue of traditional healers. This Commission drafted the revised legislation which was modelled on the one that applies to medical practitioners. The draft dealt with registration, code of conduct, fee payment, and the formation of an association of healers. The King unfortunately passed away in 1982 and the work of this commission was disrupted (Green and Makhubu, 1983).

The Ministry of Health (1983) states that the modern health care system must develop in such a way that it responds to Swazi culture and tradition. Information must be sought from the tinynango (traditional healers) and other healers in order to make modern health care services more attractive to all members of the population. The National Health Policy (1993), never mentioned any collaboration between the two systems except to be concerned about making the modern health care system attractive to the population by seeking information from traditional healers. It does not mention
anything about the improvement of the nation’s health by collaborating with traditional healers. The health policy however, acknowledged that if nothing is done to include traditional healers, modern health care services will not be attractive to the population.

Ahlulwalia and Mechin (1980) noticed that in Zaire the traditional healers’ position with regard to law was fairly ambiguous and their practices appeared to be outside the laws governing the art of healing. In Zaire, laws limit medical practice to those who hold a recognized diploma. These laws fail to lay down any guidelines whatsoever regarding the practice of traditional medicine. Ahluwalia and Mechin recommended that the laws needed to be reworked to embody traditional jurisprudence, existing legislation, and informed regulations on the practice of traditional medicine. Because of the ambiguity in present laws, traditional healers become victims of judicial conflict because everyone wants to control them, and no one has the means to do it. The healers are powerless when an accident occurs during treatment or when customers refuse to pay them.

According to Pretorius (1991) numerous legislative approaches to traditional medicine fell into four categories.

a) The Exclusive Monopolistic System: In this system only the practice of modern medicine was regarded as legal while all other forms of healing were excluded. There was among this system the strict, total and enforced monopoly and the socialist model. The former was found in the United States of America, France and Belgium and the French and Belgian colonies of Africa and the latter in Russia and the East-European socialist countries.

b) The Tolerant System: Only the system based on allopathic medicine was recognized, while the existence and significance of the traditional sector was ignored. This type of system was to be found in the German Federal Republic, the United Kingdom and the Republic of South Africa. In South Africa the Council of Associated Health Professionals made provisions for the registration of and control of traditional healers. This applies to countries like Swaziland.

c) The Inclusive Parallel System: Traditions other than allopathic medicines are recognized legally, so that the two co-exist. To be eligible for such inclusion the traditional system has to be highly formalized. These systems may be found in parts of Southern Asia, such as India. This system would not be found in any part of Africa.

d) Integrated Systems: Modern and traditional medicines are united in terms of medical training and jointly practised in unique health care system. This is an official policy. This type of system is to be found in China and Nepal.

In Swaziland traditional healers and their practice are still legally guided by the Witchcraft Act of 1905. They are not formally recognized. This implies that all Swazis who ever consulted traditional healers are also illegally doing so.

The comparison between Traditional healers and the Western Trained health Care Workers

Edwards (1986) states that the distinction between the modern and traditional is absolutely arbitrary when one considers the personal, interpersonal and community variables affecting the interchange between healers and patients within the total healing context. It is, however, a useful, generally-accepted distinction broadly denoting modern, Western-oriented, biomedical, structurally dominant system in contrast to more local, culturally relativistic, humoral, functionally strong, traditional healing approaches respectively. Traditional medicine is most commonly practised in rural areas lacking modern health care facilities. Western medicine is accepted as a treatment of choice by most, although eclectically chosen combinations of modern and traditional medicine remain common. One of the distinctions between the two is the natural vs supernatural orientation respectively to modern and traditional.

Gumede (1990) compares traditional healers and modern healers and comes up with the following differences:-

a) Modern healers are Western in origin while traditional healers are indigenous and African in origin.

b) Modern healing was fathered by Hippocrates and they date back to the Greek era. Traditional healers were in existence and practising as they do today in Kush/Ethiopia some 4500 years ago.

c) Modern healers are regarded as rational while traditional healers are considered irrational.

d) Modern healing is regarded as scientific while traditional healing is regarded as unscientific.

e) Surgical procedures in modern practice are planned, scientific and based on the study of gross and morbid anatomy while surgical practices in traditional healing are unscientific, unplanned and crude.

f) The training of the modern practitioner takes about seven years after matriculation and is available to anyone who qualifies while the training for a traditional healer is handed down from father to son, or from master to trainee, apprenticeship, journey-man, or full blown traditional healer (inyanga).

g) Aetiology of disease in modern medicine is based on the germ theory while in the traditional healing world all illnesses are man made in origin.

h) For modern healers diagnosis entails what germ causes the illness while in traditional healing it is not only what caused the illness but also who caused the illness.

i) The modern healer’s treatment is specific, individualised and streamlined to meet the presenting problem. The traditional healer’s approach is holistic. Healing involves the living and the dead, the natural and the supernatural in addition to the patient. The traditional healer treats the patient within his or her environment-physical, spiritual, emotional, past and present.
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j) The code of conduct for modern healers is laid down by medical and nursing councils while traditional healers' code of conduct is un-governed, it all depends on their ancestors.

k) The language of the modern healer is scientific, about actiology, symptomatology, diagnosis, epidemiology, endemiology, curative and preventive processes, prognosis, rehabilitation, morbidity and mortality while the idiom approach of the traditional healer is social, political, economical, moral, and even recreational and involving a change of environment.

