Title: An exploration of the development of community health forums as a strategy to improve communication between biomedical health professionals and an indigenous community: A Rural Participatory Action Research Study

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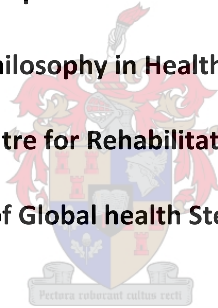

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Dedication

I dedicate this work to people of Bomvana, the community of Xhora especially the indigenous healers who above it all continues to tell their stories in their own way.

I also dedicate my work to my late brother (bhut' Yul), my cheerleader, my role model, my reason to become a better version of myself.

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Esam Gxamza (Miss G) – my beautiful princess, my strength, uMngqusho wam, isithandwa sikamamakhe. I wish and pray that from this day forward I can be able to provide you with a better life that you so rightfully deserve. I love you sthandwa sam more than words can explain. ☺

My late brother Yul, Mntambo, Novetshe, Ntethe, ndingathini na ukuthetha nawe kwelemimoya. Ndibamba ngazibini kuwe, ngothando, ngoncumo, ngenkxaso, ngento yonke. I am blessed to be in your tribe, your people. Thank you, my dear big brother. May your soul continue to rest in eternal peace. You maybe be gone but I will never forget you. Thank you for being such a blessing in my life!

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ABSTRACT

Rationale: Firstly, the existence of nine (9) clinics and a district hospital in Bomvaneland has been seen by people of this area as both a blessing and a problem as there is poor communication between allopathic health workers and the indigenous community. Allopathic health practitioners (AHP) chastise and marginalize patients who have used indigenous health (IH) prior to visiting allopathic healthcare services. Secondly, the complexity of understanding IH and that indigenous people have a concept of health that is eco-social and often communal, rather than individual. Thirdly, there is lack of institutional spaces where both indigenous knowledge system (IKS) and allopathic healthcare could be discussed for promoting wellness and quality of life of Bomvane people.

Aim and Objectives: The study explored and described the development of a Community Health Forum as a strategy to improve communication between allopathic health practitioners and an indigenous community. The main study objectives were to explore and describe:

- The process of establishing relationships and development of community partnerships.
- Development of community health forums as a strategy to improve communication between allopathic health professionals and an indigenous community.

Method: The main methods for data collection were ethnographic and participatory action research (PAR). Using participatory action research in cycles of reflection, the study covered four phases (1-4) to gain consensus on the main aim of the study, study objectives and data collection methods. During community entry and the three conferences (2016, 2018 and 2019), key community stakeholders from the nine (9) sub-municipalities of the research area participated. Mji's critical research findings were used as a tool to initiate communication. Phase 5 focused on the development of a community health forum and data was collected from four sub-municipalities (Xhora, Gusi, Hobeni and Nkanya). Purposive and snowball sampling was used to select n=37 study participants (12 being allopathic health practitioners, eight indigenous healers and 15 community members). Data-gathering methods for phase 5, included focus group discussions, in-depth interviews, (Chilisa, 2012), journaling and photography. Phase 6 was the last method of data collection which was a conference in 2019 to pilot a community health forum.

Findings: The study findings further affirmed the earlier propositions of challenges of communication and poor relationships between allopathic and indigenous health practitioners. When sick, the indigenous community uses both the indigenous and allopathic health practitioners. Some attempts had been made to improve these poor relationships by introducing a referral system, unfortunately this attempt was still not sufficient as it appears only the indigenous health practitioners refer their patients to allopathic health practitioners. This caused indigenous health practitioners to feel they are

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still not trusted by allopathic health practitioners. An outline was given by participants on the nature of future communication, including a framework that will drive the communication process between allopathic and indigenous health practitioners. At the core of this outline is a need for the communication process to be underpinned by respect for each other's human dignity. One of the major findings of the study is the development of an Interim community health forum which was achieved in Phase 6 of this study. Mji's critical research findings further affirmed negative social determinants of health (NSDH) that were blighting AmaBomvane. Unfortunately, it appears that with passage of time these had become worse with fighting of children and sickly older males suffering from ailments due to working in the mines. What gave hope out of this concerning situation is the draft MOU that was developed by the indigenous health practitioners. Within this MOU are guiding principles which are positive social determinants of health (PSDH) to support AmaBomvane to turn around the NSDH to PSDH.

Conclusion: The dual health-seeking behaviour of AmaBomvana should not be seen in a negative light by allopathic health practitioners, instead they should try to understand more about indigenous health and its practises. The chastising of indigenous patients when they have consulted indigenous healers results in the silencing of indigenous patients. Communication is at the core of proper diagnosis and subsequent care for the sick patient. The paradigmatic differences that exist between allopathic and indigenous health practitioners might need time to be resolved. The community health forum seems to offer a bridge for these two constituencies to work together in a respectful manner despite their differences. These two healthcare systems need to acknowledge their different practices and come to a realisation that working together may not be possible but working in parallel and focusing on certain areas, such as social determinants of health, would improve the health of Bomvane people. In the wake of Covid-19 Pandemic, the suggested model (CHF) is a way forward for the area.

Keywords: Indigenous knowledge systems (IKS), indigenous health knowledge (IHK), AmaBomvana, Community Health Forum (CHF), collaboration between allopathic and indigenous health practitioners.

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OPSOMMING

Rasionaal: Eerstens is die bestaan van nege (9) klinieke en 'n distrikshospitaal in Bomvaneland deur mense van hierdie gebied gesien as beide 'n seën en 'n probleem omdat daar swak kommunikasie tussen allopatiese gesondheidswerkers en die inheemse gemeenskap is. Allopatiese gesondheidspraktisyns (AHP) tugtig en marginaliseer pasiënte wat inheemse gesondheid (IH) gebruik het voordat hulle allopatiese gesondheidsorgdienste besoek het. Tweedens, die kompleksiteit van die begrip van IH en dat inheemse mense het 'n konsep van gesondheid wat eko-sosiale en dikwels gemeenskaplike, eerder as individu. Derdens is daar 'n gebrek aan institusionele ruimtes waar beide inheemse kennisstelsel (IKS) en allopatiese gesondheidsorg bespreek kan word vir die bevordering van welstand en lewensgehalte van Bomvane-mense.

Doelstellings en doelwitte: Die studie het die ontwikkeling van 'n Gemeenskapsgesondheidsforum ondersoek en beskryf as 'n strategie om kommunikasie tussen allopatiese gesondheidspraktisyns en 'n inheemse gemeenskap te verbeter. Die hoofstudiedoelwitte was om die volgende te verken en te beskryf:

- Die proses om verhoudings en ontwikkeling van gemeenskapsvennootskappe te vestig.
- Ontwikkeling van gemeenskapsgesondheidsforums as 'n strategie om kommunikasie tussen allopatiese gesondheidswerkers en 'n inheemse gemeenskap te verbeter.

Metode: Die belangrikste metodes vir data-insameling was enografiese en deelnemende aksienavorsing (PAR). Met behulp van deelnemende aksie navorsing siklusse van nadenke, die studie gedek vier fases (1-4) konsensus te kry oor die hoofdoel van die studie, studie doelwitte en data-insameling metodes. Tydens gemeenskapsinskrywing en die drie konferensies (2016, 2018 en 2019) het sleutelgemeenskapsbelanghebbendes van die nege (9) submunisipaliteite van die navorsingsgebied deelgeneem. Mji se kritieke navorsingsbevindinge is gebruik as 'n instrument om kommunikasie te inisieer. Fase 5 het gefokus op die ontwikkeling van 'n gemeenskapsgesondheidsforum en data is van die vier submunisipaliteite (Xhora, Gusi, Hobeni en Nkanya) ingesamel. Purposive en sneeubal monsterneming is gebruik om n=37 studie deelnemers te kies (12 is allopatiese gesondheidspraktisyns, agt inheemse genesers en 15 gemeenskapslede). Data-insameling metodes ingesluit fokusgroep besprekings, in-diepte onderhoude, (Chilisa, 2012), joernaal en fotografie. Fase 6 was die laaste metode van data-insameling wat in 2019 'n konferensie was om 'n gemeenskapsgesondheidsforum te loods.

Bevindinge: Die studiebevindings het verder die vroeëre voorstelle van uitdagings van kommunikasie en swak verhoudings tussen allopatiese en inheemse gesondheidspraktisyns bevestig. Wanneer siek,

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gebruik die inheemse gemeenskap beide die inheemse en allopatiese praktisyns. Sommige pogings is aangewend om hierdie swak verhoudings te verbeter deur 'n verwysingstelsel in te stel, ongelukkig was hierdie poging steeds nie voldoende nie, aangesien dit blyk dat slegs die inheemse gesondheidspraktisyns hul pasiënte na allopatiese gesondheidspraktisyns verwys. Dit verhoog weer die kwessie dat inheemse gesondheidspraktisyns voel hulle word nie deur allopatiese gesondheidspraktisyns vertrou nie. 'n Uiteensetting is deur deelnemers gegee oor die aard van toekomstige kommunikasie, insluitend 'n raamwerk wat die kommunikasieproses tussen allopatiese en inheemse gesondheidspraktisyns sal dryf. Die kern van hierdie uiteensetting is 'n behoefte aan die kommunikasieproses wat ondersteun moet word deur respek vir mekaar se menswaardigheid. Een van die belangrikste bevindinge van die studie is die ontwikkeling van 'n tussentydse gemeenskapsgesondheidsforum wat in Fase 6 van hierdie studie behaal is. Mji se kritieke navorsingsbevindings het verder negatiewe maatskaplike determinante van gesondheid (NSDH) bevestig wat AmaBomvane aan die lig gebring het. Ongelukkig blyk dit dat dit met verloop van tyd erger geword het met bakleiery tussen kinders en siek ouer mans weens die werk in die myne. Wat hoop hieruit gegee het rakende die situasie, is die konsep-MOU wat deur die inheemse gesondheidspraktisyns ontwikkel is. Binne hierdie MOU lei beginsels wat positiewe sosiale bepalings van gesondheid (PSDH) is om AmaBomvane te ondersteun om die NSDH na PSDH om te draai.

Gevolgtrekking: Die dubbele gesondheidssoekende gedrag van AmaBomvana moet nie in 'n negatiewe lig deur allopatiese gesondheidspraktisyns gesien word nie, in plaas daarvan moet hulle probeer om meer oor inheemse gesondheid en sy praktyke te verstaan. Die tugtiging van inheemse pasiënte wanneer hulle inheemse genesers geraadpleeg het, lei tot die stilmaak van inheemse pasiënte. Kommunikasie is die kern van behoorlike diagnose en daaropvolgende sorg vir die siek pasiënt. Die paradigmatiese verskille wat tussen allopatiese en inheemse gesondheidspraktisyns bestaan, het dalk tyd nodig om opgelos te word. Dit lyk of die gemeenskapsgesondheidsforum 'n brug vir hierdie twee kiesafdelings bied om op 'n respekvolle wyse saam te werk ten spyte van hul verskille. Hierdie twee gesondheidsorgstelsels moet hul verskillende praktyke erken en tot 'n besef kom dat saamwerk dalk nie moontlik is nie, maar parallel werk en op sekere gebiede fokus, soos sosiale bepalings van gesondheid, die gesondheid van Bomvane-mense sal verbeter. In die nasleep van Covid-19 Pandemie is die voorgestelde model (CHF) 'n pad vorentoe vir die gebied.

Sleutelwoorde: Inheemse kennisstelsels (IKS), inheemse gesondheidskennis (IHK), AmaBomvana, Gemeenskapsgesondheidsforum (CHF), samewerking tussen allopatiese en inheemse gesondheidspraktisyns.

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TABLE OF CONTENTS

Contents

Declaration 2

Dedication 3

Acknowledgements 4

ABSTRACT 5

OPSOMMING 7

LIST OF TABLES 16

LIST OF FIGURES 17

LIST OF ABBREVIATIONS 18

Chapter 1: Introduction 20

1.1 Introduction 20

1.2 Evolution of the problem 21

1.2.1 South Africa's health system post-apartheid 21

1.2.2 Indigenous and Alternative healthcare available in South Africa 222

1.2.3 The role of indigenous medicine in rural communities 242

1.2.4 The role of the Primary Healthcare (PHC) nurse/clinical nurse practitioner (CNP) 254

1.3 Presentation of the problem for this study 266

1.3.2 The different lenses and approaches used by both indigenous and allopathic medicine in identifying health and illness. 276

1.3.3 The lack of institutional spaces where both Indigenous Health Knowledge (IHK) and allopathic medicine could be discussed. 276

1.3.4 Poor communication channels that hinder building of trust between the different health systems in the area. 288

1.4 Motivation for the study 298

1.5 Concepts and process that underpins and drive the study 332

1.5.1 Kleinman's conceptual framework 333

1.5.2 Mji's critical study outcomes (MCSOs) 354

Stellenbosch University https://scholar.sun.ac.za

1.5.3 Participation as a vehicle that drives the implementation of this doctoral thesis. 366
1.6 Aim of the study 37
1.7 Purpose of the study 377
1.8 Objectives of the study 377
1.8.1 Short term objectives 377
1.8.2 Intermediate objectives 38
1.10 Concluding statement. 399
Chapter 2: Literature Review 40
2.1 Introduction 40
2.2 Defining indigenous knowledge systems, indigenous people, and indigenous health knowledge 41
2.2.1 Indigenous knowledge systems 41
2.2.2 Indigenous people 422
2.2.3 Issue of culture and its importance to indigenous people 422
2.2.4 Indigenous health as a community asset 444
2.2.5 Indigenous understanding and interpretation of health and wellness 444
2.2.6 Restoration and Protection of Indigenous Health Knowledge (IHK) 455
2.2.7 Indigenous healing and indigenous medicine 477
2.2.8 Summary of this section 488
2.2.9 What are the strengths and weaknesses of Indigenous Knowledge Systems (IKS)? 499
2.3.1 Challenges of IKS including IHK especially in areas where there is allopathic healthcare services. 50
2.3.2 Challenges between allopathic health practitioners and indigenous health practitioners ... 51
2.3.3 The issue of bewitched and the utilization of psychological issues 52
2.3.4 The need to recognize the strengths and weaknesses of each health system. 522
2.3.5 Summary of the section 533
2.4 Perspectives on indigenous health knowledge 533
2.4.1 International perspective 544

Stellenbosch University https://scholar.sun.ac.za

2.5 African perspective on indigenous health 566

2.5.1 Perspective on indigenous knowledge in Ghana 566

2.5.2 Perspective on indigenous knowledge in Tanzania 577

2.6 South African perspective on indigenous health 58

2.6.1 Exploring types of indigenous healers in South Africa. 588

2.6.2 Policies that support indigenous health knowledge 61

2.7 Integration of indigenous health knowledge to allopathic health knowledge: Is it a remote possibility? .... **Error! Bookmark not defined.**2

2.8 Models of best practice and Lessons that can be learnt for the research area.**Error! Bookmark not defined.**4

2.8.1 Putting It Together: The Integrated Life Course and Social Determinants Model of Aboriginal Health (ILCSDAH) .... **Error! Bookmark not defined.**4

2.8.2 Aboriginal and Torres Strait Islander Indigenous PHC Service Delivery Model .... **Error! Bookmark not defined.**4

2.8.3 Locally - Operation Sukuma Sakhe Model of service delivery**Error! Bookmark not defined.**5

2.9 Concluding statement. 666

Chapter 3: Methodology 677

3.1 Introduction 677

3.2 What informed the methodology chosen for this research study? 68

3.2.1 Who is the researcher and her stance/positionality? 69

3.2.2 Researcher as an instrument for collecting data. 70

3.2.3 Making Madwaleni home 711

3.3 Research design 723

3.3.1 Qualitative reflective research design 734

3.4 Primary drivers of the research method 766

3.4.1 Ethnographic study design 766

3.4.2 Participatory Action Research (PAR) 777

3.5 Secondary supporting designs 78

Stellenbosch University https://scholar.sun.ac.za

3.5.1 Exploratory descriptive study design 78

3.5.2 Emancipatory research designs 79

3.5.3 The use of Mji's critical research findings as a tool to initiate communication between allopathic health professionals and indigenous community. 80

3.6 Who are the Bomvana people? 811

3.6.1 Strong self- determination of Bomvana 811

3.6.2 Ancestral reverence and praising God 811

3.6.3 The consequences of the breakdown of their tribal economy 822

3.7 Selection of the research site 822

3.8 Study Population 833

3.9 Description of data collection process 844

3.9.1 Description of sections and phases for this study 844

3.9.2 Section 2: Phase-5: December 2018 – Process of developing a Community Health Forum (CHF) 89

3.9.3 Section 3: 2019 Conference and piloting a Community Health Forum (CHF) 100

3.10 Data management 1022

3.10.1 Data management for phases 1 – 4 & 6 1022

3.10.2 Data management for phase 5 1022

3.11 Data analysis 1033

3.11.1 Analysis of findings: phases 1-4 & 6 1033

3.11.2 Analysis of findings: phase 5 1033

3.12 Trustworthiness of the study 1066

3.13 Ethical considerations 1066

3.13.1 Community entry and building of partnerships 1077

3.13.2 Focus Group Discussion (FGD) as a strategy to collect data 1077

3.13.3 The issue of transparency and beneficence 1088

3.14 Concluding statement 10909

Chapter 4: Presentation of Research Findings 11010

Stellenbosch University https://scholar.sun.ac.za

4.1 Introduction 11010

4.2 Presentation of findings for section A 11010

4.2.1 Narrative presentation of findings: Phases 1-4 11010

4.3 Section B 1366

4.3.1 Phase 5: 1366

4.4 Section C: Phase 6 – 2019 Conference – Piloting of CHF 1555

4.5 Triangulation of findings from section A & B 16161

4.6 Researcher's description of the overall study process and data collection........ 161

4.7 Concluding statement. 16666

Chapter 5: Interpretation and discussion of Research Findings: Section A 1688

5.1 Introduction 1688

5.2 A narrative about assets and social determinants of health 16969

5.2.1 Assets derived from the different engagements and community participation. 17070

5.2.2 Positive social determinants of health (PSDH) 1744

5.2.3 Negative social determinants of health (NSDH) 1777

5.3 Ethnography, PAR and Emancipatory research designs – their influence on the methodology of the study 181

5.3.1 The value and contribution of scholar-activist research team 18181

5.3.2 Emergence of other indigenous healers from the community........ 18282

5.3.3 The concern and issue of children 1822

5.4 Concluding Statement. 1833

Chapter 6: Interpretation and Discussion of Research Findings: Sections B & C 1855

6.1 Introduction 1855

6.2 Phase 5: Main objective: To explore the process of developing Community Health Forum (CHF) 1866

6.2.1 Describing the existing healthcare providers in the study area. 1866

6.2.2 Identify communication channels between healthcare systems in the study area. 1899

6.2.3 Process of developing Community Health Forum (CHF)........ 19292

Stellenbosch University https://scholar.sun.ac.za

6.2.4 CHF & communication channels as bridge between healthcare systems 1944

6.2.5 Monitor & Evaluate existing CHF 1944

6.3 Section C: Piloting the CHF – 2019 Conference 1955

6.4 Development of draft MOU by indigenous practitioners – December 2019 1966

6.5 Concluding Statement 1966

Chapter 7: Reflections on the research experience and concerns on the research process: the confessional tale 1977

7.1 Introduction 1977

7.2 Reflections of the researcher – The confessional tale 1988

7.2.1 Why I chose this topic? 1988

7.2.2 Coming to Bomvana: 199

7.2.3 What then have I learned over the period of five years? (2014 -2019) 199

7.3 What have I learned? 201

7.4 Concerns related to the study process. 2022

Chapter 8: Conclusion 2044

8.1 Introduction 2044

8.2 Contribution of the study to different areas 2044

8.2.1 Community health forums as an instrument to facilitate a paradigm shift. 2044

8.2.2 Contribution to development of concepts and theory 2055

8.2.3 Contribution to literature 2077

8.2.4 Affirmation and contribution to Mji's critical findings 2088

8.2.5 Re-affirmation of indigenous knowledge holders 20909

8.2.6 A framework for development of CHFs 20909

8.2.7 Contribution of methodology 21111

8.3 Recommendations 2122

8.3.1 The Chief and AmaBomvana 2122

8.3.2 Indigenous health practitioners (IHPs) 2122

8.3.3 Allopathic health practitioners (AHPs) 2133

Stellenbosch University https://scholar.sun.ac.za

8.3.4 The DWF 2144

8.3.5 National Department of Health 2144

8.3.6 NRF and MRC 2144

8.4 In Conclusion 2144

REFERENCES 2166

APPENDICES 24141

APPENDIX A: Letter of Approval 24141

APPENDIX B: Participant information leaflet 24444

APPENDIX C: Inkcukhacha zomthathi-nxaxheba kwakunye nefomu yesivumelwano sokuthabatha inxaxheba 25050

APPENDIX D: Co-Researcher's Training Manual 254

APPENDIX E: Copy of final proposal 2688

APPENDIX F: Copy of Mji's critical findings 2944

APPENDIX G: Conference invite for 2016 conference and report 301

APPENDIX H: Conference invite for 2018 conference and report 3066

APPENDIX I: Conference invite for 2019 conference and report 31010

APPENDIX J: Draft MoU from indigenous health practitioners 316

APPENDIX K: Glossary 320

Stellenbosch University https://scholar.sun.ac.za

LIST OF TABLES

Table 1: Sample ratio of THPs compared with the ratio of medical doctors to the population .... **Error! Bookmark not defined.**3

Table 2: Participant groups, sampling methods and inclusion criteria outlines the groups of participants, sampling and criteria .... **Error! Bookmark not defined.**3

Table 3: Sampling for the four areas: Hobeni, Madwaleni, Nkanya and Xhora.................................. 97

Table 4: Data collection process for phase 5 100

Table 5: Phases of thematic analysis by Braun & Clarke . ... **Error! Bookmark not defined.**5

Table 6: Presentation of key observations and critical incidences, their influence on methodology and negative or positive social determinants of health (NSDH & PSDH) and assets (A) for Xanase community engagement. 11616

Table 7: Presentation of key observations and critical incidences, their influence on methodology and negative or positive social determinants of health (NSDH & PSDH) and assets (A) for Hobeni community 12121

Table 8: Presentation of key observations and critical incidences, their influence on methodology and codes given that relate to negative or positive social determinants of health (NSDH & PSDH) and assets (A) for Conference in 2016. 1266

Table 9: Presentation of key observations and critical incidences, their influence on methodology and codes given that relate to negative or positive social determinants of health (NSDH & PSDH) and assets (A) for the conference 2018. 1311

Table 10: Other moments that stood out as critical incidents 1355

Table 11: Summary of healthcare providers in the study area... 13737

Table 12: Objectives, themes and sub themes for phase 5 1533

Table 13: Presentation of key observations and critical incidences, their influence on methodology and codes given that relate to positive and negative social determinants (PSDH & NSDH) and assets (A). 15959

Table 14: A timeline of community engagements (2014 -2019) .... **Error! Bookmark not defined.**65

Table 15: Nature and Characteristics and Process of CHF 21010

Stellenbosch University https://scholar.sun.ac.za

LIST OF FIGURES

Figure 1: Mji's Rural Health Model (2013)... **Error! Bookmark not defined.**5

Figure 2: Map of part of Elliotdale, showing Madwaleni Hospital, the nine surrounding clinics, the villages, Mbhashe and Xhora rivers and part of the Indian Ocean........ **Error! Bookmark not defined.**3

Figure 3: Phases of Data Collection .... **Error! Bookmark not defined.**2

Figure 4: Older women's group with the researcher..1132

Figure 5: Bricks made by the community to build a cultural centre..1143

Figure 6: Building first rondavel for the cultural centre using self-made bricks..............................1143

Figure 7: The Xanase Management Committee 1155

Figure 8: The conference at the DWF in 2016 1244

Figure 9: First rehearsal in the hut with children who were very shy but performed confidently at the conference. 12929

Figure 10: The September 2018 conference – contrasting vibrancy with indigenous healers playing a major role..13030

Figure 11: Discussion groups during the conference...15555

Figure 12: The catering team busy preparing the food. 15656

Figure 13: The Interim Community Health Forum..15858

Figure 14: A conceptual framework on process of developing a CHF for the health and wellbeing of Bomvana people. 2111

Stellenbosch University https://scholar.sun.ac.za

LIST OF ABBREVIATIONS

A - Assets

AHWs - Aboriginal Health Workers

AIDS – Acquired Immune Deficiency Syndrome

AIK - African Indigenous Knowledge

AIKS - African Indigenous Knowledge System

ANC – African National Congress

ATM - African Traditional Medicine

AU - African Union

CDRA - Community Development Resource Association

CEO - Chief Executive Officer

CHCWs - Community Health Care Workers

CHFs – Community Health Forums

CNP – Clinical Nurse Practitioner

DACs - District AIDS Councils

DoH – Department of Health

DWF - Donald Woods Foundation

ECD - Early Childhood Development

EPWP - Extended Public Works Programme

FET - Further Education & Training

FGDs - Focus Group Discussions

HIV – Human Immunodeficiency Virus

HPCSA – Health Professional of South Africa

IHK – Indigenous Health Knowledge

IK - Indigenous Knowledge

IKS - Indigenous Knowledge System

ILCSDAH – Integrated Life Course and Social Determinants of Aboriginal Health

IPR - Intellectual Property Rights

IWGIA - International Work Group for Indigenous Affairs

IYA - Imbumba YamaKhosikazi Akomkhulu

KI - Key Informant

LACs - Local Municipal AIDS Councils

LIC - Low Income Countries

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LHRC - Legal and Human Rights Centre

MCSOs - Mji's Critical Study Outcomes

MoU - Memorandum of Understanding

NGO - Non-Governmental Organization

NRF - National Research Foundation

NSDH - Negative Social Determinants of Health

OPD - Out Patient Department

PAR - Participatory Action Research

PHC - Primary Health Care

PSDH - Positive Social Determinants of Health

RDP - Reconstruction and Development Programme

SA - South Africa

SADC - Southern African Development Community

SDA - State Drug Administration

SDGs - Sustainable Development Goals

SDH - Social Determinants of Health

SO - Secondary Objective

STIs - Sexually Transmitted Infections

SU - Stellenbosch University

TB - Tuberculosis

TCM - Traditional Chinese Medicine

THPs – Traditional Health Practitioners

TM - Traditional Medicine

TVET - Technical Vocational Education and Training

UCT - University of Cape Town

URT - United Republic of Tanzania

USA - United States of America

UWC - University of the Western Cape

WACs - Ward AIDS Councils

WarBOTs – Ward Based Outreach Teams

WHO – World Health Organization

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Chapter 1: Introduction

"No man should enter his house through another man's gate" (Achebe, 2000:17)

1.1 Introduction

The focus and the aim of this study was to explore and develop community health forums as a strategy to improve communication between allopathic health professionals and an indigenous community in the Eastern Cape Province of South Africa. This study used the dissemination of critical research findings from Mji's PhD study on the indigenous health knowledge carried by older Xhosa women on the management of health problems in their home situation with focus on indigenous health knowledge (Mji, 2013). The intention was firstly to use this dissemination as a process and a tool to initiate dialogue between the community and allopathic health services (district hospital and nine clinics) in the study area for this PhD study. Secondly, it also aimed to be used as an activity on how to develop community health forums with the goal of clarifying roles and pathways of care of the different role players.

Mji's (2013) PhD research outcomes covered: social health determinants that were blighting the villages of the study setting; minor and major health problems experienced by people residing in these villages; use of participation in cultural activities as a tool to determine the level of health or sickness of an individual; mapping of human and medical assets lying dormant at community level that can be used to manage health problems in the area; and, lastly Mji (2013) presented a rural health model that links together the community, clinics, the district hospital and different role players that connect these structures, starting from the community through to the district hospital.

This research study was conducted in kwaBomvana in Xhora (Elliotdale) in the Eastern Cape Province). The people who reside here are called AmaBomvana and are located in an area that is rich with herbs which are used to deal with certain ailments in their home situation. The district hospital and nine clinics have their knowledge based on the allopathic medicine while the homes in the study setting base their health knowledge on combined indigenous health and allopathic medicine of which they have little understanding of its action. This results in two existing knowledge health systems that seem to deal with the healthcare needs of this community using both allopathic and indigenous health knowledge but in a parallel fashion, as neither is aware of the scope of practise of the other (May, 2019; Mji, 2013; Jansen, 1973).

People of this area see these nine (9) clinics and the district hospital as both a blessing and a problem. The healthcare workers of this health system tended to marginalize the practice of indigenous health

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knowledge and the highly experienced women in indigenous health knowledge (IHK) who Mji (2019) classified as elite older Xhosa women who practice their indigenous healing for people in the study setting. These elite older Xhosa women use indigenous health knowledge (IHK) for the management of both minor and major health ailments in their home situation. They also act as family counsellors, custodians of IHK and mentors for younger women. Some of the challenges that the people of Bomvana are facing is the fact that some villages are so far away from health facilities and clinics making access to these service points difficult. In the event of a family member falling ill, an elite older Xhosa woman would manage the ailment within the home setting using whatever means they have available including indigenous health knowledge (IHK). When a family member is sick, and visits either one of the nine (9) clinics or the district hospital, there seems to be communication problems in explaining their ailments to the health professionals, including what they have used at home to manage the sickness. The development of community health forums is aimed at addressing this communication gap.

This first chapter will discuss the evolution of the problem focusing on South Africa's post-apartheid health system, looking at indigenous and alternative medicine. This chapter will further discuss the problem for this study, motivation for the study will also be detailed and will also mention the link between the current study and four other research studies that have been conducted in the area. Concepts that influence the study will also be discussed, followed by presentation of aims, purpose, and objectives. The chapter will conclude with outline of the thesis chapters.

1.2 Evolution of the problem

In this section, South Africa's health system post-apartheid, traditional and alternative healthcare available in South Africa, the role of traditional medicine in rural communities and the role of the Primary Healthcare (PHC) nurse will be discussed.

1.2.1 South Africa's health system post-apartheid

After the African National Congress (ANC) won the first democratic election in 1994, it made significant changes in the improvement of the lives of the previously marginalised people of South Africa by formulating policies. These policies were formulated through the Reconstruction and Development Programme (RDP) as measurement of a larger basic government policy to calibrate whether its policies would respond to and have an effect and impact on the progress of the South African people (Mosala et al., 2017; Gray & Clarke, 2000; Gessler et al., the 1995). Amongst the policies that were formulated through the RDP were health policies that also needed immediate attention from the newly elected democratic government. In the midst of this fundamental improvement of health services, the government of the day also sought to develop policies related to the area of health, which included a

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focus on basic infrastructure (water, housing and sanitation) and the implementation of poverty alleviation strategies (South African Health Review, 2017; Fink, 2002; Gray et al, 2000). Decentralisation of primary healthcare through the district health system was the major aim of the ANC's 1994 Health Plan. The plan was informed and guided by the principles of the United Nation's Alma Ata Declaration and its 'Health for All by 2000' campaign (Pan American Health Organisation, 2019; Vandebroek et al, 2004; Davies, 2000; Reddy, 1996; WHO, 1993). During this new era, the emphasis and funding shifted from the large tertiary hospitals to Primary Heath Care Clinics and Community Health Centres. This government saw the upgrading and building of new clinics, as well as the early development of the district health system, as a way to improve the healthcare services for the community at large. White Papers and policies were also developed during this time which presented a view of PHC as an important part of the overall progress of a society that focuses on 'putting the last first' (UNICEF, 2018; Werner, 1997). PHC was seen to be the key to achieving an acceptable level of health for all, as it would assist people to contribute to their own physical, social and economic development. Within these rural communities, there are other healthcare providers who are considered as alternative to allopathic services and provide indigenous healthcare. The challenge of government of the day was to overlook community-based health resources, such as indigenous health knowledge, especially in rural South Africa where health services are scarce. It is therefore pivotal to briefly present these community health assets such as traditional and alternative healthcare that is available in South Africa which was overlooked at that time of health restructuring by the ANC led government.

1.2.2 Indigenous and Alternative healthcare available in South Africa

WHO (2013) states that there has been a continuous demand for, and popular use of, traditional and complementary medicine worldwide. In some developing countries, native indigenous healers remain the sole or main health providers for millions of people living in rural areas. Hence, in its report the WHO (2019) states that South Africa is currently drafting guidance documents to ensure compliance of traditional medicine with the South African Health Professional Council (HPCSA). The WHO estimates that up to 80% of people in Africa make use of traditional medicine and this assertion has been confirmed by Bodibe (1993); Ramgoon et al., 2011 where they estimated that between 70% and 80% of African people in South Africa consult with traditional healers before going to allopathic care facilities. For instance, the ratio of traditional health practitioners to population in Africa is 1:500, whereas the ratio of medical doctors to population is 1:40 000 (Mothibe, 2019; WHO, 2008; Helwig, 2005; & Chatora, 2003 cited in Cameron et al., 2009, see table 1 below for details). Indeed, the majority of medical doctors available in Africa are concentrated in urban areas and cities. Therefore,

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for millions of people in rural areas, traditional healers remain their health providers (Cameron et al., 2009).

Table 1: Sample ratio of THPs compared with the ratio of medical doctors to the population (Chatora, 2003:5)

Countries	**Ratio of Traditional Practitioners to Population**	**Ratio of medical doctors to Population**
Kenya		
Urban (Mathare)	1:833	1:987
Rural (Kilungu)	1:143-345	1:70 000
Zimbabwe	1:600	1:6 250
Swaziland	1:100	1:10 000
Nigeria		
Benin City	1:110	1:16 400
National Average	No data	1:15 740
South Africa		
Venda area	1:700 -1200	1:17 400
Ghana	1:200	1:20 000
Uganda	1:700	1:25 000
Tanzania	1:400	1:33 000
Mozambique	1:200	1:50 000

UNICEF (2018), Stanton and Rutherford (2002) and Bodeker (1996) state that the rapid increases in the costs of modernized healthcare are forcing the poor in low-income countries (LIC) to look for alternatives to primary healthcare. Therefore, indigenous medicine is usually the first, and often the last, resort for healthcare of the poor throughout LIC (Van Niekerk, 2012; Bodeker, 1996). In a country like South Africa with its severe unemployment challenges and poverty, if the indigenous healthcare system were taken out of the equation this would affect the health of the poor majority (Mokgobi, 2012).

South Africa's Department of Health (DoH) estimates that the number of active traditional healers in this country alone is approximately more than 200 000. This means that millions of people in South Africa and across the continent consult and make use of indigenous healthcare instead of (or in addition to) allopathic healthcare. More often they do this because of choice, but commonly this is

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due to lack of access to appropriate healthcare services and/or poverty, or because these services are not available in peri-urban and rural areas. Nevertheless, indigenous health practitioners and other forms of alternative healthcare have the potential to make a valuable contribution towards improving the health of all people in South Africa (Rankoana et al., 2015). Unfortunately, there is still a history of lack of official recognition or research which has created a gap in professional standardization and functioning between these two health systems (Mokgobi, 2012).

1.2.3 The role of indigenous medicine in rural communities

Indigenous knowledge is under threat because it is carried by word-of-mouth from generation to generation. Research has indicated that IHK is evolving according to the changes in the environment, and the influence of foreign knowledge also has a direct impact on these changes. Indigenous scholars are challenged by the inability to read and write, poverty, language barriers and the lack of respect that they receive from their counterparts (Tom et al., 2019). Hence, research and advocacy is needed to assist in the preservation and restoration of this knowledge to guard against colonization, imposition and sabotage by foreign entries.

In the study area, the existence of nine (9) clinics and a district hospital are seen as both a blessing and a problem. On one hand, these facilities help the community with ailments that they struggle to handle at home such as TB, HIV and AIDS (Mji, 2013). On the other hand, they stand a risk of being chastised by allopathic health practitioner because of the alternative medicine that they utilised first prior visit to the health facility.

The role of the nine (9) clinics and the district hospital is to provide healthcare that does not marginalize communities irrespective of their education level. These allopathic healthcare facilities must ensure that the health system improves the health of all in an equitable, accountable, and affordable manner. This can only be ensured by involving community members in health-related issues because they are the people who have a better understanding of practices in managing minor and major health ailments within the home environment where the older Xhosa women play a pivotal role as first line. The older Xhosa women in the Bomvana households have a dual responsibility by being the head of the household and the carer of the sick family. In the absence of the middle generation due to migrant labour and death due to HIV and AIDs, they also bear the responsibility of schooling and disciplining the youth.

The older Xhosa women also consult the elite older Xhosa women in cases when they could not manage the ailments of their family members. Where a sick family member cannot be assisted by indigenous healing; the older Xhosa women should be allowed to communicate without fear of being chastised by professional health practitioners in revealing what they have used at home to assist sick

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family members. When and if the intervention of indigenous healing has not managed to assist the sick person, then there should be space for the family members to communicate with the health professional whether the sick person has consulted traditional healers for the management of the health problems. This then would inform the professional health practitioners on how to proceed to assist the sick person in terms of diagnosis for the management of the ailment. Unfortunately, this is not happening in Bomvanaland, instead there is a veil of secrecy between professional health practitioners in the study area and community members about who the community members visited, and what they used before consulting the allopathic healthcare providers.

1.2.4 The role of the Primary Healthcare (PHC) nurse/clinical nurse practitioner (CNP)

The nine clinics in the study setting are managed by clinical nurse practitioners for minor health problems and they further refer complicated cases to the district hospital. After the 1976 Soweto riots, many allopathic health practitioners, especially medical doctors/general practitioners, struggled to gain access to the township. Both paediatric and adult clinical nurse practitioners were subsequently trained through an in-service training of primary health care nurses and as an implementation project with health care teams in Soweto, where the PHC clinical nurse practitioner emerged (Wagstaff & Beukes, 1977). The PHC nurse practitioner would have the training and authority to assess and diagnose patients, as well as prescribe treatment and dispense medication (responsibilities previously limited to general practitioners). This resulted in the clinical nurse practitioner taking the role of managing the primary healthcare facilities.

Since in South Africa the PHC nurse was given the status of being a ‘mini doctor’ in primary care services such as the clinics (Mash, 2004), the role of the CNP and the allopathic knowledge that this professional acquired in the nursing practice is important for the study setting and its nine clinics. It is seen that when the doctor is available the PHC nurse is the mediator in the healthcare facility between the doctor and the patient (Di Paola & Vale, 2020; Vale, 2018; Mash, 2004). But the role of this PHC nurse of acting as a mini doctor was not properly communicated nor introduced to the community members that are serviced by the nine clinics in the study area. Patients were surprised by the role that the clinical nurse practitioner played and were also unsure whether the health system was taking their illness seriously by allowing a nurse instead of a doctor to fully manage their condition (Di Paola & Vale, 2020; Vale, 2018; Mash, 2004). This further worsened the levels of mistrust in the health system in the community.

The revelation about the use of alternative medication by the patient prior to visit of the healthcare facility could be beneficial to the PHC nurse. This could inform the PHC nurse about the phase of the sickness and therefore assist with a proper diagnosis and further treatment of the illness. As the role

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of the PHC nurse of acting as a mini doctor in the clinics was never clearly communicated to the community, they do not trust the CNP at the clinics, they bypass the clinic closer to their homes, and travel distances to gain access to the doctors at the district hospital. When gaining access to the district hospital they are then referred to the nearby clinic for a first consultation to gain a referral letter to the hospital, which they should have obtained from the CNP at the nearby clinic. Because patients are moved from pillar to post in trying to gain access to allopathic health services, by the time they access allopathic services their level of trust is quite low, and some might even have given up and opted for a visit to a traditional healer (Mji, 2013).

1.3 Presentation of the problem for this study

There are four main contestations that this study has identified namely: the lack of trust and veil of secrecy in practicing indigenous health knowledge creates a gap between the allopathic and indigenous healing practises; the different lenses and approaches used by both indigenous and allopathic medicine in identifying health and illness; the lack of institutional spaces where both Indigenous Health Knowledge (IHK) and allopathic medicine could be discussed; and, poor communication channels that hinder the building of trustful relationships between the different health systems in the area.

1.3.1 The lack of trust and veil of secrecy in practicing indigenous health knowledge creates a gap between allopathic and indigenous healing practises

When consulting CNPs or doctors in the nine (9) clinics and a district hospital in the study area, clients are reluctant to mention any other form of alternative care that they may have used before visiting the clinics and district hospital. The notion is that the older Xhosa women who are the primary healthcare providers within the home when a family member is sick, have a fear of being chastised by the healthcare professionals and being accused of practicing *muthi* that would increase the health ailment from minor to major sickness. The negative attitude and the secrecy of practicing indigenous health knowledge creates a gap between the allopathic and indigenous healing. Some of allopathic doctors regard their own healing as superior and regard indigenous healing as backward and worsening the ailment of the clients. Berg (2003) explains that if it is true that indigenous healers seem to work most successfully with psychological and psychosomatic illnesses, then it is imperative for psychiatrists and mental health professionals to understand the indigenous psychological mechanisms through which healing takes place.

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1.3.2 The different lenses and approaches used by both indigenous and allopathic medicine in identifying health and illness

Secondly, there is the complexity of understanding indigenous health with the notion that indigenous people have a concept of health that is eco-social and often communal, rather than individual. This has several implications for indigenous interpretation and understanding of social health determinants. For example, many indigenous peoples have a complex socio-cultural and spiritual relationship with their lands and the ecosystem, so isolation or destruction of land is not just a question of a change of location or occupation, but a profound socio-spiritual change with consequent health implications. In addition, as confirmed by Williams et al., 2020; Matuk et al., 2019; Bradshaw, 2008, it is important to understand that the very definition of indigenous is substantially socio-cultural. It includes elements of identity that may also be classed as important determinants of well-being, which means that being isolated from aspects of this identity may have direct negative impact on health. In other words, self and group identity may be an important social determinant of indigenous health. The older Xhosa women of this area maintain that by the time you see sickness, the disease has been festering for some time and, to them, the main cause of disease is fighting and broken relationships. The older women of this area assert that the existing allopathic medicine does not approach sickness and disease from this perspective and does not investigate and identifying the cause of illness to find mediating factors in this regard. To them approaching health and illness without uprooting the problem is superficial and a problem causing the revolving door syndrome – hence the belief that the hospital brought illness to their area. These opposing lenses and approaches used by both indigenous and allopathic medicine in identifying health and illness create a level of mistrust and uncertainty in the indigenous person when consulting the health services.

1.3.3 The lack of institutional spaces where both Indigenous Health Knowledge (IHK) and allopathic medicine could be discussed

Thirdly, institutional spaces, where both Indigenous Health Knowledge (IHK) and allopathic medicine could be discussed for promoting wellness and quality of life, are lacking in the health system of this area (May, 2019; Mji, 2019). Mishra et al., 2003 and Bodeker (1999) assert that the influence of education and religion which was brought to this area by foreign agents, did not respect the essence of the community's cultural existence. To this community the cultural identity of what makes one a Bomvana is very important and for them to be healthy is to be living fully as a Bomvana person. This cultural identity has certain obligations that cover the following: for Bomvana, the highest determinant of health and well-being is to live and exist as an embodiment of the culture of the clan, and as a spiritual being who honours and practices the beliefs of the clan. There is also generally a minimal to absent contribution to the young people of Bomvanaland where it is assumed that they

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can make to their own culture. Instead, on completion of local schooling many of the youngsters tend to leave the villages for the cities. Those left behind either ignore the Bomvana culture or criticize those who appear to be aligned with it. The lack of people and institutions for the creation of the Bomvana culture is a danger to the continued existence of indigenous health knowledge in this area (Mji, 2013). The development of community health forums in the study setting will assist in creating a platform where both Indigenous Health knowledge and allopathic medicine could be discussed for promoting wellness and quality of life of the Bomvana people.

1.3.4 Poor communication channels that hinder building of trust between the different health systems in the area

Fourthly, there seem to be a poor or lack of communication between the indigenous healers and allopathic healers in the study area (Van Rooyen et al., 2015). On one hand, the people of the community do not disclose the information of consulting indigenous healers before they seek help from the allopathic healing because they are afraid of being chastised by the healthcare professionals. On the other hand, the professional health practitioner does not provide relevant information to the elite women and/or older Xhosa women who take care of the sick in the home setting. The exchange of information into simple, understandable language from the health practitioner would assist the older Xhosa woman to explain the extent of the illness to the sick who are at times is unable to speak due to their illness.

The professional health practitioner needs to provide the elite Xhosa woman with relevant information on how to manage minor health ailments before they become major health ailments. This could assist the professional health practitioner to improve the services that are rendered to the community with the assistance of the elite Xhosa woman who seem to have the first encounter with the sick. The availability of Mji's (2013) results provide a springboard to initiate communication channels between the two centres of knowledge that seem to exist in the study area to promote coexistence and tolerance.

Within a community-based participatory research approach, the researcher used the dissemination process of these research findings as an activity to initiate the process of developing community health forums with the goal of clarifying roles and pathways of care about the management of health problems (social health determinants, minor health problems and major health problems) including the rural health model suggested by Mji (2013). These four critical aspects have stimulated the researcher to explore the development of CHFs as a bridge that could improve the understanding between indigenous health knowledge holders in this area and health professionals from the district hospital and the nine (9) clinics, with the goal of improving communication between service providers

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and people from the area. The intention of this study then is to bridge a gap between indigenous health and allopathic health knowledge.

1.4 Motivation for the study

As part of bringing contextually based research evidence, this motivation draws from four research studies that informed the current research which were done in the same setting as this study. Mji (2013) translated her PhD study and this resulted in three PhD studies and one research Masters. There is general a paucity of knowledge on how to effectively implement strategies and interventions that have been proven in preventing disease and to promote health of rural communities (Kerner, Rimer & Emmons, 2005). Research translation and implementation strategies must consider the specific context people live in and the impact of local, social, cultural, economic and physical conditions and resources (Ingstad & Eide, 2011; Whyte & Ingstad, 2007). Implementation should address local concerns and use local resources such as indigenous health knowledge (Tom et al., 2019). In addition, outcomes should be applicable and desirable for local communities and indigenous persons (Ingstad, 2007; Whyte & Ingstad, 2007).

Mji's (2013) PhD study explored the health knowledge carried by older Xhosa women in their home situation, with special focus on indigenous knowledge. Mji observed that the older Xhosa women utilized indigenous knowledge (IK) and herbs from their area to assist in the management of health problems in their home situations (Mji, 2013). The older Xhosa women as described by Mji are the *makhulus* who have a dual role as heads of the household (in the absence of the middle generation because of migrant labour) and healthcare providers of their families in the incidence of ailments. She further observed that these older Xhosa women would further consult other older Xhosa women outside the home for advice when the indigenous health knowledge (IHK) strategies they were using to treat their relatives was not helping. Mji classified these older Xhosa women outside the home as "elite older Xhosa women" as they were renowned in their villages for their IHK. These elite older Xhosa women were struggling with the nine (9) clinics and district hospital as they were chastised by these services once a patient, they had managed did not recover and was referred to these health services. The health services had an impression that the older Xhosa women worsened the condition of the patient and chastised the patient for having consulted the elite older Xhosa women. The patients then felt silenced by the health professional as they were afraid of being chastised. In her book "On the walk without limbs: searching for indigenous health knowledge in rural South Africa" Mji (2019), questions whether this silencing happened even before the visit to the hospital as the indigenous peoples were seeing the emergence of these colossal structures of allopathic civilization, such as the district hospital and the nine (9) clinics, and the weakening of spaces such as the home, where their own indigenous knowledge system had been learnt and practiced (Mji, 2019).

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Mji's study also made mention of the presence of three (3) institutions that impacted negatively and eroded the life of the Bomvana namely; the Christian religion (as in the Dutch Reformed Church), education (as in the presence of the schools), and the healthcare system – as in the nine (9) clinics and the district hospital (Mji, 2013). The Chief of this area believed that the enforcement of these three (3) areas by foreigners eroded the culture of AmaBomvana and contributed to the sickness we are seeing today in Bomvana (e.g., the younger generation drinking in taverns from break to dawn, disrespect by the younger generation and the younger generation moving to cities once they complete their education).

Ned's (2019) PhD study further expands on how knowledge systems from the outside impact and contribute to the continuing negative health determinants of indigenous peoples, and the effect of formal education, is still unexplored in South Africa and beyond (Ned, 2019:5). Ned maintained that there is a need to do research from the perspective of Indigenous people into the role that Indigenous knowledge systems can play in changing the formal education system for better health and well-being of indigenous peoples. The findings from her research suggested that colonial education emerged as a potential negative social determinant of AmaBomvana's health as it produced people who were deeply alienated from themselves, their lands, cultures, ancestors, languages and knowledge. Hence, once the young people had completed their education, they move to the cities. The older Xhosa women classified this form of alienation from one's birthplace as some form of sickness and a continuation of slavery (Mji, 2013). They regard this as one of the main negative social determinants of health.

Ohajunwa's (2019) PhD study is on the understanding, interpretation and expression of spirituality and its influence on care and wellbeing in an indigenous community. It highlighted the historical entrance of allopathic spirituality and healthcare into Africa, and the philosophical frameworks they represent which create tensions within South African indigenous contexts and which have negative social determinants of health and community wellbeing. Indigenous South African communities believe that allopathic healthcare and how it practises spirituality, has side-lined their indigenous spiritual practices. Ohajunwa's (2019) PhD findings coincide with Mji's (2013) study which suggests that according to older Xhosa women, there is a spiritual element to health and wellbeing as well as to sickness (Mji, 2013). The tensions that have been created within South African indigenous contexts that impact negatively on the social determinants of health and community wellbeing resulted in a sick de-rooted community in Bomvana which struggles to move forward as the pillars (religion, education and health) that held their community together have been fractured by foreign entries that undermined their cultural and spiritual interpretation of these three elements. Ohajunwa (2019) further expands how AmaBomvana have gone into a subliminal space hiding their own knowledge,

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understanding and interpretation of these three elements. When AmaBomvana then present themselves to the allopathic health services, having delved into one of these hidden knowledge systems that is indigenous health practices within the home and are then questioned by allopathic health professionals, AmaBomvana become silent. Mji (2019) questions whether this silence is about the indigenous health knowledge that has been used at home or a larger silencing of indigenous scholars that they should not have a voice nor any contribution when they enter modern society with its related structures and knowledge systems, such as the district hospital in Madwaleni.

Lastly, May's (2019) Master's thesis explored and identified the indigenous healers of Madwaleni and their relationship with ethnobotany and healthcare. The sickness these healers manage, and the herbs which are used to assist with each sickness, present some form of tension that continued to dominate the area between indigenous and allopathic health knowledge in Madwaleni. Allopathic health professionals in the area cite the lack of empirical evidence for the pharmacological effects of indigenous medicines as the reason behind their refusal to accept IHK as a valid health system.

The abovementioned studies have a common thread of looking at the allopathic knowledge as an opposing factor to indigenous knowledge. Whether from an educational, spiritual or a health point of view, there is a need to mention that these two knowledge systems exist in parallel and the current study focusses on the communication challenge as a threat between these two knowledge systems. The researcher, though focusing on Mji's (2013) PhD critical research outcome, will from time to time during the Participatory Research Activities draw from the above three studies as they also translated Mji's findings. All three point to the social determinants of health afflicting the Bomvana community.