As has been stated, the world of ritual and spirit is very different from the biomedical world. Another difference noted is the way traditional healers are trained, with no concrete body of knowledge about the body, chemistry and physiological functioning. There are also differences noted in the way certain illnesses or symptoms are named. These differences and similarities are some key points to collaboration. Each system would have to know the limits and ways of approach towards the other while still respecting the other’s system of health care practices.

Gort (1989) (cited in Hogle and Prins, 1991), states that all support for collaboration should not obscure the fact that biomedical practitioners (specifically doctors, nurses and other technicians) are opposed to the inclusion of traditional healers in the health care delivery system and are ignorant about traditional medicine in their own countries. They see only healers failed cases in hospitals or clinic settings and tend to think of traditional healers as quacks, charlatans or witch-doctors. Those biomedical practitioners who have the opportunity to work with and get to know traditional healers usually experience a major attitude change. Public health nurses and health educators seem to support a positive working relationship between the two sectors.

Traditional healers have a part to play in the health team and thus should be drawn into the health team and the trust people have in them should never be broken down (Portgieter, 1992).

Traditional healing in Swaziland is a coherent, logically consistent system of beliefs and practices that satisfies many of the physical, mental, and spiritual needs of those who participate in the system. An estimated 85% of the population make use of the traditional system. Swazi healing practices are based on a belief system of magic and religion that parallels Western science and Christianity in attempts to find order, regularity, and simplicity in the apparent chaos and randomness of nature. The traditional belief system provides answers to many questions that perplex the people. Swazi healing has a strong empirical or naturalistic component that relates to cause and effect observations made in the everyday world. The naturalistic or empirical components offer a common ground for understanding between the modern health sector and the traditional health sector, although there are many differences and even incompatibilities between these systems which underlie both theory and practice in general (Green and Makhubu, 1983).

Traditional healers are practical and not scholars. Their aim is to cure patients and their knowledge is not academic like that of modern health care professionals.

Wessels (1985) looks into the differences between traditional healers and modern doctors in terms of psychiatric disorders as related to culturally specific syndromes. Culturally, according to Wessels (1985), South Africans viewed illnesses in terms of natural, moral and magical causes.

Moral causation concerns their dead ancestors and usually stems from failure to prevent imbalance between the person, family, environment, ancestors and spirits. The type of treatment depends on the causation. When moral and magical causes are involved, the treatment must include ritual, symbolic procedures. Natural causes and somatic symptoms are treated somatically and empirically. Prevention is achieved by cleansing, purifying and protecting by ritual measures. Blacks divide illnesses according to two distinct groups: the “natural illnesses” and the “African disorders”. The “natural illnesses” include mental retardation, epilepsy, schizophrenia, affective psychoses and hereditary and organic brain disorders. Western trained doctors are generally regarded as qualified to treat these conditions, but not the “African disorders” which are regarded as peculiar to African people and are to be treated by traditional healers. The blacks or cultural-bound syndromes differ widely according to different languages. Descriptive terms in English with the Zulu names were utilized and they are as follows: Ancestral spirit possession (Ukhuthwazase), alien spirit possession (Ufufumanye and Izizwe), spirit possession by chance (Indiki), Sorcery (buthakahathi), poisoning, pollution, environmental hazards, ancestral displeasure and disregard for cultural norms (Wessels, 1985).

Hyma and Ramesh (1994) state that differences in treatment, diagnosis and practice between the traditional healers and western trained health care workers are influenced by culture, religion, levels of social and economic development and other characteristics. According to Hyma & Ramesh (1994) in India, Pakistan, Indonesia and South Korea, for example, traditional medicines have gained both national and international reputation for the efficacy of herbal remedies. The political stand in these countries is very positive as far as traditional medicine is concerned (Hyma and Ramesh, 1994).

Supporting the differences between the traditional healers and the western health care systems indicated by Hyma and Ramesh (1994), Henneman (1995) also stated differences between the medical and the nursing professions. Henneman states that nursing as a profession has its own history, social and political influences which affected its collaborative relationship with the medical profession.

Already some documented literature showed that the western healthcare workers viewed collaboration with traditional healers not on an equal basis because of certain barriers perceived by the western trained health care workers.

Stott & Browne (1973) state that collaboration with traditional healers extended only to eliciting their support, not so much on clinical matters and methodology, but rather in matters of public health, by defining those circumstances which warranted referral to the western health services, such as chest X-rays, use of protein foods and diagnosis of cancer. It was stated, in Stott & Browne’s (1973) study about clinical patterns of illness, that traditional healers were recognizing Xhosa symptom-sign complexes which they labeled. They realized that this ability to recognize the
symptom-signs had some similarity to the western health diagnostic process. This ability suggests that traditional healers have some systematic organization for their training and cross-fertilization of their ideas, or that they are remarkably uniform in their clinical impressions. This showed that the western trained health care workers did not understand the underlying principles of traditional healers’ diagnosis of the pattern of illnesses.

Shai-Mohoko (1996) states that most formal medical practitioners condemn the services of the indigenous healers on the grounds that the scientific basis of traditional medicine has not yet been established. Shai-Mohoko observed that whether these two systems, traditional and western health care, oppose or supplement each other, traditional healing practice is well established and popular among the black population. Also, in Shai-Mohoko’s study some western trained health care workers showed that they doubted the knowledge of traditional healers.

The Concept of Collaboration in the Western View

Collaboration according to Henneman, Lee and Cohen (1995) is an important concept for nursing. It is a complex phenomenon whose definition has remained vague or highly variable. Despite its elusiveness, its essence continues to be sought after as a means of improving working relationships and patient outcomes. The term collaboration has been used synonymously with cooperation or compromise which is inappropriate.

According to Henneman et al (1995) the term ‘collaborate’ is derived from the Latin word which means work together or work jointly. Collaboration is typically described as a process which stresses joint involvement in intellectual activities. In health it has been described as a joint communication and decision-making process with the expressed goal of satisfying the patient’s well and illness needs while respecting the unique qualities and abilities of each professional. It is non hierarchical in nature. It assumes power based on knowledge or expertise as opposed to power based on role or function.

Chronic Illnesses

In 1949 a Commission on Chronic Illness (cited in Phipps, Cassmayer, Sands and Lehman, 1995), defined chronic illnesses as an impairment or deviation from normal that has one or more of the following characteristics:

a. the illness or impairment that is permanent,
b. the illness or impairment leaves residual disability,
c. the illness or impairment that is caused by non-reversible pathological alterations
d. and the illness or impairment that requires a long period of observation, supervision and care.

Wellard (1997) mentions that interest in chronic illnesses as an area of research is increasing across a diverse range of disciplines. The physical, psychological and social effects of chronic illnesses feature as a major emphasis for distinguishing individual variations from the ‘norm’. Chronic illnesses have become increasingly prominent in developed countries as mortality rates from acute illnesses decrease in response to improved sanitation. One cannot say the same for developing countries, which are hard hit by all sorts of illnesses including the surge of chronic illnesses brought by the immune-compromised illnesses such as HIV/AIDS related conditions and debilitating diabetic, cancer and hypertensive illnesses.

CONCLUSIONS

The literature review shows the importance of research about traditional healers. Issues like the status of traditional healers and traditional medicines in the whole world have been addressed. The literature review addresses the legal status and practices of traditional healers as well as the categories of traditional healers. Collaborative and cooperative efforts have been discussed. Various authors give insight on why there is recommendation towards collaboration as against integration. The World Health Organization’s positive stand as far as traditional healers and traditional medicines is concerned is highlighted by most authors. Countries(Swaziland, Ghana, Nigeria and the Republic of South Africa) who took initiatives to develop projects towards collaboration were also discussed by some authors.

Most of the authors recommended research in terms of collaboration between the two systems of health care delivery. It was also recommended that studies be done concerning the management of chronic illnesses by the traditional healers.

The fact that more than 80% of the African population visit traditional healers for their health problems before they visit western health care facilities, shows a reason for collaborative efforts in order to make the patient feel comfortable with both systems (Shai-Mohoko, 1996). This can help both systems to cross check each other in terms of safe and effective health care delivery.

METHODOLOGY

The study was a qualitative research which followed the principles of Action Sciences and Action Inquiry. According to Denzin and Lincoln (1994) action science and action inquiry focus on change of organizations and systems. Action Inquiry and Action Science are forms of inquiry into practice that are concerned with the development of effective action that may contribute to the transformation of organizations and communities towards greater effectiveness and greater justice. In collaborative inquiry there is the element of shared reflection about collective dreams or missions and open rather than masked interpersonal relationships. Hence this study analyzed a process of collaboration that was aimed at bringing change in both the traditional and western health care systems so that they can have an open collaborative interpersonal relationship for the benefit of the clients they both serve. The concepts of collaboration, hypertension and diabetes were studied in relation to the meaning the participants bring to them.
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The principles of action research, in terms of bringing improvement in the practice of the traditional healers and western trained health care workers, was utilized. Stevens (1997) states that action research is used as a means to improve practice through the implementation of the research itself. It emphasizes participation and co-learning between practitioner-research and the participants throughout the interventions. The researcher learned a lot about the practice of traditional healers and how clients view both systems of health care delivery.