The older Xhosa woman, as mentioned by Mji (2013) and other indigenous healers in the study area, experience difficulties in communicating the remedies and alternatives used when managing the illness of a family member. On the other hand, family members would consult indigenous healers before consulting health facilities and by the time they visit PHC the ailment would be major. Upon arrival at primary healthcare facility, the Xhosa woman keeps the use of indigenous medication a secret because of communication channels which seem to be a point of contestation between indigenous healers and allopathic health practitioners.

On the other hand, the positive community interventions of experienced women in the community, that Mji (2013) classified as elite women due to their knowledge of supporting sick community members, traditional healers and herbalists, and who at times assist the older Xhosa women when they are unable to manage the minor health ailments at home, should be included and integrated in the primary healthcare model for the people in the study area. The next step would be to determine how allopathic health and indigenous health knowledge link with each other, which is what the study

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is trying to achieve. There should be no exclusion or imposition but an inclusion and integration of both knowledge systems in terms of what works and does not work, and the communication bridge as the core of integrating the two existing healthcare knowledges in the study area.

Hence, the importance of developing CHFs would help the researcher, as well as the stake holders to begin addressing and linking the community with the health institutions existing in the area (nine (9) clinics and a district hospital) and vice versa. But this campaign would not be possible when tensions continue to dominate the landscape between indigenous health and allopathic knowledge holders in Madwaleni. Allopathic professionals in the area mention the lack of empirical evidence for the pharmacological functions of indigenous medicines as the reason behind their refusal to accept IHK as a valid health system (May, 2019). This notion is also supported by Mji (2013) where she mentioned the communication breakdown between allopathic practitioners and the indigenous community of Bomvana.

The issue of communication challenges put a risk in the possibility of successful management of health problems in the area by not providing the IHK practitioners with a space for discussion, and the sharing of the good aspects of IHK, and this should be encouraged to be part of the health system in the study area. As older Xhosa women were losing IHK at quite a fast rate, it appeared that the rate of learning about allopathic medicine was quite slow, as has already been shown in relation to the older Xhosa women, which meant a double loss of health resources for the rural community (Mji, 2013). There was also an attitude of the nurses towards the doctors who could not communicate in isiXhosa and towards the patients who required the doctors to hear and understand the history of their illness. Malcolm (2005) explains the pitfalls of poor communication between patients and doctors in medical practice. These pitfalls may be attributed to the inability of doctors to speak the indigenous language of their patients.

While not undermining the contribution of allopathic medicine, the influence of indigenous medicine has led to the birth of new conceptualisations in medicine. As a result, one of the subjects of focus in primary healthcare is how to establish a synergy between indigenous knowledge systems, modern medicine and scientific research. The new paradigm questions the predominance of allopathic medicine over the years. In agreement, Airhihenbumwa (1995) points out that health promotion and disease prevention practices continue to operate under the strong and direct influence of the allopathic model. He argues that although benefits are derived from such influence, it seems unquestionable that a profession that anchors its reason in the ability to influence human behaviour has consistently undermined, and in most cases ignored, the centrality of culture. Mulaudzi (2001)

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advocates for a synergy that could be the interaction of the two existing bodies of knowledge so that their combined effect is greater than the sum of their individual effects.

1.5 Concepts and process that underpins and drive the study

The point of departure for this study is based on Kleinman's conceptual framework and Mji's (2013) critical PhD research outcomes and the process by which these will be disseminated. Scholars of IKS have attempted to provide theoretical frameworks for the study of the relationship between medicine and culture. Kleinman encourages that the study of IKS and biomedicine should rather take an ethnomedical approach that looks at "a healthcare system as a cultural system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions" (Kleinman 1980:28). Kleinman suggests that in order for us to truly appreciate the similarities and differences between the allopathic and the indigenous health systems, one has to understand the three core themes of health, which are entrenched around the health-related components of society (Kleinman, 1980). These include how communities respond to their health needs and are: (a) the popular (the home), (b) the folk (indigenous healers) and (c) the professional (the district hospital and the nine (9) clinics). As earlier mentioned under motivation, there is a need to adapt theoretical models that have been developed in foreign contexts before implementation. Mji's critical research outcomes and the rural health model she suggested, including the process on how these are to be disseminated, offer a possibility of first giving a critique of Kleinman's conceptual framework by highlighting the silence on how the three areas will communicate. It is in this regard that Mji (2013) presented the rural health model that suggests the development of community health forums as a bridge linking the communities and the various healers (both allopathic and indigenous healers) in the community. The development of these community health forums intends to use community participation as a process of engagement with communities and health professionals and to also afford a space for communities to be acknowledged as partners. Using a community-based model focusing on community participation, it is expected that a new model will emerge from combining Kleinman's conceptual framework and Mji's rural health model as well as the outcomes that will emerge from the participatory action research that this study intends to explore. Below is a brief overview on Kleinman's conceptual framework:

1.5.1 Kleinman's conceptual framework

The three arenas that Kleinman mentioned are the popular (the home), the folk (IKS and indigenous healers) and the professional (the district hospital and the nine (9) clinics). The *popular* arena is known as the lay, non-professional domain of the society, where ill health is first recognized and defined, and healthcare activities are initiated. The popular arena within the CHF can be seen as the older Xhosa

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women who would play a pivotal role as first line practitioners in the home environment. These women manage and treat the ill persons at home where they are not physically removed from their familiar surroundings and have the support of the family and to a larger extent the community.

The *folk* arena is presented as certain individuals who specialize in a manner of healing that is either sacred or secular, or a mixture of the two. These healers are not part of the formalized or public medical system and are in an intermediate position between the popular and professional arenas. Many of folk healers have basically similar cultural values drawn from their communities, including beliefs about the origin, significance, and treatment of ill health (Kleinman, 1980). The folk arena within the CHFs would be the elite older Xhosa women, herbalists and traditional healers. Elite women are other older Xhosa women in the community with higher IHK who are consulted by older Xhosa women when their health management strategies have failed within the home situation. Herbalists and traditional healers are also consulted by the older Xhosa women when at times they are unable to manage the Minor Health Ailments (MHA) at home (Mji, 2013). The healing of the ill person is sometimes conducted within the home environment or in the community but not far away from the family support.

The *professional* arena constitutes the legally organized and sanctioned healing professions, such as modern allopathic medicine. It consists of not only physicians of various types and medical specialties, but also the recognized allied professions such as nurses, midwives and physiotherapists. Healers in this area have the authority to question or examine their patients, prescribe powerful and sometimes dangerous treatments or medication, and take way freedom from certain people by confining them to hospitals if they are diagnosed as psychotic or infectious. During consultation, the ill person is removed from family, friends and community, at a time of great personal crisis. Patients undergo a standardized ritual of "depersonalization" and become a numbered "case" in a ward full of strangers. The relationship of the health professionals with their patients is often characterized by distance, formality, brief conversations, and often the use of professional jargon (Jansen, 1973).

The three held arenas in Kleinman's health belief model are similar to that in the study area but Kleinman did not explain how the three arenas would work together and complement each other, hence this study. It was noted that rural South Africans swing between the three arenas, and due to a lack of availability of health services and a sense as in Kleinman's study, that there is very little communication between them. Maelene (2002) and Liddell et al., (2005) who were drawn for a review of an African health belief model, explain that traditional Africans do not believe in chance, bad luck or fate. They believe that for Africans every illness has a specific intention including causation. This was supported by Liddell et al., (2005) in the description of three categories of illness in Sub-Saharan

African culture. These authors put emphasis on the need to consider African beliefs and practices when dealing with rural African people (Mji, 2013).

1.5.2 Mji's critical study outcomes (MCSOs)

As earlier mentioned in the introduction, Mji's (2013) critical study outcomes which cover the following: definition of health and illness according to the older Xhosa women; social determinants of health that were blighting the villages of the study setting; minor and major health problems experienced by people residing in these villages; participation in cultural relevant activities according to age as a tool to determine level of health or sickness of an individual; and, human and medicinal assets lying dormant at community level that that can be used to manage health problems in the area. Mji (2013) further presented a rural primary healthcare model for the management of health problems in the study areas. As already mentioned, communication between indigenous healers and allopathic health professionals was a huge problem. Mji (2013) in her rural health model suggested that community health forums could be a bridge that links the home, the indigenous healers and allopathic health services in the study area. This model is suggesting the re-engineering of PHC with the goal of reversing the negative social health determinants. Community health forums in this model are presented as bridges that could be a glue between indigenous healthcare and allopathic healthcare. Below in figure 1 is Mji's Rural Health Model:

A rural primary health care model for the management of health problems in the 18 villages of Gusi

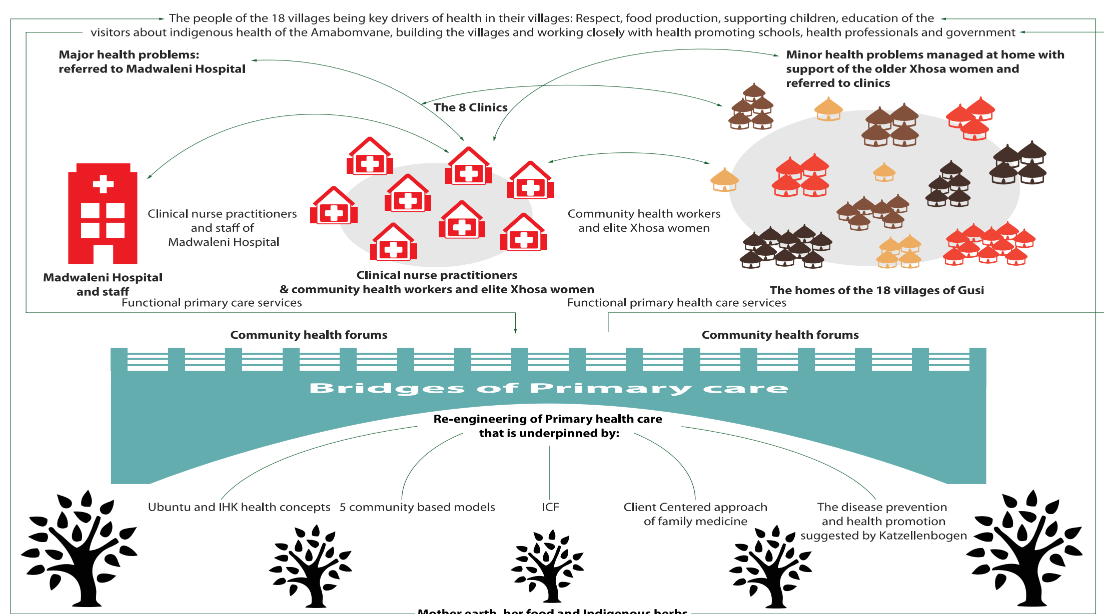

Figure 1: Mji's Rural Health Model (2013):

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From Mji's study (2013), the above-mentioned model envisages the following:

The people of Mbhashe municipality are the key drivers of the model.

The community health forums serve as a link between the various stakeholders.

The people of Mbhashe municipality are responsible for the management of minor health ailments, social health determinants and the early detection of other health problems.

The eight clinics supervise minor health ailments and social health determinants, and help with the early detection of other health problems, with proper referrals.

The hospital provides prompt intervention in the case of other health problems and in the monitoring of the smooth running of the suggested rural primary healthcare model.

Mother Earth, the sea and two rivers supply the people of Madwaleni with water, food and herbs, including grazing land for the animals.

The external agents are the government, academics, researchers and international partners.

Kleinman's model failed to address- how the three arenas will communicate while Mji's rural health model, though contextually based, left a gap where she neglected the folk arena which deals with indigenous healers and appeared to concentrate only on popular arena (Older Xhosa women and their families, elite women, and community health workers) and health professionals in health institutions. A copy of the research outcomes from Mji's study will be attached as Appendix F to this thesis.

1.5.3 Participation as a vehicle that drives the implementation of this doctoral thesis

There are six approaches that are included in the community-based model namely, the social capital model; the asset model; horizontal learning/recognition of prior knowledge; relationships in development; community participation, and model of disease prevention and health promotion (Mazibuko, 2017; Morgan & Ziglio, 2007; CDRA, 2005; Boon, 1996). Though the other approaches will be used indirectly, for the aim of this study, the focus would be community participation which occurs through the development of meaningful partnerships with communities. The reason why the study has chosen community participation is based on Rifkin's (1990) four arguments, namely, health services, economics, health promotion and social justice. Firstly, according to Rifkin (1990), the health services argument provides services that are underutilized and misused, because the people for whom they are designed are not involved in their development. Secondly, the economic argument exists in all communities, financial, material and human resources that could and should be mobilized to improve local health and environmental conditions. Thirdly, the health promotion argument that the greatest improvement in peoples' health is a result of what they do to and for themselves and it is not the result of medical interventions. And fourthly, the social justice argument that all people, especially the poor and disadvantaged, have both the right and duty to be involved in decisions that affect their

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daily lives. Therefore, strong community involvement and self-determination lead to a successful implementation of PHC (Werner & Sanders, 1997).

To grasp a community-based model such as community participation, O'Toole (1996:13) points out that the "*emergence of the PHC concept entailed acceptance of two principles that it is more important to bring about small improvements among the entire populations than to provide highest standard of care for a few privileged*" and that "non-professionals with limited training could provide crucial services". Therefore, involving local people is a way to bring about social learning for both planners and beneficiaries. Social learning means the development of partnerships between professionals and local people, in which each group learns from the other (World Bank, 1996).

This study draws its main intention from dissemination of Mji's (2013) findings. Hence development of CHFs would address the communication gap that has been left unaddressed by Kleinman's model and form a bridge between role players in the study arena, thereby giving hope for the Alma Ata philosophy of PHC. These CHFs could be used as a strategy to improve communication between allopathic health professionals and indigenous communities.

1.6 Aim of the study

Firstly, the aim of the study was to describe the process of developing Community Health Forums that would bridge the gap between allopathic health professionals and an indigenous community; and secondly, to improve communication between allopathic health professionals and the indigenous community of Bomvana.

1.7 Purpose of the study

The purpose contributed to the improvement of the health and health management of AmaBomvana people.

1.8 Objectives of the study

Using participatory action research (PAR), the researcher shared and discussed the objectives of this study with the study participants (Bergold & Thomas, 2012; Gelling & Munn-Giddings, 2011). During this discussion, these objectives were further affirmed, and though initially the study aimed to work mainly with Elite older Xhosa women, with the presentation of the first conference and the strong presence of other indigenous healers from the study, the study had to also accommodate these halers. The research objectives of this study were divided into short-term and intermediate term.

1.8.1 Short term objectives

For short-term objectives, the researcher explored the development of partnerships with the community, discussed and gain affirmation of the preliminary study objectives and where necessary

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added new objectives using the process community entry. This engagement led to the dissemination and exploration of Mji's (2013) critical research findings on the indigenous health knowledge and used a community-based participatory research cycle to disseminate these findings and where new understanding emerged that Mji did not discover integrate that new finding in this PhD report. The researcher used the dissemination process of these research findings as an activity to initiate the process of developing community health forums with the goal of clarifying roles. Mji's study was used as a springboard for the researcher to participate with the study participants in exploring and describing existing healthcare providers in the study area. This participation between the researcher and the study participants led to a further engagement of describing the existing communication channels between healthcare providers and the community and allowed the researcher to establish the type and channels of communication is required.

1.8.2 Intermediate objectives

For the intermediate term, the researcher engaged the study participants on the idea and process of developing CHFs. This engagement assisted in describing and developing a model that maps out how future communication channels and CHFs can function as a bridge between healthcare providers and community. During this research, there was a discussion about indicators for monitoring and evaluating the newly formed CHFs and communication channels as a model. In the case where it seemed that a CHF exists, but for some reason was not active, the researcher and the study participant discussed mechanisms on how to strengthen such forums. The newly developed CHF was then piloted in the four chosen areas for this research study but this was beyond the mandate of this doctoral thesis.

1.9 Outline of the thesis chapters

Chapter 1 therefore describes the emergence of the research question and presents an outline of important events that have placed this research in a community-based participatory action research model.

Chapter 2 reviews literature for this doctoral thesis whereby aspects such as, cultural relativism that one's truth depends on one's culture were discussed and further discusses the challenges affecting allopathic health practitioners and indigenous health practitioners that can be negotiated by collaborating and integrating these two knowledge systems. With a focus on communication challenges and lessons that could be learnt for the study area.

Chapter 3 outlines the indigenous methodological steps taken in the study. The selected research method, approach and design of the study is discussed in depth. The strategies employed to collect,

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analyse, ensure quality and rigorous data is also discussed. This chapter concludes with trustworthiness while ethical considerations ensured the integrity of the study.

Chapter 4 is the presentation of study findings from the narrative of the six phases that were used as the process of data collection.

Chapter 5 is the interpretation and discussion of findings for phase 1-4.

Chapter 6 is the interpretation and discussion of findings for phase 5 and 6, contribution to literature and theory.

Chapter 7 is the reflections on the research experience and concerns on the research process: the confessional tale.

Chapter 8: conclusion.

1.10 Concluding statement

The research findings from Mji's (2013) study clearly indicated that new knowledge holders such as allopathic medicine who brought in new knowledges regarding health, education and religion were gradually interfering with the Bomvana ways of knowing. It is hoped that the CHF would uncover and integrate both allopathic medicine and IHK. The CHFs would also assist the people of the study area by providing necessary support and creation of advice; provide solutions - especially in cases where a person falls sick in the middle of the night and where a scarcity of paramedical vehicles to transport a sick person to the nearest public healthcare centre.

This first chapter assisted then this doctoral thesis with:

a. Outlining the evolution of the problem.
b. Presenting the problem for this study.
c. Presenting the motivation of the study.
d. Concepts and process that drives the study.
e. Aim, purpose, and study objectives.
f. And ended with outline of the thesis chapters.

The next chapter is the literature review.

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Chapter 2: Literature Review

"No need to hear your voice when I talk about you, better than you speak about yourself… Only tell me about your plan. I want to know your story. And then I will tell it back to you in a new way. Re-writing you, I will write myself anew. I am still the author, authority. I am still the colonizer, the speak subject, and you are now the centre of my talk" (Hooks, 1990:153)

2.1 Introduction

Despite the introduction of Western medicine and healthcare systems in Africa, many African communities still rely on indigenous healthcare (Mothibe & Sibanda, 2019; WHO, 2001). Traditional healers hold an esteemed and powerful position in southern African societies (Hewson, 1998). Their role is that of physician, counsellor, psychiatrist and priest, and people visit a traditional healer for problems ranging from social dilemmas to major medical illnesses. They therefore have a role to play in building the health system in South Africa. In a country where the needs are great and resources inadequate, traditional healers can play an important and valuable role in helping communities to improve their health and quality of life (Truter, 2007).

Although modem "medicine is increasingly accepted as the treatment of choice by most" South Africans, in rural parts of the country "eclectically chosen combinations of modern and indigenous medicine remain common" (Edwards, 1986: 1273). There are certain rural areas in South Africa where indigenous health knowledge has been practiced in parallel with allopathic knowledge. This is also evident in the research area, where both modern and indigenous medicine seem to exist in servicing the community. In most rural areas where one has to travel long distance to gain access to allopathic healthcare, the most immediately available healthcare system is indigenous health knowledge. Secondly, the way allopathic healthcare describes health and illness is dissimilar to the way indigenous peoples describe health and illness. Hence, when indigenous people are ill, they go back to the healthcare management of the home which is the Indigenous Health Knowledge (IHK) where they can get a better understanding of their illness. But one realizes that in a country like South Africa (SA), as in other countries where the dominant healthcare system is based on allopathic medicine or where Traditional Medicine (TM) has not been incorporated into the national healthcare system, all other TM not indigenous to SA are termed "complementary", "alternative" or "non-conventional" medicine (Mothibe & Sibanda, 2019).

As mentioned in Chapter 1 that in the research area, there is a communication challenge between the District hospital, the nine (9) clinics at primary care level and the indigenous community. In order to cover some of the critical aspects raised in chapter 1, this chapter will be divided into four (4) sections

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that will form the subtopics with an intention of gaining an understanding on the research topic. Section one (1) will deal with aspects of indigenous knowledge systems, indigenous people and the indigenous healing and medicine. Section two (2) will focus on challenges of Indigenous Knowledge Systems (IKS) including Indigenous Health Knowledge (IHK) especially in areas where allopathic medicine is practiced. Section three (3) will discuss international perspectives, the African and South African perspectives and tackling issues on who indigenous healers are, how they are perceived by people, what the relationship is between indigenous healers and biomedicine, how the communication and scope of practice of IHK operates, policies that integrate IHK, and lastly, lessons that can be learnt for the research area. The chapter will conclude with section four (4) which will deal with models of best practice internationally, and in South Africa.

2.2 Defining indigenous knowledge systems, indigenous people, and indigenous health knowledge

This section will discuss the indigenous knowledge systems, and indigenous people with an emphasis on the issue of culture and indigenous health as a community asset. An indigenous understanding of health and wellness, and how to restore and protect IHK will be discussed. The section concludes with indigenous healing and medicine.

2.2.1 Indigenous knowledge systems

Indigenous knowledge or African knowledge, used here interchangeably, is practical knowledge based on a culture with a worldview that is interpersonal and interlinked (Oseni & Shannon, 2020; Owusu-Ansah & Mji, 2013). It is believed that an African spirit is based on a worldview that is rooted and embedded in cultural values within a community living in harmony (Owusu-Ansah & Mji, 2013). A true person is seen as human amongst others when he/she seeks both individual and collective harmony as a primary task (Sarpong, 2002; Sarpong, 1991). Like its peoples, acquisition of knowledge is collective and community-oriented. In African culture, acquired knowledge is based on a collective not individualistic. There is interdependence and interconnectedness when the survival of the group is based on the collective effort where values and harmony are rooted in an African worldview (Mkabela, 2005; Sarpong, 2002; Sarpong, 1991).

African knowledge, and its method of acquisition, therefore, has a practical, collective and social or interpersonal viewpoint. This is a practical worldview where the method of attainment is based on collective point of view. This type of knowledge is characterised by oral when it is passed by word of mouth from one to the next (Mkabela 2005; Sarpong 1991). Since this knowledge system seemed to be passed from generation to generation orally, it has its own challenges in being looked down upon by other written knowledge systems as a system that has no research basis and no point of reference

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when compared to the systems that are documented and written (Owusu-Ansah & Mji, 2013). Partly because indigenous knowledge is mainly oral and not written, and partly because it is people-centred and sometimes not so easily 'measurable' (Emeagwali, 2003), it has been mistaken by many as simplistic and not cooperative to systematic scientific investigation. Because of the oral nature of this knowledge, this therefore makes it vulnerable to scientific investigation. However, its rich complexities are found in the community ceremonies and rituals, namely, storytelling, proverbs, folktales, recitation, demonstration, sport, epic, poetry, reasoning, riddles, praise, songs, word games, puzzles, tongue-twisters, dance, music, and other education-centred activities (Ngara, 2007). Nevertheless, it has its richness intertwined with communal rites and activities such as storytelling, poetry and other informative events (Ngara, 2007). In his study Zonke (2005) further expands on and describes indigenous knowledge as infused within a particular community with skills, values and specific technology.

There are shortcomings and challenges within African indigenous knowledge. One of the challenges of African indigenous knowledge is the veil of secrecy and inflexibility to accept constructive criticism (Owusu-Ansah & Mji, 2013). This type of knowledge is also subjected to social changes in the environment just like any other knowledge (Tanyanyiwa & Chikwanha, 2011). Therefore, its acceptance must be subject to critical observation and analysis, since by its very nature and because of external forces such as colonization, it has challenges of the hidden knowledges.

2.2.2 Indigenous people

According to Melchias (2001:35) indigenous people refers to "culturally distinct groups with a different identity from the national society, draw existence from local resources which are politically non-dominant". Although the definition of the indigenous people is seen as communal and collective in its nature and not identical to the governing society, this makes it defenceless to being deprived by development process (Mothibe & Sibanda, 2019). There is no general accepted definition for indigenous people as suggested by United Nations accept that they are defined as people with historical stability and dissimilar to the governing society (Cobo, 1987).

Cobo's study findings show that at best the health situation of indigenous peoples mirrors that of the world's very poorest but is made worse by their social and cultural marginalization. It is known that currently the WHO has no authorised description for the term "indigenous" but to give a description to indigenous as cultural beings with strong communal values (WHO, 2007).

2.2.3 Issue of culture and its importance to indigenous people

The illness and healthcare systems of a particular community is defined by the value and principles of how that specific community views the world (White, 2015; Craffert, 1997). Every society develops its

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own cultural way of dealing with illnesses. For example, the Chinese, native Americans, native Hawaiians, Australian Aborigines, Indians, the Maori in New Zealand, indigenous Africans and many other indigenous peoples have their own special ways and remedies for dealing with physiological, psychiatric and spiritual conditions. A psychological perspective to illustrate this point of view has been researched using Carl Jung's concept, where these could be regarded as part of the 'Collective Unconscious' of these societies (Berg, 2003) and aspects of this collective unconscious tend to resurface in some few selected individuals in the form of traditional healers. Berg (2003) terms the "Collective Unconscious by Jung" known as life cycle rituals in indigenous community while in European culture known as Western Psychotherapeutic philosophies and applications.

George Kelly, an American personality psychologist and philosopher, developed the philosophy that he called 'Constructive Alternativism', which challenges the notion of a single objective reality (Boeree, n.d.; Pervin & John, 2001). George Kelly, an American personality psychologist and philosopher, established a viewpoint and called it a 'Constructive Alternativism' that contests the sole impartial conception of certainty (Boeree, n.d.; Pervin & John, 2001). The concept of certainty can be created, construed in many ways. For example, the traditional African healer has a different construction and aetiology about schizophrenia (*mafofonyane*) to that of a Western healer (Mokgobi, 2012). For example, indigenous healers define serious mental disorder as *mafofonyane* which is different from that of western knowledge (Mokgobi, 2012). The allopathic health practitioner focuses on the biochemical of severe mental disorder while indigenous healers focuses on who caused the illness and why (Mokgobi, 2012). It is then a question when one healthcare system has preference over the other, as in the case of severe mental disorder (Mokgobi, 2012).

In any case, the issue of severe mental disorder is still a matter of discussion even amongst allopathic healthcare writings, with many writer choosing a multidimensional approach (Beck, 1986; Luhrmann, 2012). This submits that severe mental disorder might be triggered by a diversity of issues from biochemical to ecological factors. Boeree (n.d.) maintained that no sole construction of severe mental disorder is ever absolute because the realm is too big and complex for any person to claim to have a flawless viewpoint which could be regarded as general. Thus, "almost everything, even science, turns out to be a matter of opinion, simply because it is so hard to prove or know anything beyond doubt or question" (Rudinow & Barry, 2004, p.15). So, what needs to be considered in the case of severe mental disorder is the entire concern of 'cultural relativism' that recommends the explanations of illness or bad luck are culture reliant (Teuton et al., 2007). Well, the variations in the explanation of illnesses and bad luck are qualitative in nature (Mokgobi, 2012).

Rudnick (2002) stated that the South African in this regard is just as extremely multifaceted and mixed and can be fittingly be separated into two wide classifications, namely (a) the allopathic healthcare

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view, and (b) the indigenous knowledge system. The African indigenous knowledge system has been in survival for many eras (Mokgobi, 2012). The indigenous healers in South Africa have been active with their craft by utilising what Hess (1998) mentioned as the fruit of mother earth. This notion was well argued by Barsh (1997) who maintained that indigenous healing systems do not just apply medication but contemplate a reason that one sick person has a varied cultural background, and therefore, different medication for different circumstances and people – different strokes for different folks. In other words, indigenous healers do not advocate the 'one size fits all' method to their consumers (Mokgobi, 2012). Each health management is tailor-made to agree with each consumer's ethnic principles and practices (Mokgobi, 2012).

2.2.4 Indigenous health as a community asset

In all African regions, indigenous healers are very resourceful and play a pivotal role in many spheres of people's lives (Zuma et al., 2016). Their role cannot be emphasised enough. In addition, the African indigenous healers have multiple roles of being gurus about indigenous knowledge and spirituality (Yeboah, 2000). They also assume duties and roles of being counsellors, social workers and skilled psychotherapists while performing their duties as indigenous healers (Berg, 2003; Mills et al., 2005). The amenities of indigenous healers go far beyond the use of herbs for bodily ailments. They have, for example, found to be useful in time of pre- and post-war for societal restoration and public transformation in Mozambique, predominantly in the rural areas (Honwana, 1997). It is uncertain whether allopathic healthcare services would have been suitable in Mozambique, since indigenous healers rendered ethnically applicable psychosomatic services that included communication with the ancestors (Honwana, 1997). This is no different in South Africa where a number of indigenous healers exist and practice their indigenous knowledge.

2.2.5 Indigenous understanding and interpretation of health and wellness

Relating to the current research study, indigenous health knowledge (IHK) is not restricted to time, space and extent, but keeps redefining itself according to the challenges and changes that indigenous people experience in their environment. The IHK refers precisely to home-grown methods, managements, and societal methodologies that are used by indigenous peoples when faced with health complications in their community (Mji, 2013).

Indigenous perceptions of health and wellbeing are designed by larger communal organizations, counting family, community, nature and God (Svenson & Lafontaine, 1999). Health is attained by preserving a stability of physical, mental, emotional and spiritual fundamentals (Svenson & Lafontaine, 1999). Relating to the people in the study setting AmaBomvana, good health requires not only a healthy physical body but also healthy spiritual relationships with the ancestors and with the

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environment (Mji, 2013). Ohajunwa and Mji describe the AmaBomvana intricately by affirming that their "*spiritual connections are sustained through various spiritual rites that are believed to facilitate connectedness to God and ancestors, self and others, the earth, plants and animal life*" (Ohajunwa & Mji, 2018:7). These spiritual rites through the assistance of animals, plants, vegetation and the environment of the AmaBomvana include ritual sacrifice of goats, sheep, and cattle to appease the ancestors. In addition, the brewing of traditional beer known as *umqombothi* is a means of maintaining healthy relationships with the ancestral spirits (Ohajunwa & Mji, 2018; Mji, 2013).

Bomvana people participate in definite procedures that are primarily designed to guard their complete health through strengthening their resistance and that of their relatives to endure physical and spiritual injury (May, 2019). These procedures include the preservation of spiritual balance with their ancestors and natural settings through rituals and spiritual manifestation (Winkel, 2010). To attain this balance, several activities need to be executed, such as interacting with the ancestral shades through ceremonial sacrifice, consultation with indigenous healers and using indigenous medicines known as *amayeza* (Foster, 1967). Communication with the ancestors for the preservation of health and wellbeing is conducted by qualified indigenous health experts (Dold & Cocks, 2012). Therefore, for indigenous people to be healthy the communal, emotional, and ethnic well-being of the entire society is being considered (National Aboriginal Health Strategy Working Party, 1989).

A constant and dynamic connection with motherland means that the wellbeing of community and the land plays a significant role in shaping the wellbeing of the people themselves (Green, 2008). This understanding of wellbeing proceeds a whole-of-life method and can embrace the recurrent notion of life-death-life (Australian Institute of Health & Welfare, 2014). As Mji (2013) mentioned in her study that the older Xhosa woman, among other factors, regards ploughing of the land as a source of food security as good health, whereas the inability to plough the land will result in hunger and malnutrition in children and brings about sickness in the family and ultimately in the community.

2.2.6 Restoration and Protection of Indigenous Health Knowledge (IHK)

The oppressive colonial, dogmatic and philosophical apparatuses exercised steady policies of oppression and consensus on their African subjects resulting in compete compliance of the people and dislodgement of their belief systems and systems of knowing (Pavlik et al., 2021). The movement and interruption strategies intended to impound the land and its rich resources, provoked the ruptured African communities, and hence, the loss of their knowledge systems that were closely connected and largely generated and reproduced by the very lands and environments that were taken away from them. Hence, restoration of the African Indigenous Knowledge System (AIKS) is indeed,

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one of the intimidating encounters facing decision makers and scholars today (Pavlik et al., 2021; Osman, 2009).

Another grave challenge is the defence of the indigenous resources and equally so, the indigenous knowledge linked with them from “legalized” piracy which is qualified and led to national and international (pharmaceutical, medical cosmetic) corporations and their associated research institutions. Unfortunately, it is often the instance that piracy of knowledge and resources is protected by joint arrangements between indisposed African governments and worldwide corporates under the false ploy of progress programmes (Moahi, 2007). Another associated encounter is the defence of African Indigenous Knowledge (AIK) from internet damages, information, low-cost and commercial globalization, which have deprived the local communities of their knowledge systems, resources and products. The cultural globalization is also contributing to the destruction and ultimate removal of AIKS as the inclination is to terminate undocumented and “unscientific” knowledge (ibid: 3).

Finally, there is the challenge of implementation of Intellectual Property Rights (IPR). While, the IPR is given prominence in the knowledge economy, much (if not all) of the knowledge products are vested in those who produce (but do not own) them (ibid: 4). In this regard, there are also the underlying legal and technical challenges of implementation of IPR for the benefit of the indigenous communities. Legally, IPR are of individualistic nature thus, they are not applicable to the collective and communal ownership of knowledge among the indigenous communities. Although this legal barrier is being spoken, the dissimilar terminologies of AIK (such as weaving, basketry, music, songs costumes, fashion, symbols, etc.) are being duplicated and commercially privatized by outsiders (*including the Chinese*). Technically, identification of the communities to which certain knowledge assets and/or products belong, poses another challenge as there are hundreds (if not thousands) of groups and communities in Africa.

Mostly, it can be said that monetary incentive is the core aspect supporting the protection of indigenous knowledge (Masango, 2010). This is because monetary deliberations profit both individuals and the community. In occurrences where monetary considerations are not part of the base or may be difficult to form the basis of the protection of indigenous knowledge, as is the case with myths, traditional beliefs, superstition, stories and customs, there may not be any reason for fortification. These opinions are ‘not a permanent entity that can be captured’ (Warah, 2009), within indigenous knowledge. Additionally, these opinions have no ‘facility to attract revenue for its use’ and do ‘not lead to any material benefit to any community in South Africa’. The Intellectual Bill (Masango, 2010 - “An Abomination”, 2009) consequently proposes that there is no known structure according to

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allopathic standards for indigenous healers to practice so that they can obtain material benefit. For this Bill to be operative, it needs to include and allow indigenous health knowledge a platform. However, to circulate a bill that would protect indigenous traditional knowledge in South Africa, the communities have to be consulted.

Where they are not consulted; the communities may not accomplish viable development. According to Loomis (2000), indigenous peoples' notions, values, models and exertions to explore alternate development routes have largely been disregarded in efforts to "conceptualize and operationalize sustainable development". Therefore, it can be said that until monetary facets stop being a prime point for the fortification of indigenous knowledge, the South African intellectual property laws will not be able to guard all types of indigenous knowledge. The handover of information is another flaw in indigenous healing (Mokgobi, 2012). Information is by and large not well documented because of the general deficiency of control on the part of many indigenous healers, as Asuni (1979) pointed out, and even indigenous healers who are highly knowledgeable and refined continue the practice of not putting indigenous healing knowledge in writing. This practice could, nonetheless, also be ascribed to the confidence that oral transmission of information is more influential than the printed expression (Mokgobi, 2012). Information is usually passed down from generation to generation through word of mouth or can be conveyed from the ancestors to their offspring through dreams and visions (Cullinan, 2008). As a consequence, information can be distorted, diluted or even misplaced in the passage of time (Asuni, 1979). These criticisms and other factors may hinder the proposed integration of indigenous healing and allopathic healing.

2.2.7 Indigenous healing and indigenous medicine

According to UNAIDS (2006), indigenous healing expands from managing ailments with herbs to spiritual treatment. This is perceived as an all-inclusive method that personifies the shared understanding of indigenous knowledge handed down over many generations (Ashforth, 2005). Although scholars use the overarching term 'traditional healing' when referring to many healing systems different from the allopathic healing system, indigenous medicines throughout the globe are vibrant and adaptable because of diverse regions and countries of origin and because of diverse agricultural systems in which they exist (Good et al., 1979). Indigenous healing is not a standardised healing system but differs from culture to culture and from region to region. It appears to be well-rooted in some countries and regions when equated to others (Sofowora, 1996). For example, it is well planned and reputable in countries such as China compared with countries such as South Africa and this has been discussed in the subtopic of indigenous health knowledge internationally.

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The WHO (2000:1) defines traditional medicine/healthcare as '*the total combination of knowledge and practice, whether explicable or not, used in diagnosing, preventing or eliminating physical, mental and social diseases. This practice exclusively relies on past experience and observation handed down from generation to generation verbally or in written form'*. In the interpretation of Helms and Cook (1999), indigenous healing indicates to the supportive principles and practices that originate within a culture or society and are deliberated to treat the people of a particular community. Kofi-Tsekpo (2004: i–i) notes that the phrase 'indigenous medicine' has become a slogan between the pioneers in all African countries. This is partially because the practise of herbal concoctions has expanded approval internationally and the manipulation of these medications has become a multimillion business. He further argues that the term 'African traditional medicine' is not identical with 'alternative and complementary medicine'. African traditional medicine is the African indigenous system of healthcare and cannot, therefore, be an alternative. The notion of indigenous medicine in South Africa occurred long before the progress and spread of modern medicine (Setswe, 1999). The realm of South African indigenous medicine is one in which there is no hypothetical departure from the regular and mystical domains (Beyers, 2010). The philosophy underlying the source of ailments within black South Africans is impartially alike (May, 2019). The certainty is that illness is a mystical wonder ruled by the fragmented relations amongst living persons, the ancestral spirits, animals, plants and other substances originating in the surroundings (Mji, 2013). Wellbeing, consequently, is a state of synchronisation amongst all these objects (Ohenjo et al., 2006).

The South African indigenous healing procedures shadow diverse practices in bringing about health (Mokgobi, 2014). Initially, there has to be an identification of the ailment and its origins (Mokgobi, 2014; Setswe, 1999). This is done through the procedure of prophecy during a session with an indigenous doctor. Another phase is the deactivation of the origin of the ailment either by the elimination of its cause using medicinal plants and herbs, or through ceremonial sacrifice to appease the patients' clan ancestors that are assumed to oversee their health (Mokgobi, 2014 & Setswe, 1999). In all the several phases of healing, the patient is rehabilitated within the setting of family and community (Mji, 2013). The burden of illness is shared between associated community members and all members contribute in the remedial route by displaying support and Ubuntu to the patient (Mji, 2013; Mbiti, 1969).

2.2.8 Summary of this section

This section commenced by discussing the indigenous knowledge systems, indigenous people and indigenous health knowledge. Indigenous knowledge system has been discussed as a knowledge system that is characteristically oral and passed on from generation to generation in the context of community living and activities. While Indigenous people are said to be a culturally distinct group with

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a different identity from the national society, drawing existence from local resources which are politically non-dominant. Culture has been discussed as a strength to the health of indigenous people. The importance of culture is also deliberated where Craffert (1997) argued that disease and healthcare systems in any humanity are in one way or another persistently or closely linked to the philosophy or worldviews of those humanities. As a cultural group, the indigenous understanding of health and wellness is attained by preserving a balance of physical, mental, emotional, and spiritual elements (Svenson et al., 1999). For indigenous people to fully exist in their environment, it is imperative to re-establish and safeguard IHK as part of their own identity. The section concluded with indigenous healing and indigenous medicine, where indigenous healing stretches from handling ailments with herbs, to spiritual management and indigenous medicine which dealt with the total blend of information and practice.

2.2.9 What are the strengths and weaknesses of Indigenous Knowledge Systems (IKS)?

While there are strengths, there are also weaknesses that are associated with IKS. On one hand, indigenous knowledge has played meaningfully constructive champions who have endorsed sustainable development for communities living in rural villages and remote areas (Voluntary National Review (VNR) Report, 2019; Alayasa, 2012). Indigenous knowledge community-based outlines showed significant focus on the assets of indigenous philosophy where the indigenous community is categorised by their daily living, qualities and common ideas. Social cohesion, the integration process, and special benefits for policy application from the community level are key constituents of sustainable development in local conditions (Alayasa, 2012).

On the other hand, however, there is past and current evidence that indigenous peoples have also committed environmental 'sins' through over-grazing, over-hunting, or over-cultivation of the land. It is misleading to think of IKS is always being 'good,' 'right' or 'sustainable' (Langill, 1999). The issue of over-grazing animals, over-hunting which may result in endangered species, and over-cultivation of the land may result in poor crop production which could have a negative impact on food security. It is also imperative to recognise that this is also a veiled information system that has not been given a chance to be deliberated and enhanced (Sinnot & Wittmann, 2001; Durie, 2004; Posey, 1999). What is significant is to first bring this information system into the open so that it can be recognised and secondly, be aided with facets in the information system that some might regard as unsafe or old-fashioned so that they could be detached from the information system. Consultation and accord from the knowledge owners is serious during this process of revitalisation and enhancement of this information system (Mji, 2013). The next section will discuss the challenges that affect both allopathic health practitioners and indigenous health practitioners.

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2.3 Challenges affecting allopathic and indigenous health practitioners

This section deals with the challenges that affect allopathic health practitioners in working together with indigenous health practitioners. The discussion will commence with challenges that IKS and IHK experience in areas where allopathic health systems exist. These challenges vary from insufficient knowledge of Traditional Medicine ™, inability to converse in local languages, discrimination, and emigration of allopathic healthcare practitioners. The section will also discuss the negative attitudes of the healthcare practitioners in the research study and conclude with communication as a challenge between allopathic health practitioners and the indigenous community.

2.3.1 Challenges of IKS including IHK especially in areas where there is allopathic healthcare services

The challenges that are discussed in this section are based on the research that was conducted in Ghana about the integration of indigenous healers into the healthcare system. Krah (2018) mentioned that amongst other encounters that indigenous healers experience are the matters of inadequate information of Traditional Medicine (TM) by health professionals. Krah's (2018) study indicated that healthcare workers have incomplete understanding of indigenous conceptions of health, especially the healthcare workers that work in rural allopathic healthcare facilities who are not foreigners in the communities they attend. There are regions where one finds graduates and students who are doing obligatory internship within the allopathic healthcare, and from those graduates and students, there will be a number who do not know how to converse in the local language. This prevents their understanding of the indigenous ethnic philosophies and practices that impact the community's health choices and therefore, could lead to a prejudice against Traditional Medicine (TM). This is similar to the study area of this research where one finds a handful of exchange students from Europe working and helping in the healthcare facilities from a programme organized by the Donald Woods Foundation (DWF) who could not converse in and understand the local language.

King (2006) and Homsy et al., 2004 suggest that there is inadequate understanding that is complicated by varied education which hints at discernment of healers and their clients by healthcare practitioners. This has been confirmed in the study by Krah (2018) when some allopathic healthcare practitioners linked TM with being underdeveloped and backward. Also, patients that were interviewed during this research mentioned that they were insulted during their consultations and also being denied allopathic care when exhibiting signs of usage of TM. Such poor treatment results in reluctance by the indigenous communities to seek help from the allopathic healthcare practitioners and ultimately avoiding such facilities. This mitigates against diagnosis from the allopathic healthcare practitioner and increases the danger of difficulties for the patient who desires medication and management.

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The relocation of allopathic healthcare practitioners is also an influential aspect as they move from public to private health sectors and from rural to urban areas seeking better career opportunities (Connell et al., 2006; Kingman, 2006; Stilwell et al., 2004; Pang et al., 2002). It is also evident in our public health facilities where people migrate from rural areas to urban areas to seek better job opportunities and this could result in staff shortages in rural public health facilities. The consequences of staff turnover and temporary staff engagements and internships weakens the formation of trust between healers and allopathic health staff (Krah, 2018) and this results in relations between indigenous healers and doctors being superficial, particularly in certain isolated places, where indigenous healers are often unfamiliar with the local health centre staff. This is a noteworthy as it prevents cross-referring and collaboration as referring is often a person-to-person effort (Krah, 2018).

2.3.2 Challenges between allopathic health practitioners and indigenous health practitioners

There are challenges that exist between allopathic healthcare practitioners and indigenous practitioners. In a research that was conducted in AmaThole District (Eastern Cape) by Van Rooyen et al., 2015, they illustrate that both allopathic health practitioners and indigenous health healers experience negative attitudes towards each other. On the part of the indigenous healers, the negative attitude towards allopathic practitioners is categorised by one-sided referral systems.

In contrast, allopathic health practitioners generally have a negative attitude towards indigenous health practitioners and often warn patients against seeking their services. The allopathic health practitioners highlighted that their negative attitude originated from the practices of indigenous health practitioners such as their unempirical approaches used in handling patients. Some of these include the non-use of hand washing, use of non-sterile equipment and the lack of measured prescription of indigenous medicine according to the age and weight of the patient. The second reason of the negative attitude towards indigenous healers is due to the intrusion of the effectiveness of allopathic healthcare treatments.

Allopathic health practitioners restate that in some circumstances, indigenous healers and the patient's families hinder the effectiveness of allopathic treatment by providing the patients with indigenous medicine from home. Allopathic health practitioners stated that these could possibly cause medication interactions, possibly worsening the symptoms and sometimes the death of the patient. Thirdly, the postponements by indigenous healers in referring patients to allopathic facilities could also result in negative attitudes. The allopathic health practitioners were concerned that indigenous health practitioners were keeping patients under their care far too long and only referring them when the patient's condition was at an advanced stage (from being a minor to a major ailment). Allopathic

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healthcare practitioners stated that the delays in referrals resulted in lengthy hospitalization and made it problematic to implement certain analytical, clinical and therapeutic procedures.

2.3.3 The issue of bewitched and the utilization of psychological issues

In a study conducted in the Bohlabelo district (Limpopo) by Ngomane and Mulaudzi on indigenous beliefs and practices that influence the delayed attendance of women at antenatal clinics, they confirmed that the fear of being bewitched caused the delay. These women used herbs to preserve and safeguard their unborn babies from injury (Ngomane & Mulaudzi, 2010), and also trusted the information of *ababelekisi*, preferring their care and knowledge to the rough handling that they received from midwives in allopathic healthcare facilities who look down on their indigenous principles and practices. Both these authors suggested that more consideration should be paid to expedite improvement of birth attendants at community level. The Department of Health should develop practices to reinforce unity. The midwifery and nursing curriculum should comprise teaching on indigenous handling methodology, to decrease ethnic apathy and struggle during care-giving. Transcultural midwifery and nursing modules should be compulsory in the training of nurses from the lowest level to reinforce ethnic open-mindedness (Ngomane & Mulaudzi, 2010).

South African authors such as, Strous and Eagle (2004), deliberated how opposing morals of racism, human-based counselling theory and the ideal of universal human rights are likely to affect timid cultures when white psychologists arrogantly deal with racially important material. The delivery of suitable amenities to African communities is therefore reliant on the psychologist’s capabilities. Whitehead (2003) proposes that it is vital that psychologists have precise, ethnically receptive capabilities to deliver suitable services to diverse populations, such as dissimilar ethnic and spiritual populations. Therefore, this study by Ruane recommended that white psychologists need to be culturally sensitive in the sense that South Africa’s severe mental health disorders are positioned within the background of an apartheid legacy, including matters of disadvantaged quality education, joblessness, insufficient housing and power inequalities (Blokland, 1992). Therefore, culture is sometimes used as the cypher term for class manipulation ‘in the sense of township culture and working-class culture’ (Eagle, 2005, p.51). It is on this level that the issue of cultural sensitivity is discussed, and not the level of race.

2.3.4 The need to recognize the strengths and weaknesses of each health system

Allopathic and indigenous healthcare systems each appear to carry their own strength and autonomy. The fact that each health system has been existing on its own makes it a challenge for the two health systems to work together. In an indigenous community, independent growth begins with the community's idea of a future it wants to shape, the standards it wants to endorse and of the past it

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wants to create (Cultural Survival, 2020). Community-controlled autonomous development would not openly disadvantage some parts of the ethnic culture in order to progress others. It is based on an understanding and respect for the integrative purpose of dissimilar facets of a society. The unlimited task for indigenous societies is to integrate with industrial-modern world, both state-run and private, participating in valuable structures of that unknown organisation, while at the same time confirming the honesty and symmetry that originates in indigenous culture and society (Cultural Survival, 2020).

While it is important to advocate for autonomous development, the challenge is once again the impact of globalization and the changing circumstances which afford such space for autonomy. The very indigenous community exists as a marginal in a classification where there are rules that oversee the society (Binder & Binder, 2016). The notion from the indigenous community of who caused the illness and why may cause a minor ailment to become major because the indigenous community seeks consultation from indigenous healers, which may further delay the healing process. On the other hand, the allopathic healthcare practitioners base their healing on the diagnosis of the ailment focusing on what it is and how it was manifested. There is a possibility that these two knowledge systems can complement each other to develop stronger health systems. The following section will discuss perspectives on indigenous health.

2.3.5 Summary of the section

This section has discussed challenges affecting allopathic and indigenous health practitioners. There are challenges which affect IKS and IHK especially in areas where there is allopathic healthcare. Some of these challenges include the insufficient knowledge of indigenous medicine especially by allopathic health practitioners in rural healthcare facilities. The other challenge is the existence of exchange students and doctors from Europe where they assist in the study area's health facilities but are unable to converse in the local language. The section also discussed the challenges between allopathic health practitioners and indigenous health practitioners that are characterized by negative attitudes and one-sided referrals. The issue of bewitched and the utilization of psychological issues from the side of an indigenous community concluded the section. This section ends with recommendations that the two health systems should try to work closer to strengthen health systems.

2.4 Perspectives on indigenous health knowledge

This section will be divided into three sections, international perspective, African perspective and South African perspective on indigenous health. Each section will discuss indigenous/traditional medicine of each area and the lessons that could learnt for the benefit of the research study.

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2.4.1 International perspective

The international perspective discussed in this section will be based on the Traditional Chinese Medicine (TCM) from China and Aboriginal and Torres Islander from Australia.

2.4.1.1 Traditional Chinese Medicine (TCM)

Chinese indigenous medicine is based on the viewpoint of 'Yin and Yang' which emanates from 8th century BC (Men & Guo, 2010). 'Yin' represents the earth, femininity and cold. In contrast, the 'yang' represents the sky, masculinity and heat (Latif, 2010). In China, this medicine has co-existed with contemporary allopathic medicine for centuries.

Chinese medicine unrelentingly progresses with the founding of indigenous medicine colleges and institutions. The Chinese Medicine has grown over the years with 95% of these 2600 practitioners dedicated to traditional Chinese medicine (TCM). After 1960, the method of apprenticeship was changed to a formal education system, which is a five-year course. There are 28 universities in China that offer the course in TCM and traditional pharmacology (Latif, 2010). There is also integration of TCM to medical education (NRCATM: 20).

Lessons that could be learnt from TCM

For the benefit of this research study, the holistic view of the Chinese Traditional Medicine (TCM) could be adopted for the people of Bomvane since it incorporates diagnosis and treatment of the patient's symptoms. Secondly, the fact that TCM has coexisted with modern medicine has also played a pivotal role, which could also be implemented in the South African health system where both indigenous health knowledge and modern medicine could coexist for the benefit of the majority of people who are the uncomfortable in-betweeneers as mentioned by Ned (2019) in her research study.