The design of the study followed the principles of a format recommended by Stringer (1996) as follows:

a) Resolving specific problems or crises
   i) defining the problem
   ii) Exploring its context
   iii) analyzing its components
   iv) developing strategies for its solution

b) developing special projects and programs
   i) Planning
   ii) Implementation
   iii) Evaluation

This article covers only part A of this format.

**SAMPLING**

a) **Sampling of the settings**

A population sample was utilized in the basis of a location since they were all found in the same location being the Health Care Centre. A convenient and purposeful sampling was conducted since they were the ones the researcher came across, but the western trained health care workers were those with broad and general knowledge of the topic and the clients were those suffering from diabetes and hypertension. The clients were identified in these two health care centres when they came for their check ups/ follow up care.

b) **Western trained health care workers and the clients**

The researcher planned to select three areas being one urban and two rural areas, but data saturation was reached after the two rural areas were covered. These rural areas were Sithobela Health Care Centre and Dvokolwako Health Care Centre and their surrounding areas of about 10 km. Swaziland has four regions, Hhohho, Manzini, Shiselweni and Lubombo. Sithobela Health Care Centre is bordering Lubombo and Shiselweni and Dvokolwako Health Care Centre borders Lubombo and Hhohho. These health care centres are 100km apart. Swaziland is a small landlocked country covering 17000 sq Km with a population of about 1 million (Thompson, 2000).

c) **Sampling of traditional healers**

The principles of purposive sampling and nomination was utilized, since the researcher needed assistance to locate traditional healer’s homesteads during the individual interviews. The assistant had the choice of choosing whom to locate. The selection was still purposive in that traditional healers who were chosen were those who had knowledge and who were affected by the study.

d) **Sample size**

**Individual interviews:**

The plan was to interview 10 traditional healers, ten clients and ten western trained health care workers in each of the two health care centres, hence making a total of 60 participants. This was not possible since there was saturation of data. Eventually, there were seven traditional healers from one health care centre and nine from the other health care centre; two clients from one health care centre and eighteen from the other health care centre; and ten western trained health care workers interviewed in one health care centre and six interviewed in the other health care centres. This made a total of 52 participants for the individual interviews.

**Meetings:**

During the joint meetings in the first meeting there were 41 participants at Sithobela Health care Centre and 58 participants at Dvokolwako Health care Centre. During the second meeting there were 30 participants at Sithobela and 68 participants at Dvokolwako. Some participants who attended the first time also attended the second meeting. There were also new participants who helped to verify information given by the primary participants.

**DATA COLLECTION**

A triangulation method was utilized in order to reach credibility, validity and reliability of the information collected. Data was collected using an interview guide and meetings during the phase one of the study. Kimchi, Polivka and Stevenson (1991) stated that triangulation refers to the use of two or more data resources, methods, investigators, theoretical perspectives and approaches to the analysis of the study of a single phenomena and then validate the
congruency among them. Initially, the researcher planned to use focus groups, that was not possible since it was not easy to eliminate any traditional healer nor any client who was willing to participate. The numbers recommended in a focus group of 8 to 12 would have been difficult to control in this nature of the study.

An unstandardized individual interview was utilized using an audiotape so that there was an allowance of the natural flow and freedom of questioning and answering. The meetings were utilized so that a platform for dialogue between the participants could be accomplished. According to Sim (1998) this creates a sense of a safe forum and participants feel supported and empowered by a feeling of group membership and cohesiveness.

DATA ANALYSIS

The audio-taped and written notes were transcribed, carefully analyzed. Data analysis was done according to the editing analysis style described by Crabtree and Mills (1992, p 19-20). In this form of data analysis, the text is carefully studied, searching for meaningful segments, cutting and pasting and rearranging until the reduced summary reveals the interpretive truth in the text. Units were identified, sorted out and organized into categories, the patterns and themes that connected the categories were identified. The analysis proceeded to an interpretive phase in which units and categories were connected into an explanatory framework consistent with the text. It was these final connections that formed the reported outcomes. This enabled the researcher to come out with the traditional theoretical collaborative essence of this study which was then compared to the documented collaborative concepts. Some data were presented unchanged, especially quotes from individuals which were presented as illustrations of the situations as seen by the participants themselves. In this case theorizing was also utilized (Tesch, 1992, p84-92).

Data collected using audiotape was immediately transcribed into written form and the data in Siswati (local language) was translated into English for the purposes of analysis.