2.4.1.2 Aboriginal health in Australia and New Zealand

In Australia, the Aboriginal definition of health refers "*not just to the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their community*" (Durey & Thompson 2012:9). This worldview also "includes the cyclical concept of life-death-life" (NACCHO, 2006). In Australia, the word 'Aboriginal' is used instead of 'Indigenous' as "the term Aboriginal is inclusive of all Aboriginal and Torres Strait Islander Peoples" (New Zealand, 2013). Nevertheless, in theoretical training, New Zealand uses the expressions indigenous and Aboriginal interchangeably (New Zealand, 2013). The utmost noticeable indigenous group in New Zealand are the Maori people (New Zealand, 2013). The indigenous "Maori philosophy towards health is based on a wellness or holistic health model" (Health, 2015). The Health Ministry's

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official government website provides a detailed explanation of the indigenous Maori health system; they are also cited in May (2019:34) and can be summarized as follows below: The Maori indigenous health understanding is based on three key models; *Te Whare Tapa Wa*, *Te Wheke* and *Te Pae Mahutonga* (Health, 2015). The *Te Whare Tapa* model consists of four (4) embedded concepts; namely; *Taha tinana* (physical health); *Taha wairua* (spiritual health); *Taha whānau* (family health) and *Taha hinengaro* (mental health).

2.4.1.3 The relationship between Aboriginal and Torres Strait Islander indigenous health and biomedicine

As literature suggests, many countries that have indigenous populations operate on national health policies that are not inclusive of the indigenous health systems of their indigenous population groups (May, 2019 & Oliver, 2013). Oliver (2013) argues that the "*impact of colonization and the subsequent displacement and disconnection of people both from their indigenous lands and later from their families has been significant in its subsequent effect in the use of indigenous practices including indigenous medicine*" and this has not been effectively addressed in the health policies of many countries around the world (Oliver 2013:1). Oliver further mentions that The Alma-Ata declaration on primary healthcare (PHC) signed into action by the WHO in 1978 encouraged "several countries to improve their indigenous medicine use and regulation of use within the primary healthcare model" (Oliver 2013:1). The above-mentioned declaration states that "*the existing gross inequality in the health status of the people, particularly between high- and low-income countries as well as within countries, is politically, socially, and economically unacceptable and is, therefore should be of common concern to all countries and hence each country should make redress a top priority*" (WHO, 1978).

However, as Oliver argues, although the "*holistic approach in the evolvement from primary medical care to primary healthcare as adopted by the Alma-Ata declaration has been praised, there has still been no mention of the incorporation of indigenous medicine use within the design of these health services in most countries*" (Oliver 2013: 2). As the Oliver study reveals, in Australia "*PHC for Aboriginal and Torres Strait Islander populations is currently addressed by either government- community-controlled health services that offer allopathic health care and employment to trained indigenous Aboriginal Health Workers (AHWs)*" (Oliver 2013:1). These healers are the health professionals who safeguard the distribution of all-inclusive and ethnically suitable healthcare to the particular indigenous communities and hereafter their participation in PHC has confirmed to be dynamic in fighting ailments within indigenous populations (Oliver, 2013 & Campbell & Burgess, 2011). Campbell and Burgess argue that although it is renowned in numerous remote parts in Australia as well as in other countries around the ecosphere that it is probable for indigenous medicine to coincide with allopathic medicine as part of a diverse healthcare system, it, however, remains indefinite to what

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degree indigenous medicine is proficient in conjunction with allopathic medicine in many nations (Campbell & Burgess, 2011).

It can be deduced that the indigenous health system of the Maori remains absent from the national healthcare system in New Zealand despite its richness in culture and understanding, due to a lack of representation and acknowledgement of indigenous Maori health concepts in the mainstream allopathic healthcare system of the country (Health, 2015). The health policies in most countries should address the impact of colonization where indigenous people/communities are removed and dislocated from their lands and unable to practice their indigenous knowledge and medicine. There is a space for incorporation of indigenous medicine in healthcare services because indigenous healers deliver holistic and culturally appropriate healthcare to the respective indigenous communities. It is also possible for indigenous medicine and practice to coexist with allopathic although there is still uncertainty to what extent indigenous medicine could be practiced.

2.5 African perspective on indigenous health

This section covers the African perspective on indigenous health which will be based on two countries namely, Ghana and Tanzania.

2.5.1 Perspective on indigenous knowledge in Ghana

As human beings, we will sometimes become sick and go for treatment and choose either Western medicine or treatment from a religious perspective (Ministry of Health, 2012). Although African spirituality is not in contradiction of a modern way of treating illnesses, African people believe that there are certain ailments that modern remedies cannot handle, and therefore spiritual attention is essential (White, 2015) and this defined from an indigenous healing point of view.

White (2015) states that some African traditional healers are making use of the existing technical methods to concocting their remedies and remedial procedures, and for once the existing organisations can acquire a rough idea on how indigenous healers make their remedies. There is, however, a need for allopathic health practitioners and indigenous healers to come together for discussion. This will help to build trust, to educate one another through workshops, and achieve a consensus in addressing the health issues from a holistic and broader perspective. This would also encourage Western medical practitioners to refer patients that require spiritual attention to some of these indigenous healers and vice versa. This dialogue will also help to ensure safety, quality and efficacy of indigenous medicinal products and practices, and to legalise practitioners (White, 2015). Additionally, the allopathic healthcare practitioner should be open-minded and be willing to learn from indigenous healers. The experience and the knowledge that indigenous healers have, place them

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in a position to challenge the status quo of the day – a parallel or alternative to mainstream health providers (Kgoatla, 1997).

2.5.1.1 The lessons that could be learnt from Ghana

The lessons that could be learnt from Ghana for the South African health system (especially rural health), is the fact that some of the public hospitals have also opened centres for herbal medicine where people can access healthcare with the backing of the Ministry of Health. Also, for once the modern health system can learn something of how indigenous healers prepare their medicines. However, there is a need for governments, ministries of health, Western medical practitioners, and indigenous healers to come together for dialogue. This will help to build trust, to educate one another through workshops, and to come to a consensus in addressing the health issues from a holistic and broader perspective. These could be incorporated in collaboration and partnerships between indigenous healers and allopathic health practitioners to coexist and in working together.

2.5.2 Perspective on indigenous knowledge in Tanzania

In Tanzania there seems to be a number of people who do not have access to allopathic health workers in the country (Ozioma & Chinwe, 2019). In 2007, the available primary health facilities included 4,679 dispensaries, 481 health centres and 95 district hospitals (URT, 2007). Free medical services are provided by government health facilities to vulnerable groups. However, many people from the vulnerable group maintained that they do not avail themselves of the services due to a lack of awareness on the part of allopathic healthcare workers (LHRC, 2011).

It is well documented in the Tanzania health system, that the main challenges in rural and remote areas with low population densities, such as rural Arusha and Manyara, are the poor quality of and inequitable access to health services (IWGIA, 2012) due to distances, bad roads and/or high transport costs, and many indigenous communities suffering from food insecurity (Young, 2009). While there are social ills, there are little movements towards the improvement of livelihood. There are Indigenous peoples' organizations that have already been established and these organization have taken advantage of some of the possibilities offered by the process at the national policy level in terms of participatory consultations and representation in important taskforces. This brings about the turn of the indigenous communities to make use of other possibilities, namely being actively engaged and getting their views represented in the decision-making bodies at village, district and regional level (IWGIA, 2012).

White (2015) argues that long before the advent of Western medicine, Africans had their own way of dealing with diseases and it worked for them. African indigenous healers or diviners were intelligent enough to prescribe indigenous solutions to diseases whether it had spiritual or physical causes with

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little or no side effect. When it is psychological, the person is sometimes counselled and is given the necessary attention. It is in this regard where authors in Tanzania such as Arhihenbuwa et al., 2007, to mention but a few, advocate for integration of indigenous medicine into allopathic care systems to bridge the gap between these two existing healthcare systems.

2.6 South African perspective on indigenous health

There are certain rural areas in South Africa where indigenous health knowledge has been practiced in parallel with allopathic knowledge. The case documented in this research is the case of Makanye in Limpopo Province. The Makanye case study examined the use of indigenous knowledge for preventive, curative and protective healthcare. The study recommends scientific research to explore the role of indigenous knowledge in healthcare among South African cultural groups in order to validate the knowledge and use it to achieve Sustainable Development Goals (SDGs) to ensure healthy lives and promote well-being for all people (Rankoana et al., 2015).

The case in Makanye could be linked with the study area in the Eastern Cape where indigenous healers and elite women operate to service the community of Elliotdale. The research conducted in the area by Mji (2013), where she mentioned the practice of elite women among indigenous healers who manage minor health ailments in the home setting. In addition, May (2019) researched medicinal plants and the practice of indigenous healing in an area where the community consults allopathic practitioners and indigenous healers interchangeably. The area of Madwaleni (May refers to because of the Madwaleni hospital), is rich with herbs and even *amagqobhoka* (the literate people) consult indigenous healers and they also make use of the indigenous plants as remedies such as *umhlonyane and isihawuhawu* for fever.

Although the community from this area continues to consult both healthcare systems that exist in the area, there are challenges that these systems face. Amongst the challenges that exist in the area is the communication barrier that seem to exist between indigenous healers and the allopathic practitioners from the District hospital and the nine (9) clinics in the area. This communication challenge has been discussed earlier in chapter one of this doctoral thesis.

2.6.1 Exploring types of indigenous healers in South Africa.

Traditional healers, like medical doctors, do not form a homogenous group (Ensink & Robertson, 1999). The term 'traditional healer' is an umbrella concept that encompasses different types of healers with different types of training and expertise. In South Africa, much literature on traditional healing uses the Nguni (i.e., isiZulu, isiXhosa, isiSwazi and isiNdebele) terminologies (Yen & Wilbraham, 2003;

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Rudnick, 2002; Varga & Veale, 1997; Freeman & Motsei, 1992; Upvall, 1992; Gumede, 1990a; Green, 1985).

Researchers have identified different types of traditional healers in different regions (Freeman & Motsei, 1992; Green & Makhubu, 1984). There are different types of traditional healers in South Africa and elsewhere on the African continent (Mokgobi, 2012). In the same way that it is not entirely clear how many types of traditional healers the country has, different authors disagree on certain categories; debates and discussions about categorizing traditional healers are ongoing at the legislative and academic literature level (Anokbonggo et al., 1990; Freeman & Motsei, 1992; Government Gazette, 2005; Green & Makhubu, 1984; Rudnick, 2002).

In research conducted by May (2019) in the study area she mentioned that the South African indigenous health system has been studied extensively in the country and many publications have described the various types of indigenous healers found across the various cultures of South Africa. A 1931 study by Cook documented the indigenous medical system of the amaXhosa people of the Eastern Cape and highlighted the various religious beliefs that have shaped the medical system of the amaXhosa (Cook, 1931). Work done by Broster in 1981 improved on the findings of Cook by focusing on the exact medical professionals that operate within the Xhosa medical system (Broster, 1981). Years later, pharmacologists Bhat and Jacobs explored the medicinal plant products used by the amaXhosa and provided an analysis of the safety, toxicity and regulation of these medicines (Bhat & Jacobs, 1995). Edwards cautions that ”*while on the surface there may be great variation in indigenous practices in South Africa due to its immense cultural diversity, core universal components exist which are shared by many indigenous peoples across the world, such as supernatural magical and religious practices, traditional diviners and herbalists*” (Edwards 1986: 1274). Edwards further cautions that although the archetypal role of the indigenous healer is common across global indigenous cultures, “broad non-mutually exclusive categories of indigenous healers should be avoided” (Edwards 1986: 1273). This is particularly true because each culture practices medicine in its own cultural, historical and social understandings (May, 2019).

In earlier years, the South African literature describes mainly three types of South African indigenous healers; the indigenous doctor *(sangoma/igqirha)*, the herbalist *(inyangi/ixhwele)*, and the Christian faith healer *(umthandazeli)* (Bhat & Jacobs, 1995; Berglund, 1989; Broster, 1981 & Cook, 1931), as these healers were mentioned in Mokgobi (2012) although his study focused predominantly on Sesotho speaking people because of his convenience and cultural background being Sesotho.

Although these types of healers have been mentioned in Chapter 1, it is befitting to mention them again in this chapter. In the study area of Madwaleni, as May (2019) refers to because of the District

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secondary hospital (Madwaleni), there are five categories of indigenous healers that are found in this area. Firstly, the *amaGqirha* (indigenous doctors) who specialize in divination, consulting with ancestral spirits, treatment of spiritual symptoms of illness and conducting rituals and ceremonies. Truter (2007) defines a diviner or *isangoma* as a person who defines an illness (diagnostician) and also divines the circumstances of the illness in the cultural context (diviner). Diviners are usually (in approximately 90% of cases) female, although the calling is open to people of any gender, age or status. Diviners are known by various names in different South African cultures (for example amaGqirha in Xhosa as already mentioned by May (2019), *ngaka* in Northern Sotho, *selaoli* in Southern Sotho, and *mungome* in Venda and Tsonga). Most of South Africans, however, refer to them as sangomas (as from the Zulu word *izangoma*).

Secondly, *amaXhwele* (herbalists) specialize in making herbal and animal-based medicines and also offer treatment of physical symptoms of illness (May, 2019). Truter (2007) defines a traditional doctor or herbalist as *inyangi* in Zulu, *ixhwele* in Xhosa (as did May, 2019), and *mganga* in Swahili. This healer specializes in the use of herbal and other medicinal preparations for treating disease. He possesses an extensive knowledge of curative herbs, natural treatments, and medicinal mixtures of animal origin. He does not receive a calling but chooses to become an *inyanga*. Approximately 90% of inyangas are male.

Thirdly, *amaTola* (older elite men) specialize in making herbal medicines and also offer treatment of physical symptoms of illness. Fourthly, older elite women who specialize in making herbal medicines to manage illness within the home situation and also offer treatment of minor health ailments. Fifthly, *abaThandazeli* (Christian faith healers) specialize in conducting Christian prayer to treat illness and also making of holy water. Truter (2007) defines a faith healer or prophet *(umthandazeli* in Nguni, and *muProfiti* in Sotho) as usually a professed Christian who belongs to either a mission or African independent church. They heal mostly through prayer, laying of hands-on patients, or providing holy water and ash. They believe that their healing power comes from God through ecstatic states and trance-contact with a spirit (*uMoya*), or sometimes a combination of both the Christian Holy Spirit and ancestral spirit.

IKS scholars such as Mji (2013), Gqaleni (2006), Dolds and Cocks (2002), and Setswe (1999) have extended this number by including traditional birth attendants (*ababelekisi*) who are usually elderly women who have been midwives for many years and are highly respected for their obstetric and ritual expertise (Truter, 2007). They are responsible for duties such as the teaching of behavioural avoidance among pregnant women, ritual disposal of the placentas, provision of healing medicine and traditional massage after delivery. Traditional surgeons (*iingcibi*) who perform circumcision as part of an African

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cultural initiation ceremony (Truter, 2007), traditional nurses (*amakhankatha*) and elite older women all form part of the types of indigenous healers that operate in the study area and in South Africa.

2.6.2 Policies that support indigenous health knowledge

Rules and regulations that narrate to the exercise of indigenous healing have progressed over time. After white people established themselves in Africa, bringing with them the effects of their faith, and oppressive dogmatic philosophies, they deemed African medical practices illicit by criticizing them as backward and even to the extent of referring them as barbaric (Mothibe & Sibanda, 2019). Although indigenous healers were allowed to practise their "trade" undeterred, the 1974 Health Act (during apartheid regime) barred practitioners who were not registered with the then South African Medical and Dental Council (amended in 1982 to Health Professionals Council of South Africa (HPCSA) from practicing indigenous medicine (Freeman 1992, Freeman & Motsei 1992). Indigenous healers only gained lawful acknowledgement in South Africa as late as February 2005, in terms of the Traditional Health Practitioners Act of 2004 (RSA, 2005).

Traditional Health Practitioners (South Africa, Act 22 of 2007) act was recognised to advance a Traditional Health Practitioners Council of South Africa, and to offer a controlling agenda to safeguard the safety and value of indigenous healthcare services. The act also delivers supervision and control over the indigenous healthcare profession (South Africa, Traditional Health Practitioners Act 2007). It also serves and protects the members of the public who use the services of the Traditional health practitioners (Latif, 2010).

In 2008, the policy was intended to institutionalize and deliver a platform for African traditional medicine (ATM) in the Republic of South Africa and promote the delivery of 'cost-effective and accessible client-based care'. This was urged by WHO, the AU and the SADC Inter-Ministerial sub-committee, to provide rules and regulations pertaining to the practice (Latif, 2010). It intended to implement the 'Plan of Action', called the Decade for African Traditional Medicine (2001-2010). This was adopted at the QUA/African Union at the Lusaka Summit of heads of State. The main objective was to recognize, accept, develop and integrate ATM into the public healthcare system by 2010. African health strategy (2007-2015) calls for the equality and equity of ATM with other health care providers such as allopathic health care.

The policy intended at the institutionalization of ATM but not its integration with allopathic medicine. However, the purpose was for the two to function side by side in the healthcare system. The motivation towards emerging policy was that it was known that the majority of South Africans still rely on indigenous medicine for their primary healthcare needs. The WHO recognized the necessity to

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endorse the use of it to decrease the illness and death level within South Africa and beyond and it was comprehended that there was a necessity for this rule to be regulated and institutionalized (Latif, 2010). It seems that preceding the draft policy on ATM, there was no governmental outline that controlled the profession. The panels that were recognised intended at defended the welfares of the indigenous community and the Traditional Medicine Act was an initiative for safeguarding the strategy (Latif, 2010).

There is an assertion that Africa and South Africa have to study and assume foreign knowledge and practises in regard to healthcare practice (Mulaudzi, 2001). Although, this maybe be the case according to Mulaudzi but Achebe (1988) as cited in Airhihenbuwa begs to differ when he announces that no man should enter his own house through another man's gate. Similarly, Arhihenbuwa (2006) states that no one should enter his or her profession through someone else's profession. The most relevant point in this case is to establish a rule that says no one should enter research on African health and identity through someone else's identity. In addition, time has come when the world has to acknowledge the Indigenous medicine because the indigenous people have held tight to their knowledge and are bringing this knowledge to the front hence it can no longer be ignored. The acknowledgement itself has implication on paradigm shift in healthcare and nursing. In healthcare, users are the key and are at the centre of it all and they are the people that should be considered (Arhihenbuwa, 1995) because they consult indigenous healers before or after consulting allopathic health practitioners (Kirkland et al., 1992).

2.7 Integration of indigenous health knowledge to allopathic health knowledge: Is it a remote possibility?

In Africa, indigenous healing used to happen mostly in the rural areas because of the fact that most of the indigenous health practitioners resided in rural areas. (Mokgobi, 2012). However, things seem to change with time when rural people moved to big cities because of migrant labour Mokgobi, 2012). Migration meant that indigenous people moved with their belief systems which are entrenched in their ethos and culture. This then meant that indigenous knowledge penetrated in urban and semi-urban areas where allopathic care used to be the main health provider.

Indigenous communities in South Africa and the study area, tend to use both indigenous and allopathic health practitioners. The matter of these two healthcare systems working in silos may have a negative outcome due to doubling up of medicines and care without taking into consideration the impact of each to the other. These two healthcare systems operate differently, on one hand, the indigenous healthcare system concentrates on who caused the sickness and why, while on the other hand, allopathic healthcare system concentrates on what the illness is and how has it manifested. Although

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these two existing health systems seem to operate in opposition there have been increasing calls for collaboration between them (Oseni & Shannon, 2020). The collaboration might be a long term achievement to be explored because of the nature and degree of relations between these two healthcare systems.

There seem to exist a power struggle between these healthcare systems because each healthcare claims its autonomy. The working in silos that was earlier mentioned appear to manifest and entrench itself in power struggle with a relationship that is marked by suspicion, disregard, competition and misunderstanding (Oseni & Shannon, 2020). This power struggle appear to have been moulded by several past and organisational forces, including colonization and the imposition of allopathic health system. Colonization presented strains between the general use of indigenous medicine and elevated allopathic medicine through lawful, economic and dogmatic support (Lee, 1982 & Pearce, 1982).

Although this divide seem to exist because of power struggle, one cannot deny the expert power that each possess in their respective practices. However, the allopathic health practitioners (AHPs) aspire control on medical knowledge and therefore domination of expert power (Oseni & Shannon, 2020). The indigenous health practitioners (IHPs) are not seeking control; rather they are concerned about losing expert power. This is reflected in their concern about the AHPs gaining access to their knowledge and eroding their expertise. The resistance by IHPs is perhaps reasonable given that allopathic medicine has a reputation for using ‘collaboration’ as a disguise to spread their control over and co-opt other forms of health practices (Fox & Reeves, 2014; Hardy & Phillips, 1998; Van der Geest, 1985).

The push and pull kind of a relationship between these two, presents a mountain task for effective collaboration (Reiger & Lane, 2009; Daly, 2004; Riley, 1997) since true collaboration is based on fairness (Way & Busing, 2000) and joint control (Hardy & Phillips, 1998). Additionally, power struggles create negative attitudes (Karam et al., 2018) as in Oseni and Shannon’s study where it resulted in negative impact on the relationship. Therefore, the partial achievement of collaborative efforts in Africa and in this area could somewhat be accounted for by the presence of this power struggle between these two health practitioners.

For future successful collaborations, policy and decision makers dealing with healthcare should aim at balancing power discrepancy between IHPs and AHPs. Perhaps, through these collaborations, a space can be created to iron out differences and focus on holistic care of the client (Oseni & Shannon, 2020). It is hoped that shifting of these power differences, although intimidating, it is also inspiring, the facilitation of a significant collaboration between Indigenous and allopathic health systems, will help the indigenous people of Africa.

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2.8 Models of best practice and Lessons that can be learnt for the research area.

This section will discuss three models of best practice which will focus on the Integrated Life Course and Social Determinants Model of Aboriginal Health (ILCSDAH), The Indigenous PHC Service Delivery Model and Sukuma Sakhe Model of Service Delivery from KwaZulu-Natal (KZN).

In certain areas of SA, especially rural areas, indigenous health knowledge seems to be practised parallel with allopathic health knowledge and people appear to consult both services. However, a communication challenge exists between the two systems with negative attitudes which could be addressed through dialogue and community participation. There is also evidence of gross inequality in people's health status especially the poor in remote rural areas who have difficulties accessing healthcare facilities because of distances and unworthy roads. Despite the problems of access, there are policies in place that support indigenous knowledge (Traditional Health Practitioners Act of 2004). Ultimately, SA has to learn and adopt global standards but not totally letting go of their own practices.

2.8.1 Putting It Together: The Integrated Life Course and Social Determinants Model of Aboriginal Health (ILCSDAH)

This model has been extracted from Aboriginal health where there is multifaceted, interconnecting and unified determinants of Aboriginal health which necessitates scholars and researchers to explore effective interventions (Reading & Wien, 2009). This model is based on socio-political contexts and social determinants of health as nested sphere of origin which includes four dimensions namely; physical, spiritual, emotional and mental (Reading & Wien, 2009). A specific benefit of this model is that it permits an exploration of possible paths of health influence across the life passage (Reading & Wien, 2009). The idea of health paths not only links with many Indigenous philosophies, which can adopt temporal concepts to understanding health, but might also facilitate expectation of social determinants of health that might impact vulnerable children towards adulthood. These social determinants of health might be positive or negative, which could either improve or deteriorate health and wellbeing of indigenous people. For the benefit of this study, this model could be adopted for the improvement of health outcomes in the research area, because Bomvane people also experience both positive and negative social health determinants which are multi-dimensional and interrelated directly and indirectly shaping the health of Bomvana people.

2.8.2 Aboriginal and Torres Strait Islander Indigenous PHC Service Delivery Model

The issue of culture and its importance to indigenous people has been discussed in 2.2.3 above as most prominent, but it is befitting to mention culture for this model since the seven characteristics that are discussed below are supporting culture. This model prides itself with eight characteristics but seven are discussed below which were identified including; accessible health services, community

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participation, continuous quality improvement, culturally appropriate and skilled workforce, flexible approach to care, holistic healthcare and self-determination and empowerment (Harfield et al., 2018). Accessible health services especially to remote rural areas is one of the challenges that impact on indigenous health care. Community participation and engagement is crucial in handling social determinants of health. The healthcare providers must strive to improve quality by looking for opportunities that will enhance health care. The healthcare providers must be in a position to dialogue with the indigenous communities therefore, they should be culturally appropriate and be skilful. The healthcare providers should be flexible enough to cater for the health needs of the community. The healthcare should be holistic in nature (psychosocial needs of the patient), and ultimately, healthcare providers must have self-determination and empowerment. Self-determination means that the provider must not lose focus and empowerment means that through these healthcare services, indigenous community will be empowered about health and wellbeing.

2.8.3 Locally - Operation Sukuma Sakhe Model of service delivery

Sukuma Sakhe is a Zulu term which means “let us build”. This term or concept was coined by the ANC government from their 2009 manifesto slogan “working together we can do more” (ANC, 2009). Sukuma Sakhe Model involves the community of KwaZulu-Natal where different stakeholders and the community are involved in its implementation (Gqaleni, 2015; KwaZulu-Natal, 2012). There are five important integrative areas for Operation Sukuma Sakhe namely; community partnerships, behaviour change, integrated service delivery, economic activities and environmental care. Community partnerships are not possible without community participation and engagements where various stakeholders are embedded at grassroot level. Therefore, community partnerships are inclusive of the organisations and the structures with government taking the lead with support of resources. It is through these partnerships whether from indigenous or allopathic healthcare services behaviours can be changed through dialogue and sharing of information. The behaviour can be achieved when service delivery is integrated and both healthcare providers are promoting working together. The integrated service delivery can have a positive impact on social determinants of health where economic activities can be improved. Healthy people that contribute to healthy environment can lead to sustainable livelihoods.

The Sukuma Sakhe Model for Service Delivery could be incorporated in the research area because it deals with health issues that are also related in Bomvana. One of the lessons that could be learnt from this model, is the issue of working in partnerships with mutual respect and understanding while using a uniform referral system that could improve the health outcomes of the research area.

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2.9 Concluding statement

It can be argued that all knowledge is ethnic or cultural. This argument calls for greater tolerance of ethno-knowledge (without questioning the frames in terms of which ideas of ethnic difference emerge) and makes the case that science is also ethnic. This argument is for cultural relativism; that one's truth depends on one's culture or identity or perspective (Green, 2012). It is important to note that there are significant trade-offs in accepting the idea of culture as given, because it is bound up in the origins of European romantic nationalism. Author, Thokozani Xaba, whose wider body of work makes an important contribution to knowledge debates in South Africa argues Africans (in South Africa) find themselves constantly destabilized while the benefits from the holistic approach and the egalitarian nature of indigenous medicines are not being realized. Instead, Africans are subjected to modern practices, among which are the invasive techniques of scientific medicine (Xaba, 2007).

The challenges affecting allopathic health practitioners and indigenous health practitioners can be negotiated by collaborating and integrating these two knowledge systems. Therefore, the relationship between indigenous health practitioner and the biomedicine has been impacted by colonization and subsequent displacement and disconnection of people from both their indigenous lands, and later from their families which has been significant in its subsequent effect in the use of indigenous practices including indigenous medicine.

International healthcare organisations such as the WHO are in favour of collaboration between indigenous and allopathic healing at the more formal level, despite the many criticisms levelled against traditional healing. There are a number of barriers to such integration, where some objections to integration are raised purely on religious grounds, prestige and from an economic competition point of view, while some of the criticisms seem valid and include the question of unhygienic practices by indigenous healers which pose serious health risks especially in the era of AIDS (Mokgobi, 2012) and Covid-19 pandemic (Carico et al., 2020). Nonetheless, collaboration between indigenous healing and allopathic healing is proving successful in some African countries. In these countries, healthcare professionals' perceptions and attitudes towards indigenous healing are favourable. This can serve as a lesson for South Africa in its research into the integration of the two healthcare systems. The issue of attitudes plays a critical role which both health practitioners have to be aware of and perhaps deal with. There is still a gap in the literature that deals extensively with attitudes of both these healthcare practitioners.

The next chapter will discuss the methodology of the research

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Chapter 3: Methodology

"Research was talked about . . . in terms of its absolute worthlessness to us, the indigenous world." (Smith, 1999, p. 3)

3.1 Introduction

At one time people believed that research had to be objective, with an unseen researcher and hidden subjects (Keane et al., 2017). Data needed to be quantified (Keane et al., 2017). Over time, despite all manner of qualitative research gaining credibility (Badenhorst, 2007 & Patton, 2002), indigenous knowledge (IK) researchers are still leaning towards a Western scientific paradigm which often objectifies IK in terms of its scientific validity. Furthermore, the ultimate judgement of the worth of research comes through peer-reviewed publications, citation indices, and impact factors. Journal articles are often charged for and are read by those academics who have access (Keane et al., 2017). As Smith (2012, p. 74) asked: "Who will listen?" when I speak—when knowledge production is controlled largely by the west? The challenge of IKS scholars is that their work is oral, and that some of them are unable to read or write which disadvantages them to their western counterparts. Ironically, the same measures of the worth of research are generally true and experienced by studies focusing on indigenous knowledge systems (IKS) that aim for redress and supposedly decolonized methodologies (Keane et al., 2017). With a purpose to highlight what an authentic and nuanced research methodology will look like for a South African indigenous community, this chapter comprises descriptions of methods as applied in this current study. It describes the indigenous collaborative journey between the researcher and the communities during which rich data sources and approaches were adjusted accordingly, so that they could be culturally sensitive and responsive to the context (Ned, 2019).

The chapter commences with the methodology chosen for the research study that informed the position that the study has undertaken (the vantage point of AmaBomvana drawing from Smith's work) in conducting and writing up this study. Then the chapter defines the research designs that the researcher used during this study. These research designs included qualitative reflective, exploratory and descriptive, along with ethnographic and participatory action research as the overarching designs that drive the methodology of this study. The participatory action research and ethnographic designs afforded the researcher space to interact with participants as a collective and understand the meaning and interpretation of their contribution. It was also about recognising the valuable work that has been conducted by Mji in the research area where her critical findings have been used as a foundation and a tool to initiate communication to the study participants and present both the aim and objectives for affirmation and make additions where necessary. The identification of the research site was also

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discussed. Who the Bomvana people were was then defined, focusing on their rituals. The chapter continued to present the participants from population and sampling, including recruitment strategies and a description of the data gathering methods and process. An explanation of data management, including how it was analysed followed. The chapter then concluded with trustworthiness and ethical considerations to ensure the integrity of the study.

3.2 What informed the methodology chosen for this research study?

From Chilisa's (2012) Postcolonial Indigenous framework, the researcher has adopted the four Rs (accountable responsibility, respect, reciprocity, rights and regulations of research participants) and these principles guided the methodological steps and informed the ethical dimensions and trustworthiness of the study.

The Postcolonial Indigenous framework was used in such a way that methods and research process were ensured that alienation of the Indigenous ways of doing was avoided. Chilisa (2012) reminds us that one of the shortfalls of Euro-Western research is that it ignores the role played by imperialism, colonisation and globalisation in the construction of knowledge. As Ned (2019) states, understanding the values and assumptions embedded in the research study makes it important for the researcher to be critical of the imperial power carried through a study, and thereby reducing the risk of continued othering of indigenous people.

The researcher, therefore, built the relationship with the community through a process called community entry. This process of building relationships with the community allowed the researcher to participate in some of the village life and to understand the community culture, values, traditions, and participants from the position of being an insider. As an insider, the researcher was able to reject herself as knower or redeemer and the participants as the problem, objects and/or subjects (Chilisa, 2012). The insider phenomenon is extensively explained in the chapter under the subtopic – making Madwaleni a home. Aligned with the Indigenous framework, the community guided the research process and approaches to ensure that there was no imposing and that methods used were not violent and inappropriate to the context (Ned, 2019 & Chilisa, 2012). Due to the participatory nature of the study, there were instances where the research objectives were first affirmed and where necessary modified and renewed with the contribution of the participants influenced by ethnographic and participatory action research designs. The study positioned itself in the sense that it allowed participants and the community to have a say about how they wanted to be represented and acknowledged in the study for their knowledge. Lastly, methods were chosen carefully to allow participants to reclaim their power and have control of what they want to share, how to share as well as how the shared knowledge can be presented (Ned, 2019).

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3.2.1 Who is the researcher and her stance/positionality?

I grew up in Alice (formerly called Ciskei during the apartheid era). Alice is a small town in the Eastern Cape. It lies in the west bank of the Tyhume River and houses the institution of higher education, University of Fort Hare, where some great leaders of Africa studied. The town has one of the oldest district hospitals namely; Victoria hospital and Lovedale College is situated in this town. I grew up in Kwezana (Tyhume section) where Chief Mabandla (Ah! Jongilanga) was a leader of the area where I completed my primary and secondary education. My maternal grandmother raised me. I remember when I was in standard three (grade 5), I fainted at school and the teachers thought that I had not eaten in the morning before I got to school. That was not the case, as our grandmother provided us (my cousins and me) with bread every morning before school. When I came back home that afternoon, I told my grandmother what happened and she said that my head was weak and that I easily inhale bad odours. She then organised pig's fat from our neighbour for me to rub on my nose, ears and on top of my head, which was my 'Vaseline' especially during examinations and this was my routine. It is believed that the pig's fat has powers to chase away bad and evil spirits.

After I completed my secondary education, I enrolled for a bachelor's degree in Communication at the University of Fort Hare and completed my Honour's in Psychology. I then left the Eastern Cape and spent most of my adult life in Cape Town before enrolling as a student at the University of the Western Cape for a Master's Programme.

I chose this research topic because I have worked in the Western Cape (Cape Town, Khayelitsha, Hanover Park, Guguletu, Nyanga, New Crossroads and Philippi) in various projects namely; community projects (NGOs especially in informal settlements), privately owned businesses, institutions of higher learning and in a project run by the City of Cape Town. My passion for community development grew when I was involved in community participation from the social prevention of crime through an urban upgrading project. I coordinated, monitored and evaluated various baseline surveys and this afforded me the chance to engage with different stakeholders in the various communities from Xhosa- to Afrikaans-speaking people (so-called coloured people). Besides working as a coordinator, I have also worked as a managing partner in a community project in Philippi where I was involved in curriculum design, training, facilitation and community participation to encourage women and youth in the concept of Vukuzenzele (wake -up and do it for yourself).

My passion for community research started with the interpretation of an existing questionnaire, translating the questions (from English to Xhosa), design workshops for field workers and fieldwork supervisors, and ultimately, ensuring that all the surveys are conducted accurately. The community engagements were also supported by WHEAT Trust, an organisation in Wynberg that assisted projects

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to flourish and also support their training needs. Though I came with experience of working and doing research with people from different communities, my perception of the people of Bomvana was different from the people that I worked with in the Western Cape. Hence, due to their context and culture I decided to make Madwaleni my home to learn their ways of doing things and their culture.

I have worked with diverse people from different levels (those with formal education and those without) and this enabled me to be flexible and allowed me to engage with them. I was intrigued by the fact that the development of a Community Health Forum would afford me a space to engage with such who came from different perspectives. This also allowed me to explore a different side of the Eastern Cape, since I had never visited Bomvana prior to this research study. This area of the Eastern Cape used to be called part of the Transkei during apartheid years, and the area of Umtata and surrounding towns beyond the Kei River from East London, King Williamstown to Alice and other surrounding towns before Grahamstown was known as the former Ciskei.

The allopathic health practitioners and the indigenous community seem to operate in opposing directions whereas they have a common goal of health and well-being of the Bomvana people. With the indigenous knowledge, there is concern about its vulnerability where this knowledge is under threat because it is carried by word-of-mouth from generation to generation. However, the WHO acknowledges a dearth of information and documentation on practices and utilization of different healthcare systems in the world today; especially for traditional medicine and for some of the complementary and alternative systems of medicine (WHO, 2002).

The communication challenge between the existing healthcare practitioners mentioned in other studies conducted in the area (in Mji's PhD, 2013; and May's MA thesis, 2019), also came out in most of the phases of the current study.

3.2.2 Researcher as an instrument for collecting data

Recent studies in which the investigator has been used as an instrument, include works done by Bahrami and Pezella (2015). The Bahrami (2015) study found that investigators in qualitative studies have the main role of overseeing the research study taking into consideration compliance, policies, and procedures, and especially in data gathering. Bahrami even claims that the experiences and skills of the investigator, the ability to communicate and asking the right questions are some of the most important factors that bring rigour to the research data (Bahrami, 2015). Following that same line of thought, Pezella et al., 2012 noted that the figure of the investigator as the instrument for qualitative data collection has been widely acknowledged amongst qualitative researchers. The authors argue that because the investigator is the instrument in semi-structured or unstructured qualitative

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interviews, unique investigator attributes such as personality have the potential to influence the collection of empirical materials (Pezella, et al., 2012).

The reflective process and reflexivity strengthen the data collection process when the investigator has challenges due to the events in the community, which sometimes made it difficult to access people. Reflexivity is a strategy that helped to ensure that the researcher's closeness to the study is not a threat to the credibility (Chilisa 2012). Therefore, a journal was kept recording observations, steps taken, feelings, fears and thoughts throughout the study. The contents of the journal were made available to the supervisor and the co-researcher (the role of the co-researcher is discussed in details see 3.9.2.2 below). These included new observations relating to the study, doubts, concerns and any change of plans due to communal events that may have an impact on the unavailability of people. However, these changing processes seemed to be at odds with the limiting research timelines and resource constraints, which Khupe and Keane (2017) emphasise as a necessity for the study process. Khupe and Keane position the taking of time as a mark of respect and indicate the value of an activity in Indigenous community (Ned, 2019). The co-researcher in this study, who has been a researcher in the study area for two years, was supportive and served tirelessly as a "cultural consultant" (Vakalahi & Taipa, 2013:403), not only assisting the researcher to make sense of and gain clarity on the content, as well as some of the practices observed when greeting Indigenous healers and how introductions are maws. This meant being observant, listening and learning from AmaBomvana ways of doing things and not seeing the researcher as an expert and superior while studying the research participants. I needed to let go of the colonisers' way of doing things while trying to learn more about the colonised Indigenous people - AmaBomvana.

3.2.3 Making Madwaleni home

From the community entry as the first point to engage with the community of Madwaleni, the researcher was involved with the daily chores and practices within the Nkanya village, especially Xanase. This area already has community engagement studies that were conducted by an integrated team of researchers from universities namely, Stellenbosch, Cape Town and the Western Cape. The researcher, together with her research team, stayed for the December period of 2014 in the Chieftain's household in Xanase Nkanya and this allowed the researcher to be part of this family for the duration. The research team consisted of eight members namely; my supervisor (Prof Mji), a head of physiotherapy department at UWC, a lecturer from UCT, director and founder of children's home living with disability (Umtata) and three PhD students from Stellenbosch University (SU). Furthermore, the visits during the conferences, and the other meetings with stakeholders, the researcher stayed at the Donald Woods Foundation (DWF) which is an NGO in Hobeni village, and this also became a second home for the researcher, apart from Nkanya (Xanase). DWF is situated at the centre of Hobeni one of

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the four (4) sub districts covered by this study and the organization is committed to bringing 'health to every hut' by integrating the 'accessibility' principle of Primary Healthcare (Foundation, 2017). The DWF is equipped with running water, electricity and security services that provided a sense of comfort and security for the researcher.

Being able to stay in Nkanya and Hobeni assisted the researcher to understand AmaBomvana ways of doing things, their understanding of their environment, and their relationship with their environment including plants, their animals and the land. In a participatory action research cycle, this allowed the researcher to observe and in turn allow the sample of the study to be partners and not to be seen as subjects of the study. This process allowed the researcher to become one of the participants in the research process and not just as scriber and a describer of events. With the implementation of the Participatory Action Research methodologies (PAR), the constant visits and community involvement allowed the researcher to become an insider that lived the experiences of being part of Bomvana people, and not merely an outsider looking on to describe and document the life of Bomvana.

Qualitative researchers Raheim et al., 2016 confirm and present the insider-outsider perspective in qualitative studies as not something new (Raheim, et al., 2016). They further expand that the key importance of this approach is the presentation of the researcher's positionality, including the meaning of being an insider or outsider in a given study setting, including the negotiation of researcher's status throughout the research processes (Raheim, et al., 2016).

For this study, the researcher was aware that she was an outsider coming from a different community to join a new community so that she could gain an insider perspective (May, 2019). This understanding allowed her to be more sensitive to the unequal power dynamics she was bringing in as somebody who is affiliated with a university, who is not Bomvana and who had resources that the rest of the community might not have, such as a formal education (May, 2019). Therefore, becoming involved with community engagement and shared experiences with the community on a daily basis allowed the investigator to situate herself as someone who was interested in the well-being of AmaBomvana not just for their knowledge, but as someone who wants to learn together with them about their culture (May, 2019).

3.3 Research design

This is a qualitative study that used ethnographic and Participatory Action Research (PAR) as two primary drivers of the research method with exploratory descriptive methods used as secondary supporting designs. This study design provides an in-depth description of the qualitative research techniques and strategies that were used to conduct this study. In this section, within the context of the study, a description of how the research designs influenced the data collection methods will be

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discussed including the data analyses and rigour. Emancipatory research methods were also used during the data collection process by affirming indigenous health practitioners to be open and talk about their indigenous health knowledge systems. Due to the nature of PAR, qualitative methods were supported and driven by cycles of reflection to afford opportunities where any further adjustment of the methodology was necessary.

3.3.1 Qualitative reflective research design

The qualitative reflective research design was the over-arching approach for this study. Qualitative research is depicted as softer, as providing deeper insight, but at the expense of being necessary more "interpretivist" and "subjective" in its approach. The researcher has used an "onion" approach (Saunders, 2015) where layers and layers of participatory action research are discussed in detail in the various phases during data collection. The primary goal of qualitative research is to interpret and document an entire phenomenon from the standpoint of participants, hence researcher has to timeously affirm from participants whether she is accurately describing and documenting their phenomenon (Denzin & Lincoln, 2011, Ortlipp, 2008). Irvine & Gaffikin (2006) and Etherington (2004) contended that researchers who employed qualitative research sought deeper truths while aiming to study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings that people bring to them.

Similarly, Ortlipp (2008) and Etherington (2004) maintained that qualitative researchers aspire to uncover the world through another's eyes, in a discovery and exploratory process that is deeply experienced. Qualitative features of the individual's feelings, views, and patterns are revealed without control or manipulation from the researcher (Leininger, 1985; Willis, 2007). Qualitative research methods allowed the researcher to be aware of her biases, to best minimize bias and attempt to present a situation as truthfully as possible within the limitations to ensure that the data collected from Bomvana is authentic. This helped the researcher to be mindful of the participants' viewpoint and kept references and records all the time. The engagement and consultative manner with the various stakeholders have allowed the researcher to continue reflecting during the process of data collection.

Mji (2013) states that qualitative methods include a reflective process at every stage of the study with the guidance of the supervisor and the assistance of her peers. This reflective process guided the researcher to recognize the importance of the interconnectedness and interaction of the study's different design components. Mji further infers that most scientific research designs are based, implicitly, on the positivist ideal of the objective and disinterested scientist. The positivist ideal emphasizes that the choice of research approaches and methods should be determined by the

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research questions to be answered. Maxwell (1996) differs from this when he asserts that research decisions are more personal desires, and it is important to carefully assess the implication of these decisions for the qualitative inquiry. During this process, like bracketing as explained by Tufford and Newman (2010), qualitative researchers are required to be aware of and explain potential deleterious effects of preconceptions that may taint the research process. Maxwell further asserts that qualitative researchers are driven by four main motives: (a) personal purposes; (b) practical purposes; (c) the value component of research questions; and (d) the process as the vehicle by which critical events and actions take place in qualitative research. As this is a study that is built around the relationship between allopathic healthcare practitioners and the Indigenous community, it was important for the researcher to address guiding forces when she was conducting this qualitative study (Maelene, 2002).

3.3.1.1 Personal purposes

Personal purposes embrace the commonly driven need to influence an existing situation or political stalemate. Personal purposes could even be a deeply rooted individual desire or need that has little bearing on the 'official' reasons for doing the study. It was important for the researcher to carefully examine her desires during this process to reduce bias, which may have implications for the methodology as conclusions drawn from Bomvana could be skewed and one-sided and could carry the danger of created flawed results (Mji, 2013). On the other hand, when the desires of the researcher are examined for what they are, they can make an immense contribution towards the insight, theory and deeper understanding of the data gathered about the Bomvana culture (Maxwell, 1996).

This research study from Bomvana is built around the relationship between biomedical health practitioners and an indigenous community on how they experience communication challenges and to further come up with strategies that could resolve those challenges. Therefore, it was important for the researcher to address the issue of her personal purposes and its influence on the results of this study as the researcher's stance have been discussed in 3.2.1 as an extension to personal purposes.

3.3.1.2 Practical purposes

One of the motives that drove this qualitative research was the practical purpose or objective of the study, for example, if the main aim of the study is the need to improve a situation, then the study needs to put in place plans that lead to how change would be achieved (Mji, 2013). The initial step is to check the present situation, asking questions such as, what is happening and why; and following this with an exploration of the plans and steps that need to be taken to obtain change (Maxwell, 1996; Denzin & Lincoln, 1996). The challenge in the study area is the problem of communication between allopathic health practitioners and an indigenous community. The aim, therefore, is to explore the

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development of a Community Health Forum (CHF) that will become a strategy for a communication channel in the study area. Hence the researcher chose to explore on one hand and the other to implement change. In Chapter 1 of this doctoral thesis, the researcher described communication challenges between the secondary hospital, the nine (9) clinics at primary care level and the indigenous community and a practical purpose and the goal of this study is to ultimately develop a CHF as a channel of communication in the research area. The methodology of this study will tabulate in the current chapter how this goal is to be achieved.

3.3.1.3 The value component of research questions

It is important for the study design to be able to create a plan and develop research questions that are organised in such a way that they contribute a value component that practically assists in achieving the objectives of the study. Both the key research questions and the objectives of this study are centralized around the main issues of the communication challenges between the biomedical health practitioners and an indigenous community and the development of the CHF as a communication channel.

These main issues provided the framework for the key research questions which were to be asked in order to collect relevant data which would add value to achieving the goals of the study which are the development of CHF as a platform for both biomedical health practitioners and an indigenous community to communicate, rather than to simply collect data about communication challenges.

3.3.1.4 The process as the vehicle that carries the critical events and actions

In qualitative research, the process becomes the vehicle which drives main events and actions that happen. Maxwell, quoting Merriam (1996), states that, "the focus (in a qualitative study) is in a process rather than results". The process used should guide the results of the study. Miles and Huberman (1994) attest that there is much recent research to affirm the claim that field research is far better than solely quantified approaches when it comes to creating explanations for what is classified as causality. As cited in Mji (2013), quantitative research tends to explore whether, and to what extent, variance in x causes an effect on variance in y. Qualitative research, on the other hand, tends to check how x plays a role in causal processes in y. Mohr (1982) and Ragin (1987) have defined this as the difference between variance theory (variable-orientated) and process theory (case-orientated). Variance theory deals with variables and correlations amongst them; it is based on analysing the contribution that differences in values of variables make to differences in other variables. Whereas process theory, it differs in such a way as it works with the events and processes that connect them; it is based on an analysis of the causal processes by which some events impact others (Mji, 2013).

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The strength of qualitative study is firstly the same as with the bigger understanding of a majority of the indigenous people of the world regarding health and illness (Mishra, 2003; Bodeker, 1999); and secondly it resonates well with how health and illness in Africa are explained by way of process reasoning, with the individual being seen as part of, and interacting within, their own context. Maelene (2003) further asserts that when it comes to health and illness and an African interpretation thereof, contexts and processes become critical. Africans prefer to understand the origins of illness, whereby causal effects of illness can be extrapolated.

Pertaining to the health practitioners in this doctoral study, questions such as the following were asked: How do these existing healthcare providers communicate, especially those who are not sharing the same language and culture with the community, function within an indigenous community? How could a Community Health Forum be developed? From community entry and building of relationships, to various conferences and focus group discussions, these further enriched and supported the process-orientated approach at different stages of data collection and analysis to enhance the continuity of the process and to affirmation of data by participants including rigorous cyclic methods followed by the research process of this study.

3.4 Primary drivers of the research method

Ethnographic and Participatory Action Research (PAR) were chosen as the primary drivers for the research methods for this study.

3.4.1 Ethnographic study design

Ethnographic research is both a study of interactive strategies in human life and analytical descriptions of social scenes, individuals, and groups that recreate their shared feelings, beliefs, practices, artifacts, folk knowledge, and actions (Ejimabo, 2015; Mayan, 2009; Hammersley, 2006; Foley & Valenzuela, 2005). In other words, it is both a process and product of describing and interpreting cultural behaviours. Ethnographic study design methods were selected to ensure that a suitable approach was utilized to explore and describe the study setting, sampling strategy and methods of data collection. The researcher used the ethnographic methodology to understand the culture of AmaBomvana and their response to certain events, critical incidents and key observations during the phases of data collection that are presented below in this chapter. The key observations and critical incidents during these phases are presented in Chapter 4.

The researcher has tried to understand the participant culture (ethnographic) from the point of view of the people who inhabit and inherit that culture. The human community, as opposed to the rest of the environment, is seen to have social characteristics that are the product of the interaction between its members. It is assumed that the features of social organization that are significant in community

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life are known to its members and discoverable by the investigator (Marshall & Rossman, 1995; Miles & Huberman, 1994; Rubie & Babbie, 1993).

An ethnographic study requires a close examination of the context in which the participant culture lives, to discover and understand how this has influenced the actions of the participants. In December 2014, the researcher stayed with the Bomvana people to observe their culture during the community entry phase and build relationships with the community. This experience has allowed the researcher to be embedded within this culture to understand and be sensitive towards practices of the Bomvana people. The meetings, the visits and conferences that happened during different phases of the research process were held in the study area and afforded the researcher space and time to engage and understand the community from their own perspective. Because of this, different ethnographic research methods were used in this research study to collect data, such as FGDs with the study sample, in-depth interviews with key informants, participant observation, audio recording and journal documentation (using diary and a notebook).

3.4.2 Participatory Action Research (PAR)

According to Zakus and Lysack (1998), PAR approach is qualitative in nature and Minkler et al., (2012) defines this method as a collaborative process that equitably involves all partners in the research process and recognizes the unique strengths that each partner brings. This research methodology is also described as a process of building trust and genuine collaborative partnerships, and on using study findings to help bring about changes in programs, practices, and policies that can in turn help improve health outcomes (Minkler et al., 2012). PAR methodology is geared towards planning and conducting the research process with those people whose life world and meaningful actions are under study (Encyclopedia of Sociology, 2021; Coghlan & Brannick, 2014; Reason & Bradbury, 2008). It is intended to result in some action, change or improvement on the issue being researched (Bergold & Thomas, 2012; Gelling & Munn-Giddings, 2011). Partners contribute their expertise and share responsibilities and ownership to increase understanding of a given phenomenon, and incorporate the knowledge gained with action to enhance the health and well-being of community members (Padarath & Friedman, 2008; Israel et al., 1998).