RESULTS AND DISCUSSIONS:

The Context of the Problem with Regards to Diabetes and Hypertension Management and Collaboration by both Systems of Health Care Delivery

1) Traditional Healers Profile and Categories:

a) Categories of traditional healers identified were as follows:

i) Faith healer- sangoma- herbalist

ii) Faith healer-herbalist

iii) Sangoma-herbalist

iv) Herbalist

v) Trainer (Gobela)

The categories were developed from the descriptions of how they were trained and how they practiced. There was some progressive training from the first three categories. Some traditional healers started by being a faith healer, then ancestors will manifest themselves, hence they will go for training as a sangoma. After that, they will train as a herbalist, whereby they learn about medicines, their preparations and administration and dispensing, from the same or another trainer. Some traditional healers would begin by being possessed by the Holy Spirit as faith healer either laying hands or prophesying and using only minerals and water. They would then progress to learning about herbs, their preparations and dispensing hence they were called faith healer herbalist. Some began their training as a sangoma and end up learning about herbs and handling them. Some will then be shown by their ancestors that there are now ready to become trainers themselves, and would seek guidance from their former trainer or another trainer. A herbalist is known as a medicine man. They do not necessarily need to be possessed by spirits or ancestors (Makhubu, 1978). Gort (1987) also observed that there were no lines of demarcation between the traditional healers. Due to economic demands, even a sangoma who is suppose to smell the witch, end up doing the treatment in order to have some gain.

b) Gender, age and period of training:

Females formed a very few percentage among those who were interviewed and during the meetings. There were only about 30% of the sample being females. All the females fell under the category of being a sangoma-herbalist. The healer would devine, smell, foresees, prepare and prescribe medicines. About 80% of the population were aged between 50 and 70 years old. The remaining 20% were the younger generation aged between 20 to 35 years old. The training period varied between 6 months to 3 years. There were about 20% of the traditional healers who never went for any training, but claimed they learned through dreams. Sangoma-herbalist had the longest training of about 2 to 3 years. Much as the traditional healers did not mention any formal curriculum like the western trained health care workers, they do undergo a process of training similar for each category.

c) The practice of traditional healers:

There was the comprehensive roles of all the traditional healers. According to Makhubu (1978) and Gumede (1991) the sangoma would only Devine and carry out certain rituals. All traditional healers were discovered to be engaged in all the functions of diagnosing, preparing and prescribing medicines. This was the influence of changing traditional medicines and socioeconomic status as mentioned by Gort (1987). They also mentioned a long list of illnesses that they
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could treat. The categories of treatment were different from the western way, whereby a doctor would be a specialist like a gynaecologist or an obstetrician. It was difficult to classify the traditional healers according to the western categories, since some of them would be doing activities as a gynaecologist as well as an obstetrician and also handle mental disorders.

d) Management of diabetes and hypertension by traditional healers

There was no cultural or traditional name given to these illnesses by traditional healers, much as traditional healers mentioned similar symptoms of these illnesses to that mentioned by the western trained health care workers. They also stated that these illnesses were new in their field. One of the reasons being that they relied on the western facility for diagnoses. The lack of traditional healer name for these illness, lack of adequate knowledge about the pathophysiology and the lack of an objective diagnosis of hypertension and diabetes strongly emphasize that traditional healers should collaborate with the western trained health care workers in the management of these two illnesses. About 80% of the clients consulted both systems when it came to the management of these two illnesses. They claimed that traditional healers used the elements of culture when it came to management of these illnesses.

There was also the difference in the approach, whereby the western health care approached these illnesses on the caring and maintenance while the traditional healers claimed a total cure of these illnesses. This was based on the fact that traditional healers treat the symptoms and once the symptoms are gone, to them that is cure, while the western trained healers treat the symptoms and the underlying cause for the symptoms and they know that the underlying causes of diabetes and hypertension cannot be cured.

e) Traditional medicines used for the treatment of diabetes and hypertension:

There were a few differences in the groups of plants from one traditional healer to another and similar plants were used for diabetes and hypertension. Eighty percent of the traditional healers used the aloe (inhlababu), Momordica (elematidea, foetida) ‘inhubaba’, Momordica (involucrata) ‘inkhakha’, the flower of a banana, cannabis “insangu” and nlhiziyokulu for the treatment of both illnesses. It was noted that there similar plants used for diabetes as well as hypertension were being the aloe, inshubaba and inkakha.

This information is very valid to understand traditional healers for the process of facilitating collaboration, since the western trained health care workers are well understood and their training and practice is well structured and similar for each class of professional.