PAR involves conducting research that recognizes the community as a social and cultural entity with the active engagement and influence of community members in all aspects of the research process (Schulz et al., 1998a; Hatch et al., 1993). Community participation is widely accepted as a desirable feature of any health system and is an important aspect of developing and fostering effective governance at various levels of the health system (Padarath & Friedman, 2008). For this research study, PAR allowed the study sample and the researcher to be equal partners in terms of the decisions

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that would affect the development of the CHF. The development of the CHF was a shared idea during community entry when the researcher was establishing relationships. The community engagements in the various platforms, from the community entry and building of relationships, meetings, visits and various conferences (from 2016 to 2019) in the respective villages enabled the researcher to gain valuable information for the purpose of this research. The PAR design in this study was represented in the six phases that are discussed in detail during the data gathering process. The expected outcome of this stage was the formation of the CHF that was piloted in July of 2019. The researcher kept a diary and a fieldwork notebook to record and diarize notes during this experience.

In a qualitative research method, PAR was used as a process that is about the action of the research study encompassing all the objectives. This was achieved when the researcher gained entry, observed the participants in their natural environment through the different phases during data collection. These phases encompassed the exploration, building relationships, disseminating Mji's critical findings, presentation and affirmation of study aims and objectives and where possible, adjusting and creating new objectives, and lastly engagement with study participants in the process of developing Community Health Forums.

3.5 Secondary supporting designs

Exploratory descriptive methods were used as secondary designs for the researcher to explore from the study participants the nature of communication that existed between allopathic health professionals and the indigenous community and to further describe how they see the development of community health forums as a strategy that will improve communication between them.

3.5.1 Exploratory descriptive study design

Exploratory descriptive research methods intend to explore and describe the research questions and does not intend to offer final and conclusive solutions to existing problems (Hunter et al., 2019; Babbie, 2007), hence the researcher explored and described from the participants' point of view. To determine the nature of the problem, this type of research is not intended to provide conclusive evidence but helps us to have a better understanding of the problem (Cargan, 2008). When conducting exploratory descriptive research, the researcher ought to be willing to change their direction because of revelation of new data and new insights (Saunders et al., 2012). Therefore, exploratory descriptive research is used to define and/or clarify a problem and subsequent research is expected. Exploratory descriptive study designs are essential when breaking new ground because they afford space for reflection about events and facilitate the probability of yielding new insights and understanding of the area in the research process (Cargan, 2008; Babbie, 2007; Somekh & Lewin, 2005; Katzellenbogen et al., 1987).

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This research design afforded the researcher an opportunity to explore the development of the Community Health Forums (CHFs). Before the development of these CHFs, the exploration and description of the existing healthcare providers in the area was important. The contribution from this method allowed the researcher to engage with participants and gain information that will assist in understanding the healthcare providers in the area.

3.5.2 Emancipatory research designs

Emancipatory research designs tend to illuminate issues of power and marginalisation. It highlights aspects related to theory of minority groups and the process of giving voice to their cause (Marshal & Rossman, 1995; Miles & Huberman, 1994). The indigenous health practitioners, the majority of whom were excluded from modern education, carry a double burden − firstly (Clough, 1998); that the knowledge they carry is seen and classified by the Western culture that sees itself as the examiner of modern knowledge systems as being outdated and secondly, as included as part of the group of minority knowledges which is overlooked by allopathic medicine (Clough, 1998). Lastly, because the indigenous knowledge holders/scholars transfer knowledge by word-of-mouth, this knowledge system faces the problem of not having a voice to transfer that knowledge into the global arena; mainly because it is situated in an environment that does not have access to the global space due to factors, such as not being able to read or write and technological deprivation (Mkhize, 1973).

This study researched the aspect that in the rural Eastern Cape there are some indigenous health practitioners who still carry IHK and that this knowledge can be revived, explored and described, documented, affirmed, and made accessible to a more available to a wider audience.

Researchers such as Ohajunwa (2019) describe how indigenous knowledge system holders such as AmaBomvane, have gone into a subliminal space and are now unconsciously, but routinely, practising their vocations of caring and mediating in family conflicts, ‘in the dark’, and without acknowledgment for their contribution to society. The indigenous/local scholars are caught between two conflicting forces − the forces of the West which present itself as carrying scientific knowledge; and the forces of the indigenous community which asserts as having similar skills and knowledge systems learnt and carried from birth and for generations. Indigenous scholars throughout the world present similar experiences of colonisation and oppression by forces mainly from the West, which continue to present their superiority by defining ‘the other’.

Some researchers cleverly respond to this situation by conforming on the type of research questions to be explored in communities. This then further entrenches the situation and is already evident by the power of inequity which is highlighted by what gets studied in the first place (Clough, 1998; Mkhize, 1973). Emancipatory research speaks truth and uncomfortable challenges to dominant

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power. Likewise, ethnographic and PAR study designs used in this research, enabled the researcher to focus on the healing practices of AmaBomvane health practitioners, and in this way tried to contribute towards the process of emancipating and affirming their IHK.

3.5.3 The use of Mji's critical research findings as a tool to initiate communication between allopathic health professionals and indigenous community

As already explained in chapter 1 under motivation, section (1.4) and the section on concepts and process that drives the study (1.5), communication problems between allopathic health professionals (AHP) and indigenous community (IC) featured strongly in Mji's critical study outcomes (MCSO). The older Xhosa women had elaborated how they felt chastised by AHP when consulting the nine (9) clinics and district hospital if they have used indigenous health knowledge (IHK) in the management of health problems of their relatives. Secondly, they also felt that the clinics and the hospital did not deal with the root causes of their relatives' illness, as the curative approach used by both the clinics and District hospital was in contradiction with the IKS manner of understanding health and sickness – to them the main cause of sickness were social determinants of health which the clinics and the hospital were not addressing. MCSO were be used for this study in the following manner:

a. Assisted in initiating communication between allopathic health professionals from the district hospital, the nine (9) clinics and the indigenous community. Using the process of PAR and reflective cycle, the MCSO were affirmed, if there were new aspects that emerged from the dissemination process, these were documented.
b. Drawing from one of the major MCSO, which was identified as communication, this posed a challenge between allopathic health professionals from the district hospital, the nine (9) clinics and the indigenous community, during community entry and the various phases of this research. The aspect of the communication challenge was shared with all key stakeholders, the main aim of this doctoral thesis was discussed, and objectives of this study were agreed upon.
c. Other findings from MCSO were social determinants of health (SDH) which were either positive or negative. Positive social determinants of health (PSDH) were strongly related to their spirituality and ancestral reverence, being able to feed their families until satiety and having peace within their villages. Negative social determinants of health (NSDH) included young people drinking in taverns from dusk to dawn, young people moving to work in cities etc. (see appendix F). Assets (A) lying dormant at community level were also identified e.g., indigenous herbs and methodologies on how to manage minor health problems within the home situation, and lastly, the process that older Xhosa women measure health and illness

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using participation as a yard stick. Through PAR cyclic approach, these findings were further affirmed and if related new findings emerged – they were documented and discussed.

d. Building on trust that was earlier developed by Mji (2013) amongst AmaBomvana people, this research aimed to consolidate this trust by presenting combined conferences between allopathic health professionals from the district hospital, the nine (9) clinics and the indigenous community and using a non-blaming approach that focused on raising awareness of the challenges of communication between these two stakeholders, an opportunity was given for the two sides to listen to each other.

Below in section 3.4 is a description of AmaBomvana:

3.6 Who are the Bomvana people?

3.6.1 Strong self- determination of Bomvana

The researcher saw AmaBomvana as people with strong-self-determination. The AmaBomvana people had a holistic approach to wellbeing, identifying spirituality as integral to their wellbeing. The highest determinant of health and wellbeing for the Bomvana person was to live and exist as an embodiment of the Bomvana culture, as a spiritual being who honoured and practiced the beliefs of the Bomvana (Ohajunwa, 2019; Mji, 2013; Jansen, 1973;). There are certain pre-requisites for achieving this status, the capability to plough the land and provide indigenous food for the family until the family is well satisfied. Raising, supporting and educating children from conception until they become young adults who know and respect their culture and spiritual pathways, living without strife and contention, brewing Xhosa beer for participating in ancestral reverence to cultivate a relationship with God (Ohajunwa, 2019; Mji, 2013; Jensen 1973;). The fact that the AmaBomvana had not destroyed their crops or cattle during the Nonqgawuse era of cattle killing and burning of the crops meant that they were able to perform these obligations and follow their spiritual pathways. They stood tall and proud of their identity as the AmaBomvana and as change began to filter into their context —primarily in the areas of health, education and religion — this resulted in them starting to lose their strength, strong self-determination and identity.

3.6.2 Ancestral reverence and praising God

Another factor is the issue of rituals and ancestors which seem to play a vital role in the life of Bomvana (May, 2019; Mji, 2013). The Bomvana feel themselves totally dependent upon their own ancestors in all vital aspects of life: procreation, cattle and other property, as well as in the 'being' of the family as a whole. According to the Bomvana, UThixo (God) existed from the very beginning and emerged from the sea. UThixo was the first ancestor from whom the people originated. God was brought to bear by AmaBomvana when they needed a way of filling in the gaps in their knowledge. This filling of the gap

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with God also happens when a relative is ill and they lack both knowledge of the illness and the skill to help the relative concerned, so they use the hospital as a 'last resort'. It is perceived that this is because the hospital itself was a mission hospital and the Bomvana related to the care at Madwaleni Hospital as being similar to praying.

The relationship with ancestral life in Bomvanaland is the ultimate concern to which all social aspects of life can be referred. It is not only a social phenomenon; it is a religion, but a religion of great social importance (Mji, 2013; Jansen, 1973). Ancestral religion is not a compartmentalized concept to the Bomvana, 'It is life to the African thought' (Jansen, 1973). This is expressed in the welfare of the group and is of greatest concern to the indigenous health beliefs in the tribal system (Mishra, 2003; Bodeker, 1999).

3.6.3 The consequences of the breakdown of their tribal economy

The breakdown of their tribal economy forced the traditional Bomvana into the turmoil of rapid cultural change (Mji, 2019). This is the process of acculturation in South Africa which affected thousands of Africans to mainly work as labourers in mines (Mji, 2013; Jansen, 1973). The impact of migrant labour on Bomvana life cannot be overestimated; their manpower in the vital period of life (18-50 years) was continuously withdrawn from their tribal society and mobilized for the labour market (Jansen, 1973). Migrant labour practices have left these villages with an absence of the middle generation. During their presence, the role of the middle generation was to build the economy of Bomvana by ploughing fields and build homes and environment, while the older generation was supposed to instil discipline and guidance in the younger generation, and to teach them about the traditional practices of being a Bomvana. With the absence of the middle generation from the community because of migration, this role and responsibility falls to the older Xhosa women, and the older generation now has a dual responsibility. Bomvana now lives below poverty line and is blighted by social determinants of health and diseases such as TB, Malnutrition and HIV & AIDs.

3.7 Selection of the research site

The study setting is kwaBomvana in Xhora (English term being Elliotdale thus used interchangeably in this study) located alongside the Mbhashe River all the way up to Umtata in the Eastern Cape Province of South Africa. Elliotdale is situated within AmaThole District Municipality which is a category C municipality with municipalities such as Mbhashe, Mnquma, Great Kei, AmaHlathi, Ngqushwa and Raymond Mhlaba, falling under its jurisdiction. Elliotdale falls under the Mbhashe municipality. The town of Elliotdale lies 50 km South of Umtata and 22 km South-East of Mqanduli. As indicated in Figure 3.1, the differently coloured surroundings with red dots indicate the nine different clusters of villages within Xhora namely; Elliotdale which is the town, and next to it are two clusters called Soga and

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Melitafa; in the middle of Xhora, there are three clusters called Bomvana, Madwaleni/Gusi (where the - Madwaleni hospital is positioned) and Mqhele. Lastly, closer to the sea, there are two clusters called Hobeni and Nkanya with Nkanya being the furthest and is along the sea. All these clusters of 6-8 villages are serviced by clinics (with each clinic named after the village). However, the focus for this research study was only on four clusters of villages namely, Hobeni, Madwaleni, Nkanya and Xhora. These four areas were purposely selected because Hobeni and Nkanya are both located towards the sea, while Madwaleni (known as Gusi) is located in the middle surrounding the hospital, and the Xhora village closer to the main roads and town. Each village ward has an elected Chief and a Councillor residing in the ward and the clusters of villages linked to each ward. Some contextual incidents that influenced the sampling of the villages included the geographical issues as a legacy of apartheid, with services located far away from some villages and some being closer to others (Mji, 2013).

Below, in Figure 2, is the map of part of Elliotdale, showing Madwaleni hospital, the nine surrounding clinics, the villages, Mbhashe and Xhora River and part of the Indian Ocean.

Figure 2: Map of part of Elliotdale, showing Madwaleni Hospital, the nine surrounding clinics, the villages, Mbhashe and Xhora rivers and part of the Indian Ocean.

3.8 Study Population

The study population was made up of adults 18 years and above, both male and female (Allopathic practitioners, indigenous healers and members of the community) from the nine (9) village clusters which are: Xhora, Melitafa, Soga, Mqhele, Bomvana, Madwaleni/Gusi, Hobeni, Nkanya and Mkhatazo. As the process of implementing the methodology of this study follows a PAR approach, before describing the study sample, the description of the data collection process follows.

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3.9 Description of data collection process

Data gathering process was conducted through six phases (see PhD proposal objectives) and these phases will be discussed in three sections namely; **section one** will present phases one to four (1-4) while **section two** presents phase five and the **last section** which will present phase six. These three sections present how the implementation of the study was organized according to space and time that data was collected, while the phases present the cyclic process of participatory action research with completion of each phase offering space for reflection and for critical outcomes to be taken to the next phase (Bergold & Thomas, 2012; Gelling & Munn-Giddings, 2011; Freire, 1968).

For all these phases, the study population has been discussed in 3.8 above as a blanket approach whereas the selection of participants will be described per phase in 3.9.1. For each phase, the objectives of the study will be discussed as they are relevant to each phase. The participants for phase 1-4 and 6 were purposefully selected from community entry including selection of participants from the various conferences. Key stakeholders such as Chiefs and Paramount chief of the nine principalities, the Donald Woods Foundation with its community networks for the project of health in each hut, the clinical nurse practitioners from the nine clinics and health professionals from the nine villages assisted in identifying key role players and people that might be invited for each phase. There are reports that were compiled after each conference, these reports are attached as appendices at the end of this document (see Appendix D and E). Below is a brief description of each section and phase for the study:

3.9.1 Description of sections and phases for this study

The three sections and phases for this study are:

(a) **Section 1: Comprise of 4 phases that covers:** Phase 1: Community entry and establishment of relationships including discussion of the research objectives with the goal of first affirming with key stakeholders the objectives and where necessary modify and add new objectives. Phase 2: Dissemination of Mji's critical findings; Phase 3: 2016 Conference – Indigenous healers of Madwaleni and Phase 4: 2018 Conference - Establishment of communication channels.

(b) **Section 2: Phase 5:** December 2018 - The development of Community health forum and

(c) **Section 3:** Phase 6: 2019 Conference - Piloting of the community health forum. Below is the presentation of the 3 sections with their 6 phases.

Section 1: Phases 1 – 4

This section presents the first four phases of data collection during participatory action research from community entry; visiting of various villages and meeting with stakeholders; and, to various

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conferences. These phases are presented in a cyclic manner; therefore, each phase is interconnected with the next phase. Although in the discussion phases 5 and 6 are presented separately, the stages of the data collection reflect the interconnectedness of each phase to the next in a cyclic manner as PAR brings about its twists and turns. With reference to the conferences where programmes were planned and designed, these programmes had to be amended because of participatory research which leads to accommodating burning issues at the time and changing of the programme in terms of priority. The presentation of these phases will include the rationale for each phase, the participants and outcomes. For the preparatory stage of the research study, the researcher was introduced to the community of Madwaleni by Professor Gubela Mji, who is also the supervisor for this study. Prof Mji has spent many years in the area of Madwaleni conducting research for her PhD dissertation, and hence served as a valuable asset in the researcher's initial efforts of community entry. Professor Mji also assisted with understanding of the culture of the AmaBomvana as she had spent many years engaging with the AmaBomvana on both personal and professional levels. The key observation and critical events marked the ethnographic design where these are documented as elements that influenced the methodology of this study. Below is the presentation of the four phases that cover community entry, establishment of relationships and dissemination of Mji's PhD findings.

3.9.1.1 Phase 1: Community entry and establishment of relationships

During this phase exploratory descriptive and emancipatory research designs were applied where the researcher was introduced to the community of Xanase (one of the areas where the team has started some research work). Community entry allowed the researcher and her supervisor to visit the participants in their respective villages and spaces that were accessible to them. For this research study, community entry started in Nkanya, in December 2014 where participants were purposely selected from Xanase and came from the group that the supervisor selected from a community project for upliftment and development of the Xanase area. With the assistance of key community stakeholders from Xanase village, one of them being Chieftain Nobhejile, we were able to attend an Imbizo (Chief's gathering in Nkanya consisting of approximately 50 people) and where I was introduced to the Chief and permission was asked to conduct research in the area. Amongst the people that attended the Imbizo, the majority were adults from the villages of Nkanya and I was able to initially disseminate Mji's critical findings and present my study objectives. The Chief and people in this Imbizo encouraged me to continue with my study expressing their own needs that will be presented in the findings. It was then befitting that the Chieftain arranged a meeting with the Paramount Chief Nobangile for the researcher to gain access to all the nine principalities of the Mbhashe municipality including the nine Chiefs and their Chieftains who preside over these nine principalities. Subsequent community entries for the other three (3) principalities (Hobeni, Xhora and

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Madwaleni/Gusi) after the community entry for the Nkanya principality followed a similar format whereby it was easier to enter these principalities as my study was already explained to the other nine principalities by the Paramount Chief in Inqila, which is the Paramount's Chief meeting that brings together all Chiefs and Chieftains from the nine principalities of Mbhashe. Since this phase of community entry afforded the researcher a space to develop relationships with stakeholders, it then further allowed the researcher to continue making plans for data collection for other phases including the format these phases will take. The dissemination of Mji's critical findings, including the discussion of the research objectives, with the goal of first affirming objectives with key stakeholders, and where necessary modify and add new objectives, became the next phase for the study which will be discussed in phase 2 below.

3.9.1.2 Phase 2: Dissemination of Mji's critical findings and affirmation of research objectives

The second phase of the study represents the meeting with the respective Chiefs from Nkanya and Hobeni, Xhora and Gusi and the secondary hospital, as well as the Donald Wood Foundation, and including educators from the schools (Hobeni primary) and the Technical Vocational Education and Training (TVET) College. The research designs for this phase were exploratory descriptive and emancipatory. We started with Xhora clinic as this is at the entrance of Mbhashe Municipality on the main road from Umtata. This was followed by visiting the household of the Chief of the Xhora principality. The afforded an opportunity to meet with indigenous healers in the study area (iTola) and a faith-based healer at the homestead of the Chief. Professor Mji was accompanied by three PhD candidates she was supervising, with the researcher being one of them. During this time, the researcher was afforded an opportunity to present her intention to conduct research in the area. After the meeting with the Chief, the Donald Woods Foundation afforded a space for the PhD candidates to present their proposals to the foundation while the Foundation presented the work they are doing to promote health in every hut of the nine (9) principalities where their work was focused more on HIV, AIDS and chronic diseases.

It was through these engagements with the Donald Woods Foundation employees that the researcher intentionally used a purposeful sampling strategy to select participants for the three (3) principalities (Hobeni, Gusi, Xhora and Gusi) for phase 5 of this study. The researcher did not focus in Nkanya at this phase, as dissemination of Mji's findings and affirmation of study objectives in Nkanya was already covered during community entry in Phase 1. During the visit of the next areas, the initial discussion was on dissemination of Mji's findings and followed by discussion of the research objectives with the goal of first affirming objectives with key stakeholders and where necessary modify and add new objectives. We visited Hobeni Primary school where we were attended by an educator who was also

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an indigenous healer. During this time, a visit to Hobeni Clinic was also arranged to meet with the sister in charge. Since the homestead of the Chief is in the same village as the clinic, Mji arranged to meet with the Chief of Hobeni to disseminate her critical PhD findings and also to introduce the researcher. From the Chief's place a visit to the TVET College was arranged to introduce the research team. After a day, a visit to Nkanya Clinic, Vukukhanye Clinic and Madwaleni hospital was arranged to introduce the research team to respective biomedical practitioners. Through this phase, which mainly consisted of dissemination of Mji's critical research findings in the four (4) principalities (Hobeni, Xhora, Gusi & Nkanya), and introduction of PhD study in the four (4) principalities including the dissemination of Mji's findings to the DWF. As Mji's findings were only disseminated in the four areas, the DWF had a perception that all the nine (9) principalities should receive Mji's critical research findings and in addition, Mji had received NRF funding that required her to include all nine (9) principalities. This afforded the dissemination of Mji's critical findings in all the nine (9) principalities in phase 3 of this research. The researcher was afforded a platform to engage with respective stakeholders and these engagements continued in the conference that was held in 2016. The conference is discussed in detail in the next phase.

3.9.1.3 Third phase: 2016 Conference – Emergence of indigenous healers of Madwaleni

The July 2016 conference was arranged at Hobeni to include the whole community i.e., nine (9) principalities of Mbhashe region, and was held at the Donald Woods Foundation (DWF). Approximately 100 people attended this conference where exploratory descriptive and emancipatory research designs were applied. Hobeni, as mentioned in the study population, is situated in the middle or at the centre of Gusi villages, which then in turn means that DWF is at the centre. The DWF organization is committed to bringing 'health to every hut' by integrating the 'accessibility' principle of Primary Healthcare, which also focuses on access to basic health services (Foundation, 2017). The participants from the conference represented the nine (9) principalities of Mbhashe area and were also appropriate for the purpose of the study. The DWF was instrumental in inviting the communities from the nine (9) principalities and health professionals from the nine (9) clinics and the District hospital. The conference was attended by indigenous healers, health practitioners and various leaders from nine (9) areas of the Mbhashe Municipality. This conference was held at the DWF where elite older Xhosa women who were the focus of Professor Mji were invited, but the conference was mostly filled with other indigenous healers commonly known as traditional healers. The reason why Mji's research focus was on elite older Xhosa women was due to funding from the NRF as well the current study. Although the intention of the conference was to focus on elite older Xhosa women, the presence of indigenous healers meant a change in the direction of the study because of PAR (twists and turns).

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On the first day of the conference, it became clear that healers of the Mbhashe area consisted far more than the popular arena mentioned in Kleinman. It appeared that there was another area that Mji's (2013) study had not acknowledged and that was the folk arena, where over and above the elite older Xhosa women, the conference had to accommodate the different indigenous healers from the nine (9) principalities. The first day of the conference focused on dissemination of Mji's PhD findings and presentation of PhD studies, and day two was intended to focus on social determinants of health. A detailed report for this conference is attached at the end of this document as one of the appendices. Due to the fact that the first conference was inundated by indigenous healers who, similar to the elite older Xhosa women, also wanted to be integrated into allopathic medicine. In 2017 the lead researcher for the study on elite older Xhosa women recruited a Masters student who was also a researcher and training to become an indigenous healer. This researcher was placed in the research site and stayed at DWF to conduct a study that explored the indigenous healers of Madwaleni. She was also a biochemist and an indigenous initiate at the time, and she played a crucial role in assisting with this research study.

2016 Conference process and outcomes:

During the first day of the conference in 2016, the researcher had the opportunity to present her research study to the community. The conference was intended to address the elite older Xhosa women of Gusi, but the conference was dominated by other indigenous healers. The emergence of indigenous healers forced the meeting to take a turn and addressed the presence of these healers. The indigenous healers expressed their desire to work closely with biomedical health systems in the area. During this conference, the communication challenge was then addressed as an issue that seemed to exist between indigenous healers and biomedical health practitioners.

The second day was meant to focus on discussion of social health determinants in Hobeni using the model for community engagement that was used in Nkanya (Xanase area). PAR came into play when the discussions were dominated by a recent problem of children fighting with each other in villages surrounding Hobeni, and parents taking different sides. Solutions were discussed with follow up meetings planned with the Chiefs, leaders, stakeholders and parents from the various villages to engage the youth and also use the impact of various NGOs in the community. As mentioned above, communication was a contributing factor in the relationship of the existing healthcare providers, therefore, it was befitting for the study to establish communication channels which will be discussed in the section below. A brief outcome of bringing in a researcher who was also an indigenous healer will be presented in the findings of this study.

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3.9.1.4 The fourth phase: 2018 Conference - Establishment of communication channels

A year later, drawing from outcomes of the conference that was held in 2016. A master's student was employed to conduct a study to explore and understand the indigenous healers of Madwaleni. During her study, a group for indigenous healers was developed (Makukhanye group) to untangle the problem of children fighting and also the challenge of communication between indigenous healers and biomedical health practitioners. The addition of the master's student to the research team enabled the researcher to ask the master's student to act as her research assistant during phase five.

Following on from the conference in 2016, a further conference was held in 2018 held in a community hall in Qatywa, which is part of Nkanya Approximately 200 people from the nine (9) principalities attended this conference where exploratory descriptive and emancipatory research designs were applied. The first day focused on the children of Madwaleni, especially their needs and those living with disabilities, their vulnerability and, community cohesion and the community working together to support children. The issue of moral regeneration was discussed as a tool to support children and highlighted the need for communities to come together and develop support for all children. The second day used the dissemination of Mji's critical findings as a way of mapping out existing health services providers in this area and pathways of care from community to the clinic to the secondary hospital, but the communication challenge between the two existing healthcare systems in the area again dominated the discussions. The conference concluded with the future building of relationships between indigenous health practitioners and biomedical practitioners. The mapping out of the existing health services paved a way for the intention of this study to establish a Community Health Forum (CHF) which will be discussed in the following section below.

3.9.2 Section 2: Phase-5: December 2018 – Process of developing a Community Health Forum (CHF)

In this section the researcher intended to have a selected sample that will focus on triangulating some of the outcomes that had emerged on the previous four phases, including phase 6 below. This process included four (4) principalities namely, Hobeni, Madwaleni (Gusi), Nkanya and Xhora. More contained research methodologies such as focus group discussions and in-depth interviews (with key informants) were carried out by both the researcher and research assistant where PAR and ethnography research designs were applied. However, there was one instance where the research assistant participated in a focus group discussion due to the valuable knowledge she was able to contribute in the area. The research assistant was a biomedical scientist and an indigenous healer initiate at the time of this research study.

The fifth phase of the research represented five focus group discussions and three in-depth interviews with key informants (two registered professional nurses and a principal indigenous leader) and were

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conducted at the venues which were accessible and negotiated with the participants. The researcher was only accompanied to the research sites by the research assistant because the other research team members had already managed to complete their research studies in mid-2018. The researcher was able to secure focus group discussions during December of 2018. This is the time of year when the Bomvana are busy with their traditional ceremonies including celebrating coming-of-age of boys to manhood, appeasing the ancestors for a good year, celebrating achievements of new homes, and other important events that happened during the year. Though it was sometimes a challenge to get people to attend scheduled meetings such as FGDs and interviews, the space also afforded the researcher an opportunity to observe the culture of AmaBomvana as December was a month where most family members were at home – this period has been regarded as suitable for families to do rituals that link them with the ancestors and the culture. Some of the Chiefs had to preside over these rituals and could not find time to secure an appointment because of various events in the village that needed their attention and presence. While Imbumba YamaKhosikazi Akomkhulu (IYA) could not be organized because the Chief's wife also had to preside over these celebrations. However, the Chief from Hobeni had allowed the researcher to continue with her data collection irrespective of whether he was available at the time. The use of snowball sampling came into play to assist the researcher during this celebratory period of the research area.

3.9.2.1 Linking with participants in the villages

Through the process of community entry, the Chiefs of the four (4) villages assisted the researcher to access participants and key informants for the study. The Chiefs assisted the researcher with key informants who would guide the researcher in accessing relevant participants. The combinations of purposive and snowball sampling were used to select, and access participants as guided by village leadership structures.

3.9.2.2 Reciprocal training and relationship building with research assistant

The training between the researcher and the research assistant was reciprocal in the sense that each one was learning from the other (see Appendix D, p.249). The research assistant was both a biomedical scientist and an indigenous healer initiate at the time of this research study. She was also a researcher in the study area completing her master's research. Her experience was an added advantage for the researcher because this assisted the training and eased the building of the relationship. A research training manual was initially developed by the researcher in English and later translated in IsiXhosa. It was used step-by-step to go through the research process and how she fitted in as a research assistant in terms of her roles and expectations. The research assistant also had an opportunity to contribute

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where she thought a structure and an approach would not work for the community. Lastly, a structure on how to manage information and consent was covered.

Role playing of the methodology, including focus groups discussions, was discussed as the main procedure for collecting data. I also added one-on-one interviews with key informants, and this added value to the research data collected. One-on-one in-depth interviews were conducted with two professional nurses and an indigenous healer who made valuable contributions to the study objectives as they are knowledgeable about AmaBomvana ways of living and knowing. The time and the hours that the research assistant assisted in the collection of data was remunerated using the university's hourly rate for research assistants.

3.9.2.3 Study sampling

Sampling of the villages:

The sampling approach was used to identify villages where the phenomenon of interest is strongly represented (Chilisa, 2012). Some contextual incidences that influenced the sampling of the villages was geographical as the legacy of apartheid meant that services were located far from some villages while being closer to others (Mji, 2013). Applying snowball and purposive sampling were considered for inclusivity as well as opportunistic sampling in which indigenous and allopathic health practitioners identified other practitioners who could participate, including members of the community. From the nine identifiable clusters of villages in Elliotdale, approximately three clusters are close to the sea, another three are situated more centrally, and three are closer to the main roads. Thus, four principalities were purposefully selected: Madwaleni (area known as Gusi) located right in the middle surrounding the hospital, Nkanya and Hobeni both located towards the sea, and Xhora village closer to the main road and town. Both a village chief (indigenous leader) and a counsellor (political administrator) govern each cluster. The key criterion was to select villages in a manner that would ensure information-rich sources and seek maximum variation that accounts for diversity existing within the villages.

Sampling for study participants from the 4 principalities:

The Chiefs of Hobeni and Nkanya assisted in locating suitable participants for the study. All participants voluntarily participated and were drawn from the villages in the study setting. The main inclusion criteria was that participants should be above the age of 18 years. The socio-economic background of the sample was a mix between low and middle with some participants who could not read nor write.

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Study sample:

The sample comprised five groups of participants. Purposive sampling was used for three groups to consciously select and include certain participants (Tashakkori & Teddlie, 2003) based on their ability to best answer the research question (Creswell 2009). Snowball sampling was undertaken for two groups using community members to find participants who might have been difficult to identify by ordinary means who had specific traits and who were known and trusted in the community (Polit & Beck 2013).

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Table 2: Participant groups, sampling methods and inclusion criteria outlines the groups of participants, sampling and criteria

Groups	Sampling	Criteria
Hobeni Clinic Focus Group (four allopathic health practitioners and four community members)	Purposive sampling	Willing to participate. A minimum experience of more than three years working as: registered nurse, enrolled nurse. Have worked in a rural or urban public hospital, clinic or community healthcare centre for more than three years. A community member who resides in Hobeni.
Hobeni DWF Focus Group (six young females which consisted of three data capturers and three field workers)	Purposive sampling	Willing to participate. A minimum experience of working as data capturer and field worker at an NGO for more than three years.
Madwaleni Focus Group (all females consisted of an elderly retired allopathic health practitioner and three traditional healers, one who was also a biochemist)	Snowball sampling	Willing to participate. A minimum experience of more than three years working as: registered professional nurse. Have worked in a rural or urban public hospital, clinic or community healthcare centre. A minimum of three years' experience as: as indigenous healer consulting and treating clients while practising at home. Enrolled as a student for Masters Programme.
Nkanya Focus Group (three traditional healers and six community members)	Snowball sampling	Willing to participate.

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		Have assisted communities with indigenous medicine and consultation while practising at home. A respected royal member, has knowledge about indigenous medicine and contributing in community upliftment and development.
Xhora Focus Group (five allopathic practitioners, two traditional practitioners and one community member)	Purposive sampling	Willing to participate. A minimum experience of working more than three years as: registered nurse, enrolled nurse. Have worked in a rural or urban public hospital, clinic or community healthcare centre. Have assisted communities with indigenous medicine and consultation while practising at home.

Table 2 presents the focus group discussions and opportunistic interviews with participants and how these participants were selected to affirm the main objective of the study. There were instances where the objectives were modified because of the nature of the research method which aligned itself with PAR design. Although, the sample of this study was derived from both purposive and snowball sampling, the PAR nature of the method had a great influence. The sample had managed to include the different stakeholders from the community who participated in the process of developing the Community Health Forum.

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Study sample and sampling methods: The decision about who to include in the study sample was made during community entry where the study samples in the study were selected purposefully to ensure that suitable participants who can answer the research questions to get rich data were included. Participants were selected from the four clusters of villages namely; Hobeni, Madwaleni (Gusi), Nkanya and Xhora. The total study sample for phase 5 of this study comprised participants and key stakeholders, 11 being biomedical practitioners, seven being indigenous practitioners and 16 being members of the community. From the 34 participants, 26 were females and eight were males. Table 3 below illustrates the sample. All the study participants from the community were eager to participate. The presentation of sampling strategy and the study sample for the four (4) study areas i.e., Hobeni, Gusi, Nkanya & Xhora, is presented below.

Study sample and sampling methods for Hobeni: Initially, the sampling methods for Hobeni was via the Imbizo (Chief's gathering) and Imbumba YamaKhosikazi Akomkhulu (IYA) but these two did not materialize. The Chief of Hobeni was engaged with village meetings and rituals that needed his attention and presence at the time of the research. The wife of the Chief was unavailable because she also presided at the community rituals during this time. However, the Chief of Hobeni granted the researcher permission to proceed with her research study. Then snowball sampling came into play where the researcher had to access participants from the DWF and the clinic. Therefore, there were two focus groups that were held at Hobeni village, one at the clinic and the other at DWF. The sister in charge organized the Hobeni Clinic focus group discussion which comprised eight participants with healthcare practitioners and Expanded Public Works Programme (EPWP) women who were working at the clinic during the research study.

Hobeni Clinic (HFGD1): This focus group consisted of eight (8) females comprising four allopathic healthcare practitioners and four community members (Extended Public Works Programme – EPWP). Before the focus group discussion, the researcher was able to explain the purpose of the discussion. Participants were given a chance to ask questions before the discussion was resumed. It was agreed that the discussion would be conducted in isiXhosa to accommodate all participants since the language spoken in the area is predominantly isiXhosa. The focus group discussion was conducted at Hobeni clinic with the assistance of the professional nurse who provided us with an office space. The duration of the discussion was approximately two hours.

Hobeni DWF (HFDG2): A second focus group discussion was held at DWF where the manager at the foundation was approached to assist with participants for this research. The researcher was allowed

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to speak to one of the field workers who suggested other participants to fulfill the objectives of the study. Snowball sampling came into play because she suggested field workers and data capturers as suitable participants for the study. Before the focus group discussion could resume, the researcher explained a consent form to the discussion participants and all participants signed the forms. There were six (6) young female participants in this group. It was agreed that participants could use any language to express themselves (English or IsiXhosa) during the discussion. The discussion was conducted at one of the lecture venues at the foundation with the permission of the facility manager. The duration of the focus group discussion was approximately one hour and twenty-five minutes.

Study Sample and sampling methods for Madwaleni (Gusi) (MFGD3): Snowball sampling came into play where this focus group was organized via a field worker from DWF who also lived in Madwaleni. She organized her mother (a retired nurse) with other indigenous leaders from the area. At the time for the scheduled discussion, the retired nurse and most of the indigenous leaders were at a local gathering where another indigenous leader was deceased. When the researcher and her assistant arrived at Madwaleni the intended focus group was no longer available. The researcher then asked the field worker to assist and two female indigenous healers were called out of the village meeting to honour our discussion. Although the retired nurse was unavailable, she suggested another retired professional nurse to assist and it was arranged that the focus group discussion could be held at her home which was nearby Madwaleni hospital and easily accessible to all participants. The participants for this group discussion consisted of the retired professional nurse, an indigenous healer, indigenous initiate and a biochemist who was also an indigenous initiate and a researcher at the time of this study. The duration of the discussion was approximately one hour and ten minutes.

Study and sampling methods for Nkanya (NFGD4): This focus group discussion was organized via iTola, the Chairperson of the Clinic Committee, and the member of the Makukhanye organization for indigenous healers. There were nine (9) participants for this focus group discussion, which comprised the Chief from Nkanya, an indigenous leader, three young males, one young female, a middle-aged female, and an elderly male. Snowball sampling was applied because iTola recruited all participants for this discussion. Before the discussion could resume, a consent form was read and explained to the participants. All participants signed the consent form and it was agreed that the discussion would be in isiXhosa to accommodate all participants. The discussion was held at Nkanya Clinic and the duration of the discussion was approximately two hours.

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Study and sampling methods for Xhora (XFGD5): This focus group discussion was organized via a key informant who is a healthcare professional and this group was a mix between healthcare workers and indigenous healers. The Xhora focus group discussion was held at the offices of the Outreach Programme boardroom at Xhora. This group was comprised of seven (7) participants: two female professional nurses, two female enrolled nurses, one middle-aged male healthcare professional, youth female indigenous healer and a youth female community member. The duration of the focus group discussion was approximately two hours and 30 minutes. A male middle-aged principal indigenous leader joined the group towards the end of the discussion because of his commitment during this time of the year, but his valuable contribution was recorded as an in-depth interview. The table below indicates the four areas where the sample were selected.

Table 3: Sampling for the four areas: Hobeni, Madwaleni, Nkanya and Xhora

Data sampling	Principalities	Biomedical health practitioners	Indigenous healers	Community members	Total sample
FGDs	Hobeni Clinic	4	0	4	8
	Hobeni DWF	0	0	6	6
	Madwaleni	1	3	0	4
	Nkanya	0	1	8	9
	Xhora	5	1	1	7
KIs	Hobeni	2	0	0	2
	Xhora	0	1	0	1
	Total sample	12	6	19	37

Strategies and process of Data collection: The following section describes the strategies and discusses the process of data collection for this research study. The process of data collection comprised focus group discussions (FGDs) and in-depth interviews. The FGDs were selected from the four (4) principalities while in-depth interviews were selected from Hobeni and Xhora. Figure 3 gives the cyclic manner of PAR which informed data collection because of its twist and turns and the researcher was

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afforded space to modify and adapt new objectives for the benefit of this study, for instance the main objective was modified as a process to develop a Community Health Forum and the inclusion of different conferences also assisted in this regard.

Description of Strategies: For the primary sample, focus group discussions (FGDs) were used as well as Mji's critical findings and a guide to facilitate the discussion. Before facilitation, the researcher had to briefly give her personal experience and background before a professional relationship could be formed in order to establish and solidify a personal relationship. The focus group was arranged in such a way that everyone had to sit in a circle facing each other so that nobody's back was facing another person. This technique is based on the indigenous Bomvana belief that having your back to someone creates bad energy and leads to conflict and resentment. When you look someone in the eye and your body is facing them, you invite good energy that will bring health and friendship. The guide for the focus group discussion was designed in such a way that it tackled the objectives of the research study and included questions that asked participants to describe and explain the existing healthcare providers in the area, describe and explain communication channels between biomedical healthcare providers and indigenous healers, and give thoughts on how a Community Health Forum (CHF) can be developed. How communication channels with CHF can function as a bridge between healthcare givers and an indigenous community? And to describe the indicators that could be used to monitor and evaluate the newly formed CHFs.

Process of data collection: The data was collected by using focus group discussions (FGDs):

To conduct FGDs, the researcher and research assistant visited the participants where they were located except for the sample from Hobeni (DWF) where the focus group discussion took place at the DWF because the participants were at work during the time of data collection. For the other four, the venue for the group discussions was at a place that was accessible and convenient to all participants. The duration for the focus group discussions was between one and two hours, while the interviews were between 35 – 60 minutes. The interview guide for these engagements was conducted in isiXhosa which is the language used in the research area. The consent forms were written in isiXhosa and for those participants who could not read nor write, the consent form was read to them and were allowed to sign with an X as an indication of their consent to participate in the study. The ethical principles were also considered during this process and these ethical principles are discussed in detail in the section of ethical considerations within this chapter. At the end of each focus group discussion, the

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researcher showed her appreciation and thanked all participants for agreeing to take part. The process of focus group discussions discussed above, has been applied for all four principalities.

- Opportunistic sample

Opportunistic sample comprised three in-depth interviews with two biomedical health practitioners and a principal indigenous healer. The two in-depth interviews with registered professional nurses were conducted in Hobeni while the in-depth interview with the principal indigenous leader was conducted in Xhora at the Outreach Programme where a focus group discussion was conducted. These were conducted at spaces and venues which were accessible to the participants. The in-depth interviews also included objectives which were also mentioned above during focus group discussions.

- In-depth interview with a key informant 1

An in-depth interview was conducted with Sister X one of the two professional nurses who was employed by Donald Woods Foundation (DWF) at the time of the study. Sister X has operated as a Senior Nurse Practitioner and Nursing trainer in Madwaleni for over four years. At the time of the study, she was leading the training of Community Health Workers and clinic nurses in the study area. She has been working at DWF since the organisation started in the various communities of Gusi. She has vast knowledge in biomedicine and working within communities understanding and respecting the community with their traditions and beliefs. The interview was conducted at DWF where she resides while working in the various clinics and communities for the foundation. The interview guide that was used for the focus group discussions was also used for this interview. The duration of the interview was approximately an hour.

- In-depth interview with a key informant 2

An in-depth interview was conducted with Sister Y who is a professional nurse who has worked in the biomedical field for most of her career and had worked as a matron at a big public hospital in Port Alfred for many years. In Madwaleni, she facilitated the Women's Forum, Community Health Outreach Program as well as training Community Health Workers alongside Sister X. She was also one of the professional nurses who was employed by DWF at the time of the research study. The conversation was conducted at the DWF where she resided at the time. The conversation was approximately an hour.

In-depth interview with a key informant 3

Another in-depth interview was also conducted with a principal indigenous leader who joined the focus group in Xhora at a later stage. The period of December is mostly a time of rituals and much of

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the time indigenous healers assist the community with certain rituals. Due to his vital role in the community, this participant joined the focus group discussion late. His contribution was used in the study because he represented one of the key informants. His contribution lasted for about 35 minutes. Table 4 below shows the data collection process.

Table 4: Data collection process for phase 5

Sample	Principalities	Participants	Data collection Methods
Snowball & Purposive	Hobeni Clinic	8	Focus group discussions
	Hobeni DWF	6	Focus group discussions
	Madwaleni	4	Focus group discussions
	Nkanya	9	Focus group discussions
	Xhora	7	Focus group discussions
Opportunistic	Hobeni	2	In-depth interviews
	Xhora	1	In-depth interview

3.9.3 Section 3: 2019 Conference and piloting a Community Health Forum (CHF)

The last section presents the sixth phase which was the Conference of 2019 where an Interim Committee was elected to form a Community Health Forum where PAR, ethnography and emancipatory research designs were applied. Outside this conference, the Community Health Forum was mandated to sign a Memorandum of Understanding (MoU) between the two existing healthcare systems in the area. This conference followed a conference that was held in 2018 with a focus on children of Madwaleni especially their needs and living with disabilities. The 2019 conference provided another opportunity for the research outcome which was the formulation of a CHF with biomedical health and indigenous health practitioners. The conference was held at Qatywa in Madwaleni near the Chief’s place. This phase addressed the objective to develop a Community Health Forum.

3.9.3.1 Conference participants

For the 2019 conference, all nine (9) principalities were represented from the biomedical health fraternity as well as the indigenous healers of Madwaleni. Approximately 250 people attended the

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conference. These participants were suitable to deal with the objective of dealing with communication challenges between the two existing healthcare systems in the research area as a majority of them had attended the previous conferences and some were people who had been seen during the early phases of the study.

3.9.3.2 Conference Aim and Rationale

This conference is the culmination of the previous five (5) phases of this study and included the work done behind the scenes by the research assistant who managed to assist the indigenous healers to develop an indigenous healers' group (Makukhanye) while on the other side conducting workshops with the nine (9) clinics and district hospital on how these spheres of health services could work together. From the conference in 2018 a decision was made that there is a need for a memorandum of understanding to be developed between indigenous healers and biomedical health professionals and this MoU needed to have terms of reference on how these two spheres of knowledge will work together.

3.9.3.3 Conference process and outcome

During the conference, the participants were divided into small groups (in a roundtable manner) where groups were purposefully mixed in terms of representation from both allopathic practitioners and indigenous healers. The roundtable strategy allowed participants to contribute by giving each one a chance to speak. This technique is similar to the focus group discussions where participants face each other in a situation and nobody's back is facing another person. However, the intended objective of the conference was initially to sign a Memorandum of Understanding (MoU) between the two health practitioners that exist in the area. Nevertheless, PAR influenced the conference and allopathic health professionals and indigenous healers to again step back and focus on the challenges faced by both parties when needing support from each other. The key issues that came out of group discussions were communication, accountability, transparency, referral system, protective garments and lack of respect. The discussions were strongly based on communication as a challenge between the allopathic health practitioners and the indigenous community. An interim Community Health Forum was then elected because some of the indigenous healers were not present at the conference due to community rituals that were happening at the time. It was agreed by all representatives at the conference that the interim CHF will continue and commit to monthly meetings that would strengthen the existence and functioning of the CHF, which would ultimately deal with the issue of communication and other related issues that affect the working together of both health systems. This

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interim forum would then later meet with relevant stakeholders and a draft MoU would be compiled and tabled for discussion.

Figure 3: Phases of Data Collection

3.10 Data management

3.10.1 Data management for phases 1 – 4 & 6

During the first four phases of data collection, the data was recorded by a scribe and thereafter circulated to all the participants during these phases. There were reports and notes from community entry, visits to villages (clinics, secondary hospital, school and TVET College) where participants could be accessed. Reports from these engagements will be attached as appendices at the end of this document with the list of names of the Interim Committee that was nominated during 2019 conference.

3.10.2 Data management for phase 5

During phase five, a recording device was used to capture the narratives and the researcher made notes after each focus group discussion. Focus group discussions were conducted in such a way that names of participants were not recorded except when participants signed the consent forms. All data was first transcribed verbatim to prepare for member-checking. Both the researcher and the co-researcher understood the indigenous language that was used by the participants.

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After the translation by an independent translator, the researcher then checked the translations to ensure that there was no meaning lost from the data. In the case where some translations were incorrect and lost meaning, the researcher and co-researcher retranslated the data. The audiotapes and transcriptions were kept in a lockable bookcase and the researcher can only open the bookcase. The electronic copies were put in an electronic file with a code known only to the researcher. Raw data will be destroyed after five years, which is the stipulation of the institution in which this study was carried out.

3.11 Data analysis

3.11.1 Analysis of findings: phases 1-4 & 6

The data that was collected during these phases was used as a platform to present the findings during phase five (5) because they presented the engagements with the various stake holders from the respective communities and the dissemination of Mji's PhD critical findings as foundation for the current study. These engagements informed and assisted the researcher with the kind of instruments and research tools to use for data collection. The data that was collected during these phases was presented as narratives in Chapter 4 (presentation of the findings). These narratives presented the process on how each phase transpired. For each phase, the process of participatory action research was highlighted with pivots and critical incidents that contributed to richness of the study methodology and ultimately influenced the research process of phase 5 which ultimately culminated in phase 6. Narrative analysis of the data was further applied with descriptions of the critical incidences and pivots that contributed to the PAR cyclic process and contribution to improvement or change in the methodology. Drawing from the framework gained from Mji's critical findings, coding of critical incidences and key observations was done if these incidences are contributing to PSDH, NSDH, assets and the research process.

3.11.2 Analysis of findings: phase 5

Data collected from phase 5 was translated from isiXhosa to English by the researcher. The transcriptions were then back translated to IsiXhosa by an independent Xhosa translator to ensure trustworthiness of the translation. Theme identification was utilized as one of the most fundamental tasks in this qualitative research by generating initial codes (illustrated in table 5 below) where data transcription and translation were done by reading and re-reading the data while noting down initial ideas. According to Whitehead (2004), themes emerge from the characteristics of the phenomena being studied. All emerging themes from this research were subjected to analysis and these included

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emerging themes from the focus group discussions tackling the objectives of the study. Data from snowball, purposive and opportunistic sampling were analysed where themes emerged using the objectives as a yardstick.

The recorded data was transcribed verbatim and the transcription utilised as the database for the study (Creswell, 2009). In analysing the data from the phases, double checking and back translation was conducted by the researcher. Thereafter, the verbatim translated transcripts were organized by village and read in detail taking an iterative and reflexive process. This process meant that the researcher had to go back and forth to make sense of and understand the data. This was done bearing in mind the methodological frameworks that were intended for this study. Interpretation was collectively done with the research assistant and with the assistance of participants through deliberations during member-checking.

For the data from one-on-one (in-depth) interviews, the researcher conducted thematic analysis. Methodologically, the researcher used thematic analysis for the interviews following Braun and Clarke's (2006) guiding work on thematic analysis. Each transcript was read one after the other several times in order to become intimately engaged with the data (Marshall & Rossman, 2011) and then they were all placed next to each other to identify codes, categories and themes that cut across all transcripts (as illustrated in the table below). This familiarity with the transcripts helped in the process of identifying and selecting relevant data that spoke to the aims and questions of the study.

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Table 5: Phases of thematic analysis by Braun & Clarke 2006:87

PHASES	DESCRIPTION OF THE PROCESS
1. FAMILIARISING YOURSELF WITH YOUR DATA	1. Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. GENERATING INITIAL CODES	2. Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
3. SEARCHING FOR THEMES	3. Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
4. REVIEWING THEMES	4. Collating codes into potential themes, gathering all data relevant to each potential theme.
5.DEFINING AND NAMING THEMES	5. Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
6. PRODUCING THE REPORT	6. Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme. The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

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When all the above steps for the different focus groups and information from key informants were completed, each focus group discussion was synthesized to analyse across the subunits and finally drawing out themes that emerged from these discussions. The level of analysis has guided the researcher in the discussion of findings as part of answering the key research questions of the study.

3.12 Trustworthiness of the study

Strategies for trustworthiness of the study focused on the strengthening of credibility, dependability and confirmability of data, and the transferability of findings (Moon et al., 2016; Lincoln & Guba, 1985). However, Morrow's (2005) critique is that this long tradition of using this parallel to positivist criteria in other paradigms has been widely criticized for creating logical inconsistencies. She thus recommends a move away from these standards to more intrinsic standards that emerge directly from qualitative endeavours as aligned to the paradigm chosen for a study. This would serve as a way of rejecting the attitudes that other paradigms are not rigorous enough.

The researcher double-checked the accuracy of transcriptions by presenting participants' viewpoints accurately and adequately. Selection of participants was purposeful. All transcripts were checked during field note taking, themes and categories were organized during follow-up interviews. Verbatim quotes are presented in the research report and observational data was systematic by recording field notes in the field and audio taping.

Peer debriefing assisted with the process of examining all documentation and processes, and this would act as an auditing process. The researcher for this study reviewed the raw data and analysed it, performed data-reduction and data-analysis products, data-reconstruction and data-synthesis products. According to Babbie and Mouton 2009, if the auditing process is managed adequately, it can be used to determine dependability and conformability.

Extensive field notes were taken on the environment in which the study took place. The notes gave the researcher an opportunity to compare observations with the researcher's original theoretical ideas and this process allowed the researcher to pick-up contradictions from the initial assumptions. Reflexivity came into play where the researcher examined both herself and the research relationship.

3.13 Ethical considerations

The research protocol was presented to the Health Research Committee of Stellenbosch University, Evaluation Committee and received an approval to conduct the research and was allocated a number (**S17/05/103)** as a point of reference. The ethical principles of the Declaration of Helsinki, the South

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African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research were adhered to. Ethical considerations raised questions about ethics which were concerned about the rigor, responsibility and respect of the practices of researchers. As a result, there were strict systems in place to encourage and enforce ethical practice. However, some kinds of research created specific challenges, which may not be adequately addressed by institutional frameworks for ethical conduct in research. This was particularly the case with participatory research, where the boundaries between researchers and 'research subjects' begin to blur. Therefore, Indigenous research supported the view that the community should be actively involved in the research process. The researcher as an instrument for data collection has been already discussed in 3.2.2 above is also considered in ethical dimensions.

3.13.1 Community entry and building of partnerships

Through community entry and building of partnerships, the community's involvement and participation was ensured. Working closely with the research assistant who moved full time into the area of Madwaleni during the course of her data collection, assisted in understanding the community where the Donald Woods Foundation in Hobeni village became her home. The reason why the research assistant decided to live in the study area was because she wanted to fully understand the AmaBomvana indigenous healers, their ways of doing things, their understanding of their environment, their connection to spiritual beings, and the relationships they have with the plants and animals of their land. The research assistant, as an investigator at the time, felt that the best way to achieve this was by becoming a part of the community. The experience of the research assistant was beneficial and as such an added asset to this study. Firstly, permission was obtained from the Chiefs (cluster of villages) and secondly, from the ethics approval sought from Stellenbosch University.

3.13.2 Focus Group Discussion (FGD) as a strategy to collect data

For the purpose of this study, Focus Group Discussions (FGDs) were used as a strategy to collect data and these FGDs included a mix of people from those who can read and write both English and IsiXhosa to those who can neither read nor write in both languages. It was agreed that during the discussions the consent form should be explained in the mother tongue, therefore, the researcher explained the consent form verbally to all participants in IsiXhosa. The consent form explanation covered aspects such as: the aim of the research; the research process, the role of each participant and benefits to participating in the study; permission needed to write down and record the discussions; the principles of anonymity, privacy and confidentiality by protecting individual names; their right to withdraw from

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the research process at any time; a feedback of findings workshop and that they will be acknowledged all the time for their contribution (see Appendix B as an example of information leaflet and the consent form).

Even for those who could read or write English, they also preferred the consent form to be explained in IsiXhosa. Participants were given an opportunity to ask questions for clarity, which was required in every event involving data collection. Two copies (one copy for the research record keeping and the other for the participants to keep) were provided for each participant to sign. Access to the study site and participants was through the first five phases of data collection procedure where the researcher via her supervisor managed to enter the community and built partnerships with the Bomvana community. The community entry was the key element when the supervisor introduced the researcher to the Paramount Chief and the respective Chiefs from the cluster of villages. An added advantage for the researcher was the ability to speak and understand the spoken language of the area. This allowed the researcher to engage the community on the research process in terms on how it could be positioned and aligned to their needs.

3.13.3 The issue of transparency and beneficence

The issue of transparency was achieved through explaining the purpose of this study until participants were clear about what is expected of them. FGDs allow participants a safe space to participate in group conversations willingly and freely. Given the Indigenous qualitative paradigmatic nature of the study, the data collection spaces were seen as transformative as they served as knowledge-sharing spaces with both the researcher and participants co-constructing knowledge.

Beneficence concerns “the provision of benefits and balancing those benefits against the risks of participation” (Fontes, 2004:163). Non-maleficence refers to our duty as researchers to do no harm (Barrow et al., 2020; Yick, 2007). It was the responsibility of the researcher to take special care not to stigmatize participants further and to ensure their safety. This was achieved in the focus group discussions by allowing each person an equal chance to contribute to the conversations at a given time. It was the responsibility of the researcher to account to participants and answer questions arising. Given that this is a minimal risk study, there was no discomfort anticipated. In addition to going through ethics approval from both the University and the Provincial Department of Health in Eastern Cape, the Batho Pele Principle which is embedded within the IKS stance allowed the researcher to reflect on herself and therefore respected and honoured the participants as she would wish for herself.

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3.14 Concluding statement

The past three decades has involved enormous revolutionary work towards breaking away from the positivist approaches whereby the locus of power and control is firmly lodged with the researcher (Khupe & Keane 2018; Chilisa, 2012; Smith, 2012; Mertens, 2010; Lincoln & Guba, 1985). This view assists the researcher in the way of knowing when knowledge production also involves both the researched and the researcher (Laible, 2000 cited in Chilisa, 2012). There are questions that are constantly asked when one is grappling with the consciousness of being Black dealing with issues of ethics and respect as adopted from Chilisa's (2012) work. The questions are: whose side am I on?; Am I challenging and resisting dominant discourses that constantly marginalize my people (Indigenous people) and how?; Who am I writing about (self or others or both)?; What narrative needs to be rewritten?; Do the researched own a description of themselves?; Have I captured the voices of the researched in a way that they can recognize and know themselves and would like others to know them?; What humiliation have theories and bodies of knowledge caused to Indigenous people?; What body of IK can I use to counter such harmful theories?; How are Indigenous people portrayed in literature and eventually in my research study?; Is there any deficient thinking or theorizing? (Chilisa 2012 cited in Ned, 2019). These questions were not easy to answer but they have further made the researcher reflect on the role of imperialism, colonization and globalization in the construction of knowledge, thus enabling the researcher to reject academic and methodological imperialism (Chilisa, 2012) through being guided by the four Rs as principles, which also assisted the researcher in ensuring a negotiated, culturally responsive methodology that is suitable for AmaBomvana. Hence PAR was an overarching research design and enveloped all the research methods used for the benefit of the research study.

The next chapter will be the presentation of findings.

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Chapter 4: Presentation of Research Findings

Until the lions produce their own historians, the story of the hunt will glorify only the hunter (Achebe, 2000, p.73)

4.1 Introduction

The chapter for presentation of findings was divided into three sections where section A is a presentation of research findings from phases 1-4 in the form of narratives, section B presented research findings from phase 5 and section C presents findings from phase 6 section C. For section A, the stories that arose from the first level of analysis, which involves the collection of participants' stories, observations and field notes are presented (Sharp et al., 2019; Polkinghome, 1995). Participants were grouped; a story was constructed per phase weaving in data from observation, journaling and field notes from context. There were also instances during these phases where all nine principalities were included in the respective conferences. As Russell Bishop (cited in Smith, 2012) suggests, storytelling has been used as a research tool, to represent the truth of AmaBomvana, positioning them as retainers of control in the storytelling process. These narratives highlighted hidden aspects about AmaBomvana, their culture and experiences. These hidden aspects were either observed by the researcher or identified as critical incidences that emerged during the research process. For section B: thematic analysis was done for research findings from phase 5 using Braun and Clarke's (2006) and Whitehead's (2004) approach. Phase 6: 2019 Conference – Piloting of Community Health Forum, will be presented in section B after phase 5 – section c phase 6 was presented as the process of describing and developing CHF because it affirms the development of CHF. Lastly, triangulating research findings from section A with those from section B, which assisted in contributing to aspects that were used in developing a communication model as part of the outcome of this PhD study.

4.2 Presentation of findings for section A

4.2.1 Narrative presentation of findings: Phases 1-4

The narratives for phase 1-4 emerged from the following study objectives:

- Explore the concept of development of community health forums during community entry and development of partnerships.

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- Disseminate and explore consensus agreement on Mji's critical research findings on the indigenous health knowledge and use of participatory action research cycle to implement and improve these study findings.
- Describe the process by which the older Xhosa and/or elite women communicate and engage with the clinic and hospital-based health providers.

These phases are briefly described below:

Phase 1 - Community entry and the building of community partnerships; Phase 2 - the building of community partnerships and dissemination of Mji's critical findings; Phase 3: Conference of 2016 - Dissemination of Mji's critical findings continued; and Phase 4: 2018 Conference - Establishment of communication channels.

Phase 1: Community entry and building of community partnerships – Nkanya sub district and the village of Xanase.

Nkanya and Hobeni are located towards the sea and further away from town (Elliotdale), Madwaleni hospital and tar road that leads to Umtata. Xanase is a village within Nkanya sub district where community entry started. The people of Xanase have close relationships where every family member is known by the Chieftain of the village, who is a mother, grandmother and a head of the household from the royal family of Tshezi (Gwebindlala). The relationships within the families of this village are closely knit with positive spirits amid facing negative social health determinants and which include challenges of access to health facilities, lack of schools (primary and secondary) where children are subjected to travel long distances, and this contributed to children dropping out of school at a young age. Although the people of Xanase have challenges such as social health determinants, they have positive spirit, a willingness to accept change and allow strangers to assist in their community development. The scholar-activist team described in chapter 3, which constitutes various researchers from US, UCT, UWC and 3 PhD students, has assisted the people of Xanase. I am one of the PhD students.

The community members who were represented in the first community engagement consisted of older males and females, middle-aged female generation, young males and young females. However, there was an absence of the middle-aged male generation due to migrant labour that meant valuable information was missing.

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This phase started at Nkanya (Xanase village) which is one of the nine principalities of Mbhashe district. My supervisor had conducted earlier visits and established a relationship with the Chieftain during her own PhD studies and feedback sessions. We were a group of PhD students and researchers (two PhD students and four researchers) and we loosely called ourselves the scholar-activist team. The main aim of this visit was to: (a) introduce the PhD students to the study area; (b) pilot a model of community engagement which focuses on how to reverse social determinants of health identified in Mji's critical research findings; and (c) start introducing the PhD students to the indigenous leadership of Nkanya area. By the time we arrived at Xanase (one of the Nkanya villages), the Chieftain had organised a meeting with the community to welcome us and to hear what we came to do in the area. We were allocated a rondavel at the Chieftain's place where we slept and kept our belongings for the duration of two weeks. The rondavel had no lock on the door and our valuables and belonging were safe all this time. We also organised mattresses, a stove, and other items to use during our stay. Although we sometimes ate with the Chieftain's family, there were a lot of us and we felt that we do not want inconvenience the family so we decided to cook independently as well.

The first major workshop was facilitated by five members of the scholar-activist team and attended by approximately 40–50 community members spanning all age groups. This workshop assisted us as PhD students to start learning about people of this area. People were gathered along how the Xanase village was organised i.e., male older people, older women, daughters in-law (oomakoti/*makotis*), youth and children, people in the village were more in touch with each other and all layers of the community were represented at the workshop. Although all layers of community were present, younger males and elderly males were present but the middle-age males were not. This has been an issue in the area where due to migrant labour and working in big cities and in mines, that generation has been absent. However, the middle-aged female generation (daughters-in-law) was there and elderly males who presented with poor health from mines. During the workshop, they narrated the pains they have regarding their employers from the mines as they never received neither pension nor compensation for their ill health. The workshop began in a plenary, but the facilitators soon observed that only certain members spoke in the bigger group, mainly the men and a few older women. The youth and most of the younger women were silent. What was interesting was that in this patriarchal society the young men were the quietest of all. The participants were then split up into five groups namely, the youth were split into young women (*oomakoti*), young men, the middle-aged group into women, then elderly women and elderly men formed their own group. Below is a picture of the middle-aged group women facilitated by the researcher:

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Figure 4: Older women's group with the researcher

Source: Photograph taken by Melanie Alperstein, on 12 October 2014, at the Xanase village, published with permission from Melanie Alperstein.

In the groups, they all discussed positive and negative social determinants of health, what assets and skills they had and what their dreams were for the future. When the groups came together, the discussions from the groups were pooled and from their dreams for the future, some plans were prioritised. There were plans to raise chickens, start a communal garden, explore spring protection, start a cultural centre and cultural tourism, and an early childhood project for preschool children. The three projects that were pursued in the end were the exploration for clean water supplies and sanitation, the building of rondavel for cultural tourism as well as the cultural centre, and an early childhood project. A community committee was elected to continue with the development in the area and the Chieftain gave her unwavering support to the committee. We also gathered that there were community members who had skills to uplift their village, *ukwakha umzi* (building a home) men are taught how to respect their households, how to relate to their wives and children, how to build a home and how to relate to extended family and relatives. People here even learnt to build their own home from making bricks to erecting the house. Before building a home, men are also taught how to make bricks which is called "*ukutena*" (see figure 4.1 and 4.2 respectively referenced from Ned (2018:126))

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Figure 5: Bricks made by the community to build a cultural centre.

Figure 6: Building first rondavel for the cultural centre using self-made bricks.

After the two-day workshop, a Xanase Management committee was selected to drive various activities of addressing the negative social determinants of health.

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Figure 7: The Xanase Management Committee

Source: Photograph taken by Melanie Alperstein, published with permission from Melanie Alperstein

After the workshop, a visit to the Chief's place was facilitated via the Chieftain from Nkanya (Xanase). It was during this meeting (Imbizo as it is called by the Chief) presided by the Chief at his homestead and which is attended by Chieftains and members of the community only by invitation from the Chief, my supervisor was afforded a platform to disseminate her critical outcomes and also introduced the scholar-activist team including the PhD students to the Imbizo. The supervisor assured the Chief and the Imbizo that the researchers will come back to present their findings after completion of their studies. After attending the Imbizo, we then concluded the first round of community entry and establishment of relationships that was in Nkanya. In table 6 below, key observations and critical incidences that emerged from phase one are listed, including their impact on methodology and social determinants of health.

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Table 6: Presentation of key observations and critical incidences, their influence on methodology and negative or positive social determinants of health (NSDH & PSDH) and assets (A) for Xanase community engagement.

Key observations and critical incidences	Influence on the methodology	NSDH & PSDH and Assets (A)
By the time we arrived at Xanase community has organised people for the meeting.	This showed grassroots leadership that is available to support village initiates, this gave hope to the researcher that when it is time for her data collection, she will have support in drawing up the community to participate in the research.	A: there is grassroot support for community initiatives and Chieftain and the leadership of Xanase are pro-active in guiding the community of new initiatives.
The rondavel we stayed in had no lock on the door and our valuables and belonging were safe all this time. During the night, we slept with the door unlocked.	This gave researcher a sense of safety and that she could engage with community members in a secure and safe environment without worry of personal belongings being stolen when visiting various stakeholders in the community. This also gave a perception of the character of the community, that they can be trusted with valuable items of other people including a level of trust amongst community members themselves as community members were role playing who they were – a trusted community.	A: - Security, respect for the private property of others. - Presence of a trusted community.
The majority of households were unfenced, this enabled people to visit and move during the day from one household to the next, from one family to the next without appointments. They also seem to create their own time in a continuous manner.	This presented to the researcher the vast contrast between this area and where she comes from - the urban area – where there are tall fences separating the households, and people had to make appointments to visit each other. This less disruptive and continuous approach was used during research and the researcher refrained from imposing to the people the urban individual	PSDH: - Community continuity including continuous village relationships with needs addressed as they emerge.

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	approach that the researcher is used to.	
In the workshop, younger males and elderly males were present as opposed the middle-aged generation of men who were not there. The elderly males that were there presented with poor health from mines without receiving their pensions.	Migrant labour has syphoned middle-aged males - leaving young males without role models – and resulted in a lack of discipline and excessive consumption of alcohol. The researcher will also observe this thread during the different phases of the study.	NSDH: -The absence male middle-aged generation exerted an extra burden in the upbringing and lack of discipline to the younger males. - Ill health of elderly male - With absence of middle-aged males no one to build the village and produce food.
The middle-aged female generation was there but were however, silent during discussions as they need to show respect in the presence of the older women (*makhulus*) where the concept of *ukuhlonipha (respect)* is being practised.	Middle aged females are seldom listened to. Researcher felt she would need to find a way to engage with young people and female middle generation during her research using PAR to ensure that this is done in a respectful manner.	NSDH: - Lack of contribution of female middle generation. - Confirmation of parochial approach of this community.
The workshop began in a plenary, but the facilitators soon observed that only certain members spoke in the bigger group, mainly the men and a few older women.	The concept of *ukuhlonipha* contributed to the plenary session where it was observed by the scholar-activist team where the middle-aged generation and *oomakoti* were silent in the presence of the older generation again her approach will be similar to the above.	Assets & NSDH: - Used to keep peaceful community. - Negate contribution of the middle-aged female and the young in village developmental matters.
The youth and most of the younger women were silent.	This was important for the researcher to note that there were community dynamics and informed the researcher there were issues to consider during data collection especially in study sampling to ensure that she selects a sample that is more inclusive.	NSDH: - As above

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What was interesting was that in this patriarchal society the young men were the quietest of all.	The generation gap between the older male generation and younger males was evident where there was no connection between the two generations. The absence of the middle-aged male generation was a contributory factor which was also a concern for the research study where the views of young males are considered as important as those of the older-male generation in constructing and developing the CHF as a strategy of communication in the various villages of Gusi.	NSDH: - As above
We also gathered that there were community members who had skills to uplift their village like *ukwakha umzi* (building a home).	The researcher will continue observing and learning from the community with regard to skills they have.	A: - Skills that some community members have to build a home and a place of safety for their families.
I observed as my supervisor was afforded a platform to disseminate her critical outcomes and introduced the scholar-activist team to the Imbizo.	I was able to learn on how Mji's critical incidences were presented to the community and how questions were addressed. This prepared me for the presentation of these findings in the next presentations in the other study area.	A: - Presence of the scholar-activist team and my supervisor in the research area to role play some of the activities.

Phase 2: Dissemination of Mji's critical findings

This phase started at the DWF where the scholar-activist was accommodated in 2015. During this visit, the PhD candidates were afforded space to present their research proposals to the foundation. During these presentations, the PhD candidates also related to the fact that they would ask for assistance and support during their research. There was a possibility that DWF would become a home-away-from-home since it is situated in the middle of Gusi that makes it easy to access other villages, which were piloted for the research. DWF is situated in the middle of Hobeni where the village just like Xanase is located closer to the sea but further away from the District hospital and farthest to the tar road that leads to Umtata. The time spent at the DWF allowed the research team to observe and connect with the traditions of the organisation i.e., how the DWF being located in the middle of Hobeni has state-of-the-art security which makes it difficult for the community of Hobeni to access the resources that

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seem to be provided by this organisation. The absence of an approach that addresses social health determinants in the work that this organisation is providing in the various villages of Gusi was a concern to the PhD students. Their programme "health in every hut" seems to provide medication and support on allopathic medicine by advocating for numbers of people who adhere to treatment as opposed to also assisting the community with their social health determinants. It appeared that they were using a medical curative approach to the conditions that were blighting the people of these villages. To the researcher this appeared to be like a second wave of colonization.

The purpose of this phase was to disseminate and share research findings that emerged from a PhD study that explored indigenous health knowledge (IHK) utilised by older Xhosa women amongst the AmaBomvana people in a rural research site in the Eastern Cape Province. The purpose of this PhD study was to pilot a rural health model, which would promote the integration of the indigenous health knowledge, carried by the older Xhosa women and facilitate appropriate health seeking behaviour on clients that utilise primary health services in this area. The Donald Woods Foundation (DWF) played a crucial role in assisting the process of dissemination of these findings in all the nine (9) principalities.

We went to visit the Chief who was an elderly male. The Chief stayed with his wife and grandchildren. We gathered that his son was the Chief although he was not living in the area. Therefore, in the absence of his son, the Chief would take the reins because he had vast knowledge of what was going on in the village, and as a result, he invited a traditional healer who was also a faith-based healer. That was when we gathered that a person could have a calling both as iGqirha and as a Prophet. Most of the talking was done by the Chief's wife because the Chief had a mild stroke therefore his speech was blurry, and not quite clear, so his wife interpreted and narrated to us what the Chief was saying. The Chief's wife was also concerned about the level of crime in their village especially burglary where she indicated that their home had been robbed.

From the Chief's place, we went to visit Xhora clinic where we met with a male nurse and shared our studies. He seemed to feel indigenous healers worsen the condition of people and make them sick. Our visit with him was a little bit longer because we were trying to explain the importance of indigenous and allopathic health healers working together, then he showed some interest and wanted to enrol as a student at Stellenbosch University.

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After our visit from the clinic, we went to a Further Education and Training (FET) college where we interacted with the teaching staff. FET is about skilling the community, but we gathered that the staff were not from Gusi, but from Umtata and travelled every day to the college.

From the FET College, we went to the DWF where we booked accommodation to settle there during our visits. At DWF, their presentations focused more on diseases while the three candidates' presentations focused more on social determinants of health. The Chief Executive Officer (CEO) of the DWF felt that the three studies were too deep and showed no interest. Their work at DWF focused on the number of people who are sick, and they trained field workers to collect statistics and send these numbers to respective donors. We also noticed that DWF was in the centre of Hobeni village with state-of-the-art security. This place was not easily accessible from the gate to the library, which was supposed to assist the community. This seems like a white elephant in the middle of a rural village.

The next morning, we visited the primary school in Hobeni village next to DWF. There was also a tavern next to the school. Although the principal was not available at the time of our visit, the deputy principal who was a lady teacher assisted us. We gathered that she had other hats, being a traditional healer and a tavern owner. This seemed like a contradiction from Mji's study where the makhulus talked about the lack of respect from their grandchildren due to their use of alcohol, drinking with older people in these taverns. As an educator who supposed to instil discipline and respect, owning a tavern was a bit dodgy.

After our visit at the primary school, we drove to the Hobeni clinic and asked to see the sister in charge. She was a bit aloof although by the end of our meeting she seemed convinced when we presented our studies. We continued to Vukukhanye clinic where we also disseminated Mji's findings, and our PhD studies were welcomed. On this second visit, we managed to cover the four areas (Xhora, Hobeni, Gusi and Nkanya) where I needed to do community entry for my research. This then concluded our second round of community entry and establishing relationships.

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Table 7: Presentation of key observations and critical incidences, their influence on methodology and negative or positive social determinants of health (NSDH & PSDH) and assets (A) for Hobeni community

Key observations and critical incidences	Influence on the methodology	NSDH & PSDH and assets (A)
Donald Woods Foundation (DWF) played a crucial role in assisting the process of dissemination of these findings in all the nine (9) sub-municipalities.	Noted this kind of support and how it can best be utilised to support the study methodology. Working closely with DWF could mean that as I focus on the four (4) areas – there is also an opportunity for the study to cover all nine (9) areas during the conferences.	A: - DWF is an asset to the area.
Male nurse at Xhora clinic seemed to feel that indigenous healers worsen the condition of people and make them sick.	Affirmation of Mji's critical findings	NSDH: - The negative attitudes of the allopathic healthcare practitioners.
He showed some interest and wanted to enrol as a student at Stellenbosch University.	For the researcher to keep an open mind and not be judgemental.	A: Available people that could be capacitated and role that could be played by researchers in facilitating capacity building.
Chief invited a traditional healer who was also a faith-based healer.	The invitation extended by the Chief to the healer assisted the researcher to understand the important role that the Chief has in communicating and connecting the research team with relevant stakeholders.	A: - Important to identify the Chiefs important role to researchers and research activities.
A person can have both calling as iGqirha and as a Prophet.	Researcher has a lot to learn from the community – have to keep an open mind and learn.	A: - Saw this dual practice that it could be an asset in dealing with an IK interpretation of health and illness.
Unlike Xanase where we slept on unlocked areas, and doors opened, the Chief's wife was also concerned about the level of crime in their village, especially burglary. Where she	Researcher will again need to continue observing the character and culture of the different communities in this area.	NSDH: Became aware of crime and its negative impact.

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indicated that their home was robbed.		
Gathered that the staff were not from Gusi, they were from Umtata and they travelled every day to the college. FET is about skilling the community, concerning about the authenticity of the information provided by the FET staff who are not even residing in the area.	As researcher will continue observing this influence of change brought by external agents such as these teachers and DWF – I need to use PAR to ensure full participation of community in the research process to ensure that they become more confident of their skills.	Assets + NSDH - FET staff from outside Gusi can also contribute to the learning of children. - Lack of teachers from the area a NSDH as practical examples from the community cannot be used.
DWF's presentations focused more on diseases while the three candidates' presentations focused more on social determinants of health.	Noted this deviation of DWF focus from our studies – will continue observing the contribution of this work to the villages including how this work fits in my research.	A: - DWF's appear to be an asset to the community, what is not clear is the impact of the work they are doing to the community.
The CEO of DWF felt that the three studies were too deep and showed no interest.	As above.	NSDH: - Lack of interest by DWF this appear to be NSDH.
Deputy principal from Hobeni primary school other than being a lady teacher, she had other hats, being a traditional healer and a tavern owner.	Will continued observing role of the school (education) during the research and see how schools can be included in development of CHF.	NSDH: - Conflicting interests of a teacher seen as NSHD.

Phase 3: Conference of 2016 - The nine (9) principalities and the emergence of indigenous healers of Madwaleni

The Donald Woods Foundation, Stellenbosch University and the University of Cape Town jointly hosted the two-day conference. It aimed at reporting to the Bomvana people on Mji's critical research findings and providing a platform for the community to chart a way forward for incorporating local health concerns into rural health interventions. The Daily Dispatch reported on the first conference held at the Donald Woods Foundation. The July 2016 conference was arranged at Hobeni to bring in the whole community i.e., nine (9) principalities of Mbhashe region. The intention of the conference was to bring the whole community together and bringing the DWF closer to the people with the goal of disseminating Mji's critical findings.

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Strengthening of Relationships with the DWF:

Because this was the first conference, it was felt that would be easier to hold it at the DWF, but we were concerned about the type of venue which was a traditional academic type of lecture hall which limits small group discussions as furniture cannot be moved. When we arrived at the DWF the day before the conference to check on arrangements, the venue was literally still being completed. We had already been in the community for a few days seeing that all transport, assisted by the DWF, to pick up the elderly women, traditional healers and other community members had been well organised. The DWF was organising the catering. Coordination of the nine sub districts in preparation for the conference. The people from Xanase played a crucial role in the conference as Mji's critical findings already had been disseminated to them and they had started with three (3) projects (water and sanitation, cultural tourism Centres and Early Childhood Centres) and wanted to share this experience with the people from Hobeni on the 2nd day of the conference. It was late when the day ended, and we were concerned about people from Xanase being able to get transport to their homes when dropped at Madwaleni Hospital by the DWF transport. We were concerned and disappointed that the DWF were not keen to have them sleep over and go home the next day. Fortunately, they managed to reach their homes safely. Elderly people and indigenous leadership of the Mbhashe district felt uncomfortable that we held a conference that aimed to unite indigenous healers and allopathic medicine at the DWF. They also felt that the hall built in a conference style of sitting was not suitable for their needs.

The Conference at the DWF in 2016

Over the two days, almost 100 people including indigenous healers, village elders, chiefs, community leaders, local health services providers and residents took part in an Indigenous Health Conference at the Donald Woods Centre at Hobeni over the weekend. Below is a picture depicting the conference at the DWF.

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Figure 8: The conference at the DWF in 2016

Source: Photograph taken by Melanie Alperstein, on 01 July 2016, at the Xanase village, published with permission from Melanie Alperstein

It was successful in that service providers heard the voices of the community, but there was possibly a lot of input. The biggest concern was that one speaker raised the hope of a sustainable food security project, but never returned to the community after the conference, to this day (2020). The conference highlighted the need to build closer future relationships between indigenous healers and allopathic health practitioners.

First day of the conference

The first day of the conference focused on disseminating Mji's critical findings. It was also related to the fact that it appeared that traditional healers and allopathic health healers have tried to come together previously, but no one followed up and as a result, each group was blaming the other. It was evident that these two groups were not serious and willing to work together. Communication came out strongly as one of the challenges between the two existing healthcare providers in the area. While the allopathic medical people were more organized as they have the colossal institutions that support them – the indigenous healers were in disarray as they did not have a formal structure to hold their gatherings except the home, i.e., they did not have an organization. The critical incident was that the conference intended to focus on elite women (the *makhulus*) who are the healers at Madwaleni but was mostly filled with other indigenous healers commonly known as traditional healers.

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Second day of the conference

The second day of the conference presented on one side that we wanted to bring community engagement while working on Hobeni and bring Xanase experience of community engagement and working on social determinants of health. We used a different venue for the second day, a rondavel at DWF. Apparently, the rondavel was designed in such a way that people from outside cannot see what is happening inside and the people inside cannot be distracted by the outside world. The rondavel was used also as a place for Imbizo, which was peculiar because an Imbizo is conducted in the Chief's homestead, next to the kraal and presided over by the Chief (colonization of the Imbizo).

We were not aware that the Hobeni community would role play for us the impact of negative social determinants of health and how they affected the youth. We started the workshop by presenting Mji's findings on Social determinants of health and the work that the Scholarship activist team were doing in Xanase. Xanase was there to share their experience. Then the Chief's wife mentioned that she needed to share something about the children of Hobeni (the fighting amongst themselves and heinous crime in the village) that maybe we should start with in addressing social determinants of health. We were shown the end tail of impact of social determinants of health, where children were fighting, and this really brought out the result of conflict. On the 2nd day, after the conference we were asked to facilitate a meeting of the Hobeni community who were having some problems in the community. We had asked some key members of the Xanase community to attend and share their experience of dealing with organising and issues in the community. Although the people of Xanase were there, our relationship with them was not strong and they wanted to share their experience at the conference.

It was a rich discussion, and some interventions were planned to deal with some of the challenges particularly with the youth. A year later, a biochemist and/or traditional initiate at the time was employed as a researcher to attend to the needs of the indigenous healers in the study area. Furthermore, she also assisted the traditional healers to organise themselves and develop a group called Makukhanye, which will be discussed further in the following phase.

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Presentation Table 8: Presentation of key observations and critical incidences, their influence on methodology and codes given that relate to negative or positive social determinants of health (NSDH & PSDH) and assets (A) for Conference in 2016.

Key observations and critical incidences	Influence on the methodology	NSDH & PSDH and A
The biggest concern was that one speaker raised the hope of a sustainable food security project, but never returned to the community after the conference, to this day (2020).	This was a revelation for the researcher not to make empty promises to the community – involve community on what is feasible.	NSDH: Making empty promises to the vulnerable communities.
The critical incident was that the conference was intended to focus on elite women (the knowledgeable older Xhosa women- *makhulus*) who are the healers at Madwaleni, but the conference was mostly filled with other indigenous healers commonly known as traditional healers.	To be careful as a researcher not to assume I know everything about the community – to learn from the community.	A: - Over and above elitist women there is an existence of a host of other indigenous healers in the community.
It appeared that indigenous health healers and allopathic health healers have tried to come together but no one followed up and as a result, the groups were blaming each other.	As this PhD study is focusing on development of community health forums, with the intention of a closer working relationship – researcher will need to be alert of this aspect of lack of continuity and of blaming each other. Need to understand what undermined continuity and trust and what can still be saved from this process.	NSDH: - Lack of follow -up on process of trying to work together instead continue finger pointing and blaming each other.

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It was evident that these two groups were not serious or willing to work together.	Aware of this to the process and methodology of this study – further discussed with supervisor on how best accommodate these opposing groups. Employment of a biochemist and/or traditional initiate at the time as a researcher to attend to the needs of the indigenous healers including unifying them to a group of all the indigenous healers in the study area.	NSDH: - Lack of willingness to work together.
Communication came out strongly as one of the challenges between the two existing healthcare providers in the area.	Affirms Mji's critical findings and further affirms the importance of this research study. To monitor this in various stages of the research process.	NSDH: - Communication challenge is a threat to possibility of these two existing healthcare providers in the area working together.
During meeting at DWF noted that rondavel was also used as a place for Imbizo, which was peculiar because an Imbizo should be conducted in the Chief's homestead, outside next to the kraal, presided over by the Chief (colonization of the Imbizo).	Raised questions related to the relationship between DWF, the residing Chief and community. It appeared that there is some form of underlying power issues. As a researcher – will be aware of the power struggle between DWF and community.	NSDH: - Colonization of the Imbizo where white supremacy came into play by building a rondavel for Chief's meeting.
The indigenous healers to organise themselves and develop a group called Makukhanye.	An organised group of indigenous healers assisted the process of data collection through an organised structure	A: - An organised group of indigenous healers was developed and to give a sense who specialises in what.

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	to fast track the communication between participants.	

Phase 4 - September 2018 Conference - Establishment of communication channels

This conference was conducted in a community hall in Qatywa as a response to feedback in 2016 from the community that they would prefer that a second conference be held in the community. By this time, a research assistant who was a trainee to become a traditional healer was already working in the area. The focus of the conference was to link with key community stakeholders that would participate on the NRF project on elite older Xhosa women. The outcome of this conference was as planned to relink with the elite older Xhosa women as well as the Madwaleni allopathic health practitioners from both the district hospital and surrounding clinics. The focus of the conference was to: (a) Follow-up on the issue of fighting children and the work that has been done to address the problem, and secondly (b) present the indigenous healers of the area including their newly formed organization Makukhanye as well as their healing practises and the challenges they have in working together with allopathic health systems in Madwaleni.

For the second conference, we opted to use our community engagement strategy and hand over the conference to the Xanase community group to run with it, with us facilitating from behind. Although it was a partial risk, we had been engaging with this community over the past four years and had trust in the process. When we first started engaging with the Xanase community prior to 2014 and at the workshop in December 2014, we found a community that looked only at their deficits and their needs. The community suffered not only from financial poverty, but also poverty of the mind and spirit (Alperstein, 2019), that was December 2014. In September 2018, this group portrayed a very different community, a community that may still be suffering financial poverty, but no longer displaying poverty of mind or spirit. This was now a community that insisted on and successfully hosted and organised all the logistics for a truly rural conference for the 18–19th of September 2018, as part of series of rural conferences in this area to connect with the rural people that are part of the community engagement process. They also felt strongly that the conference should be moved to a community hall after the lessons learnt from the previous conference held at DWF.

When the scholar-activist team arrived a week before the conference to check on progress the Xanase people had made in preparing for the conference, the team found an excited and organised

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community, slightly nervous and apprehensive, but filled with confidence. The venue had been secured, with the community contributing to the hiring costs (taking ownership of the event, a sign of gratitude towards community development). A team of caterers had been established and the menu for all meals, with all quantities calculated, were clearly documented. They had also involved children to participate in the conference in the form of orating poems. Some were about their own development, schooling and how the present government is supporting the rural child through child support grants. They had also prepared some indigenous songs and dances. Upon the scholar-activist team's arrival, the children were ready to do a dress rehearsal. Below is the picture of children that performed in the conference:

Figure 9: First rehearsal in the hut with children who were very shy but performed confidently at the conference.

Source: Photograph taken by Melanie Alperstein, on 09 September 2018, at the Xanase village, published with permission from Melanie Alperstein

It was an exciting moment that moved many to tears when children were performing confidently. For catering, a sheep was bought from a local farmer and fresh vegetables were bought from Ikhaya Loxolo, a sister NGO in Hobeni.

The first day of the conference focused on disability and moral degeneration giving an opportunity to deal with challenges of infighting of children identified in the first conference. On the second day of the conference highlighted the needs from the first conference, focused on the work of indigenous healers and collaboration between indigenous and allopathic health knowledge and practices. Below is a picture of indigenous healers performing their dances at the conference:

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Figure 10: The September 2018 conference – contrasting vibrancy with indigenous healers playing a major role.

Source: Photographs taken by Melanie Alperstein, on 19 September 2018, published with permission from Melanie Alperstein.

The day after the conference ended with members of the scholar-activist team and the Xanase Community Development Committee, as well as the catering team for the conference and some youth volunteers, reflecting, not only on the conference, but also on events and processes from the first community workshop in December 2014. This reflection was initiated and stimulated by 60 printed photographs that photo-documented event chronologically at certain points along the journey from 2014 to 2018. These photographs were put up in a hut in the village for the week before the conference and then moved to the conference venue. The photographs were used as Freirean "codes" to promote reflection and discussion (Dunham, 2018).

The second conference brought out that there had been progress over time, and they had moved from fear to pride and confidence. They had a sense of achievement and future possibilities, and lastly what the photographs meant to them. It was amazing when community members at first did not recognise themselves and where they lived in the photographs. As one community member remarked that, it was as if they were looking at scenes from overseas. Then they saw themselves and each other and it made them realised that they had a lot to give. Hosting the students from the USA made them proud

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of what they could do with local resources like making bricks, using straw for mats, roofs, blinds. This was a moment of pride and a sense of self-assurance and value. The question was then; could this moment be sustained and built on? Other areas of concerns are the ECD project that seemed to suffer pre- and post-COVID-19. Is there not enough support in the village? It has been difficult to get a co-facilitator to work with the ECD facilitator. The ECD garden was thriving at Xanase and hopefully it is still going and that the communal garden has been started and is thriving. The cultural centre is also stalled and is it apathy or village politics? There is still a long way to go to achieve the goals set.

Table 1: Presentation of key observations and critical incidences, their influence on methodology and codes given that relate to negative or positive social determinants of health (NSDH & PSDH) and assets (A) for the conference 2018.

Key observations and critical incidences	Influence on the methodology	NSDH & PSDH and A
We found a community that looked only at their deficits and their needs.	This meant that the researcher needed to work with the community for them to realise that they have their own assets within the community and people who make a difference in their daily lives.	NSDH: - A community that looked at their deficits and needs.
Initially, the community suffered not only from financial poverty, also poverty of the mind and spirit (Alperstein, 2019), that was December 2014.	This is the strength of participatory action research – while exploring there is also the influence of change. The researcher had to engage with the community to help them realise their ability and work on issues of self-doubt (self-awareness).	NSDH: - A community that suffered from financial poverty, broken spirits and inability to explore their mind).
Now this community insisted on and successfully hosted and organised all the logistics for a truly rural conference for the 18–19th of September 2018 with all quantities calculated, were clearly documented.	The ability to host a conference on their own affirmed the work that this community and the scholar-activist team achieved over the years. Working together, we can achieve a lot. For the researcher, this ongoing process of exploring, revealing challenges and taking action was part of PAR in action which must	A: - A community that has an ability to host a conference and to take care of the logistics until completion.

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	continue for the rest of the research process.	
They had also involved children to participate in the conference in the form of orating poems.	The involvement of children shows inclusivity and engaging with younger generation. Again, this asset lying dormant the researcher will need to see how it will fit in during the development of community forums – who are the children in relation to the indigenous knowledge that need to work together with allopathic medicine and where is the interface.	A: - Young children partaking in the conference displaying their skills.
Some were about their own development, schooling and how the present government is supporting the rural child through child support grants. The honesty and openness of young voices came through –	The inequality and issues of poverty that seem to crop up for researchers to take note. To the researcher when does this voice get killed and children later opt to stay in taverns and drink from dusk till dawn – where does it all go wrong – where do the children get lost? Has the school system anything to say about this – in Mji's 2013 research older women had already started complaining about how children came back from school no longer trusting and respecting them on the indigenous knowledge they hold. The researcher will continue to observe and study through PAR.	PSDH: - Developing the young minds, availability of government grants, all these have a positive contribution to the development of community.
They had also prepared some indigenous songs and dances.	Despite their plight of poverty, children share their ability to sing and dance. Raised questions to the researcher with regard to when do children start knowing about poverty.	A: - Different skills are displayed by young children.
For catering, a sheep was bought from a local farmer and fresh vegetables were bought from	There is a lot to learn from the community – researcher need to observe more.	A:

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Ikhaya Loxolo, a sister NGO in Hobeni.		- Farming and ploughing of vegetables contribute to food security in the area.
Members of the scholar-activist team and the Xanase Community Development Committee, as well as the catering team for the conference and some youth volunteers, reflected, not only on the conference, but also on events and processes from the first community workshop in December 2014.	Reflections (cyclic manner) in a participatory action research that each step feeds on the next step (interlinked). Good to be part of PAR in action. Need to continue this reflective cycle even in the next phases.	PSDH: - The exposure of Xanase community to the first workshop – 2014 – contributed to the development and growth of this community. Letting go of their deficits but focusing on their assets. Backward and forward approach – what to let go and what to consider for the future.
During this discussion, the secretary of the project committee had a major realisation and paradigm shift, and exclaimed, “Now I understand that civilisation is not something that is outside, it comes from within”.	The researcher saw possibility for sustainable change with community looking internally to uplift itself – she will use this possibility for change during the PAR process of facilitation for the development of a CHF.	A: - What does the community have? Messiah factor – expecting an outsider to bring change and development in the area. Knowledge and assets are lying dormant in the community.
One man remarked that he suddenly realised that they expected the youth to know these indigenous practices, but they had never taught them.	A lot to learn from this community about impact of colonization and its ruminants during this research need to assist all the different layers of the community to regain their voice and confidence.	NSDH: - The oversight of older generation of not sharing and teaching Bomvana culture to younger generation may result to this culture to disappear.
During the visit, what stuck the team though was how the children were the most excited and animated when doing the ride at the back of the bakkie. These children were singing, reciting, and had a great time.	As research is advocating for indigenous healer’s voice to come to the surface – need to be careful of dwelling only in the past – need to take indigenous knowledge systems to the present – what then is the role of this knowledge for the present young generation.	PSDH: - Sense of appreciation, singing, reciting and having a great time contributes as positive attributes to health and wellbeing.

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The team wondered if this was because it was something new, something they did not often get a chance to do, or the valuing of modernity in the form of a vehicle.	What does it mean to a rural child to have access to modern life? Is it about modern life or something new? Indigenous knowledge systems have been hidden – how can one bring it to the surface and what is the role of the young to this knowledge.	A: - The voices of the young are an asset and might be a reminder to indigenous scholars not to throw out the baby with the bath water.
The second conference brought out that there had been progress over time, and they had moved from fear to pride and confidence.	The influence of the scholar-activist team to build self-confidence in this community over time. This was the outcome of PAR – to bring pride and confidence to communities.	PSDH: - Movement from fear to pride.
Then they saw themselves and each other and it made them realised that they had a lot to give. This was a moment of pride and a sense of self-assurance and value.	Community assets that could assist as building blocks of community engagement and participation.	A: - Acknowledgement, self-pride and self-assurance brought a sense of value to the community.

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Table 2: Other moments that stood out as critical incidents

OTHER MOMENTS THAT STOOD OUT AS CRITCAL INCIDENTS
A moment that stood out was during one of the visits by some of the scholar-activist team while in the process of trying to infuse some of the project intentions to committee members. During the analysis and discussion with the committee about the quotation they had prepared for furnishing the rondavel, the question was raised whether some of the things they intended to purchase could be made from natural, locally available resources, e.g., beds, tables and chairs that could be made from wood. They could design and make things using local skills, for example, grass curtains and mats. Reflecting their culture through their own creativity will enhance the intention of the project. During this discussion, the secretary of the project committee had a major realisation and paradigm shift, and exclaimed, "Now I understand that civilisation is not something that is outside, it comes from within". This could be attributed to the idea of the "Messiah" which is regarded as someone coming from outside who may come to save the day (refer to themes and subthemes from Phase 5). She was so excited that it was difficult to get her to stop talking during the rest of the meeting. She wanted to stay with that idea and further unlock it and continue her exploration of this important idea. This pointed to the need for many more opportunities for this kind of dialogue. There was no opportunity to explore the topic with other members of the committee, as time is always a problem with these time-limited visits. Instead, we made a note of this comment and when we were planning for the next cycle of activities for the project, we decided to continue exploring this in Imbizo (Chief's meetings). Going back to who AmaBomvana were before modernity entered their quiet existence, and what civilisation is still lying dormant within, and what processes the community are suggesting bringing this civilisation to the surface. This process began when discussing what children should be learning in the ECD project. While exploring and discussing the possibility of the preschool children visiting different homesteads where they could learn indigenous practices in different homes and be told stories by elderly members of the homestead, another similar moment happened during an Imbizo in 2017. One man remarked that he suddenly realised that they expected the youth to know these indigenous practices, but they had never taught them. This started a lively discussion of what young children could be taught and this plan was implemented from then on. Following this approach, children can learn from an early age what it is to be a Bomvana, their ways of doing and being, the rituals, their history and culture, their civilisation. This can all be learnt from the elders in the homes and hopefully

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documented by the ECD facilitator assisted by other youth. If the knowledge of the elderly is not documented, it could disappear.
During a visit by some of the scholar-activist team later in 2018, the team had an opportunity to accompany the children to one of the elderly women's home where she entertained then with a traditional folklore story. They listened intently especially as she acted out the story. She then showed them how she cared for her pipe. We felt this was progress on the children learning about Bomvana ways of doing and being. During the visit, what struck the team was how the children were the most excited and animated when riding at the back of the bakkie. These children were singing, reciting, and had a great time. The team wondered if this was because it was something new, something they did not often get a chance to do, or the valuing of modernity in the form of a vehicle.
In general, there has been progress in the research area but there are still issues of who holds power in the community.

4.3 Section B

4.3.1 Phase 5:

Main objectives for these phases were:

a. Phase 5: to explore the process of developing Community Health Forum (CHF)
b. Phase 6: to pilot the developed community health forum.

The secondary objectives (SO) for phase 5 were:

1. Explore and describe existing healthcare providers in the study area.
2. Identify communication channels between existing healthcare providers.
3. Describe process of developing Community Health Forum (CHF).
4. Explore and describe how CHF and communication channels can function as bridge between existing healthcare systems.
5. Monitor and evaluate the newly formed CHF.

The secondary objective for phase 6 was to develop a memorandum of understanding between Allopathic health providers and indigenous healers.

4.3.1.1 Phase 5: to explore the process of developing Community Health Forum (CHF)

Participants in this phase were drawn from the four-piloted villages namely Hobeni, Gusi (loosely known as Madwaleni), Nkanya and Xhora. Tables were used to present data for the first secondary

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objective. Data for secondary objectives 2-5 was presented as themes and subthemes that emerged from thematic analysis. These themes were presented with supporting statements drawn into narratives from the process of coding and categorizing of data and direct quotes from the participants.

Below is the presentation of the combined data for phase 5 for the four areas according to secondary objectives (SO):

4.3.1.2: SO 1 - Explore and describe existing healthcare providers in the study area

The table below represents the summary of healthcare providers in the study area. This information assisted in providing the list of the healthcare providers drawn from participants from the focus group discussions (FGDs) and in-depth interviews. It was noticed that during the discussion that there was no mention of *AmaTola*, elite older Xhosa women and *iingcibi* as these people form part of the healthcare providers in the area as mentioned in other research from the study area (Mji, 2013 & May, 2019). Below in table 4.6 is a summary of healthcare providers in the study area:

Table 3: Summary of healthcare providers in the study area

	Allopathic Health Healers	Indigenous Healers
Healthcare providers of the study area	- Hospital: Medical doctors, nurses from various departments (e.g., OPD, Obstetrics and Gynaecology, Medicine and others), occupational therapists and physiotherapist - Clinic: Clinical nurse practitioners and auxiliary nurses. - Donald Woods Foundation: nurses, community healthcare workers (CHCWs) - Social Workers based in Elliotdale. - Mobile clinics: nurses & occupational therapists and physiotherapist - School health services: nurses - Ward Based Outreach Teams (WarBOTs)	- AmaGqirha - AmaXhwele - Ababelekisi - AbaThandazeli - Churches / Priests
Brief description of roles of the health-care providers	Nurses/clinic - Attend to minor and major ailments at clinic level. - Serves as a mini doctor in the absence of a medical doctor. Community Health Care Workers (CHCWs) - Visit the clinic and links the community with the clinic.	AmaGqirha - Assess the patient. - Examine the patient and if weak refer the patient to hospital. AmaXhwele

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	- Help sick people who are bed ridden at home. - Fetch treatment for people and pregnant women and ensure that patients are taking treatment. - Advocacy programme for communicable diseases (e.g., completion of TB treatment). Social Workers - Assist in poor homes with grants related to child support, disability and old age. - Assist people living with depression. - Help in child abuse and domestic violence. Mobile clinics - Drive around our areas and assist people in health-related issues. School Health Services - Services that are provided by DoH to visit schools. - Assess children with problems; refer them to nearest health facility. Ward Based Outreach Teams (WarBOTs) - Provided door-to-door campaigns, bringing services to the people. Medical Doctors/District hospital - Attend to referred cases. - Attend to major ailments. - Occupational and physio therapists: address impairment and disability.	- Deal with physical and emotional health related issues. - Deal with court cases and marriage cases. AbaThandazeli - Lay hands on you and pray. - Use holy water. - Put on you a wool. - Give you a purgative. Ababelekisi - Usually, older women who perfected the skill of midwifery over the years through experiencing, witnessing and assisting in many births throughout their adult lives. - Usually attend to women during pregnancy, labour and the postnatal period in different ways.

The table above gives a detailed account of the healthcare practitioners that were mentioned by participants during the research. The exploration and description of the healthcare practitioners in the area is divided into two main categories namely allopathic and indigenous.

4.3.1.3 SO 2: Identify communication channels between healthcare systems in the area

Four themes were identified as communication channels that existed between allopathic and indigenous healthcare workers and these were:

- The community healthcare workers (CHCWs) are communication link between the community and the clinics.
- Existing channel of communication characterised by one-sided referral system.

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- Channel and process of communication marked with shouting and chastising.
- Behavioural change needs to be channelled and communicated to relevant stakeholders.

Theme 1 – The CHCWs are the communication link between the community and the clinic.

According to study participants, community healthcare workers (CHCWs) based at the nine (9) clinics in the study area and the Donald Woods Foundation serve as a link between the homes of sick people and service provider. This includes tracking and reporting non-compliant clients to the clinic. These CHCWs visit every household and assist the community with their social needs especially health related needs. They also assist mothers who give birth at home to register their children at Home Affairs for birth certificates to obtain social grants. Subthemes that emerged from this theme were:

- Serve as a bridge between communities and allopathic healthcare system.
- Mobilise community members to use available health services.

Sub Theme 1 – Serve as a bridge between communities and allopathic healthcare system

The presence of the DWF with its community health workers is an asset to the area as it assists in being a bridge between the homes of people of this area and the community. The CHCWs play a crucial role where the nurses from the clinics are unable to reach remote areas in the villages. These CHCWs communicate the needs of the community to the clinic and encourage community members to visit the clinics for health-related issues.