2) Defining the Problem of Collaboration

a) Enhancers of collaboration:

i) Similarities about the concept of collaboration:

There were similarities in the way that traditional healers, clients and western trained health care workers defined collaboration. Statements like “working together, sharing ideas, seeing one’s idea together, connecting, going deeper in a relationship, helping one another, working hand in hand and coming together” were mentioned by all of them. This showed that they all understood what collaboration means to them. The concept of collaboration described by the participants was similar to the documented concepts of collaboration described in the literature by Henneman et al (1995).

ii) Importance of facilitating collaboration:

More than 80% of the participants were positive about the need for collaboration between the traditional healers and the western trained health care workers in the management of illnesses. There were statement such as collaboration “is important, is necessary, is needed”. Participants stated that certain conditions needed the western intervention while other conditions needed the traditional intervention, hence the need for the two systems to collaborate. One western trained health care worker stated that “we need traditional healers and they also need us”.

iii) Consequences of collaboration:

Participants felt collaboration will facilitate the treatment of many complicated illnesses such as HIV/AIDS which no one profession can handle alone. Traditional healers and clients who use traditional herbs will feel free to consult the western facilities and hence patients would be brought in time or come in time, since at present they fear to be ridiculed and hence they come late for treatment in the western facilities.

Hence 80% of the participants viewed collaboration as being essential with positive consequences between the two systems of health care, this shows some readiness and a strength of all the participants to engage in collaborative strategies for the management of illnesses.

b) Barriers for Collaboration:

A positive willingness to collaborate was expressed by 80% of the participants and they all agreed that it was long overdue, but they noted certain barriers as follows:

i) Naming of diseases and treatment

Traditional healers did not have a traditional name for diabetes and hypertension while the western trained health care workers have definite names of diabetes and hypertension. One western health care worker said “at present we get a lot of different information about the same illness from traditional healers so that we end up not knowing whether
it is the same illness that they are referring to or it is another illness”. This difference creates a barrier in that they cannot refer patients to traditional healers since they do not agree with the naming of these illnesses. Hence they will not know whether they treat illnesses based on the way they name it or based on the fact that it is the same illness.

ii) Giving and taking credit for the cure

About 60% of the traditional healers and 50% of the western trained health care workers stated that it was not clear who had treated the illness if patients combined western and traditional medicines. One western trained health care worker said “Patients end up not knowing whether the help came from the herbs or from the western medicines, so patients should take one type of medicines at a time to see where the help comes from.” One traditional healer said “When a traditional healer successfully treated someone, no one gave praises.” This becomes a barrier since both western and traditional would like to take credit for the cure. So it would be difficult to admit that one is failing to treat the patient, hence the long keeping of patients by either the western facilities or the traditional facilities before referrals are done.

iii) Ethical differences in practice

About 20% of the western trained health care workers felt that they would be endangering patients if they can collaborate with traditional healers since they felt they were differences between the two systems. A few traditional healers also felt that there was no need to send patients to the western trained health care workers with illnesses considered supernaturally caused. The Following were perceived as differences:

Different requirement for training and education:

This became a barrier for collaboration even among the traditional healers themselves. Some traditional healers would not undergo training at all and some were either trained for shorter periods while others were trained for longer periods. The training of traditional healers was considered informal, in that they do not have any formal curriculum or written curriculum.

The western health trained health care workers curriculum did not address or incorporate collaboration with traditional healers, although one of the nurse’s pledge states that they should collaborate with other professionals. One western trained health care worker said “collaboration with professionals or other health workers involved in alternative medicine is very important, but the problem is with the orientation towards these other fields of health care delivery during the training periods of doctors and nurses, and this of course should include the homeopathy practitioners as well as the traditional healers.”

It was also noted that traditional healers do not have an explicit, “official” and systematic way of managing illnesses as do the western trained health care workers.

Lack of transparency:

Eighty percent of the participants, especially the clients, expressed concern that traditional healers maintain secrecy about their medicines. One client said “even as a client you never know the name of the medicines from a traditional healer, except that you will only be told how much to take, whereas in the western medicine, the medicine’s name will be written in your packet”.

Due to the lack of transparency, there is a danger of combining both traditional and western medicine which have the same effect and hence resulting in unwanted reactions as well as over dosage and exaggerated side effects without the awareness of the other health care worker. Some traditional healer’s medicines are secretly administered in the hospitals and this was expressed as a concern by the western trained health care workers.

Different perspectives about illnesses:

There are a lot of differences that were states ranging from causes to treatment as well as the believes about achieving a cure and maintenance.

Traditional healers believe that illnesses are mostly caused by bewitching. Most of their treatment are based on removing the signs and symptoms rather than removing the cause. Once they remove the signs and symptoms then they have reached a cure. While on the other hand western trained health care workers have learned that illnesses can be caused by multiple factors. They also aim at removing the signs and symptoms, but also removing the causative factor. They also believe that with certain illnesses you will never reach a cure, but you can control them, for example diabetes and hypertension.