MamThembu said:

> *Community Health Care Workers (CHCWs) report the patient to the clinic. Non-compliance to treatment. Person who missed appointment at the clinic. (HFGD1)*

Sub Theme 2 – Mobilise community members to use available health services

The CHCWs from the DWF (health in every hut) run a programme of mobilising community members to consult the nearby clinics for check-ups. This assisted people from this indigenous community who in the past only received healthcare from indigenous health practitioners. In general, there is minimal understanding from this community of the role of allopathic care. Hence diseases are brought late to the health services when they have already complicated. This has been alluded by one of the participants from EPWP:

MamFene responded:

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> *DWF go around community provide people with information to do cancer check-ups and other ailments. DWF visits houses, door-to-door. (HFGD1)*

Theme 2 – Existing channel of communication characterised by one-sided referral system

This theme indicates that the relationship between allopathic healthcare practitioners and indigenous healers is marked by one-sided referral where indigenous healers are expected to refer clients to the clinic. But on the other hand allopathic health professionals hardly refer to indigenous healers, though they acknowledge that there are some illnesses that they struggle to manage which they also believe that indigenous healers could assist. Both participants who were allopathic health practitioners and indigenous healers have confirmed this fact. This theme was common from four groups. The following statements allude to the above:

A retired professional nurse remembers a workshop held few years back:

> *In a meeting/workshop with medical doctors and herbalists at the hospital years back, we were given advice that when you see a person who is very sick refer such a person to the medical doctor. Then you can do whatever after because medical doctor will first do his. (MFGD3)*

It appears that there is a process that needs to be followed as this professional nurse from Xhora, states:

> *After our workshops, they (indigenous healers) bring clients first to the clinic. They do not start with their medication. (XFGD5)*

This process is further affirmed by one of the participants from Hobeni clinic FGD:

> *Indigenous doctors are also available but when they see that they cannot provide any service for you, they refer the case to the clinic. There was a meeting that was held here at the clinic that ask the clinic and traditional healers to work together. The traditional doctor should have a referral form to the clinic. (HFGD1)*

While another indigenous healer from Nkanya complained that:

> *There is little movement. An indigenous healer can refer to the clinic and give that person a referral with a stamp, but not all of us are able to do that. (NFGD4)*

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One of the key informants from Hobeni, a professional nurse confirmed that allopathic practitioners (educated people) consult indigenous healers, but they hide this fact from the indigenous community. She responded:

> *Allopathic health practitioners do consult indigenous practitioners but after 9 (when it is dark or during the night).*

From the above direct quotes, it appears that there is clear understanding and guidelines for the need for indigenous healers to refer patients to allopathic healthcare system (district hospital and nine (9) clinics), on the other hand, indigenous healers describe the movement and referral process of patients to their side as little movement as it appears that allopathic health professionals do not refer to indigenous healers. Conversely, although allopathic health professionals hardly refer to indigenous healers, on the quiet, they also consult indigenous healers.

Theme 3: Channel of communication marked with shouting and chastising

This theme indicates the type of communication the allopathic practitioners portray to the indigenous community. The type of communication is characterised by the negative attitude towards indigenous healthcare practice. Communication between the indigenous community and the nurse at the clinic is marked with shouting, scolding and chastising especially when the client has visited a traditional healer prior the allopathic healthcare. Weak, poor communication creates a gap between allopathic and indigenous healthcare.

One of the field workers from DWF confirmed this by stating:

> *Communication is very bad. When you first visit indigenous doctor then after you visit clinic, upon arrival at the clinic with imikhamelo and other stuff, nurses shout about that and tell you that if you have not used alternative medicine you could be healed. (HFGD2)*

While a key informant, a professional nurse from Hobeni alluded to this fact by responding:

> *Communication channels are not that strong, despite the fact that this has been introduced there is still a gap. Healthcare providers were the key people to introduce good communication between the two parties, but one will find a healthcare worker (clinics) scolding a person who admits having been to the*

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> *indigenous practitioner, due to complications or state of condition that one comes with, or brings his/her … (KI1)*

Both allopathic practitioners and indigenous community confirmed the negative attitude that allopathic practitioners display to community members. This attitude further exerts pressure on the type of relationship between the two healthcare systems in the study area.

Theme 4: Behavioural change needs to be channelled and communicated to relevant stakeholders

This theme spoke to a need for behavioural change though it is known that change is considered as difficult when a person is accustomed to the way of doing things in a certain manner. This theme concentrated on behaviour change from indigenous healers where they need to consider the issue of hygiene during their practice. Participants suggested that indigenous healers need to consider behaviour change including hygienic practices and rinsing of stones before and after mixing different herbs. The space where IK healers keep the indigenous medicine and how they prepare the medicine to dispense to their client's hygiene on this needs to be improved. The following sub-themes and statements support this assertion:

Sub Theme 1: Lack of hygiene practice

The lack of hygiene from indigenous healers was raised as a concern during a workshop. The lack of hygiene includes the herbs that indigenous healers used for healing. The space where they keep their medicine and how they prepare the medicine for dispensing.

Sub Theme 2: Rinsing of stones before and after mixing herbs

The rinsing of stones is seen as one aspect of keeping up with hygiene. There are different medicines for different ailments. Some medicines are used for human consumption (drinking or bathing) and some are used for cleansing of the house. Medicines for cleansing the house are regarded toxic for human consumption. Therefore, the idea of rinsing stones before and after mixing herbs is advisable. As this quote below attests:

> *We were advised about the herbs that we used. We are illiterate. Now we take these herbs and mix, then they said we should rinse the stones. Let us get used to the idea of rinsing the stones before mixing another herb. On the other hand, your stones should be two but always be cleaned because people need different herbs one for bathing and another for other purposes. (MFGD3)*

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The above quote from and indigenous healer from MFGD3 showed the willingness from indigenous healers to listen and change.

4.3.1.4 Objective 3: Process of developing Community Health Forum (CHF)

Four themes were identified from the data from participants for the process of developing Community Health Forum and they were:

- Chief as the first point of community entry.
- Realize that indigenous healers have a wealth of knowledge in treating some ailments.
- Awareness on health-seeking behaviour.
- Create a platform that is responsive to the needs of community, indigenous healers and allopathic health professionals.

Theme 1 – Chief as the first point of community entry

This theme indicates that whatever intentions a community has, the first point of entry is the Chief of the village. Therefore, they should inform the Chief and tabulate their intentions. With the permission of the Chief and his approval, this then leads to acceptance by the community, which gives the community a better position to nominate people according to their profession as representatives in the CHF. The Chief hosts meetings related to the community health forum at his homestead, next to the kraal.

The following sub-themes and statements support this assertion:

Sub Theme 1 – Permission and advice

The Chief of the village is the first point of entry to the village. He is in a better position to give sound advice to an idea. He has the power as a royal leader to give permission to the projects and development in the community.

> *We should meet at Chief's place and explain to the Chief what we are thinking. (HFGD1)*

A field worker from DWF said:

> *An appointment with Department of Health (DoH), community and stakeholders. Chief's homestead. The Chief and the board, the councillor, herbalist, indigenous*

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> *doctor, faith-based healer, nurse, medical doctors, community health workers, NGO (DWF and Ikhaya Loxolo for the disabled children). (HFGD2)*

Sub Theme 2 – Approval and support

The workers from DWF responded that the Chief of the village should be in the forefront to organise the CHF. All stakeholders from the community, together with Department of Health (allopathic health practitioners), should meet at the Chief's homestead to discuss the CHF.

> *We need an appointment with Department of Health (DoH), community and stakeholders and all these groups should meet at the Chief's homestead. (HFGD2)*

Theme 2: Realize that indigenous healers have a wealth of knowledge in treating some ailments

This theme focuses on some of the ailments that are treated by indigenous healers. Indigenous healers treat all people of the community from infants to the elderly. There are different medicines for different ailments. Some of the illnesses they manage are related to cleansing of the blood through use of potions, supporting people struggling from seizures, where there are beliefs related to evil hexes, assist by removal of these hexes. New-born babies too are supported from their childhood illnesses while those with demons that usually manifest itself like a mental state/illness like schizophrenia are also supported by the statements below and the table in Appendix F. These ailments are written in isiXhosa and an attempt of English translation is made. Below are direct quotes supporting this theme:

> *Another thing when we already developed the forum, they will know that Sinalo is an indigenous doctor who specialises in umeqo for instance. Then a doctor so and so from Madwaleni sees a client representing with symptoms like the client has diabetes but cannot help the client then the doctor will contact me because we will have established that communication. (HFGD2)*

The above quote points to skills of supporting patients with symptoms of hexes which might manifest as diabetes-like symptoms, whereby clients might be at risk to have their legs amputated.

A registered male nurse from Xhora confirmed that a peculiar case of a patient that a Psychiatric doctor was unable to treat and was referred to an indigenous healer.

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> *I used to work at a Psychiatric Department in UMzimkhulu where there was a person who came for treatment, was admitted there. The indigenous doctor was now confused, then the person came to speak with the doctor. Then the allopathic doctor spoke to the traditional doctor and they signed an agreement I am coming to this point when you say there seem to be nothing referred from the allopathic side to the indigenous side. It was a Psychiatric doctor that took an initiative {Because we do not know amafufunyane} we just heal {No we do not know them} people with our own medication, then the Psychiatric doctor saw that there was more than meets the eye, then he communicated with the traditional healer and then everything was alright. (XFGD5)*

Theme 3: Awareness of health-seeking behaviour

It is important for health professionals from the allopathic realm to understand that the community members will do anything and everything when confronted with a sick family member. This is seen at Madwaleni when a carer will seek help from both allopathic and indigenous practitioners. It is a known fact that clients do consult both traditional and allopathic healthcare therefore, it is necessary for both traditional and allopathic practitioners to create a space where they can work together for the health and wellbeing of their clients. This approach is supported by the sub-themes and with direct quotes that are extracted from participants of this study.

Sub Theme 1 – Dual consultations

In an African society, dual consultation is not seen as a taboo because allopathic medication is focusing on what and why the illness is, while indigenous medication focuses on who caused the illness and how.

A retired professional nurse responded:

> *Community members do consult allopathic healthcare practitioners as well as indigenous healers. People still believe in indigenous medicine and still believe in hospital. Neither health system is better than the other, but the two should be complementary, recognising that the culture and beliefs of patients influence their health-seeking behaviour'. (MFGD3)*

Sub Theme 2: Focus on who caused illness and why

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Indigenous people dwell on who caused their illness and why, and this could delay the treatment of the ailment while it can be a minor ailment but because of the superstition might be a major ailment, which can then further complicate the ailment and be difficult to manage from an allopathic healthcare system.

> *Another thing that delays the progress of people is superstition of being bewitched whereas the person has TB then by the time it is diagnosed the person would be worse. Look at the way he/she is coughing, coughing non-stop. As you are giving them treatment be suspicious and know that you were taught in those meetings that this could be TB and it cannot be detected by traditional herbs but by an X-Ray. (MFGD3)*

Theme 4: Create a platform that is responsive to the needs of community, indigenous healers and allopathic health professionals

Participants expressed the need for creation of a platform that could respond to the needs of community, indigenous healers and allopathic health professionals. This platform must afford indigenous healers a space where they are characterised, recognized and acknowledged as healthcare providers. It also should be underpinned by respect for each other of the work each is doing. Some of the sub-themes that emerge from this discussion were:

Sub Theme 1: Develop a unified health system that is accessible to the community

In Bomvana, there are more villages than clinics that can provide healthcare services in the area. The existence of a forum would assist in the development of a link between the community and allopathic health services and this would improve access to services. The forum also allows healthcare practitioners a space to work in a closer vicinity because in every village there will be a member of the forum which means access to healthcare for the community.

The Chief alluded:

> *There should work in a close vicinity so that if the doctor is unable to assist the patient can be referred there and there so that the person may not die. (NFGD4)*

Sub Theme 2: Community needs to be in the forefront of the CHF

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The respective indigenous healers saw themselves as the owners of the forum, therefore; they are responsible for the operations of the forum. This sub theme suggests that community members must take a lead in issues that concern their health. “Nothing for us without us”. When the community takes ownership of the forum, this will prevent the forum from collapsing.

A registered professional nurse stated:

> *The owners who are elected community members run it. It is just that we did not monitor when it sits, because they supposed to have their own schedule for their meetings. In addition, the Eastern Cape Province does monitor because there should be monthly minutes that ensures that these community health forums are active every month. The reason why we do not have any information right now it is that we are not full time because they operate on their own. We only come when there is a need. (XFGD5).*

A retired professional nurse alluded:

> *For it not to collapse this depends on those people (indigenous leaders) who came for a request. I think these are the people who supposed to have a backbone and support and follow through so that it does not collapse, so it does not end on the way. Since it has already started but does not exist anymore. (MFGD3)*

Sub Theme 3: Creates a space and a platform for level of understanding and trust

Developing the forum creates a space and a platform for healthcare practitioners to assist the indigenous community with a level of understanding and trust**.** This space can be created by both healthcare system working hand in hand and showing willingness to listen to each other.

ITola stated:

> *I am going to the saying that states that there should communication between the community, indigenous doctors, herbalists and medical doctors. Because the medical doctor does not trust the medicine that I bring as an herbalist. Moreover, I am not trusting the pills that the medical doctor as educated as he is. I trust my own medication. There will be trust when I know how his pills works in a person. Then I will also tell him, how my herbs work in a person. Then there will be communication that is proper that will result to development in our areas. (NFGD4)*

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Sub Theme 4 – Avail resources for forum's sustainability

However, for it to function properly and extend its services to the larger and broader community resources must be available otherwise, it cannot reach remote areas. There is a challenge in the area where there is cluster of villages closer to the clinics and the district hospital while there is a cluster of villages farthest from the main roads and the town, with some in the middle of Gusi. These challenges, therefore, pose a threat on the limited or no resources to sustain the forum (accessibility of villages to healthcare facilities).

The Chief stated:

> *Forum can be developed but if there are no resources, there could be a lack because villages that are not all nearer to it surround the clinic (NFGD4)*

4.3.1.5 SO 4: CHF & communication channels as bridge between healthcare systems

Theme 1: Nature and characteristics of communication

The main theme that emerged from this objective was related to the nature and characteristics of the communication. Participants from the five-focus group discussion were committed to develop certain attributes how future communication will happen. Each group wanted to contribute on what they saw as future way of communicating. They saw this nature and characteristic of communication as a bridge between the two existing healthcare systems in the area. They were able to contribute certain aspects which they saw as aspects that would support communication which for this research are organized as subthemes and are as follows:

Sub Theme 1: No looking down, no undermining but acknowledgement & mutual respect

This deals with the undermining tendencies that each healthcare system might impose upon the other, when it is advised that this behaviour is unacceptable from the members of the CHF. This might have a negative impact on the working together of these two health systems. Another participant responded:

> *I think we should not look down upon each other. If maybe I refer a person to the clinic, the clinic should not undermine me. Moreover, not undermine the referral if the person used traditional medicine. The clinic should continue from where I left off. (HFGD2)*

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One of the allopathic healthcare practitioners from XFGD5 asserted the acknowledgement and mutual respect where he mentioned:

> *It was a Psychiatric doctor that took an initiative, then the Psychiatric doctor saw that there was more than meets the eye, then he communicated with the traditional healer and then everything was alright. (XFGD5)*

Sub Theme 2: Use all available communication methods to link with stakeholders

This theme indicates that members of the Community Health Forum can make use of available methods of communication with the access of mobile phones when they encounter challenges in their respective villages. Use of mobile phones can bridge communication gaps between CHF members. The use of mobile phones assist members of the forum to communicate with each other since their villages are scattered and there is a challenge of transport and roads to the nearest healthcare facility. HFGD1 responded:

> *I think we can use phones. When you see a person in the village that is not well then you know a representative from the forum. Then you know who to contact when you see such a person and the representative from the forum will meet this person. (HFGD1)*

Sub Theme3 – A continuous responsible communication channel that reports to its constituencies

The forum consists of different healthcare practitioners. Therefore, it is the responsibility of the various stakeholders from the forum to report to their respective constituencies:

> *I think my sister, when we have already formulated a structure, we can say we can meet on Tuesdays in a week and develop a forum, then whatever we agree upon here as a structure as a person who represent traditional doctors I will spread to my traditional doctors. Even the representative for the nurses will spread to their colleagues. Then we agree that each month we meet twice to discuss pertinent issues that concern our health in the community. Then we discuss our resolutions and everything we discuss there. Then when we leave, we go with an understanding that from here we go there, and we operate like this. (HFGD2)*

Sub Theme 4: Create and promote communication channels for an integrated referral system

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Since the forum consists of different stakeholders from both allopathic and traditional practitioners, an integrated referral system is critical to prevent patients falling between the cracks of the two health systems. The following statement also confirmed by the group:

> *Another thing when we already developed the forum, they will know that Sinalo is a traditional doctor who specialises in umeqo for instance. Then a doctor so and so from Madwaleni when he sees a client representing with symptoms like the client has diabetes but cannot help the client then the doctor will contact me because we will have established communication. (HFGD2)*

Sub Theme 5: Develop a team to coordinate and monitor

There should be a team or committee that would be responsible for coordinating and monitoring the operations of the forum. NFGD4 mentioned:

> *The forum will not be the people who are the healthcare providers but would be the people who will coordinate and monitor the process. Then they will be responsible to invite the healthcare providers then it will be right. (NFGD4)*

4.3.1.6: SO, 5: Monitor & Evaluate existing CHF

Five themes were identified for monitoring and evaluating the existing CHF, and these were:

- The use of communication as a monitoring and evaluation tool.
- Collate feedback from constituencies and beneficiaries of the structure.
- "Messiah factor" to support the CHF and prevent collapse.
- Guiding document on how to operate.
- Training the forum on communication skills.

Theme 1 – The use of communication as a monitoring and evaluation tool

Proper communication will enable members of the forum to tackle issues in a manner that is understandable and acceptable to each other. HFGD1 responded:

> *We communicate to each other as a group. When there is a problem, we communicate with each other. If there is a problem here at my village, if maybe there is a problem that I have encountered, there should a place where we can meet to discuss such problems. So that our forum may not fall apart. (HFGD1)*

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Theme 2 - Collate feedback from constituencies and beneficiaries of the structure

For the forum not to collapse, it is of utmost important for the constituencies and the beneficiaries of the structure to give feedback on its operations:

> *If there is a forum, there should be a committee. Everything for the community there should be a committee. Everything that you formulate there should be a committee. It should be known that there is chairperson here, there is so and so and etc. Who is the committee of this forum? They make sure that the meetings are held here, and the minutes are recorded. It is checked then we can see about the volume of people consulting the clinic. Moreover, we see the people not being criticised from the clinic that it does work now. (HFGD2)*

Theme 3 – "Messiah factor" to support the CHF and prevent collapse

There is a tendency from rural people that something better will come from outside, the "Messiah factor." The community believes that something better and genuine will come from an outsider to rescue their situation. This tendency has been alluded to by an indigenous healer when she responded that external people (like researchers) could assist the community to revive the existing structure. Nevertheless, for the forum to function properly and not to collapse, it needs the cooperation and working together from both allopathic healthcare practitioners and the indigenous community.

> *If it can be revived even you can assist us to revive it. If you can assist us. We would be happy, {maybe it would not end} maybe it will never end because we were looking forward to it and like it {it teaches us} it teaches us. (MFGD3)*

Theme 4 – Ownership of CHF by community members

This theme suggests that community members must take a lead in issues that concern their health. "Nothing for us without us". Taking ownership of the forum by the community, will assist the forum to be sustained and not collapse:

> *For it not to collapse this depends to those people (indigenous leaders) who came for a request. I think these are the people who supposed to have a backbone and support and follow through so that it does not collapse, so it does not end on the way. Since it has already started but does not exist anymore. (MFGD3)*

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Theme 5 - Guiding document on how to operate

A guiding document and policy must be formulated on how the forum should operate. A guiding document will assist forum members not to deviate from the goals that the forum intends to achieve. The guiding document may be used as a yardstick for the benefit of the community:

> *To sustain it firstly, it is to provide it with stationery then with a guiding document on how to operate. Secondly, to have its own policy on how to operate. Therefore, it also needs transport as the Chief has mentioned. Thereafter, workshops as much as possible for the people who will be responsible for the health of the community. In addition, try to organise money for catering so that they can have something to eat when they are meeting. Because if there is nothing to eat people will not stay but try to have something to eat even if there is nothing for their pockets. Then they should have reports to each other, and then there should be management from DoH to visit the forum occasionally. It should not end here alone but to have a reporting board that will correct certain issues. Then it should be said, this and that should be corrected. Then it could exist for always. (NFGD4)*

Theme 6 – Training the forum on communication skills

Communication is essential; therefore, the forum members must be equipped via a communication skills workshop to be able to learn how to communicate better with members of the community:

> *In addition, the forum will be trained on how to communicate with people so that they may not harass a person and that may result to an attitude and anger. So, these are things that I think can assist us, there are many it will take me the whole day. (NFGD4)*

Communication seems to be the key element or is in the middle of developing the process and, ultimately to the process of monitoring and evaluating the forum. Without proper communication channels, the forum is doomed to fail. Therefore, communication is priority to enable the forum to function properly.

The following table 12 illustrates the objectives from phase 5. However, the objective that explores and describes the existing healthcare providers in the area is not included. This objective has been tabulated extensively in table 11 above.

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Table 4: Objectives, themes and sub themes for phase 5

Objectives	Themes	Sub Themes
1. Explore and describe existing healthcare providers in the study area.		
2. Identify communication channels between existing healthcare providers.	• The CHCWs are communication link between the community and the clinics. • Existing channel of communication characterised by one-sided referral system. • Channel and process of communication marked with shouting and chastising. • Behavioural change needs to be channelled and communicated to relevant stakeholders.	- Serve as a bridge between communities and allopathic healthcare system. - Run campaign programmes to mobilise community members for health services. - Legalisation of indigenous healers - Provide workshops for indigenous healers. - Lack of hygiene practice - Rinsing of stones before and after mixing herbs
3. Describe process of developing Community Health Forum (CHF).	• Chief as the first point of community entry • Awareness on health-seeking behaviour • Closer proximity of healthcare • Create a platform that is responsible to the needs of community, indigenous healers and allopathic health professionals.	- Permission and advice - Approval and support - Dual consultations - Supernatural source - Develop a unified health system that is accessible to the community. - Community is in the forefront of the CHF. - Creates a space and a platform for level of understanding and trust. - Avail resources for forum’s sustainability

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4. Explore and describe how CHF and communication channels can function as bridge between existing healthcare systems.	• Nature and characteristics of communication	- No looking down, no undermining but acknowledgement and mutual respect - Use all available communication methods to link with stakeholders. - A continuous responsible communication channel that reports to its constituencies - Create and promote communication channels for an integrated referral system. - Coordinate and monitor in-between
5. Monitor and evaluate the newly formed CHF.	• The use of communication as a monitoring and evaluation tool • Collate feedback from constituencies and beneficiaries of the structure. • "Messiah factor" to support the CHF not to collapse. • Guiding document on how to operate • Train forum on communication skills	

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4.4 Section C: Phase 6 – 2019 Conference – Piloting of CHF

Although this phase represented one of the narratives, it is befitting to present it after phase 5 since it confirms the importance of developing CHF. The third conference was held at Qatywa community hall next to the Chief's place. All districts were well represented from the nine (9) principalities with allopathic health practitioners and indigenous healers of Madwaleni. The intention of the conference was to sign a Memorandum of Understanding (MoU) between the two existing healthcare systems in the area. However, the conference had to afford a space for the research outcome, which was the formulation of a CHF through the two existing healthcare providers. Chief Ngubengcuka supported the conference, although from time to time he excused himself from the conference because of his other responsibilities in the community. It was agreed that chairing of the conference should be shared between the hospital manager and iTola from Makukhanye indigenous healers' group. The Xanase group was also present at the conference to participate and to share their experiences with the scholar-activist team.

The 2019 Conference

The two-day conference started with indigenous healers leading each day with their prayers. An indigenous healer was allowed to *ukuphahla ibhekile* with i*silawu* (an enamel bucket with an indigenous herb). Below are pictures of discussion groups during the conference:

Figure 1: Discussion groups during the conference

Source: Photographs taken by Khaya Tshabalala, published with permission from Khaya Tshabalala

Before the conference could start, *ukuphahla* was performed; the indigenous healer used a wooden plank to stir the mixture. The contents of the mixture had to make a white foam, which was supposed to be in a mountain-like shape as a good sign to appease the ancestors. The mountain-like shape signifies that *icamagu livumile* (all is well) because the person who performs *ukuphahla* needs to be

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ahlambuluke/ukuhlambuluka (be of sound mind, no quarrels against other people pray and be humble, be at peace). After this session, the indigenous healers would beat the drum and start singing and praising because the mountain-like shape foam has been achieved and the dancing will be performed in a circular fashion.

The participation was amazing because the discussions adopted a bottom-up approach with indigenous healers who were very vocal, very cautious not to lose who they are, they did not allow everything to be taken over by allopathic health practitioners and were owning the space. This hall gave the indigenous community a sense of ownership and control. The previous conference was held at DWF were indigenous health practitioners felt that the infrastructure at the foundation was not conducive for their movement and the sitting chairs were attached to the desk. The community hall gave them a sense of ownership and control which allowed them to perform freely their rituals (including dancing) to start each day. Although, there was some misunderstanding with some members at the conference who were against the amalgamation. There was also a tendency for allopathic health practitioners to separate themselves from indigenous healers and as a result one of the co-researchers suggested seating arrangement that allowed participants to be mixed, then roundtable groups were facilitated. From these roundtable group sessions, communication challenges emerged as the main issue of concern. There was growth from the Xanase group, organising, working together, learning from 2018 conference and were being responsible for catering. Below is a picture of the Xanase catering group:

Figure 12: The catering team busy preparing the food

Source: Photograph taken by Melanie Alperstein, published with permission from Melanie Alperstein

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The conference was well organised and well attended because the scholar-activist team had pre-meetings with allopathic health practitioners. Because Makukhanye group of indigenous healers was now a formal, organized group unlike the conference in 2016, thanks to the work of the research assistant placed in the area. The critical incidents of the conference were to sign the MoU between healthcare practitioners in the area. We did not rush the MoU because there were issues of importance and these issues were related to the community and allopathic health practitioners. The first day of the conference dealt with these issues and amongst them, communication and lack of respect came out strongly. The second day of the conference dealt with challenges between indigenous healers themselves, where May (2019) stated in her study that even indigenous healers undermine each other in terms of healing powers and supremacy. The conference suggested that they needed to iron out their relationship. The issue of Social Determinants of Health also came out again, focusing on nature, children, adults and medicine. On the third day, Xanase group was afforded a space to share and reflect on their own experiences as a way of motivating other villages to be involved in their community development. The Chieftain from Xanase responded by saying:

"Yhoo, I have to tell you this now we know we have money in Xanase, savings group, benefits of the project have started."

The conference concluded with development of an Interim Community Heath Forum that will be piloted, and its first duty was to draft the MoU and ultimately present a document about SHD post 2019. Below is a picture of the Interim Community Health Forum:

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Figure 23: The Interim Community Health Forum

Source: Photograph taken by Khaya Tshabalala, published with permission from Khaya Tshabalala

The development of a draft MoU: The conference concluded by piloting a Community Heath Forum that would drive the process and draft the MoU and ultimately present a document about SHD post 2019. It remained to be seen whether the challenges of the piloted CHF would change pre- and post-COVID-19. The development of a draft MoU is also dependent on the CHF.

After this conference, the indigenous healers of the selected Community Heath Forum met to draft an MOU as their perception was that they are indigents of the health of AmaBomvane, as health workers from the clinics and hospital were quite busy, it would be easy for them to initiate this process and bring to the combined Interim CHF committee a draft MOU for discussion (attached in appendix J). Below in table 13 is the presentation of key observations and critical incidences, their influence on methodology and codes given that relate to positive and negative social determinants (PSDH & NSDH) and assets.

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Table 5: Presentation of key observations and critical incidences, their influence on methodology and codes given that relate to positive and negative social determinants (PSDH & NSDH) and assets (A).

Key observations and critical incidences	Influence on the methodology	NSDH & PSDH and Assets (A)
Indigenous healers leading each day when they performed their prayers. An indigenous healer was allowed to *ukuphahla ibhekile* with i*silawu* (an enamel bucket with an indigenous herb).	One of the research designs that was used during this research was ethnographic design when a researcher is afforded a space to experience participants' culture and traditions (direct observations). Researcher concluded that there is a lot to learn from this culture.	PSDH: - There are leaders from indigenous fraternity. The ability to lead the day with their own way of praying.
The contents of the mixture had to make a white foam, which was supposed to be in a mountain-like shape as a good sign to appease the ancestors. The mountain-like shape signifies that *icamagu livumile* (all is well).	Ancestor reverence is one of the health aspects that Mji (2013) mentioned in her study which is one aspect of SHD. PAR allowed the integration of both indigenous ways of doing things and modern ways presented here by Christianity in the form of prayer. This was a sign of where the PAR process is with regard to these 2 groups of healers.	PSDH: - These two groups of healers can complement and be an asset to each other.
The indigenous healers would beat the drum and start singing and praising because the mountain-like shape foam has been achieved and the dancing will be performed in a circular fashion.	This current research and the cyclic manner of dancing of indigenous healers reminded the researcher of how far the research process has come, where each phase of data collection affirms and interlink to the next phase.	PSDH: -The indigenous healers were allowed a space to showcase their skills and assets lying dormant at community level.
The participation was amazing because the discussions adopted a bottom-up approach with indigenous healers being very vocal. "Nothing about us, for us without us" the involvement of the community as partners in decision making is a key element in PAR.	Affirmation to the researcher of the stage of research. The acknowledgement and respect from allopathic practitioners lead to involvement of the indigenous practitioners.	A: As above.
There was also a tendency of allopathic health practitioners	Reminded research of the main purpose of this study is to create a	NSDH:

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separating themselves from indigenous healers. "Us and them."	communication strategy for healthcare practitioners in the study area to work together. For the researcher this indicated of the amount of work that still needs to be done with allopathic healers for the integration to happen.	- This is the focus of this study.
The critical incidents of the conference were to sign the MoU between healthcare practitioners in the area. We did not rush the MoU because there were issues of importance and these issues were related to indigenous community and allopathic health practitioners still feeling there are communication issues that still need to be ironed out. An interim CHF was developed.	For the researcher to use Reflexivity, moving in a cyclic manner is the key for participatory action research and be happy with small steps achieved – an interim community health forum.	A: - Presence of an interim committee for a forum was elected.
Indigenous healers undermine each other in terms of healing powers and supremacy.	The supremacy of other indigenous healers from their own as indicated by May (2019) with undermining tendencies. Similar to allopathic healers there is also a lot of work that need to be done amongst indigenous healers to bring them together as a group.	NSDH: - Among indigenous healers there is inequality in terms of healing powers, and this creates a division between them.
The issue of Social Determinants of Health also came out again, focusing on nature, food security, children, adults and medicine.	This reminded the researcher to keep focusing on the purpose of this research which about the health of people from this community – AmaBomvane.	PSDH**:** **-** The recognition of this by conference participants was an asset on its own.
Xanase group was afforded a space to share and reflect on their own experiences after they have completed tabling this conference.	Experiences from Xanase development group could expand and benefit other villages – maybe role of PAR could assist in this regard.	A: - The Xanase group with their skills of hosting a conference could be an asset to the Madwaleni community.

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The conference concluded by piloting a Community Heath Forum. The ability to elect a community health forum from the nine principalities affirms this current study.	Piloting of CHF affirms this research study. The main objective of the research study is affirmed.	A: - The community health forum is an asset to the study area.

4.5 Triangulation of findings from section A & B

The greater the triangulation in research, the greater the confidence a researcher will have in their findings (Denzin & Lincoln, 1998). The rationale for this is that no single method alone can adequately treat all problems of discovery and testing. In the study the researcher made use of a combination of various sources for data collection i.e., story- telling, focus group discussions, opportunistic interviews, and journaling. The study covered 6 phases to illuminate the research problem from different angles. Five themes appear to be common during data collection and presentation of findings and these were: (a) assets that AmaBomvane community have, (b) the positives determinants of health that appear to be linked to assets, (c) negative social determinants of health that seem to be blighting AmaBomvane and these appear to be worsening each day, (d) the different paradigms that allopathic and indigenous practitioners appear to operate in, (e) and possibility of developing a community forum as a bridge between the two health practitioners in Bomvane. It was quite invigorating for me to hear participants in these focus group discussions and opportunistic interviews expressing their views on the process of developing CHF.

4.6 Researcher's description of the overall study process and data collection

The research study conducted in Madwaleni went through various community engagements and participation with the presence and guidance of the scholar-activist team. In 2014, the researcher visited the area of Gusi at Xanase (Nkanya) where she stayed at a Chieftain's place rondavel for a period of two weeks. The rondavel had no key, and the belongings of the scholar-activist team were safe and secured. The safety and security of the belongings is an indicator of how respectful AmaBomvane are on other peoples' property (asset). The Chieftain with other members from the community organized a meeting with the community of Xanase (± 32 households reside in the area). During the meeting, the researcher observed that initially the community of Xanase expected the government and foreign entry to rescue them from their poverty with social grants and hand-outs, the Messiah factor (negative social determinant of health) seemed to have captured this community

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who were looking to the outside for help. Using the three research canons of this study: ethnographic, PAR, and emancipatory methodologies facilitators were able to assist the community realize that their wealth, health, and wellbeing is placed dormant in the community. During the workshop, the community of Xanase raised their concerns about their basic needs which were water, electricity, and toilets. The group was then encouraged to start a co-operation that will tabulate the needs of the community during which the scholar-activist team assisted them to connect with different government departments to fulfill their needs.

During the two weeks, the researcher stayed with the people of Xanase, observing their way of doing and participated in household chores at the big rondavel and sometimes being involved in singing and praying as the head of the household is a born again Christian (the Chieftain). This informed the researcher about some of the culture and characteristics of being a Bomvana – family bond, Christianity and respect, and therefore contributed to ethnography as a research design for the study (positive social determinant of health and an asset).

The Chieftain linked the scholar-activist team to a presiding Chief Zwelithobile who accommodated the team at an Imbizo during which Prof Mji introduced the team and further made a summary of her critical research outcomes. The community entry stage was further extended to various components of the community: the schools, FET College, clinics, and the district hospital, focusing on only four clusters of villages namely, Nkanya, Hobeni, Madwaleni and Xhora.

In December 2015, the scholar-activist team visited the place of Bomvana but stayed at Donald Wood Foundation (DWF) in Hobeni, a shift from a faraway village of Xanase (Nkanya) to a more central Hobeni, which is closer to both the town (Xhora) and the sea (next to Xanase). The researcher appreciated the fact that for her initial community entry she started in Nkanya and Xanase, as in this area, while participants were struggling with the Messiah factor, she could still see some of the attributes and assets of AmaBomvane that were mentioned in chapter 3. Staying at DWF brought a new understanding of emerging community-based institutions that they too want to colonize the communities they serve. The team visited Xhora clinic and the house of the Chief Gwebixhala, a retired Chief who could not speak properly. His wife attended to us and interpreted the conversation to the Chief. The Chief's wife mentioned that she was married to the Chief for more than thirty years and after the Chief retired because of old age, their house had been broken into. This was a far cry from the space of tranquillity in Xanase where we slept with doors open and people from the village meandered from one household to the other, this informed the researcher about the ways of doing

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in Xhora which is closer to civilization and to the main road where crime seems to be rife – the wake - up call to the presence of negative determinants of health and that there are differences with regard to cultural practices in the research area. There was also an invitation from an indigenous healer with dual practice (igqirha/faith-based healer). There was also a primary school teacher who had knowledge about indigenous practice, medicine, and healing, but she also had a drinking place (Tavern) close to the school, this reminded the researcher of the concerns expressed by the older Xhosa women about the youth drinking in taverns with older people from dusk to dawn – and which raised questions with regard to how a teacher can practice and maintain the culture of Ukuhlonipha which is critical for peace and stability of AmaBomvane.

Then in 2016, a conference was organized at DWF and although the conference was intended to focus on the experienced older Xhosa women in matters of indigenous health knowledge, the elitist women, and several indigenous healers were present with a sprinkle of allopathic health practitioners. The conference allowed the researcher to engage with the community of Gusi on a larger scale where the nine (9) sub-municipalities were present. It was during this conference where the two existing healthcare providers mentioned communication as a challenge in their relationship to collaborate. This communication challenge between the existing healthcare providers affirmed the main objective of the study – the process of developing CHF. The conference informed the researcher about the characteristics of the participants for the study (indigenous healers, allopathic health practitioners, faith-based healers, elitist women, schools, and churches). This was an ideal situation for the process of developing CHF (asset). The researcher noted some of the adjustments that might need to happen in her study to include the different healers and segments of the community. Having studied the approach of PAR methodology, she was confident that the adjustments that needed to be made would be accommodated by the methodology.

In 2017 & 2018, a researcher, biochemist, and an indigenous initiate at the time of this study was employed by SU to conduct research in the area and to also assist indigenous healers of the area to form an organized group. This was quite strategic, as the researcher continued to work quietly between the opposing groups (indigenous practitioners and allopathic health professionals). Using PAR and emancipatory methodology she managed to assist the indigenous practitioners to unite and form an indigenous group - Makukhanye, but also because she was a biochemist, it was easy for her to converse with allopathic health professionals – they had already started bringing her in for difficult cases between indigenous healers and patients. As this was good, it raises questions about why

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allopathic health practitioner have not managed to develop this type of relationship with indigenous health practitioners of the study area.

Then in December 2018, the researcher engaged with the community of Bomvana on a small scale where she conducted focus group discussions and in-depth interviews. These engagements are interpreted and discussed in Chapter 6 as phase 5 and phase 6, respectively. The expectation of the researcher in 2016 was not fulfilled in 2018 where snowball and convenient sampling came into play – one of the disadvantages of PAR (expectations versus actual realities). During 2018, an organized group of indigenous health practitioners group called Makukhanye was developed. It is this group that was involved in 2019 conference in Qatywa where indigenous healers were given a platform to showcase their skills. A platform that allowed them to have a voice without being chastised by allopathic healthcare practitioners. Although the conference intended to formulate a MoU between the indigenous healers and allopathic healthcare practitioners, an interim CHF was established because communication between indigenous healers and allopathic healthcare practitioners was still a big problem and a challenge. Hence the decision taken to pilot a CHF, which then affirms the main objective of the current study.

During December 2019, some of the members from Makukhanye Indigenous Healers Group drafted a MOU which is attached as an appendix J at the end of the document. The drafting of MOU is an indicator that AmaBomvane were reclaiming who they were before foreign entry and new knowledges, which is a testimony for emancipatory research design. They finally had their own voice and an ability to shape community engagements and further build healthy communities by engaging with allopathic health practitioners. Somehow this action made the researcher happy, as she felt that she had left a community that is stronger than when she entered.

The following Table 14 gives a timeline of community engagements of the researcher between 2014 and 2019.

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Table 6: A timeline of community engagements (2014 -2019)

Year	Event	Impact on study methodology
2014	Xanase community engagement Chief as a first point of entry	- Messiah factor – NSDH - Dissemination of Mji's critical research findings (MCSO) - Building relationships
2015	Meeting the Chief, visiting schools, clinics and hospital 1st visit at DWF	- Second round of community entry – building of relationships. - A place to stay and observe relationships between DWF and community.
2016	July Conference	- Communication as a challenge between indigenous healers & allopathic health practitioners – need to develop CHF.
2017	A researcher employed by SU	- An asset for the current study. - Start of emancipation of indigenous health practitioners and awakening of the allopathic medicine to poor relationships between allopathic health & indigenous practitioners.
2018	Researcher engaged with the community (focus group discussions and in-depth interviews) Expertise of research assistant (biochemist/an indigenous initiate) contributed to the study. Conference to address issue of children fighting and bringing forward the	- PAR (twists & turns) - PAR, Ethnography and emancipatory methods implemented between various stakeholders.

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	voice of indigenous health practitioners.	
2019	July Conference – piloting CHF December - MoU development	- Affirmation of the main objective - Piloted CHF – an asset - Emancipatory research design – PSDH

4.7 Concluding statement

Section A, phase 1-4 assisted the researcher in introducing the study to the community and development of community partnerships. The ethnographic methodology and PAR assisted in understanding where AmaBomvane are including both positive and negative social determinants of health that appeared to be blighting Bomvane. Phase 5 was able to offer an in-depth exploration of the study aim and objectives. Issues emerged from the 37 participants who formed the sample for this phase, about community challenges between allopathic and indigenous health practitioners. Participants from this sample provided insight on how the development of a Community Health Forum could function as a bridge between allopathic health practitioners and an indigenous community. Both focus group discussions and opportunistic interviews acknowledged the existence of the two healthcare systems in the research area. There was an indication that there are ailments that are managed by allopathic health practitioners as well some ailments are managed by indigenous healers. Although those ailments that are managed by indigenous healers have been practiced in secrecy, and these achievements are hidden from allopathic health doctors because of the quality of the relationship between allopathic health doctors and indigenous healers. The sample showed a vast amount of information regarding the process of developing the Community Health Forum. Data indicated that there are a number of healthcare providers in the area. From allopathic health practitioners to indigenous healers and an indication of what type of ailments, these healthcare providers are able to manage. There was a general understanding that when a Community Health Forum has to be developed, that all existing stakeholders need to be represented. In terms of the communication channels between the existing healthcare providers, there are still undermining tendencies and an unacceptable attitude from the allopathic health practitioners towards indigenous healers when they gather that a client has consulted an indigenous healer prior to visiting an allopathic healthcare facility. Although on the other hand, the very same allopathic health practitioners who

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undermine the indigenous healers during the day, consult these very indigenous healers under cover of darkness.

It is hoped that through this research the existence and the developed CHF would function as a strategy to improve communication between allopathic health practitioners and indigenous community. The representatives from both allopathic health practitioners and indigenous health practitioners give hope that both healthcare practitioners in the area will have an equal chance and a platform to tackle their concerns. Lastly, the chapter concluded with the effectiveness of the CHF, where it was suggested that community members as beneficiaries should conduct monitoring and evaluation with the guidance and assistance of the Department of Health. In the case where a CHF has been established but no longer functions, mechanisms to revive the structure should be put in place to strengthen and sustain it.

This chapter will be followed with the chapter on discussion of findings.

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Chapter 5: Interpretation and discussion of Research Findings: Section A

It is difficult to speculate whether any reasonable progress could be achieved in the current apprehensive environment where the dominant knowledge has continued to ride roughshod over local knowledge, regardless of whether the former is perceived as overly ethnocentric or not (Sillitoe & Marzano, 2009).

5.1 Introduction

The interpretation and discussion of research findings are discussed as Chapter 5 and 6 respectively. This chapter presents an interpretation and discussion of the research findings that emerged from presentation of data from section A. The chapter will focus on data presented in chapter 4 that emerged from phases 1-4, while phase 5-6 will be discussed in Chapter 6. The four (4) phases represent the various stages where the researcher engaged with different stakeholders from the study area. The researcher used narrative analysis to understand how research participants constructed their present story of UbuBomvane including the story of their own personal experience, which means there is a dual layer of interpretation i.e., the story of UbuBomvane as an indigenous community and their personal story as AmaBomvane actors in this indigenous community. Firstly, the research participants interpret their own lives through the narrative. Then the researcher interprets the construction of that narrative. A narrative approach is concerned not only with the story-telling components or characteristics of an account, but also with the social interactions between an interviewer and an interviewee that encourage and influence the way that an account is presented (Kim, 2016).

There are questions that are constantly asked when one is grappling with the consciousness of being Black dealing with issues of ethics and respect as adopted from Chilisa's (2012) work. These questions are detailed in Chapter 3, but they remain to be answered in the following chapter with the discussion of phase 5. The researcher hoped that she answered some of the questions that are asked by Chilisa in terms of the participants that were represented in the various phases of the current study.

The main concern of the researcher is the issue of othering of the indigenous community and its health practitioners by allopathic healthcare. Although all these questions asked by Chilisa may not be all answered, the researcher tried to interpret the raw data as closely as possible to the objectives of the study. These objectives for phase 1-4 were to:

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- Explore the concept of development of community health forums during community entry and development of partnerships.
- Disseminate and explore consensus agreement on Mji's critical research findings on the indigenous health knowledge and use of participatory action research cycle to implement and improve these study findings.
- Describe the process by which the older Xhosa and/or elite women engage with the clinic and hospital-based health providers (this later changed to engagement of indigenous health practitioners with the clinic and hospital-based health providers)

The chapter commences with the interpretation and discussion of critical incidents and observations where social determinants and assets were identified and coded with regard to: Assets (A), positive social determinants of health (PSDH), negative social determinants of health (NSDH) and some of these critical incidents and observations influenced the methodology of this research study. Using the ethnographic method and PAR the researcher analysed these critical incidents and observations regarding their meaning including the adjustment required on methodology. Below the researcher describes some of her reflections on the research process:

5.2 A narrative about assets and social determinants of health

As mentioned earlier in chapter 4 regarding Mji's critical research findings (social determinants of health – positive [PSDH] or negative [NSDH] that were blighting the villages of the study setting including assets lying dormant at community level) were used as one of the tools for community entry, developing partnerships and discussion and adoption of objectives for this PhD study. One of Mji' critical findings was to highlight the assets, the PSDH and NSDH. The WHO Commission on Social Determinants of Health (CSDH) raised three fundamental aspects that underpin social determinants of health and these are:

1. Where do health differences among social groups originate, if we trace them back to their deepest roots?
2. What pathways lead from root causes to the stark differences in health status observed at the population level at present?
3. Considering the answers to the first two questions, where and how should we intervene to reduce health inequities? (WHO, 2010).

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PHC programs lack systematic supportive policy frameworks and structure and means to support addressing negative social determinants of health. This makes it hard for services to act on the WHO Commission on the Social Determinants of Health's recommendations. However, PHC services can be more responsive to social determinants of health given more support and by building alliances with communities and social movements (Baum et al., 2013). This doctoral thesis is about being part of building this alliance though community health forums by ensuring that there is continuous engagement between indigenous health practitioners and allopathic health professionals. The re-engineering of PHC, can assist with systemic support that will in turn assist the services in nine clinics to focus less on curative care and concentrate more on social determinants of health. They also need to work closely with allopathic practitioners to see how a bridge can be built between District hospital and clinics by focusing on social determinants of health.

The critical incidences that were drawn from phases 1-4 i.e.: the community entry and dissemination of MCSO, and from the various conferences where the nine (9) sub-municipalities afforded the researcher a space to engage with research participants on a larger scale, assisted this study to affirm Mji's critical findings on assets, PSDH and NSDH. The section below discusses (a) the assets that are lying dormant in the community, (b) positive social determinants of health (PSDH) and (c) Negative social determinants of health (NSDH). All these aspects impact positively or negatively on the health and wellbeing of Bomvana. Below is subsection on assets:

5.2.1 Assets derived from the different engagements and community participation

There are several assets that were identified during community entry and building of relationships, dissemination of MCSO, community participation and engagements. The following discussions are related to the assets identified from the community of Bomvana. The assets that were identified were as follows: UbuBomvana – being a Bomvana, Indigenous leaders, existing healthcare providers and the environment contributing to health and wellbeing of Bomvana, Donald Woods Foundation (DWF) and Khaya Loxolo Centre for Children with disability, Accessibility to formal education and Having a community hall embedded within the community.

5.2.1.1 UbuBomvana – being a Bomvana

Although the question of who the Bomvana people are has been discussed in Chapter 3, it is befitting to give a brief description in this chapter. The AmaBomvana people had a holistic approach to wellbeing, identifying spirituality as integral to their wellbeing. Another factor is the issue of rituals and ancestors which seem to play a vital role in the life of Bomvana (Mji, 2013). AmaBomvane

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emphasized the issue of Bomvane obligations which were: all households have a responsibility for their families to produce enough food to feed each family member to satiety, to look after children from conception to 18 years of age, having respectful children who understand the culture of AmaBomvane, living with peace and brewing Xhosa beer for ancestral reverence. The breakdown of their tribal economy forced the traditional Bomvana towards the turmoil of rapid cultural change. This is the process of acculturation in South Africa which caused thousands of Africans to mainly work as labourers in mines (Mji, 2013; Jansen, 1973). This tended to have a negative effect on health where elderly men in the area voiced out in the community engagements, stating the lack to health facilities and access to government grants.

UbuBomvane siyabuphila (Ned, 2019:109) meaning that being a Bomvana is a state of mind, as being a person. This assertion is supported by participants from Ned's (2019) study where they speak about nothing else but a way of life. These assertions directly relate to the way Bomvana people view health and wellbeing. Ned (2019:109) mentions when we speak about *impilo* (health) – we speak about our way of life; we speak about living well and happily with plentiful food. This is to say, we are well and eating well depending on what we perceive as good nutritious food for us. It means we can perform our traditions and rituals accordingly. Additionally, this is to say there is no existence of sickness in our bodies with all generations participating in key activities of the village according to age, stage, and gender. That is what health speaks to, for us as AmaBomvane. Our being together with our ways of living which assist us to maintain this health is our health. Our ways are always about maintaining health and harmony here.

Being a Bomvana is regarded a healthy person who contributes to health and wellbeing from the older Xhosa woman who takes care of her sick family member and managing the sickness using her indigenous knowledge (Mji, 2013), to the middle-aged generation woman who plays a supportive role to her mother in-law to maintain the family and taking care of the younger generation while the middle-aged male generation is absent due to migrant labour. Taking part to the rituals of being Bomvana is another factor for instance; appeasing the ancestors (brewing of *umqombothi*), praising God, ploughing the fields for food security and the males protecting their families by building blocks and homes, while the younger generation maintains the process of *ukuhlonipha.*

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5.2.1.2 Indigenous leaders, existing healthcare providers and the environment contributing to health and wellbeing of Bomvana

The people of Bomvana are still led by indigenous leaders from the Chiefs and the Chieftains who form a council. The Chief of the community governs the people, and he resides at *Ikomkhulu* (the royal homestead) where he calls people for *Imbizo* (a meeting that is presided by the Chief and is held next to the kraal at the Chief's homestead). Members of the community are invited to the *Imbizo* when the Chief needs to address certain issues that impact on the health and wellbeing of the community. However, post-democratic elections, the ANC government introduced zoning and demarcations of our communities to assist in putting human resources and supporting good governance when providing services to the community. The introduction of Wards and Ward Councillors came into play to assist in taking services to the people. Ward Councillors are supposed to work with community development committees who are located within the various communities. Unfortunately, when introducing the Councillors, the existing government never clarified that they are supposed to be administrative wing of the indigenous leaders. Instead you find the two spheres of power competing whereby the Chief would be having an Imbizo and the Councillors their own administrative meeting, the question that needs to be asked, are the councillors not part of the village and subject to the Chief, if the Chief is having an Imbizo, are they not also supposed to be attending?

Within a community, there are different healthcare practitioners, from allopathic health practitioners (District hospital and several community clinics, mobile clinics, school health services, WarBOTs, social workers and DWF/CHCWS) to indigenous healers (already mentioned and discussed in Chapter 4 with Igqirha as a Prophet (indigenous healer who is also a faith-based healer), and elite older Xhosa women (the *makhulus*).

These different healthcare providers assist the community with health-related issues and are consulted by members of the community for various reasons. But the fact of the matter is that community members consult both types of healthcare providers in their area. With the assistance of CHCWs who work closely with the community and the clinic to advocate for testing and treatment adherence. The parallel functioning of health professionals in the research area creates unnecessary bottlenecks and finger pointing when the health outcome of the patient is not according to the expected result of whoever is seeing the patient after being seen by the other health provider. The mother earth with its plants and is rich with natural herbs that provide the different indigenous healers with indigenous medicine to practice their treatment and healing. Animals such as goats and cows are

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mostly used during ancestral reverence rituals. The sea contributes with rains to nurture the fields and for animals to graze and multiply for the sustainability of Bomvana, because without all these factors Bomvana would perish. The ownership of cattle in Bomvana is a way of life and a household is recognized as such by the size of its kraal.