About forty percent (40%) of traditional healers look down upon western medicines, claiming that they are not as strong as the traditional herbs, hence they do not bring about a total cure. Some western trained health care workers also looked down upon traditional healers and ridicule them. About 20% of the western health care workers did not agree that collaboration should take place between the two systems. One western trained health care worker angrily said “I do not want to collaborate with traditional healers because I do not believe they know what they are doing, I feel we western health carers are able to diagnose and treat illnesses, so we do not need them. Traditional healers make cuts on the body and put in the dirty staff which can cause infection on a diabetic patient”.

Traditional healers believe that certain illnesses do not need an injection, which is normally practiced by the western trained health care workers. They stated that, when a patient suffering from that illness is injected, the patient would die instantly. Such illnesses are termed “likubalo” related to some sexually transmitted illnesses or whereby one have crosses over some spills which a witch put in his or her path. Gumede (1990) called this type of illness, umeqo, meaning to cross over.
Facilitating Collaboration Between Traditional Healers and the Western Trained Health Care Workers in the Management of Illnesses in Swaziland

Safety and Efficacy of traditional medicines and the differences in practice:
Traditional health care medicines are not screened and the doses of one type of medicine differ from traditional healer to traditional healer. The measurements of doses and administration are not clear to the clients nor to the western trained health care workers. Most clients and western health care workers were concerned with the safety and efficacy of traditional healers medicines and their practices which involves a lot of rituals.

iv) Differences in power
There was a joint agreement between traditional healers, western trained health care workers and the clients that traditional healers do not have any regulatory body in Swaziland and that they are not officially recognized or legally recognized. Much as they have two official organizations, these organizations do not have legal powers over all the traditional healers in Swaziland. The majority of traditional healers were found to be non affiliates of these two organizations. Traditional healers are called ‘witch doctors’ by the Act of 1905 which up to date governs traditional healers. Much as most western trained health care workers have associations, they also have a regulating body called the Council. All western trained health care workers function legally in defined institutions either in governmental or private sectors. All this formal and legal standing give the western trained health care workers more legal power over the traditional healers irrespective of whether their medicines are effective or not. This created a problem in that the two parties could not collaborate effectively until they all come to the same level of legality and formality.

Much as the traditional healers view themselves as healers, there is no office under the Ministry of Health for traditional healers so that they can also be seen as part of the health care system delivery in Swaziland. The Ministry of Health and Social Welfare view the traditional healers as being classified under the Ministry of Home Affairs since their roles are to keep culture through ritual performances rather than being part of the healing forces of Swaziland.

v) Differences in perception about payment
The western health care systems have standardized charges for government and private sectors for each condition. Government charges are lower than the traditional healers and the private sectors. Traditional healers charges range from a consultation fee, bag opening fee and a last payment after achieving the cure referred to “a cow” since in the past clients used to pay a live cow for a cure. This perception about a cure brings a bias towards cure rather than maintenance since there is an implication to pay this cow once a cure is reached.

3) Proposed strategies

a) Regulatory body of Traditional Healers/Council:
In one of the meetings all participants including traditional healers, clients and western trained health care workers jointly proposed that there should be a legal body of traditional healers. They also stated that there should be a department of traditional healers under the Ministry of Health and Social Welfare seeing that traditional healers are also concerned about health of the nation. They consider the Ministry of Health to be their rightful place to establish a department.

This proposal was seen as a way that will provide control over all traditional healers practice. One traditional healer said “Government should recognize us and the Ministry of Health should be able to control traditional healers and not treat us as if we are not part of those rendering health. We feel that we have to be recognized as healers and not as ‘witch doctors’.

One western health care worker said “You traditional healers have upon yourselves to work a situation like in some of the countries such as Nigeria where they have an official department of traditional healers”. Traditional healers were urged to start by developing a country wide constitution or act of traditional healers in Swaziland.

b) A register of all traditional healers in Swaziland:

While working on establishing the council of traditional healers in Swaziland, they should be registering their names under the present two organizations, being the Traditional Healers Organization and Tshipanyana Tendzabuko Association. All traditional healers should write their names, location, gender, category, type of training and at least five illnesses that they treat.

c) Formal referrals:
The participants decided that there should be development of formal referral forms or cards to be used by traditional healers and western health care workers. There should be visits of clients by traditional healers in the hospitals and western trained health care workers should visit the homesteads of clients and traditional healers.

d) Change of attitudes:

Traditional healers and clients requested the western trained health care workers to have a positive attitude towards clients who started visiting traditional healers before visiting the western health care facility. Traditional healers were also requested to be open towards the western health care workers and should not conceal information as well as live in secrecy.

e) Open communication and regular contacts:

Traditional healers and western trained health care workers as well as clients should at least have three meetings per year, organize joint workshops, seminars and conferences to discuss about health issues of the country. They can do
this through formulating a hospital/traditional healer committee.

f) Survey on traditional healers and traditional medicines:
The western trained health care workers expressed a great need for research to be conducted on traditional healers practices and their medicines. Safety and efficacy should be the most priority.