5.2.1.3 Donald Woods Foundation (DWF) and Khaya Loxolo home for disabled children

DWF organization is in the middle of Hobeni which is further away from the main road to Umtata but is closer to the sea. This organization has a programme that provides “health in every hut” where community healthcare workers (CHCWs) conduct door-to-door visits, advocating testing and treatment compliance. These CHCWs serve as a link between the clinics and the community. The DWF is also used as a bed and breakfast that accommodates visitors who come to do research in the area – a home away from home. Donald Woods Foundation (DWF) played a crucial role in assisting the process of dissemination of Mji’s findings in all the nine (9) principalities. In 2016, the nine (9) principal municipalities of Mbhashe region contributed with almost 100 people including indigenous healers, village elders, Chiefs, community leaders, local health services providers and residents who took part in an Indigenous Health Conference which was held at the DWF with financial aid from the National Research Fund (NRF) project. The DWF provided transport for the elderly women, indigenous healers and other community members, and organised the catering for the conference.

Later the research team discovered the Khaya Loxolo home for children with disabilities. Unfortunately, both these community-based assets seem to struggle to understand how they will work closely with the community they serve. Khaya Loxolo struggles to form a bridge between the homes of children with disability and Khaya Loxolo, with the latter painting the parents of children with disabilities as uncaring and placing themselves as better carers. On the other hand, the DWF continues with colonial practices and being arbiters of a standard of behaviour for AmaBomvane to the level of building a hut at the DWF for the Chief of this area to meet with his people instead of his kraal. Mji and Ohajunwa (2020) in their chapter on Ubuntu, ethics and human rights: implications for rehabilitation practices in indigenous African families of persons with disabilities (PWDs), asked this question: *How do we know which institutions provide good care?* They further expanded that the best way to think about care institutions is to model them on how they link to families. Good care in an institutional context has three central foci: the purpose of the care; a recognition of power relations; and the need for pluralistic, tailoring of care to meet individuals’ needs. These two institutions based in Hobeni still seem to struggle with this focus.

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5.2.1.4 Accessibility to formal education

In Madwaleni, there is a FET College which provides further education to the community and which is about skilling the community. There are also about 20 schools for the nine sub municipalities, but it is not clear what is taught in these schools. The example is the deputy principal who owns a beer hall which left researchers with lots of unanswered questions, and while it was clear that most teachers were from areas outside Bomvane, this also raised questions on who and how the children will be taught about the culture of AmaBomvane.

5.2.1.5 Having a community hall embedded within the community and other social related activities

The conferences of 2018 and 2019 were held at Qatywa community hall where the community felt free to voice their concerns. The community hall is located next to the Chief's place. There are projects namely; water and sanitation, a cultural tourism centre and Early Childhood Centres that have been initiated by the community of Xanase. The Xanase community also created a photo-document with events from 2014 to 2019 where they showcase their journey from a community with deficits to a community with confidence. There is also a sprinkling of taverns which are used as places of entertainment as one enters the respective villages of Gusi with the presence of the young and elderly male generation. The question that needs to be asked is: are these taverns selling Xhosa beer or beer from the South African breweries – as the Bomvane equate drinking Xhosa beer with spiritual reverence. Can it be the same when one drinks beer from South African Breweries at a Tavern, instead of drinking Xhosa beer next to the kraal of one's forefathers? The beer that is produced from maize grown in the Bomvane fields?

5.2.2 Positive social determinants of health (PSDH)

There were also positive determinants of health identified during community participation and community engagements and these were: Safety and security, Ukuhlonipha – to uphold Bomvana culture, Indigenous skills lying dormant at community level - Building skills, Community participation and involvement. These determinants of health are discussed below:

5.2.2.1 Safety and security

It is noticeable in the area that households in the village are unfenced. This allowed the community continuity – including continuous village relationships – to address needs as they emerged. This allowed people to visit and move during the day from one household and one family to the next without appointments. They also seem to create their own time in a continuous manner. This positive attribute presented a vast contrast between this area and the urban area where the researcher comes

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from – where tall fences separate the households, and people make appointments to visit each other. This less disruptive and continuous approach was used during research and the researcher had to refrain from imposing on the people the individual urban approach she is used to.

During the first visit to Xanase community in 2014, the scholar-activist team was allocated to a rondavel which had no lock on the door. During their two-week stay at the Chieftain's homestead their belongings were safe and secured. It seems that crime in this area is not an issue. This also gave a perception of the character of the community, that they can be trusted with valuable items of other people including a level of trust amongst themselves role-playing who they are – a trusted community.

5.2.2.2 Ukuhlonipha – to uphold Bomvana culture

Ukuhlonipha from this community can be seen as two-fold: firstly, that one does not take what does not belong to them, which is a sign of respect (respect other peoples' belongings and property). Secondly, ukuhlonipha is when young people are taught that elderly people have a voice in the community. This is portrayed most especially to *oomakoti* (daughters-in-law) who most of the time are not from Bomvana and are expected to remain silent in the presence of their mothers-in-law or elders. According to Bomvana culture "*inyathi ibuzwa kwabaphambili"* which is a Xhosa idiom that translates as older people are the best for knowledge. Therefore, the middle-aged women (the *makotis*) had to show respect in the presence of their mothers-in-law. Most of the makotis are not from Gwebindlala and since they are not from this area, they are not seen as being capable and able to teach about Bomvana culture. This is also the case with the young males who have little or no say in the issues that concern *UbuBomvana* (being a Bomvana).

5.2.2.3 Indigenous skills lying dormant at community level - building skills

Building skills are mostly seen from a male perspective as men being providers and protectors of their families and households. This becomes a shared activity between both males and females where females make the bricks and males do the actual building of the rondavel. As researchers we felt that this was the tip of the iceberg – maybe the scholar activist team might follow this up by doing an inventory of the skills that are lying dormant at community level. It appears that Community members have skills to uplift their village, from brick-making to making mats and blinds. Men from the village are taught how to respect their households, how to relate with their wives and children, and ultimately, how to relate to their extended family and relatives. Brick-making enables a man to make and own a home for his family.

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5.2.2.4 Unlocking of Community participation and involvement – the value of PAR in PSDH

The journey from 2014 to 2018 showed progress over time, when the community moved from fear to pride and confidence. There was a sense of achievement and future possibilities which were marked with moments of pride and a sense of self-assurance and value.

The first conference that was held at the DWF afforded the community a platform to chart a way forward to incorporate local health concerns into rural health interventions. The Daily Dispatch (a local newspaper operating in the Eastern Cape for years) published the first conference. There was coordination of the nine (9) sub districts in preparation for the conference. The dissemination of Mji's study piloted a rural health model that promotes the integration of the indigenous health knowledge. Allopathic practitioners stated the importance of working together with indigenous and allopathic health healers. In 2018, the group from Xanase portrayed a very different community, a community that may still be suffering financial poverty but were no longer displaying poverty of mind or spirit having started an ECD garden and is thriving.

As a result, in 2019, people from Xanase played a crucial role in the conference where they were responsible for catering and sharing their experiences of growth and community development from 2014 to 2019. In September 2018, the community insisted on, and successfully hosted and organised all the logistics for a truly rural conference. In the 2019 conference, the vegetables and sheep that were used for catering were bought from Ikhaya Loxolo, a non-governmental organization caring for children living with disability and the sheep from a local farmer, which was an indication of food security in the area.

The various conferences were successful in that service providers heard the voices of the community focussing on disability and moral degeneration. The community participation and engagements built closer future relationships between indigenous healers and allopathic health practitioners. Although in the first conference of 2016, allopathic practitioners were more organised as they have the colossal institutions that support them, the indigenous healers were disorganised and disconnected. As a result, in 2017, a research assistant was employed by SU to assist the indigenous healers of Madwaleni and to form an organised group called Makukhanye. This group was responsible for leading the conference of 2019 in prayer and ultimately responsible for drafting a draft MoU between indigenous healers and allopathic health practitioners. The Makukhanye Group for Indigenous Healers became the first step in addressing the first contestation of the problem whereby it was felt that the indigenous practitioners lack institutions where they can practise their vocation of indigenous healing.

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5.2.3 Negative social determinants of health (NSDH)

In chapter 3, it was alluded to that colonization and apartheid, including migration practices, had broken down the Bomvane economy. Bomvane is now living below the poverty line with diseases such as TB, HIV and AIDs, malnutrition, alcoholism, and violence. Identification of NSDH by researchers assist in understanding, where and how we should intervene to reduce NSDH (WHO, 2010). In the process of identifying critical incidences and observation, the following NSDH were highlighted: Challenges facing education and health in the study area; no space or platform for existing healthcare practitioners to interact; Ukuhlonipha has a downside; the negative Impact of migrant labour; the DWF; disempowerment; and a sense of helplessness. Below is presentation on NSDH:

5.2.3.1 Challenges facing education and health in the study area

At Hobeni, a primary school accommodates children under the age of 13 years, but because there is no high school in the area, children older than this age tend to drop out. At Hobeni, it is also noticeable that a tavern is situated outside the gate of the school. Similarly, a tavern is located at Madwaleni nearby the District hospital. A deputy principal teacher at Hobeni Primary school owns a tavern, which is rather peculiar when the young children are fighting and experiencing a lack of discipline staying in these taverns from dusk to dawn. This seems to be contradictory and conflicting for a professional who supposed to instil respect and discipline in an area where there are young people consuming alcohol.

There is also a FET College in the area, but the staff from the college are not from Gusi and travel from Umtata every day. But the FET is about skilling the community, so there are concerns about the authenticity of the information provided by the FET staff who do not reside in the area.

The healthcare facilities in the area are situated far away from the majority of villages, with fewer villages having access to nearby clinics. Even the District hospital is located at Madwaleni to service the nine (9) clusters of villages of Gusi, Mqanduli and Xhora. The attitude of the allopathic health practitioners also contributes to the lack of service with blaming and shaming of indigenous healers. Allopathic health practitioner mentioned that indigenous healers worsen the condition of people. Indigenous healers experience challenges in working together with allopathic health systems in the area.

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5.2.3.2 No space or platform for existing healthcare practitioners to interact

It was noticed that during the 2016 conference, both indigenous and allopathic health healers have tried to come together but no one followed up. Each group blamed the other and this indicated that these two groups were not serious or willing to work together. Communication came out strongly as one of the challenges between the two existing healthcare providers in the area, hence the process of developing a CHF was crucial. Indigenous healers were in disarray as they did not have formal structure, consequently the employment of a researcher in the area assisted in establishing the Makukhanye group of indigenous healers as an organized structure, while the allopathic health practitioners have their institutions such as the district hospital and the nine (9) clinics. The level of participation of indigenous health practitioners in the conference in 2018 and 2019 showed that this group now has their own platform.

5.2.3.3 Ukuhlonipha has a down-side

The concept of *ukuhlonipha* has been introduced as a top-down approach where the young are expected to respect the old but this process is not reciprocal, it is one-sided. This is in contradiction with the definition of health from one of the elite older Xhosa women who described Ukuhlonipha as reciprocal, that the old must respect the young and vice versa (Mji, 2013). The relationship may have a negative impact on the young where they are silent and cannot articulate what they really feel. This could then promote the frustration and anger which leads to fighting amongst young males. The silence and suffering may be displayed by drinking in taverns from dusk to dawn. Even the elderly male generation sits and drinks together with these young males, which makes it difficult for them to instil discipline. The absent parents (middle-aged male generation) due to migrant labour left a void in the upbringing of young males. The lack of preparation of the young males for the rite of passage is also a role and a responsibility of the parent.

The concept of ukuhlonipha is even introduced to the *makotis* when they marry, where they are expected to listen to their in-laws as a norm. Most of the *makotis* have limited information about UbuBomvane because some of them are not from the area, however, even if one is born a Bomvana a *makoti* is not expected to talk back to in-laws, especially to the elderly. Moreover, in an African/indigenous culture, looking at an elderly person in the eye is regarded as a sign of disrespect while in European/white culture not making eye contact is a sign of disrespect.

One also needs to first study this approach of Ukuhlonipha together with its tenets, it is a challenge to criticise without understanding. As earlier highlighted, indigenous knowledge systems have hidden

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knowledge systems which Ohajunwa classify as subliminal space for Africans. It is within this context that when many Africans try to come out and negotiate an open space, they find themselves having to change their ways of being and becoming, and come up with survival strategies, which for some might be NSDH. Mji et al., 2017, in their chapter of *Being and becoming an African* present derooted African persons behaving as if they have lost their moral compass that guided them as Africans. Due to not knowing where and how they fit in the modern world, as they try to acclimatise to new knowledge systems and new ways of being, there is little time to invest in building becoming Africans including noble concepts such as Ubuntu and Ukuhlonipha. These concepts themselves are always becoming and require some time to invest in building them.

5.2.3.4 Negative Impact of migrant labour

Migrant labour also contributes to the health and wellbeing of the Bomvana. With the absence of the middle-aged generation who seek employment in big cities, the young male generation lacks discipline and guidance. This absence of the middle-aged generation contributed negatively where these young males are left without role models. Some of the elderly males who had returned from migratory labour, complained of having no income or compensation for their ill health. The impact of migration had not only affected the younger male generation but also the elderly, who may seek financial support from their sons (the migrated male generation). As a result, the burden of the home lies on the shoulders of the older Xhosa women who need to take care of the households when their husbands are drunk from the tavern, the ill-discipline young males who are also drunk and unruly and this adds unnecessary stress to the elderly women who might be suffering with her own ailments.

5.2.3.5 The Donald Wood Foundation (DWF) – A powerful distant colossal structure

The DWF is as located in the middle of Hobeni and has state-of-the-art security which makes it difficult for the community of Hobeni to access the resources that seem to be provided by this organisation. The “health in every hut” seems to provide medication and support on allopathic medicine by advocating for a number of people who adhere to treatment as opposed to also assisting the community with their social health determinants. There seems to be an absence of an approach that addresses social health determinants in the work that this organisation is providing in the various villages of Gusi. It appeared that they were using a medical curative approach to the conditions that were blighting the people of these villages.

When we presented our PhD studies at DWF, and they also presented, but their presentation focused more on diseases, and the CEO of DWF felt that the three PhD studies were too deep and showed no

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interest. The work at the DWF focused on the number of people who are sick. They trained field workers to collect statistics and send these numbers to respective donors. The Foundation also has a library but school children cannot easily access it due to the security gate – no access in and out. The building of the DWF stands as a white elephant in the middle of a rural village. The conference of 2016 was held at one of the lecture halls, the design which limits small group discussions as furniture cannot be moved. The facilitators were concerned about people from Xanase being able to get transport home when dropped at Madwaleni hospital by the DWF transport. The scholar-activist team were concerned and disappointed that the DWF was not keen to allow them sleep over and go home the next day.

The elderly people and indigenous leadership of the Mbhashe district, however, felt uncomfortable that a conference aimed at uniting indigenous healers and allopathic medicine was held at the DWF. The hall built with conference-style seating, was not suitable for their needs. There is also a rondavel built at the premises that was designed in such a way that people from outside could not see what is happening inside and the people inside cannot be distracted by the outside world. The purpose of the rondavel is to accommodate the meeting of the Chief (Imbizo), thereby colonizing the Imbizo. Again using PAR by 2018 to 2019 one could already see some changes happening at the DWF starting to focus on PSDH – unfortunately even with this approach, there was reluctance to learn from the indigenous ways of being and becoming (Mji et.al., 2017), and learn the indigenous ways of ploughing and looking after stock. Instead, the DWF was bringing in genetically modified crops and injecting the cows to produce more calves. The question is, at what costs to the health of Bomvane? Kwame Nkrumah warned Africans of the need to look not to the West and not to the East, but forward – letting go of the Messiah mentality (Obeng, 1997).

5.2.3.6 The impact of a frail Chief on his reign

The Chief from this area was retired and his son was therefore the Chief, although he did not live in the area. Most of the talking was done by the Chief's wife because the Chief had a mild stroke and his speech was blurry. Chief's wife was also concerned about the level of crime in their village when their home was also robbed. The level of crime in this area is the indicator of the impact of civilization and colonization as compared to Xanase which is far away from the main road and the town.

5.2.3.7 Disempowerment and a sense of helplessness

In the area there is also a tendency to disempowerment and a sense of helplessness which can be attributed to the "Messiah factor" where help needed is offered by people from outside who are not

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from Bomvana. This was a big concern when one speaker had raised the hope of a sustainable food security project, but to date (2020) had never returned to the community after the conference. During the first community entry, the community looked only at their deficits and their needs. This community suffered not only from financial poverty, but it also suffered from poverty of the mind and spirit (Alperstein, 2019). There was an ECD project that was initiated but it seems to have suffered both pre- and post-COVID-19. The community also has difficulty in getting a co-facilitator to work with the ECD facilitator. The cultural centre that was started is stalled and it is not yet known whether apathy took over or it stalled because of village politics. The community is then at a crossroad where the assets of the community are lying dormant and there seems to be no motivation to continue with the project. The question remains – is the community looking for help or rescue from outside Bomvana?

5.3 Ethnography, PAR and Emancipatory research designs – their influence on the methodology of the study

5.3.1 The value and contribution of scholar-activist research team

The scholar-activist team contributed in the area by identifying assets which were lying dormant in the community. The first community entry at Xanase allowed the team to engage with this community who seemed to suffer not only from economic poverty but with poverty of mind and spirit (Alperstein, 2019). There were some activities that scholar-activist team facilitated when conducting commissions during the Xanase workshop. It was the scholar-activist team that notified the lead facilitator (who was responsible to guide the workshop) while the researcher was part of the scholar-activist team participated in the workshop by recording, co-facilitating and observing participants for journaling all field notes of the group dynamics when other community members were silent (middle-aged female generation and the young males). The researcher was at the workshop that was facilitated during community engagements using PAR to lead all the groups to identify their assets. This led to the independence of the Xanase group, the employment of a research assistant by SU in this area also contributed to allowing the indigenous group to organise themselves and the research assistant to bridge a gap between conferences. Although there was no conference in 2017, the research assistant was embedded in the community – ethnographic design came into play. The research assistant continued with the dissemination of Mji's critical research findings, and continued to work with the District hospital, clinics and indigenous healers, pulling these key stakeholders together using communication as a bridge to link them. By creating a bridge between indigenous health practitioners

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and allopathic health practitioners, the outcome was the development of the Makukhanye indigenous health practitioners' group with improved communication between the hospital, the clinics and indigenous health practitioners, thereby strengthening both health systems in the study setting.

5.3.2 Emergence of other indigenous healers from the community

The 2016 conference held at the DWF was intended to relink the elite Xhosa older women to the community. However, the conference was attended by many other indigenous healers from the community. The DWF hosted the communities from the nine (9) sub municipalities of Mbhashe and the researcher had to engage with participants on a larger scale. PAR came into play when the conference had to acknowledge the presence of other indigenous healers and their concerns – one applied the twists allowed by the PAR method to prevent application of cut-and-dried solutions. The suitability of the venue was raised by several dissatisfied indigenous healers. With the employment of the research assistant who was also a trainee indigenous healer, a second conference was moved to a local venue that was agreed upon by the indigenous community. It is also from this 2016 conference that infighting children at Hobeni sub municipality were identified. This implied then, that as an outcome of the 2016 conference: PAR, ethnographic and emancipatory research methods were used to respond to the following:

A. The identification of a larger forum of indigenous health practitioners and the need to see that they are integrated into the NRF project of the Elite older Xhosa women that has as its main aim integrating indigenous health knowledge with allopathic medicine.
B. The need for employment of a research assistant to support the enlarged group of indigenous health practitioners.
C. The problem of infighting children, which was seen dimly as such a grave NSDH. The problem therefore continued to be addressed by the research assistant and DWF researchers in developing a community- based strategy to assist with the problem and the first day of the 2018 conference was fully dedicated to this problem.
D. The unhappiness of the community with the chosen venue at the DWF – hence the next conference in 2018 was held in the Qatywa hall.

5.3.3 The concern and issue of children

The second conference was held at Qatywa in 2018, at a venue organised by the indigenous scholar communicating between the indigenous healers and the allopathic health practitioners (from District

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hospital and the clinics). In 2016 the PAR methodology assisted in bringing to the surface the problem of infighting of children of Hobeni – this emerged on the second day of the conference. In 2018 the first day of the conference focussed on children with disability and in fighting of children, sharing community skills of dealing with growing up children. On the second day of the conference in 2018 the indigenous practitioners and the community took ownership of the conference. They felt comfortable as the conference was brought to the community and indigenous healers talked freely about their knowledge system. An indigenous healer (iTola) facilitated the conference with the assistance of the indigenous scholar playing a supportive role. Using PAR, the research process was also able to accommodate the group from Xanase who shared their growth and experiences because they cooked for the conference and shared their benefits of starting a savings project, shared their growth - not only for themselves but for the benefit of the community of Madwaleni.

5.4 Concluding Statement

The chapter discussed the interpretation of results from the different community engagements where focus group discussions, note taking and journaling of critical events informed the data of the study. Although the data was formulated (deduced) from the narratives, PAR played a significant role while at the same time not negating ethnography as a way of understanding and respecting events from the point of view of the participants. The researcher managed to keep the data as authentic as possible.

Narrative smoothing tends to impose a threat when a researcher tries to make a participant's story coherent, engaging, and interesting to the reader. It is like brushing off the rough edges of disconnected raw data. However, it can also be problematic because it involves certain omissions, such as the selective reporting of some data (while ignoring other data), or the lack of context due to the researcher's assumption that what is clear to him or her will also be clear to the reader. Spence (1986:12) states, by failing to provide the background information and context surrounding a particular clinical event, by failing to "unpack" the event in such a way that all its implications become transparent, the author runs the risk of telling a story that is quite different from the original experience. Although researchers try their level best to keep to the original experience, lingering questions still exist of data transparency during investigation and establishment of the trustworthiness of the analysis presented.

With that being said, it is in the best interest of the researcher to narrate a story that leans towards the objectives of the research study. It is therefore plausible when the researcher gives a detailed narrative analysis and interpretation from the raw data, note taking and journaling. The next chapter

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will give a detailed interpretation and discussion of findings for phase 6 as the main objective of the research study, tackling the various secondary objectives and piloting of the CHF as the affirmation of the main objective.

Therefore, chapter 6 is presented as the discussion and analysis of research findings.

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Chapter 6: Interpretation and Discussion of Research Findings: Sections B & C

There are benefits to be gained by giving more opportunity to local communities to determine their own destinies (Sillitoe & Marzano, 2009)

6.1 Introduction

This chapter presents interpretation and discussion of research findings for section B and C. The chapter based its interpretation and discussion on the last two phases namely; phase 5 and 6. It also included an additional component which was the development of a draft MOU by the indigenous health practitioners. Phase 5 was the process of developing the Community Health Forum while phase 6 was the piloting of the Community Health Forum. The development of the draft MOU by the indigenous practitioners happened when researcher had already completed the process of data collection which culminated in the development of an Interim Community Health forum in Phase 6.

The six (6) phases represent the various stages where the researcher engaged with different stakeholders from the study area. Since the presentation of data was already done in Chapter 4, Chapter 5 & 6 present interpretation and discussion of findings. The focus for chapter 5 was interpretation and discussion of findings for section A: Phases 1-4 while chapter 6 presents interpretation and discussion of findings for section B & C Phases 5 and 6 and development of a draft MOU. The chapter will commence with presentation and discussion of findings for phase 5: the main objective of the study and also give details of the secondary objectives.

The main objective of the study was to define a process of developing the CHF, while secondary objectives were to explore:

- the existing healthcare providers in the area,
- communication channels that exist in the area,
- communication channels as a bridge between existing healthcare providers, and
- the monitoring and evaluation mechanism for the newly developed CHF.

After presenting interpretation and discussion of findings for phase 5 the same approach will be used for phase 6, giving details of the observations during the 2019 conference where a CHF was piloted, and after which an MoU was drafted. The chapter then concludes with the reflections of the researcher.

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6.2 Phase 5: Main objective: To explore the process of developing Community Health Forum (CHF)

This section of the chapter deals with the main objective of the study which is the process of developing Community Health Forum. This process was achieved over five secondary objectives to ensure that the objective for phase 5 is fully addressed. The information that assisted in the process of developing the CHF was drawn from participants who constituted focus group discussions and the in-depth interviews whereby themes were presented with supporting statements drawn into narratives from a process of coding and categorizing data and direct quotes from the participants. Below is the presentation of the interpretation and discussion of the secondary objectives that support the main objective for phase 5.

6.2.1 Describing the existing healthcare providers in the study area

Every society has various systems in place to maintain and restore health and well-being (Van Rooyen et al., 2015; Figueras & McKee 2012). These systems are influenced by differences between cultures and their understanding and interpretation of health and disease. Additionally, these systems may include indigenous healing and allopathic health systems (Van Rooyen et al., 2015; McCleod & Chung 2012). In the study area, two healthcare providers seem to exist namely; indigenous healthcare practitioners and allopathic healthcare practitioners.

These healthcare practitioners appear to exist in parallel where each healthcare system operates on its own or within silos. This situation in the study area was presented in Chapter 1 as one of the main problems. Using ethnographic and PAR methods, this proposal was further affirmed. There are different groups that are identified from the indigenous healthcare practitioners namely; amaGqirha, amaXhwele, abaThandazeli and churches. Similar to other global indigenous health practitioners, these various groups of healers hold a holistic view of health that is inclusive of both the physical and spiritual elements of illness (May, 2019; Zonke, 2005; Mishra et al., 2003; Bodeker 1999). Indigenous healers in Africa are more concerned about who caused the illness and why (Liddell et al., 2005; Maelene (2002). This is similar to the way indigenous practitioners of the study area view health and illness (May, 2019).

Mji's work on the indigenous health knowledge of Madwaleni notes that the AmaBomvane people view illness as the result of broken relationships between family, communities, the ancestors and the environment. Therefore, for health and wellbeing to be regained these relationships will need to be re-established through cultural rituals with each directly aimed to the type of relationship that has

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been broken and what the ancestors require for the re-establishment of the relationship (Mji, 2013). While Ohajunwa (2019) highlights the spiritual element and its contribution to health and well-being and the importance of having a balanced relationship with the spiritual world, the indigenous practitioners of the study area appear to be gate-keepers of this spiritual world for AmaBomvane. On the other hand, however, allopathic healers are more concerned with the diagnostic approach (what and why). These different approaches should enhance each other and benefit people in the study area instead of being in opposition to each other.

The different indigenous healers assist the community using different methods and procedures. In the case of amaGqirha, there is an element of secrecy on how they established the ailment of a client. From May's study (2019), the amaGqirha of Madwaleni blatantly refuse to share any details of how they diagnose and manage an illness with anyone outside of their scope of practice. This is partly due to the highly sacred nature of the *ukuthwasa* training process, which requires an immense amount of knowledge exchange through ritual and ceremony between the ancestors and the trainee. Hence, knowledge that is exchanged outside of the ritual context is frowned upon and discouraged. The reason for this resistance to share IHK outside of ritual context is rooted in fear that the ancestors will reject an iGqirha who shares his/her knowledge outside of ceremonial context.

IHK scholars such as Dold and Cocks (2012) argue that the fear of indigenous healers to share their knowledge is fuelled by the cultural understanding of the ancestors as being emotionally explosive spirits that punish transgressions with the utmost vigour should anyone overstep their boundaries (Dold & Cocks, 2012). Consequently, the amaGqirha might honestly be afraid that the ancestors will punish them if they share their knowledge. Which then raises many other questions such as, what is the role of ancestral knowledge in healing and who owns this knowledge, the ancestors or the people? If the ancestors draw their power and knowledge from the natural environment, then how can they claim ownership over the environment which is supposed to be equally shared by everyone in the community? (May, 2019:132).

Consequently, allopathic health professionals of Madwaleni argue that this unwillingness of indigenous healers to share their IHK strategies causes distrust and miscommunication between the two parties. The unavailability of knowledge about what herbs are being administered to patients, and how these herbs are being prepared and regulated, has resulted in the allopathic healthcare professionals of the area rejecting everything associated with indigenous medicine. Allopathic

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healthcare professionals believe that this challenge can be overcome if the indigenous healers lift the veil of secrecy about their practices and herbal medicines (May, 2019).

The DWF in the community offers a programme known as: “health in every hut”, this literally means that the CHCWs and field workers that are trained at the Foundation visit various homes in the community and carry outdoor-to-door campaigns. As much as the work done by DWF is important in terms of community outreach, the question that one may ask is whether the organization is bridging the gap between the community and the clinics? Or is it duplicating the work done at the clinic? It is unclear whether the organization has really considered the social determinants of health that seem to be blighting the Bomvane community is a factor in the health and wellbeing of Bomvana people.

This organization does not have a reference or acknowledgement of indigenous healers of the area, let alone extending a hand to the work that these indigenous healers do. There is no indication whether the foundation extended an invitation to try to understand the work indigenous healers do in the community. Then this raises a concern that this organization recognises only allopathic healthcare systems but neglects the indigenous healthcare system while being embedded in an indigenous community.

This raises further questions like, what is the point of building a state-of-the-art infrastructure in the middle of an indigenous community if you are going to offer health in every hut? Would you achieve this objective if you ignore the other healers that are embedded inside these huts? It appears that even during this phase of SA democracy, Western cultural dominance is still at play. The disempowerment of indigenous communities and disregard for their knowledge systems still continues. The indigenous community is expected to be happy with what is being offered without the involvement of indigenous healers. The outcome then results in double consultations with Bomvana people running from pillar to post between allopathic health facilities and indigenous healers seeking solutions for their sick relatives.

The nine clinics and the presence of the Donald Wood Foundation embedded at community level is a welcome development in the study area. What is critical is that these services need to be in touch with the needs of the community and focus more on social determinants of health (Ridde et al., 2007) rather than duplicating the curative care that is offered by Madwaleni hospital. With the re-engineering of primary healthcare, it is hoped that the clinical nurse practitioner based at the clinic can play a critical role in bridging the gap between indigenous health practitioners lying dormant at

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community level and allopathic healthcare offered by Madwaleni hospital and the clinics (NDOH 2010). The development of the CHF could assist in this regard, thereby developing a bridge between the clinics and indigenous community, as in the study by Mji (2013) that suggested the pairing of community health workers with elite older Xhosa women. Mji (2013) although acknowledging indigenous healers as people that the elite older Xhosa women and community referred to when struggling with the illness of a person, overlooked the need to also improve the relationship between indigenous healers and the allopathic healthcare system in the study area as this was not the focus of her study.

Although there are issues of communication and mistrust, there are various ailments that are managed by indigenous healers which are recognised by both indigenous community and allopathic healthcare practitioners. As indicated in Chapter 4, there are some ailments that indigenous healers manage and these ailments are summarised in Table 11. Whitehead (2003) suggests that it is imperative that psychologists have specific, culturally responsive competencies to provide appropriate services to culturally different populations, such as different racial and religious populations. In this regard, with consultation and by working together patients presenting with psychosomatic symptoms can be referred to iGqirha, adopting a similar approach to that of the healthcare system that exists in China where both healthcare systems are recognised and operate together in patient referrals, at the same time operating in parallel for their scope of practise (Latif, 2010).

6.2.2 Identify communication channels between healthcare systems in the study area

According to study participants, community healthcare workers (CHCWs) based at the nine (9) clinics in the study area and the Donald Woods Foundation serve as a link between the homes of sick people and service providers. CHCWs are key members of the community who work with allopathic healthcare systems that share language, culture and connections with the local patients (Zheng, 2020). There are four tasks of CHWs as described by the Global Health Delivery Project at Harvard namely; assisting individuals and communities to adopt healthy practices, conducting outreach to ensure access to care, providing or supporting primary and chronic care, advocating structural changes related to community health needs (Ballard, 2018). These four tasks are not far off from some of the social health determinants for which the Bomvane community require support.

In Madwaleni, pregnant mothers receive home visits (HV) by CHCWs who assist them to collect their treatment from the surrounding clinics. These HV can be associated with those found in OR Tambo District (Eastern Cape Province), where a study by Stansert Katzen et al., 2020, mentioned HV by

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CHCWs during antenatal care. Mothers receiving HV were significantly more likely to suggest better care at antenatal clinics (Villar et al., 2001) and were more likely to be exclusively breastfeeding at three months. They were also less likely to have taken their infants to an indigenous healer at three months, potentially protecting their infants from what is seen by allopathic health services as harmful practises.

Are they really harmful practises or are these mothers being indoctrinated to look down on indigenous medicine, as allopathic medicine hardly has the knowledge or understanding of indigenous medicine since its practice is hidden and lacks openness? As a result some clients may be reluctant to consult indigenous healers, as in the case of these mothers from OR Tambo. It appears that these two health systems still need to learn about each other. The role played by CHWs is important in improvements in maternal caretaking, especially in rural areas. Future research in the area, related to CHCWS can focus to structural and social dimensions of health to assist women with more comprehensive maternal and child programmes, and by combining the indigenous health knowledge that is held by birth attendants that are available in the study area.

The DWF and the clinics seem to have joined hands in ensuring that there is good communication between the clinics and the community by strengthening the health systems in the study area. As mentioned earlier, the CNP who is the manager of the CHWs, needs to support the CHWs to focus on social determinants of health and indigenous health knowledge that is lying dormant at community level. The majority of the community health workers and nurses are from the same community, these allopathic carers, expect the indigenous patients not to have used indigenous health knowledge prior to visiting the hospital and clinics, while on the other hand, they consult the indigenous health practitioners secretly at night. It appears that the veil of secrecy is not only practised by indigenous patients who consult the hospital but also by health professionals who consult indigenous healers.

However, the work promoted by CHCWs in the study area has also been tarnished by the nature of communication that exists between the indigenous community and allopathic health practitioners. A negative attitude is displayed in communication by allopathic health practitioners to the indigenous community, particularly when the allopathic practitioner has been informed that a patient has consulted an indigenous healer prior to visiting an allopathic healthcare facility. This attitude may have a negative impact in cases where these two health systems may consider collaboration and working together (Van Rooyen et al., 2015). It can also be difficult when there is no mutual understanding and respect that could lead to collaborating and complementing each other. Perhaps

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it is a bridge too far for these two beginning to operate in equal manner where they operate in parallel as in in the case of China health system. In this case, while two different health systems seem to exist, it should not be that one should be pulled from one side to the other, but to find a common ground between them. For the study area the common ground and connection between these two is the health and wellbeing of Bomvana.

The power dynamics between these two contesting health providers appears to prevent them from seeing the main focus which is the health and wellbeing of Bomvana. Power dynamics can be seen in power disparity where a monumental paradigm shift may be experienced between two health systems (Oseni & Shannon, 2020). Power differential as a source of power dynamics (Karam et al., 2018) where the present outplays the past, the modern ways of doing as present while indigenous way of doing regarded as past and primitive. Ultimately, the western ways of doing embedding itself in an indigenous community tends to hold the high moral ground and owns the space of interacting. But with communication, power dynamics may be neutralised and be the means to bring these two systems together, thereby acknowledging that each system has something to offer to people of Bomvane.

The communication channels in the study area are also marked by one-sided referrals where indigenous healers are expected to refer clients to allopathic healthcare facilities and allopathic practitioners (Van Rooyen et. el., 2015). Indigenous healers stated that their working relationship with allopathic health practitioners before the publication of the *Traditional Health Practitioners Act* had been characterised by a one-sided referral system, with indigenous health practitioners referring patients to allopathic health practitioners. It is acknowledged that Indigenous health practitioners refer patients to allopathic health practitioners as they had the knowledge, skills, technology, and equipment to investigate diseases and better manage the patients. This one-sided referral further enhances the power imbalances and the feelings from indigenous health practitioners that they need to convince the allopathic health practitioners of their relevance and discipline in their scope of practise. Allopathic healthcare workers, being arbiters on the behaviour of indigenous health practitioners, do not reciprocate (Clough 1998, Mkhize 1973). This one-sided referral system further enhances the feelings of indigenous healers not being trusted healers by allopathic health practitioners.

Apart from communication, behavioural change needs to be channelled and communicated to relevant stakeholders in the case of hygiene practice. It has been observed that indigenous healers in

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the study area need workshops and training on how to maintain hygiene. The lack of hygiene practices that have been observed relates to various issues such as the storage of medications, the equipment used for preparing medication, and the packaging and dispensing of indigenous medicine. In the study conducted at AmaThole District (Eastern Cape Province), these behavioural changes were categorised as the unscientific methods used by indigenous health practitioners such as non-use of hand washing, non-sterile equipment, and the lack of measured prescription of indigenous medicine according to the age and weight of the patient (Van Rooyen et al., 2015). It is also important to highlight that indigenous practitioners are the holders of a knowledge system that has been neglected, even with knowledge systems such as allopathic medicine that have been given a platform to be studied and improved, in earlier years many a slip between the doctor's scalpel and patients body has occurred and this knowledge system, because it has been given a chance to be improved, these types of mistakes have gradually been minimised. Mji (2019) in the chapter in her book that about the elite older Xhosa women, presents a case study of one of the elite women who seems to use certain measurements in giving herbs to her patients, she also uses differential diagnoses to understand how her patients are responding to her care. Other older Xhosa women from the same source demonstrate how they relate their scope of practise to new diseases, whereby they attest that conditions such HIV and AIDs require allopathic care as such patients are too weak to handle some of the indigenous herbs and approaches.

Although indigenous knowledge systems lack modernisation, indigenous healers are nowadays open-minded and seek new ways to improve on their approaches, especially in the wake of new viruses (COVID-19). Bringing the indigenous health knowledge and its practitioners to the centre of discussions will assist this scope of practise primarily to be better understood. In areas where there are aspects that need to be changed can assist the indigenous healers to first understand what does not work or is outdated in their scope of practise before removing or improving a specific element of the indigenous health knowledge and scope of practise (Clough 1998, Mkhize 1973).

6.2.3 Process of developing Community Health Forum (CHF)

This is the main objective of the research study. The process of developing the CHF was crucial for this study in the sense that it affirms the purpose of the research study. As secondary objectives, the main objective used focus group discussions and in-depth interviews to gather information.

The indigenous community is traditionally governed by Chiefs and Chieftains but post-apartheid (1994) there are also Ward Councillors who also assist in the needs of the community. The Chief, however, is the point of entry for any development that needs to be established in a rural village. The

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Chief, with the assistance of his Chieftains (the council), can guide the process on how the CHF will function and are in a better position to know the community members from indigenous healers to allopathic practitioners. They are also in a better position to guide and advise researchers to indigenous healers who have a wealth of knowledge on treating some indigenous ailments. This goes hand-in-hand with the health system of the research area, as each clinic is close to an indigenous leader, the Chief and the clinical nurse practitioner as the head of the clinic informs the indigenous leader (the Chief) of the status of the clinic. This suggestion for the Chief to be the point of entry for the community health forum is unlike the existence with the DWF, whereby the Foundation has built a rondavel for the Chief of Hobeni to conduct his Imbizo inside the yard of DWF.

In a rural village, the family members can do absolutely anything and everything when seeking medical attention for their loved ones. The health-seeking behaviour is seen in the study area where relatives may seek assistance from indigenous healers and allopathic practitioners is seen by the indigenous community as normal. This dual consultation system seems to be endorsed by nurses who are also indigenous healers (Van Rooyen et al., 2015). In some clinics in the study, the professional nurses who are also an indigenous healer experienced role conflict related to their own professional role, these role conflicts relate to, expectations from colleagues and from management when working in the clinical area whilst advocating for capacity building of indigenous and allopathic health practitioners. This dual use of indigenous healers and allopathic practitioners by this indigenous community needs to be seen positively, and what is necessary is for practitioners to share their scope of practise with the other practitioners, including development of healthcare pathways whereby the community is educated and aware of who they should consult first and for which ailment. The CHF must be aware of health-seeking behaviour where the indigenous community practices dual consultations (visiting both AHP and IH). This gives the CHF an understanding of health-seeking behaviour from an advantage point.

As indicated in Chapter 4, indigenous healers based their treatment on who caused the ailment/sickness and why, while allopathic practitioners concentrate on the diagnostic approach of the ailment (what is the illness and how it can be managed/treated). It is therefore important to create a platform that is responsive to the needs of the community where both indigenous healers and allopathic practitioners can share the space, acknowledging that each healthcare system has a positive contribution to offer the indigenous community. Without sharing the space, neither indigenous healers nor allopathic practitioners will be able to tackle the social determinants of health that have

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an impact on the health and wellbeing of Bomvana people (WHO, 2010). From these findings, the community needs to be in the forefront for the CHF to be sustained, where the statement "nothing for us without us" holds sway. Onus is to be in the community, therefore, ownership of the CHF by the community – one element that can lead to sustainability. Another element suggested for sustainability is to make resources available. Most rural villages are remote; therefore, CHF will have difficulties in reaching many communities without available resources.

6.2.4 CHF & communication channels as bridge between healthcare systems

With the process of developing a CHF, the nature of communication needs to change between the existing healthcare providers in the study area from negative attitudes and chastising of indigenous healers by allopathic practitioners, to mutual respect and understanding. These are crucial components to promote working together and for effective collaboration (Van Rooyen et al., 2015). The mutual respect and understanding between the two existing health providers in the area can be achieved when these health providers stop blaming each another and have an open-minded approach to accept that they are different. Therefore, the nature of communication must change from looking down and undermining to acknowledgement and mutual respect. The change in the nature of communication can be achieved by gaining knowledge about the way these two systems work (Oseni & Shannon, 2020). Each health system should take time to learn from the other with the assistance of the developed CHF. The CHF must use an available communication method where use of mobile phones is in the centre of communication, but other avenues can be explored such as word of mouth from Imbizos, Ward Councillors, IYA, clinics, NGOs from the community and CHCWs.

The CHF, therefore, must create and promote communication channels for integrated referral systems between indigenous healers and allopathic practitioners (Oseni & Shannon, 2020; WHO, 2013; Oppong, 1989 & Pearce, 1982). Using a cyclical approach to communication, and to promote continuous feedback to beneficiaries. It will also be important to develop a team to coordinate and monitor the function of the CHF. This team needs to include allopathic and indigenous health practitioners responsible for the governance of the CHF and reporting back to the indigenous community as the beneficiaries of the CHF.

6.2.5 Monitor & Evaluate existing CHF

This objective has been regarded in the proposal and Chapter 1 as a long-term objective, where further research in the study area can be conducted to fulfil this objective. It is therefore suggested by the

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researcher that this objective falls beyond the scope and main objective of this current study. However, data collected during this stage is documented.

Use of communication as a tool to monitor and evaluate the CHF: Communication is used to assist the CHF to tackle issues of misunderstanding. It further assists the CHF to get feedback about its effectiveness from beneficiaries – the indigenous community. The indigenous community is taking ownership of the CHF and is distancing itself from the Messiah approach and waiting for out siders to come and save the community. Instead, the Bomvane community is reaching from within for internal civilization, acknowledging their own strengths and assets. Therefore, ownership of CHF by the community affirms the statement "nothing for us without us". However, the CHF needs guiding and policy documents in a language that is understood by the indigenous community in the area, on how to operate to decrease and/or eliminate the element of deviation. However, ownership comes with responsibility. Communication once again came into play when CHF needed training on communication skills, therefore, communication is the key and the glue. Broad and Alison (2002) in their paper on nurse practitioners and traditional healers, stated that an alliance of mutual respect is needed in the art and science of health practices. Malcolm (2005) emphasized the importance of effective communication between healthcare providers and the patient. The CHF can assist in dealing with some of the challenges that will be faced in monitoring and evaluating the CHF.

The fifth phase for the process of developing the CHF is followed by the sixth phase of piloting the CHF. The approach will be similar to that used for phase 5. The sixth phase is discussed below:

6.3 Section C: Piloting the CHF – 2019 Conference

Without repeating the findings presented in Chapter 4, the acknowledgement of the indigenous healers by allopathic practitioners was an indication that this community has grown and matured from undermining the allopathic healers to understanding and respecting the culture of the practice. From 2016, where the conference was held at a colonised village of Hobeni (the existence of DWF) to a community hall in 2019 where community members had a free will and ability of free movement without restrictions, in a space where they could freely talk about themselves.

Communication discord still lingered as threat: Although there was freedom to communicate, mistrust still lingered as a threat between the two existing health systems. The mandate of the forum was to formulate a Memorandum of Understanding between the two existing health systems. It was not possible to tackle this with this communication problem still lingering, but instead an interim CHF

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was elected. It was then befitting for the conference to tackle this issue and delay developing an MOU to be handled by the CHF.

6.4 Development of draft MOU by indigenous practitioners – December 2019

After the conference, the Makukhanye indigenous group of Madwaleni organised themselves to develop a draft MOU and also tabulate positive social determinants of health for their community and the way forward (see Appendix K). The drafting of the MoU affirms the definition of who AmaBomvane are: strong self- determinate members of Bomvana (Jansen, 1973; Mji, 2013) – the ability to write a draft MoU without allopathic health practitioners has shown the growth of indigenous health practitioners. It appear that they were claiming their space, their ability to speak out and letting go of the “Messiah factor” - expecting foreign entry and knowledge to rescue them - and to finally gain their confidence and self-determination.

To the researcher, this showed some growth from the indigenous community, gaining confidence and self-worth where they seemed not to depend on foreign knowledge and slowly letting go of the “Messiah factor”. This is an affirmation who AmaBomvane were before the penetration of foreign knowledge in their area. This was also inductive approach of PAR and an emancipatory research process (Morales, 2016).

6.5 Concluding Statement

This chapter is the continuation of the interpretation and discussion of findings of Chapter 5 but, in this chapter the focus was on the process of developing the CHF and the piloting of the CHF. The emerging themes that kept resurfacing were that the indigenous people of Madwaleni do not resent the allopathic knowledge, they were just pained by the way it has been used as an oppressive tool instead of as a supplementary tool. The people of Madwaleni look up to the hospital as being supreme, with them habitually looking down on their own health system. The process of developing CHF is discussed as the main objective of the study with secondary objectives supporting bridging the gap between the two existing healthcare systems. The 2019 conference where CHF was piloted affirmed the main objective of the current study.

The reflection on the research process follows as chapter 7 of this dissertation.

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Chapter 7: Reflections on the research experience and concerns on the research process: the confessional tale

No need to hear your voice when I talk about you better than you can speak about yourself… Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. Re-writing you, I write myself anew. I am still the author, authority. I am still the coloniser, the speak subject, and you are now the centre of my talk (Hooks, 1990:153)

7.1 Introduction

This chapter discusses the reflections on the research experience and concerns related to the research process. The discussion commences with the way I see myself and the world around me, how formal education influenced my thinking. I (how I chose the topic, my journey) and the chapter concludes with researchers' concerns on the study process.

No need to hear your voice when I talk about you better than you can speak about yourself… Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. Re-writing you, I write myself anew. I am still the author, authority. I am still the coloniser, the speak subject, and you are now the centre of my talk (Hooks, 1990:153).

The quote above takes me back to my school days when I used to think that formal education was an answer to all. Going to school and acquiring formal education is the best solution and all my questions can be answered. For me, going to school meant that I could tackle challenges and solve problems and therefore, become a knowledgeable person.

But as I grew up with a loving brother, respectful, soft spoken, and humble man, but yet firm and forever supportive, he taught me the importance of education and that with respect, not looking down on the other person, and it could provide me with wisdom. I always kept that with me wherever I went because people come from different backgrounds and so their situations differ. This is what I brought to my research study; having that sense of respect and not undermining other people, acknowledging and accepting that we have different backgrounds.

Formal education contributed a lot on how I see and view my surroundings. Formal education to me meant that having authentic information was regarded as contributing to knowledge. But this also made me realize that when I embarked on this journey that I do not have enough information about

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indigenous knowledge where *inyathi ibuzwa kwabaphambili* (to gain knowledge you must draw from previous scholars). This is a Xhosa idiom which points to the elderly experience and their vast knowledge. It was naïve of me to think that formal schooling and education is the best and most powerful of all knowledge.

7.2 Reflections of the researcher – The confessional tale

Miller et al., 1998 suggests that *confessional tales* reveal "how field work odyssey was accomplished by the researcher". The primary audience for confessional tales are, students in fieldwork – those who are in search of guidance and reassurance regarding the fieldwork experience. They maintain that confessional tales to some extent reveal the researcher's vulnerability because they demonstrate "the human qualities of the researcher" Confessional tales explore how researchers viewed things at the beginning of the study and saw things differently at the end. They provide the researchers with an avenue for confessing their personal biases, revealing their shock or surprise, blunders, character flaws, and bad habits.

7.2.1 Why I chose this topic?

Various topics were presented to me by supervisor as work that she wanted to explore with potential doctoral candidates and pursue at Madwaleni. I chose the topic - The need to develop community health forums - as I saw it as a positive social determinant of health. By exploring this topic, I could be part of the solution for this community as explained in Mji's critical research findings. From Mji's (2013) study the study area seemed to have been blighted by negative social determinants of health. Indigenous structures such as Imbizos, chiefs, different family structures and their roles seemed to have collapsed due to colonization and migration of the middle generation to cities including apartheid. Chiefs had suggested a "backward or/and forward movement" that is examining their way of doing things whether it is working or not and combine this with new modern knowledge systems. During this backward or/and forward movement, and examination of old and new knowledges systems, there might be a need to reconcile the two without imposition.

There is a reading on "AmaBomvana" by Jansen that is a must to understand the health and cultural dynamics of Bomvane. While reading this text, one must take cognisance of the fact that this book was written by a white person. Therefore, while reading this book, it is necessary to use a critical approach, for instance where the author made mention that while engaging with the mothers during medical consultations, she felt that children were too clingy on their mothers and which for her, their

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behaviour was very strange. There could be several factors that made the children clingy: perhaps it was the first time that these children had an encounter with a white person, or they were clingy because they were sick. On occasions when children are sick, children turn to be unhappy with their physical being and become fussy which would result in them being clingy to their mothers. This book was written in 1972 for primary healthcare. A second question that I needed to ask myself was, is there any written text between 1972 until today about AmaBomvane? How will I contribute to the people of Bomvana? Will I be able to do an authentic presentation of who AmaBomvane are?

7.2.2 Coming to Bomvana

Culture and language (UbuBomvana) have blessed me with indigenous knowledge and other ways of being and doing. The experience and knowledge that I gained when I worked in different organisations and companies in Cape Town and working with different cultural groups (Xhosa-speaking and Afrikaans-speaking) afforded me a space to understand that language is a powerful tool for communication. These spaces gave me a sense to understand my passion for community engagements and participation for the development of our communities, hence I chose this topic of developing a Community Health Forum (CHF). It is important when conducting research to understand the language spoken in the study area. This helps a researcher to translate maybe from English to isiXhosa and do back translation to avoid losing the meaning in translation. For example, in the study area, the concept of *ukuhlonipha* can be used by *makoti* in certain words where she cannot say because they are related to the father-in-law. And, in some families, *makoti* cannot pronounce words starting with an ”F” if a family name begins with “f”. Instead, she will replace this with a “Y”, as in the case of Faniswa – Yaniswa and so forth. Then if a researcher does not understand the language of *ukuhlonipha*, this may lead to misunderstanding and misinterpretation of what is said.