Traditional healers also expressed a concern that their medicines should be tested to find out what brings about the cure. Traditional healers stated that once a patient has been diagnosed by the western trained health care workers with an illness, they should bring that patient to be treated by a traditional healer who knows how to treat that illness, so that they can have a proof that traditional medicines do work. One traditional healer said “I treat diabetes and hypertension. I do not know what my medicines contains that bring about the healing properties. I would like any one who has the know how to test and find out what is in my medicines. A lot of clients report improvement in their symptoms after taking this medicine.”

CONCLUSIONS:
The study’s focus was the analysis of the process of facilitating collaboration. Barriers which were identified are viewed as differences between the two systems of health care delivery, western and traditional. These differences brought the understanding of the roles of traditional healers in the community, which are different from the roles of the western trained health care workers. Troskie (1995) stated that unless the western health care systems acknowledge the reality of the differences between the two spiritual worlds in the republic of South Africa, the western trained health care workers will not be able to develop skills to collaborate with traditional healers in the primary health care services. To build such a relationship there should be an attitude of tolerance and acceptance that the traditional African way of thinking is different. Despite these differences, all parties involved must realize that there are both good and bad characteristics in both worlds.

Similarities between the traditional healers and western trained health care workers were expressed as enhancers. The other positive move was the joint development of strategies. The strategy of establishing a regulatory body was seen by all participants as being the umbrella for all collaborative strategies to take place. There was the inherent principle of community development which implied that all members should participate in assessing, planning, developing and delivering services and that should be generated within the community through working partnerships (Glick, Hale, Kulbok & Shetting, 1996).

The process of personal transformation took place as interactions occurred towards the realization that collaboration was necessary, and actions were taken to facilitate collaboration.

Two of the strategies were implemented. One of them came to completion being the establishment of the safety and efficacy of traditional medicines whereby there was a comparison of clients utilizing traditional medicines only and those who only utilized western medicines for the management of hypertension. The other strategy of developing the legal structure or Council of Traditional Healers is still underway.

Lastly, a traditional collaborative model was identified which was compared with an existing western style of a collaborative model as follows:

<table>
<thead>
<tr>
<th>Traditional collaborative model</th>
<th>Barriers</th>
<th>Strategies</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Defining attributes</strong></td>
<td>naming of disease</td>
<td>legal body of trad. healers</td>
<td>Formal control of traditional healers</td>
</tr>
<tr>
<td>working together</td>
<td>ethical considerations</td>
<td>two-way communication</td>
<td>Improved quality care of clients</td>
</tr>
<tr>
<td>sharing ideas</td>
<td>different educational process</td>
<td>exchange of information</td>
<td>Increased scientific body of clients</td>
</tr>
<tr>
<td>connecting two things</td>
<td>lack of transparency</td>
<td>research on traditional medicine</td>
<td>traditional healers and medicines</td>
</tr>
<tr>
<td>helping one another</td>
<td>doubt about safety of trad. medicines</td>
<td></td>
<td>empowerment of trad. healers</td>
</tr>
<tr>
<td>work hand in hand</td>
<td></td>
<td></td>
<td>clients informed choices facilitated</td>
</tr>
<tr>
<td>come together</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>see one idea.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Western Collaborative model by Henneman, Lee & Cohen (1995)**

<table>
<thead>
<tr>
<th>Defining Attributes</th>
<th>Antecedents</th>
<th>Consequences</th>
<th>Empirical Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint venture</td>
<td>individual readiness</td>
<td>supportive, nurturing</td>
<td>Multidisciplinary round, standards use of ‘We’ vs ‘I’</td>
</tr>
<tr>
<td>cooperation</td>
<td>understanding/acceptance</td>
<td>self worth</td>
<td>Dialogue between team members</td>
</tr>
<tr>
<td>willing participant</td>
<td>confidence and trust</td>
<td>spirit de cop</td>
<td>High scores of collaborative practice scales</td>
</tr>
<tr>
<td>shared planning</td>
<td>excellent communication</td>
<td>interpersonal cohesiveness</td>
<td></td>
</tr>
<tr>
<td>team approach</td>
<td>organizational values</td>
<td>improved productivity</td>
<td></td>
</tr>
<tr>
<td>shared responsibility</td>
<td>interdependent visionary leaders</td>
<td>improved patient outcome</td>
<td></td>
</tr>
<tr>
<td>non-hierarchical relationship</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
There were similarities and differences between the two models. One outstanding attribute was that the traditional identified model did not give room to empirical evaluations as yet.

REFERENCE LIST