7.2.3 What then have I learned over the period of five years? (2014 -2019)

In 2014, I have learnt that if I put my mind to it, I follow through with the first decision that I made to choose my topic and stick with it. During community entry and engagements, I also learn that I am battling with my own Messiah factor (not trusting myself and wanting to be redeemed from outside), focusing on what I do not have and forgetting what I have (my assets). What am I having when I cannot provide for my family? The issue of bread and butter which translates to monetary value.

The education system that I so cherished bandaged me to think that applying for a job is the way to go, I cannot think of being a professional and after qualification look for a job, instead of looking for

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opportunities to create jobs. Being forced by circumstances to do a PhD because I am unemployed, one simply believes that life will turn out for the better. A notion to think that embarking on a PhD will turn my life around and perhaps the university will provide me with a job. But after more than four of years embarking on this journey, I have realised that it is more than that, it is about finding myself, and making sense of who I am. I am drawn to this topic and research study because of who I am and who I have become. I started to realise that there is more to life than what I expect to get, but rather what I can give, because everyone around me has something to give. I liked the slogan of the ANC: Each one teaches one – every life story has a lesson.

7.2.3.1 My journey – the research study

Coming into a rural community for my research was an advantage because I also grew up in a rural community on the other side of the Kei River (part of Eastern Cape former known as Ciskei, Alice, where the University of Fort Hare is located). However, the community from this area was a slightly different in the ways of doing – staunch believers in traditional ways compared to where I grew up. Encountering the Chiefs including attending the Imbizo (Chief's meeting) was a totally new experience because from where I came from, these meetings were only attended by males and the community members usually get feedback from the headman. I can simply say, I was elevated to a higher level as I joined the scholar activist research team which there was also a danger of being one of the Messiahs by the struggling community.

In 2015, meetings with the scholar activist research team gave me a platform to see myself from another angle – part of a group who wants to assist a community in need. But the Messiah factor still lingers on. Because I was not employed at the time and the issue of getting to these meeting was a bit of a problem for me, it dawned on me that to ask the group to help me with taxi fare while knowing deep down that I would rather use this taxi fare to buy bread for my child who was staying with me at Nyanga during this time. Each time, when a meeting was scheduled my heart would sink because of the taxi fare issue. It was during these meetings that I was able to identify an employment opportunity. Perhaps, these meetings were not a waste of my time, now I can relate with other team members because there is a possibility that I can also provide for my child. I received an offer to work at St Mary's Nursing College. Finally, my chance – my breakthrough. I was both excited and anxious to move to KZN because it was my first time without relatives or friends from that area. But I moved with my child.

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In 2016, I moved to KZN, excited about the job opportunity but never realising the impact it will have on my PhD candidacy. From Cape Town to Marianhill (Pinetown), it is quite far. Juggling my new job, a completely new environment with its norms and practices was hard. Fortunately, with the mentorship and guidance of my supervisor I managed to present to the Evaluation Committee from US via Skype, and with minor issues to consider I proceeded to the next phase to get an approval from the Ethics Committee. Then I could start with my data collection. Our first conference in July 2016 exposed me to another level of community engagement with internal students from DWF and other two PhD students who shared their knowledge with me.

In 2017, I was still in KZN, but now there was an introduction of another team member to the research team, Thando May. She is a biochemist by profession and a trainee to be an indigenous health practitioner, but at the time, she was employed by SU as researcher. Because Thando was staying in Madwaleni as a research assistant, was very supportive when it came to advising and guiding me on issues to consider for data collection. She supported me in December 2018 during my data collection process for phase 5.

7.3 What have I learned?

I did learn. From a naïve postgraduate who grew up in a rural village but spent most of her adult life in Cape Town, I learned that there is more to life than a level of education. While reference meetings from VPUU and community engagements and participation sort of prepared me, these engagements were slightly different because of research designs involved in the process. I came to realise that qualitative research is far richer, more exciting and fulfilling but complicated when dealing with the community, especially looking for social determinants of health. This also brings back memories of my first-year study about Maslow's hierarchy of needs (physiological needs – health related; safety needs – security; love and belonging needs (relationships); esteem needs – the self; self-actualization – fulfilment of full potential). I can relate to physiological needs and self-actualization and these two levels from Maslow relate to my journey. I saw myself as a needy person, not having a job and now realising my dream of contributing to a body of knowledge and literature to change the lives of Bomvana people. But as a novice researcher, I still needed to explore other communities, continue to learn and develop myself further and take to account that there is no cut-and-dried method, especially when dealing with qualitative research advocating for community engagements and participation.

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7.4 Concerns related to the study process

The study attempted to remain true to its nature of being exploratory and descriptive but because the development of the Community Health Forum, use of a qualitative research method, PAR, ethnography and emancipatory research designs were used as an envelope which is about the action of the research study which encompassing all the objectives. PAR by its nature has its twists and turns.

The collection of data, period (December 2018) also played a role when gathering data. This time is the season when the Bomvane are busy with their traditional ceremonies from celebrating the coming-of-age of boys to manhood, appeasing the ancestors for a good year, celebrating achievements of new homes and other important events that happened during the year. Though this was limiting to the data collection, the researcher learnt a lot about the culture of AmaBomvane through observing these celebrations. She also learnt how to adjust her data collection plan to still achieve her objectives.

Initially, the researcher intended to collect data accessing the participants from the Imbizo of the respective Chiefs of the four cluster of the villages and from the Imbumba YamaKhosikazi Akomkhulu (IYA) but these meetings could not materialize. The Chief could not find time to secure an appointment because of various events in the village that needed his attention and presence. While IYA could not be organized because the Chief's wife was no longer active in the organization. Again, here the researcher was supported by the retired nurse and the research assistant to do snowballing to achieve her data collection objective. The researcher had to also understand that the village has its own rhythm and norms she must let go of having expectations, she has to facilitate, observe and describe – not to try and push for a certain outcome.

There were just general challenges of avoidance where both indigenous health practitioners were avoiding being in the same room, and this could only be overcome by bringing everybody to a neutral space such as the conferences in 2016, 2018 and 2019.

Organizations that represent people with disability are scarce in the area. The study lacks the presentation of people with disabilities and minimal involvement of the organisation such as Khaya Loxolo that works with children living with disabilities. It is important to see disability as a human experience. As this study also observes and describes the culture of AmaBomvane, there is still a need to understand how the Bomvane respond and work with persons with disability. But due to the fact

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that this study was not focusing on disability, the study could not give full attention to the exploration and description of functioning of Khaya Loxolo.

The researcher, though a Xhosa, is not a Bomvane. Thus, perhaps it was not possible to gain access to, or even to notice, some of the cultural nuances that could have brought a deeper understanding on the communication challenges that indigenous healers encounter from allopathic health practitioners. This raises questions regarding exactly which method to follow in conducting and interpreting the lived experiences of indigenous people by an outsider. Follow-up studies should be conducted by local researchers in order to possibly gain more accurate information and to be able to interpret the cultural nuances more accurately. The study, however, did make use of the services of a research assistant who was residing in one of the villages of Bomvane for the period of her research study.

Perhaps the greatest challenge of the study lies in its attempt to suggest the integration of IHK with the existing allopathic system in the 18 villages of Mbhashe Municipality. The danger of this is that IHK can only serve as a mere add-on to the existing allopathic healthcare system. Indigenous healers expressed their concern of the undermining tendencies and being looked down on by allopathic doctors. The health model for the Mbhashe Municipality is that which has been suggested by Mji and could assist the promotion of primary health in the study area – as earlier mentioned, the re-engineering of PHC might help in this regard. The CHF needs a way forward in terms of how it will be sustained and clear guidelines on how this CHF can be governed and by who? – This falls beyond the scope of this research study.

The concluding chapter follows as the final chapter for this dissertation.

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Chapter 8: Conclusion

"Nothing for us without us"- Letting go of the Messiah factor.

8.1 Introduction

The study aimed to explore the process of developing a Community Health Forum as a strategy to improve communication between biomedical health professionals and an indigenous community. The study collated data using community engagements and participation from community entry and building of relationships, to various conferences, and ultimately through focus group discussions and in-depth interviews, with ethnography, PAR and emancipatory research designs as primary drivers of the methodology. The data confirmed that communication problems are the primary source of the challenges that seem to blight the indigenous community and the healthcare system in the area. The development of a Community Health Forum (CHF) was a strategy to create a bridge and a communication platform between indigenous health and allopathic practitioners existing in the study area. This chapter aims to draw conclusions for this doctoral thesis by highlighting the following:

A. Critical contributions of the study to the following areas:
   - Community health forums as an instrument to facilitate paradigm shift,
   - Development of concepts and theory,
   - Literature,
   - Affirmation and contribution to Mji's critical findings,
   - Re-affirmation of indigenous knowledge holders,
   - Development of a framework for development of community health forums, and
   - Methodology.

B. Recommendations, and

C. Conclusion of the study.

8.2 Contribution of the study to different areas

8.2.1 Community health forum as an instrument to facilitate a paradigm shift

The main aim of this study was to explore the development of a CHF as a strategy to improve communication between allopathic health professionals and an indigenous community. The development of the CHF was developed through community engagements and participation where

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building of partnerships was crucial between the researcher and the indigenous community. Although there were challenges and still-existing challenges between the two existing health paradigms in the area, a compromise was reached to put aside their differences and to focus on their commonality, that is, the health and wellbeing of Bomvana people. The challenge of communication has underlying factors of power dynamics where each paradigm seeks dominance over the other.

Initially, there seem to be an assertion that allopathic health practitioners from the District hospital and the nine clinics deny the indigenous community the power of making decisions for themselves, therefore infringing on their human rights (National Patients' Rights Charter, 2008). Part of this is to suggest that these communities have no rights to seek an alternative opinion and treatment other than that prescribed by allopathic medicine (Flint & Payne, 2013). The development of a CHF must be able to break boundaries and stereotypes that were enforced by the power dominance of the allopathic health systems in this indigenous community (Mills et al., 2006). Both existing health systems in the area need to realise that neither health system is better than the other, but the two should be complementary, recognising that what is important is the culture and beliefs of patients that influences their health-seeking behaviour.

This thinking is further highlighted by authors of studies such as: Nemutandani et al., 2018; Campbell et al., 2010; King, 2000 and Madiba, 2010: decolonising the mindsets, attitudes, and practices of the allopathic and indigenous health practitioner in postcolonial society. These authors alluded to the importance of collaboration with allopathic healthcare systems whereby in their situation terms and conditions were initially dictated by allopathic health practitioners (AHPs). With such models taking the form of organised training workshops where the indigenous health practitioners (IHPs) were invited to "listen and learn from the allopathic health practitioner". This similar to what the indigenous health practitioners were initially complaining about in the study area, the one-way referral system. These authors further believe that real change and thorough understanding will happen when both parties are prepared to learn from each other. For the study area, one hopes that the newly developed CHF will address some of these challenges.

8.2.2 Contribution to development of concepts and theory

The concept of *ukuhlonipha (respect)* being a way of life to uphold the culture of Bomvana. When outsiders enter Bomvana as visitors, this notion of *ukubuka iindwendwe (honouring the visitors)* should be scrutinised because it is most of the time misguiding. *Ukubuka iindwendwe* literally means that making the visitors feel at home, hence the owner of the household would say to the visitors

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"*khululani iibhatyi kusekhaya apha*" meaning take off your jackets and relax, this is your home. In other words, saying to foreigners they must relax, is not the same for saying you must do whatever you want. This study observed this culture of *Ukuhlonipha* as it is played out amongst Bomvane families and noted that it can be inhibiting as it takes out the voice of the person. It is the impression of the researcher that the same situation plays itself out when indigenous patients present their cases in the hospital and are asked about what they have used, and as they are also respectful of the allopathic health providers as people who are educated, they feel shameful of taking ownership of the indigenous health knowledge they have used before consulting the hospital. The study had already revealed that allopathic health practitioners from the study area consult indigenous healers at night and in secret, but they never reveal nor communicate this to their colleagues. Therefore, if those people from the community who acquired formal schooling are ashamed of bringing to light indigenous healthcare and its practises, then one wonders how much of a burden it is to those with no formal schooling to talk about indigenous health knowledge. It appears that a veil of secrecy exists on the use of indigenous health and healing from both the educated and uneducated persons in the indigenous community. This creates vulnerability of the indigenous knowledge where, for instance one had hoped, that educated indigenous scholars would be more willing to admit having used indigenous health knowledge. The question that one should ask is: How can the practice of indigenous knowledge be recognised in the area? How can communication be improved between the healthcare systems in the area? The process of developing a Community Health Forum is suggested as a bridge between the two existing health systems.

There is also a need to what kind of health knowledge existed before the introduction of allopathic healthcare into the study area, which focused on curative care instead of social determinants of health. The narration about AmaBomvane in chapters 3 and 4 respectively, has answered some of these concerns when health and wellbeing was attributed to positive social determinants of health. The existence of their land, plants, their animals, and the sea especially, and provision with herbs is relevant in management of their ailments. The older elitist Xhosa women as mentioned by Mji (2013) were at the centre of managing ailments in the home setting and assisted in heading the households of Bomvana. Bomvane equated to be Bomvane with certain obligations of keeping a healthy family to contribute to healthy villages. This was done by focusing on positive social determinants of health. Like the Maori of New Zealand, to be healthy was to be Bomvane (Durie, 2004 & Jansen, 1973). In the absence of the male generation due to migration practises, a vacuum is left in the upbringing of the young generation which has broken down family fibre and the Bomvane are now blighted by diseases

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such TB, HIV and AIDs and malnutrition. With the development of the MOU the developed CHF has already shown that it may contribute positively to the revival of positive social determinants of health.

8.2.3 Contribution to literature

Firstly, in Chapter 1, the study presented four main contestations and amongst them was poor communication channels that hinder the building of trustful relationships between the different health systems in the area. This is further affirmed by literature reviewed for this study whereby poor communication marks the relationship between allopathic and indigenous healthcare practitioners. On one hand, the poor communication is marked by the negative attitudes of allopathic health practitioners especially the clinical nurse practitioner (CNP), when she gathered that indigenous community consulted indigenous healers and therefore used indigenous medicine prior visiting the healthcare facility. On the other hand, poor communication is marked by the veil of secrecy by the indigenous community not divulging the use of indigenous medicine prior to visiting the allopathic healthcare facility. This poor communication between these two healthcare knowledge systems may result to the misdiagnosis of the illness. But, with the existence of the CHF in the area, this creates a platform for both healthcare systems to speak openly about their healthcare practices, ultimately resulting in health promotion and disease prevention programs and this will keep the indigenous community healthy.

Secondly, in Chapter 2, bilateral agreements seem to exist between ailing African regimes and international corporates under the false pretext of development programmes (Moahi, 2007). The foreign entry in African land comes with certain elements of coming to take and own the African ways of doing in the false pretext of bringing development into underdeveloped communities. With the concept of *Ukuhlonipha* having a downside, where the people of this area seem to give utmost respect to the visitors and in turn are taken advantage of by opportunists in the name of rural development. This is seen in communities like Bomvana where researchers and scholars come to do research and may never come back again in the area to plough-back and make community contributions as a social responsibility. But this study has managed to pilot and implement a CHF that is used by indigenous healers as a platform for health and wellbeing of Bomvana. The drafted MoU is a step forward in the right direction where indigenous healers are in the forefront and taking ownership of their CHF to see its functioning and sustainability.

Thirdly, the knowledge that these indigenous healers bring in the functioning of the CHF should be recognised as their own – the challenge of implementation of Intellectual Property Rights. The area of

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Bomvana is rich with traditional plants and herbs that are used by most of these indigenous healers to manage some ailments in the area. With the existence of the CHF (working together with AHPs) in case the herbs are brought in the open and used for healing in the modern context (taken to laboratories for testing), then Intellectual Property Rights should be tabled in the open. Some of the indigenous medicines are taken out of the country and return packaged in fancy bottles and sold back to our communities at great expense. The CHF, in their guiding document and policy for operation, should consider ways of handling Intellectual Property Rights as one of the issues needing to be addressed. Similar to the development of intellectual rights for the Khoisan people of South Africa.

Fourthly, there is dual consultation where Africans seem to consult both healthcare practitioners as literature indicated and as confirmed by the participants of the study. But as debates continue raging about choices related to which healthcare system Bomvane should choose, one has to say that the issue here is not about rejection of one to favour the other (Durie, 2004). The two health systems can operate parallel to each other. In terms of health seeking behaviour, indigenous people do consult both healthcare systems, even though these systems may seem contradictory (Mji, 2013; Buhrmann, 1983). On the other hand, there already are some allopathic health practitioners who are starting to recognise and acknowledge the healing qualities of indigenous healers (Bok, 2004; Buhrmann, 1983). This suggests that the focus should shift from superiority, dominance and supremacy to identifying opportunities for these two health systems to work together as a unit (Mji, 2013; Bok, 2004).

8.2.4 Affirmation and contribution to Mji's critical findings

The social determinants of health in the area, as cited by Mji (2013), continue to be unaddressed, and it appears from this study they have become worse and matured. During the workshop in Nkanya, the elderly males from the mines, raised their health concerns suffering from HIV/AIDS while bringing these diseases back to infect their community and they had no access to pensions to provide their families and were worried about their role in the community (especially in teaching respect to young males). The young children continue to fight because there are no role models, as the father is absent because of migration. Malnutrition and stunted growth have become the order of the day. Now the AmaBomvana live below the poverty line. When health inequities are not addressed, the health status of the people of that area worsens. One of the major contributions of the study is to observe the decline of the health status of Bomvane, especially in areas that are closer to the hospital and Elliotdale, which is the town for Madwaleni.

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8.2.5 Re-affirmation of indigenous knowledge holders

The CHF that serves as a communication platform to form a bridge between the two existing healthcare systems in the area, by placing the indigenous Chief as point of entry for discussion of matters related to the CHF, which is giving acknowledgement to indigenous ways of being. Community entry and the building of relationships starts with the permission of the Chief. The Chief is the point of entry of the village to address issues that relate to the community. He knows the community members and different stakeholders in the community. He presides over *Imbizo* (Chief's meeting) to tackle social determinants of health with community members at *Ikomkhulu* (his homestead). This affirms the status of indigenous leaders, that they too can be a bridge that works with allopathic and indigenous health practitioners.

This study has created a platform for indigenous healers to work closely with allopathic healthcare practitioners, one hopes that this will result in each opening their slates and teaching each other about their scope of practise. As has already been shown in Mji (2013), the indigenous community, especially those living close to the hospital, are sadly rapidly losing indigenous knowledge system, and while they are losing this important community resource, they are not adopting much of the allopathic healthcare medicine due to: (a) Communication challenges between indigenous patients and allopathic health practitioners, (b) that the majority of indigenous patients, have not attended formal education and cannot read and write, (c) and lastly, the attitudes that exist between the two groups, whereby indigenous patients see the hospital having brought all the illness because it concentrated on curative care with patients but never addressing the core course of their illness with a revolving door syndrome characterising the type of health management of the hospital.

8.2.6 A framework for development of CHFs

The study had also contributed to considerations to undertake when planning to develop a Community Health Forum (CHF) in indigenous communities. The following may be considered:

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Table 7: Nature and Characteristics and Process of CHF

Nature and Characteristics of the CHF	Process of CHF
➢ Indigenous people playing a leading role. ➢ The CHFs a communication link between the community, clinics, and hospital. ➢ A platform that is responsible to the needs of community, indigenous healers, and allopathic health professionals. ➢ Awareness on health-seeking behaviour and analysis of existing communication channels. ➢ Design strategy for behavioural change which needs to be channelled and communicated to relevant stakeholders.	➢ Improve access to proximity of healthcare services. ➢ Create protocol for future nature and characteristics of communication. ➢ Use nature of communication as a monitoring and evaluation tool. ➢ Collate feedback from constituencies and beneficiaries of the structure. ➢ Train forum on communication skills. ➢ Guiding document and policy on how to operate. ➢ Seek external support for sustainability of the forum.

The figure below consists of a flowchart that depicts a conceptual understanding of the process and stages of developing a community health forum.

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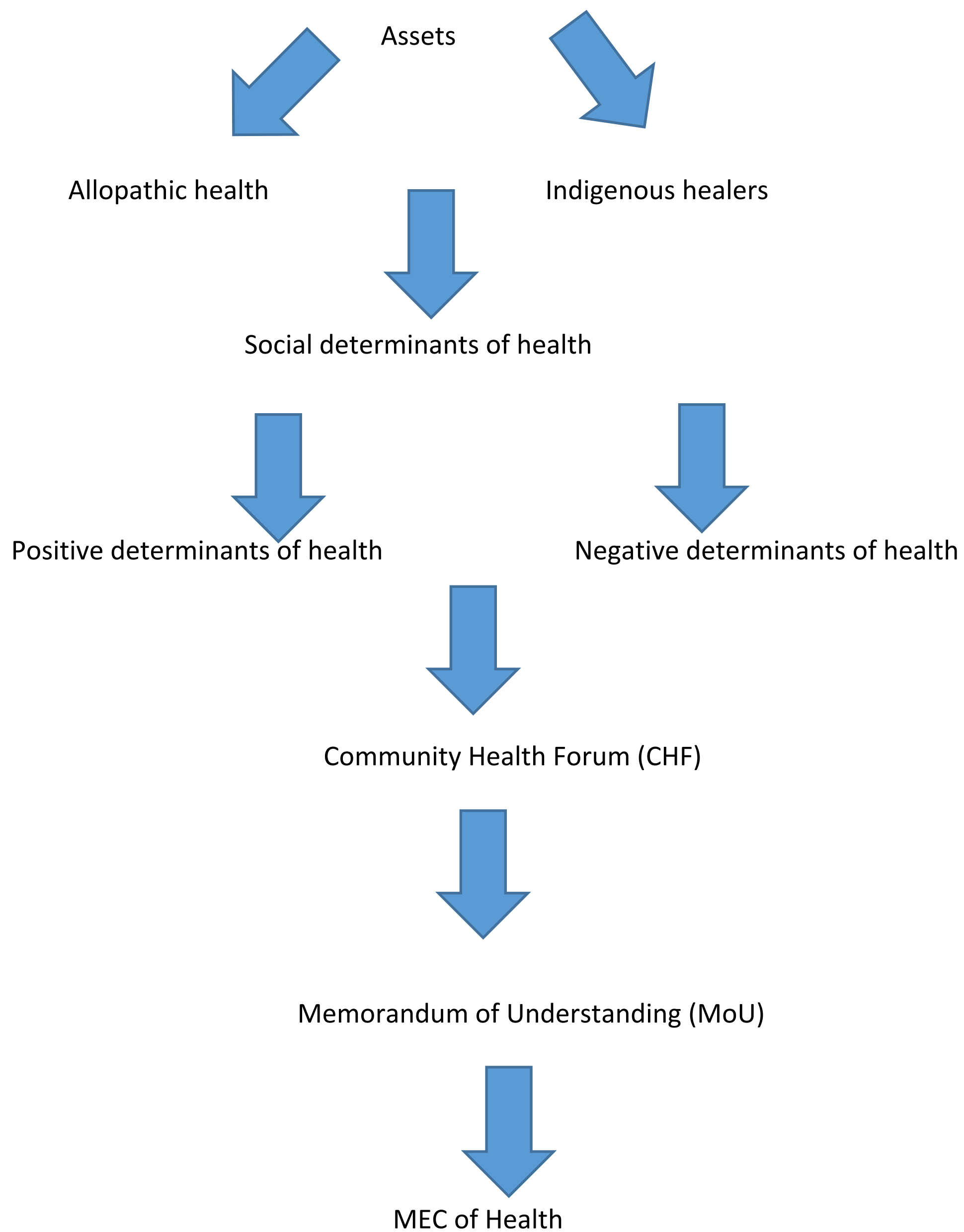

Figure 3: A conceptual framework on process of developing a CHF for the health and wellbeing of Bomvana people.

8.2.7 Contribution of methodology

The use of PAR, ethnography and emancipatory research designs assisted the CHF in becoming a reality when it was piloted in the conference of 2019. The piloted CHF affirms the main objective of the study and further contributes to the body of knowledge that exists in the research of the rural

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community of South Africa. The scholar-activist team, with its vast knowledge, contributed to the knowledge and experience the community of Gusi, who must unlock it and to further claim it (UbuBomvana) before the entry of foreign knowledge. The team assisted the community to unlock their potential and realise their assets and skills to uplift their community – assets lying dormant in the community, civilization is within. Although Mji's (2013) study focussed on elitist women, there was an emergence of other indigenous healers through these research designs used in the study. PAR with its twists and turns, proceeded in a cyclic manner and allowed a space for other indigenous healers to emerge.

8.3 Recommendations

8.3.1 The Chief and AmaBomvana

In a community like Gusi, the Chief's role is first and foremost to bring stability and growth to his villages. The foreign entry such as the DWF must not detract the Chief from safe-guarding his indigenous sovereignty (Logan, 2009; Bizana-Tutu, 2008). The rondavel built in the yard of the Foundation to be used for the Chief's meeting (*Imbizo*), is a sign of colonization. While an Imbizo is a meeting called by the Chief and presided over by him at his homestead, and held next to the kraal, members of the community attend by invitation from the Chief. The Foundation that has state-of-the-art security in the middle of a rural community must not by any means impose white dominance and power over the Chief. There are certain practices and rituals that need no foreign entry or western intrusion and modification.

The community of Bomvana must realise that civilization is within. There are assets lying dormant in the community that can change their determinants of health. The indigenous community has traits and knowledge to turn their situation around. There is no need to wait for a foreign Messiah, they have their own Messiah – which their strength as unit, working together and pulling all their resources together to develop their villages. Their building skills are one aspect to explore the creation of cultural tourism, with the concept of *ukuhlonipha* maintaining the balance between respect and silencing the voice of the young who are the future elders of Bomvana.

8.3.2 Indigenous health practitioners (IHPs)

The indigenous healers should draw a line between *ukuhlonipha* and *ukubuka iindwendwe* where allopathic health practitioners (district hospital and nine clinics) claim the space of Bomvana. There is a thin line between *Ubuntu* and *ukuhlonipha*: Making an outsider feel comfortable at your own

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expense. The visitors may take advantage of your generosity and kindness because you are afraid of making the visitors uncomfortable but within the same breath, you are making yourself uncomfortable – being uncomfortable while making others comfortable. With the developed CHF in the area, indigenous healers as community members must take ownership of the CHF and be at the forefront. The CHF cannot be sustained without the support of the indigenous community. IHPs should create a space of communication and transparency for the CHF to function properly and accept that they (IHPs) and AHPs are coming from different paradigms and that working together may mean working in parallel with each other.

8.3.3 Allopathic health practitioners (AHPs)

AHPs should accept the fact that dual consultations do exist in the villages, therefore indigenous communities do consult both indigenous healers and allopathic health practitioners. The type of communication that is characterised by negative attitudes toward indigenous medicine and healing must become a thing of the past. An integrated referral system is encouraged where allopathic health practitioners refer clients to indigenous healers. There should be a recognition and acknowledgement of certain ailments that are managed by indigenous healers. AHPs should create a space of communication and transparency for the CHF to function properly and accept that they (AHPs) and IHPs are coming from different paradigms and working together may mean working in parallel with each other. There is a renewed challenge for AHPs where a new medical model which represents the cure, prevention and management of biological diseases using the reasoning and principles of evidence-based medicine (Fuller, 2017; Fuller, 2016). Although using clinical guideline-directed medicine, this cannot be achieved without the involvement and communication with an indigenous community that these AHPs service (Fuller, 2017; Engel, 1977). Lastly, both existing health systems in the area need to realise that neither health system is better than the other, but the two should be complementary (Nemutandani et al., 2018).

In cases where AHPs seem to resist or are in contradiction with the communication strategy that has been put in place in the area, the developed CHF. This resistance of the AHPs to accept the CHF and the drafted MoU should be presented to the provincial MEC for Health Department. The CHF with indigenous healers should consult the MEC of health who has the power to enforce and see that policies and laws are considered during local governance. Therefore, CHF should understand and know the lines of accountability from the clinic level to District and Provincial levels.

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8.3.4 The DWF

Although it may seem that they are doing a great job for the community, there are issues of jurisdiction – where boundaries should be set**.** The building of a rondavel for Imbizo in a white-owned building and space, is a violation of human rights and traditional sovereignty. The organization deserves the right to assist the community as an NGO but the community has a right to be involved in the development of its own community (nothing for us without us). The white dominance and foreign knowledge, and ways of doing cannot be othering the AmaBomvana ways of doing. The organization should include in its community development and "health in every hut" an element of social determinants of health. The state-of-the-art building erected in the middle of a rural village is a contradiction when the very same village people do not have access to the organization. The organization should review its security systems to accommodate the village community.

8.3.5 National Department of Health

As suggested by the Chief, the developed CHF at local level should proceed to district, regional and national levels. The Department of Health (DoH) should understand that rural communities need to take a lead in their health issues but with the assistance and guidance from the department. The sustainability of the developed forums depends on the support of resources from the department. The process of monitoring and evaluation also depends on the department but working together with different stakeholders from the CHF with community members as beneficiaries of the health services.

8.3.6 NRF and MRC

These institutions which support research in higher learning institutions should also reach out to remote areas such as Mbhashe municipality to conduct research and assist communities. There is still a lot of research that needs to be funded. Access to funding should be made easy for the layperson who is not registered or affiliated to an institution of higher learning.

8.4 In Conclusion

The study presented the research problem with two existing healthcare systems marking their relationship with a lack of trust that created a gap between them. These health systems are different, and their approaches are different. There seems to be no space or platform for these knowledges to work. The main challenge was the poor communication between the two.

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The study reviewed literature to tackle the challenge of communication that was mentioned above. For this to happen, an understanding about indigenous people, indigenous knowledge systems and indigenous health, medicine and healing was discussed. There was an emphasis on the literature on how indigenous knowledge systems cope in the presence of allopathic knowledge systems where power dominance impacted negatively on the communication process.

The methodology provided three research designs namely, PAR, ethnography and emancipatory, which provided the study with focus group discussions and in-depth interviews to understand the dynamics of existing healthcare providers in the research area. With its twists and turns, moving in a cyclic manner, PAR further provided the study with new objectives and extended the research to a wider community of nine (9) principalities instead of focusing on four (4) areas, which was the initial intention of the study.

The nine (9) principalities presented data that was used for community entry and establishment of relationships with different stakeholders from Bomvana. The emergence of other indigenous healers from Madwaleni negated the only indigenous healers in the study by Mji, where she focused on elitist older Xhosa women. The employment of a researcher, biochemist and indigenous scholar managed to organise a structure for indigenous healers called Makukhanye. Makukhanye drafted a MoU (which affirms the emancipatory research, where communities take ownership) between indigenous healers and allopathic practitioners, while an interim CHF was formed to affirm the main aim of this research study.

The findings were interpreted and discussed according to phases, since the study was cyclic in nature and considering all the twists and turns that were afforded by PAR. With the process of developing a CHF taking the centre stage as a bridge to improve communication between two existing health systems in the area. The reflections of the researcher in the process were discussed relating the tale of her journey. It covered her influences pre- and post-data collection and furthermore, how this journey has changed her. With limitations of the study mentioned, especially when the researcher is a colonised scholar, not a Bomvana, although a Xhosa, but she has lived her life on the other side of Kei River, which is many ways different from the ways of doing of Bomvana. The conclusion gives a summary of what the whole study was about with recommendations for a possibility of future research.

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APPENDICES

APPENDIX A: Letter of Approval

Approval Notice
New Application

08-Dec-2017

Ethics Reference #: S17/05/103

Title: An exploration of the development of community health forums as a strategy to improve communication between biomedical health professionals and an indigenous community: a rural participatory action research study

Dear Ms Faniswa Gxamza,

The **Response to Modifications** received on **02-Nov-2017** was reviewed by members of the **Health Research Ethics Committee 2 (HREC2)** via **expedited** review procedures on **08-Dec-2017** and was approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: **08-Dec-2017 – 07-Dec-2018**

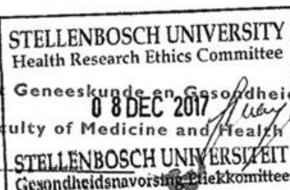
Please remember to use your protocol number (S17/05/103) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired.
The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.
Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No. 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles, Structures and Processes 2015 (Departement of Health).



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Faculty of Medicine and Health Sciences

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Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities (Western Cape Departement of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Departement of Health (healthres@pgwc.gov.za ; Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za; Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents, please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at 021 938 9677.

Included Documents:
Protocol Synopsis
Protocol
Application Form
General Checklist
Information Leaflet and Consent Form – In-depth Interviews and Focus Groups
Investigator's Declaration F Gxamza
Investigator's Declaration G Mji
Investigator's Declaration S Reid
CV F Gxamza
CV G Mji
CV S Reid

Yours sincerely,

Francis Masiye,
HREC Coordinator,
Health Research Ethics Committee 2 (HREC2)

Fakulteit Geneeskunde en Gesondheidswetenskappe
•
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INVESTIGATOR RESPONSIBILITIES
Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research: You are responsible for making sure that the research is condcuted according to the HREC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research.
2. Participant Enrolmment: You may not recruit or enrol participants prior to the HREC approval date or after the expiration date of HREC approval. All recruitment materials for any form of media must be approved by the HREC prior to their use. If you need to recruit more participants than was noted in your HREC approval letter, you must submit an amendment requesting an increase in the number of participants.
3. Informed Consent: You are responsible for obtaining and documenting effective informed consent using **only** the HREC approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed consent documents. Keep the originals in your secured research files for at least fifteen (15) years.
4. Continuing Review: The HREC must review and approve all HREC approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the HREC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in HREC approval does not occur.** If HREC approval of your research lapses, you must stop new participant enrolment, and contact the HREC Office immediately.
5. Amendments and Changes: If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the HREC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written HREC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the HREC should be immediately informed of this necessity.
6. Adverse or Unanticipated Events: Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occuring at this institution or at other performance sites must be reported to the HREC within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the HREC's requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Health Research Ethics Committee Standard Operating Procedures www.sun25.sun.ac.za/portal/page/portal/Health_Sciences/English/Centres%20and%20Institutions/Research_Development_Support/Ethics/Application_package. All reportable events should be submitted to the HREC using the Serious Adverse Event Report Form.
7. Research Record Keeping: You must keep the following research-related records, at a minimum, in a secure location for a minimum of fifteen years; the HREC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the HREC.
8. Reports to the MCC and Sponsor: When you submit the required annual report to the MCC or you submit a required report to your Sponsor, you must provide a copy of that report to the HREC. You may submit the report at the time of continuing HREC review.
9. Provisions of Emergency Medical Care: When a physician provides emergency medical care to a participant without prior HREC review and approval, to the extent permitted by law, such activities will not be recognized as research nor will the data obtained by any of such activities be used in support of research.
10. Final Reports: When you have completed (no further participant enrolment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the HREC.
11. On-Site Evaluations, MCC Inspections, or Audits: If you are notified that your research will be reviewed or audited by the MCC, the Sponsor, any other external agency or any internal group, you must inform the HREC immediately of the impending audit/evaluation.

Fakulteit Geneeskunde en Gesondheidswetenskappe

Faculty of Medicine and Health Sciences

STELLENBOSCH UNIVERSITY
Health Research Ethics Committee
08 DEC 2017
STELLENBOSCH UNIVERSITEIT
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APPENDIX B: Participant information leaflet

TITLE OF THE RESEARCH PROJECT: An exploration of the development of community health forums as a strategy to improve communication between biomedical health professionals and an indigenous community: A Rural Participatory Action Research Study

REFERENCE NUMBER: S17/05/103

PRINCIPAL INVESTIGATOR: Faniswa Desiree Gxamza

ADDRESS: Centre for Rehabilitation Studies

CONTACT NUMBER: 021 938 9090

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the research team any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee at Stellenbosch University and will be conducted according to the ethical guidelines and Principles of the International Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Department of Health (Eastern Cape) Ethical Guidelines for Research.

The research study is an exploration of the development of community health forums to improve communication between biomedical health professionals and an indigenous community. Your confidentiality will be protected by giving you the option not to be identified. Your name will not be used in the research and interview documents will be stored in a secure facility. Only the researcher and supervisors have access to the information. In addition to the step taken above, your confidentiality will be further protected by sending the research findings back to you, so you can examine and edit any findings that could identify you before the data is published. However, there is always a possibility of your specific community being identified and potentially stigmatised after publication or dissemination of the findings.

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The interviews and focus groups will be audio recorded. Please sign here or thumbprint if you agree to allow audio recording of the interview and focus group.

If you are willing to participate in this study please sign the attached Declaration of Consent and hand in to the investigator.

Yours sincerely

Faniswa Gxamza

Principal Investigator

Declaration by participant

By signing/thumbprint below, I …………………………………..………… agree to take part in a research study entitled *(insert title of study)*.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurized to take part.
- I may choose to leave the study at any time and will not be penalized or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the research team or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ....…........………….. on (*date*) …………....………. 2018.

Signature/thumbprint of participant Signature of witness

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PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT: An exploration of the development of community health forums as a strategy to improve communication between biomedical health professionals and an indigenous community: A Rural Participatory Action Research Study

REFERENCE NUMBER: S17/05/103

PRINCIPAL INVESTIGATOR: Faniswa Desiree Gxamza

ADDRESS: Centre for Rehabilitation Studies

CONTACT NUMBER: 021 938 9090

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the research team any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee at Stellenbosch University and will be conducted according to the ethical guidelines and Principles of the International Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Department of Health (Eastern Cape) Ethical Guidelines for Research.

What is this research study all about?

The study will be undertaken in the district of Elliotdale (Eastern Cape Province) of South Africa.

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The study sample would be derived from four clusters of villages namely; Hobeni, Madwaleni, Nkanya and Xhora.

The researcher will purposefully divide the study sampling into two groups namely the Imbizo and the Amakhosikazi Akomkhulu (women from the chief kinship) to allow women a platform to freely voice their concerns in the absence of their male counterparts/figures.

The total number of participants to be recruited for the study will be 64.

The main purpose of the study is to improve the health and well-being of the AmaBomvane people.

Why have you been invited to participate?

You have been invited to participate in this research because you are an adult male/female (>18 years) living in Elliotdale. It is hoped that your contribution to this research would answer the following question: How can the development of Community Health Forums improve communication channels between the district hospital, the 9 clinics and the indigenous community of Bomvaneland?

What will your responsibilities be?

To participate in the discussions about the development of Community Health Forums in your piloted village.

Will you benefit from taking part in this research?

Participants will not be paid during this study. It is hoped that the results of this research will contribute to improve communication channels between the two centres of health knowledge that seem to exist in this research area.

Are there any risks involved in your taking part in this research?

No, there are no foreseeable risks.

The interviews and focus groups will be audio recorded. Please sign or thumbprint here if you agree to allow audio recording of the interview and focus group ---------------------------

Is there anything else that you should know or do?

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You can contact Faniswa Gxamza at tel. 031 700 2685 if you have any further queries or encounter any problems.

You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by this research team.

You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing/thumbprint below, I …………………………………..………. agree to take part in a research study entitled *(insert title of study)*.

I declare that:

I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.

I have had a chance to ask questions and all my questions have been adequately answered.

I understand that taking part in this study is voluntary and I have not been pressurized to take part.

I may choose to leave the study at any time and will not be penalized or prejudiced in any way.

I may be asked to leave the study before it has finished, if the research team or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ....…........................ On (*date*) …………..………… 2018.

Signature/thumbprint of participant Signature of witness

Declaration by investigator

I *(name)* ……………………………………………..……… declare that:

I explained the information in this document to ………………………………..

I encouraged him/her to ask questions and took adequate time to answer them.

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I am satisfied that he/she adequately understands all aspects of the research, as discussed above

I did/did not use an interpreter. (If an interpreter is used then the interpreter must sign the declaration below.

Signed at (*place*) ....…..…………….. on (*date*) ………...………... 2018.

Signature of investigator Signature of witness

Declaration by interpreter

I *(name)* ……………………………………………..……… declare that:

I assisted the investigator (*name*) ………………………………………. to explain the information in this document to (*name of participant*) ……………..………………………….. using the language medium isiXhosa.

We encouraged him/her to ask questions and took adequate time to answer them.

I conveyed a factually correct version of what was related to me.

I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) ....…..…………….. on (*date*) …………..……………….. 2018

Signature of interpreter Signature of witness

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APPENDIX C: Inkcukhacha zomthathi-nxaxheba kwakunye nefomu yesivumelwano sokuthabatha inxaxheba

ISIHLOKO KUPHANDO LWEPROJEKTHI: Ukuphononongа indlela ekunokuthi kuqulunqwe iforami yezempilo ekuhlaleni ezakuthi iphucule unxibelelwano oluphakathi kwesibhedlele, iiklinikhi kwakunye namaziko ezempilo asekuhlaleni: Uphando lwasezilalini

REFERENCE NUMBER: S17/05/103

UMPHANDI OYINTLOKO: Faniswa Desiree Gxamza

IDILESI: Centre for Rehabilitation Studies

INOMBOLO YOMNXEBA: 021 938 9090

Uyamenywa okokuba uthabathe inxaxheba kolu phando lweprojekthi. Sicela okokuba ufunde oku kulandelayo okuzakunika inkcazelo malunga neprojekthi. Sicela okokuba ubuze nayiphi imibuzo engakucacelanga ngokupheleleyo kubaphandi bethu.

Kubalulekile okokuba waneliseke yingcangciso malunga nolu phando nangayo nendlela ezakuthi ubandakanyeke. Kwaye ukuthabatha kwakho inxaxheba akunyanzelisi konke-konke unakho ukungavumi ukuthabatha inxaxheba. Ukuba ngaba awuvumi kuthabatha nxaxheba kolu phando, oko akuyi kubanamiphumela emibi ngakuwe. Kwaye unakho ukuyeka nangawuphi umzuzu emveni kokuba ubuvumile ukuthabatha inxaxheba.

Olu phando lunikwe impepha-mvume yidyunivesithi yaseStellenbosch phantsi kwekomiti eyodwa ejongene nempatho namalungelo abantu xa kusenziwa uphando. Kwaye ndithembisile kwabasemagunyeni njengomphandi oyintloko okokuba yonke into ezokwenziwa kolu phando iza kulandela imiqathango eyabekwa lihlabathi jikelele eHelsinki ngo2008.

Lumalunga nantoni olu phando?

Olu phando luza kwenzelwa kwindawo ebizwa ngokokuba yiXhora (eMpuma Koloni) eMzantsi weAfrika.

Isampule/abathathi-nxaxheba baza kuchongwa kwezi ndawo zilandelayo; Hobeni, Madwaleni, Nkanya kwakunye naseXhorha.

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Umphandi uza kuwahlula amacandelo ezophando abe mabini ngokubizwa kwawo abe ngala; Imbizo kwakunye nama-Amakhosikazi Akomkhulu ukunika kumakhosikazi ithuba lokuthetha ngokukhululekileyo kungekho abantu abangamadoda.

Inani labathathi nxaxheba kolu phando liyakuba ngamashumi amathandathu anesine (64)

Eyona njongo yolu phando kukuphuhlisa impilo nendlela yokuphila kubantu bakwaBomvane

Kutheni umenyelwe ukuba uthabathe inxaxheba?

Umenyelwe kolu phando kuba ungumntu omdala wendoda/umfazi (>18 iminyaka ubudala) ohlala eXhorha. Sinethemba lokokuba inxaxheba yakho kolu phando iza kuphendula le mibuzo ilandelayo: Ingaba ukusekwa/ukuqulunqwa kweforamu yezempilo yoluntu ingaluphucula njani unxibelelwano phakathi kwesibhedlele, iiklinikhi ezilithoba kwakunye nabantu abasebenzisa amayeza emveli apha kwaBomvane?

Luyintoni uxandiva lwakho?

Ukuthabatha inxaxheba kwiingxoxo malunga nokusekwa kweforamu yoluntu ejongene nezempilo kwindawo ohlala kuyo.

Ingaba kukhona oza kuzuza xa uthe wathabatha inxaxheba kolu phando?

Abathabathi nxaxheba abazohlawulwa kolu phando. Sinethemba lokokuba iziphumo zolu phando zizokuncedisa ekuphuculeni iindela zonxibelelwano phakathi kumacandelo olwazi kwezempilo abonakala ekhona kuyo le ndawo yophando

Ingaba kukhona ukonzakala okunokwehlala xa uthabatha inxaxheba kolu phando?

Hayi, asingetsho ukuba kungakhona ukwenzakala

Ingaba ikhona enye into omele ukuba uyayazi okanye uyenze?

Ungaqhagamishelana noFaniswa Gxamza kule nombolo yomnxeba 031 700 2685 ukuba unayo imibuzo okanye uhlangabezana nengxaki

Ungaqhagamishelana neHealth Research Ethics Committee kule nombolo yomnxeba 021 938 9207 ukuba unengcamango okanye unezikhalazo ezingakhange zabe ziphenduliwe liqela labaphandi

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Uza kufumana ikopi enenkcukhacha kwakunye nefomu yentatho-nxaxheba zibe zezakho

Isivumelwano ngulowo uza kuthabatha inxaxheba

Ndityikitya apha, mna ………………………. ndiyavuma ukuthabatha inxaxheba kolu phando (Ukuphonononga indlela ekunokuthi kuqulunqwe iforami yezempilo ekuhlaleni ezakuthi iphucule unxibelelwano oluphakathi kwesibhedlele, iiklinikhi kwakunye namaziko ezempilo asekuhlaleni: Uphando lwasezilalini)

Ndiyavuma okokuba:

Ndiyifundile okanye ndifundelwe ngenkcukhacha nesivumelwano sokuthabatha inxaxheba kwaye zibhalwe ngolwimi endilwaziyo.

Ndibenalo ithuba lokubuza imibuzo kwaye yonke imibuzo iphendulwe ngokwaneliseka.

Ndiyaqonda okokuba ukuthabatha inxaxheba kolu phando alunyanzeliswa kwaye andikho phantsi koxinzelelo lokokuba ndithabathe inxaxheba.

Ndingakhetha ukuyeka nangawuphi umzuzu kwaye andisayi kohlwaywa nangayiphina indlela.

Ndingacelwa ukuba ndiyeke ukuthabatha inxaxheba nangaphambi kokuba olu phando lugqitywe, okokuba iqela labaphandi okanye umphandi ubona ukuba oko kungandinceda, okanye andiyiphumezi imiqathango ebekuvunyelwene ngayo kolu phando.

Ityikitywe/ngobhontsi (indawo) …………………………………. Ngomhla ………………………….2018

Umthathi-nxaxheba……………………………… Ingqina……………………………..

Isivumelwano ngumphandi

Mna (igama) ……………………………………………….…… ndiyavumelana noku:

Ndikucacisile oku kulandelayo ku …………………………………..

Ndimkhuthazile okokuba abuze imibuzo kwaye ndathabatha nethuba elaneleyo lokuphendula

Ndanelisekile okokuba uyayiqonda yonke imiqathango yolu phando, njengoko icacisiwe ngasentla

Khange ndisebenzise toliki

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Ityikitywe/ngobhontsi (indawo) …………………………………..ngomhla ………………………..2018

Ityikitywe ngumphandi Lityikitye ingqina

Umyalezo kumthathi-nxaxheba

Mthathi nxaxheba obekekileyo, ndigqithisa ilizwi lombulelo ongazenzisiyo. Ndithi mazen' ethole, ndibulela ngokuthi uvume ukuthabatha inxaxheba kolu phando. Ngethemba lokuba ikhona inzuzo oyakuyifumana ngenxa yegalelo lakho.

Ukuba ubenayo eminye imibuzo onayo okanye kubekho okukhumbulayo ongakhange wakuthetha nceda unditsalele kule nombolo yomnxeba: 083 436 9229

Enkosi

Owenu ozithobileyo

Faniswa Gxamza

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APPENDIX D: Co-Researcher's Training Manual

Research Assistant Training Manual

Study Title: An exploration of the development of community health forums as a strategy to improve communication between biomedical health professionals and an indigenous community: A Rural Participatory Action Research

Name: Miss Faniswa Desiree Gxamza

Student number: 13661477

May 2018

Table of Contents

1. Purpose of the research assistant training manual……………………………………………………..4

2. Introduction……………………………………………………………………………………………………… 4

Stellenbosch University https://scholar.sun.ac.za

3. Description of a focus group……………………………………………………………………………….4

4. Ethical Considerations………………………………………………………………………………………….5

4.1 Focus Group Questions……………………………………………………………………………………..6

4.2 Study Sampling………………………………………………………………………………………………….6

5. Limitations of Focus Group Research……………………………………………………………….7

5.1 Generalizability………………………………………………………………………………………………….7

5.2 Influence of other participants…………………………………………………………………………7

6. Research Assistant Roles……………………………………………………………………………….7

7. Planning for the Focus Group………………………………………………………………………..8

7.1 How to access space for conducting the focus groups…………………………………………..8

7.2 Payments or purchases……………………………………………………………………………………..8

8. Conducting the Focus Group……………………………………………………………………………..8

8.1 Recording the focus group………………………………………………………………………….…8

8.2 Facilitating the discussion…………………………………………………………………………………10

8.2.1 Managing of the time……………………………………………………………………………………10

8.2.2 Keeping participants focused…………………………………………………………………….…10

8.2.3 Ensure everyone participates……………………………………………………………………...10

8.2.4 Moderating disagreement…………………………………………………………………………….10

8.2.5 Probing for further details…………………………………………………………………………….11

8.2.6 Paying attention to slackers……………………………………………………………………………11

8.3 How to deal with interruptions and people leaving early?..11

8.4 How to conclude the focus group?...12

9. What to consider after the Focus Group?..12

Stellenbosch University https://scholar.sun.ac.za

9.1 How to prepare for Data Analysis?...12

9.2 Intellectual Property Statement for Research Assistants……………………………………….13

10. References…………………………………………………..…………………………………………………….14

Appendix A: Participant Information Leaflet

Appendix B: Participant Information Leaflet and Consent Form (Imbizo)

Appendix C: Participant Information Leaflet and Consent Form (Imbumba YamaKhosikazi Akomkhulu)

Appendix D: Study Interview Guide

Appendix E: Checklist - Supplies

Appendix F: Checklist - One day prior to focus group

Appendix G: Checklist - Day of the focus group

Appendix H: Template for taking field notes

1. Purpose of the research assistant training manual

The purpose of this document is to provide information to the research assistant/s to guide them on how to conduct focus groups for collecting qualitative research data in the field of Medical and Health Sciences. This document also provides on the university's requirements on the issues of what to consider during a research study. It also tabulates the expectations of the Principal Investigator (PI). The intention of this guide is not regarded as a replacement but rather as a supplement to research meetings, electronic communication or face to face conversations. In the case when the research assistant/s have questions on how to plan or conduct the focus group, the PI should be consulted.

2. Introduction

This is a manual training guide for research assistant/s on how to plan focus groups when collecting data for qualitative research. It covers the purpose of the manual training guide as indicated in the previous paragraph, description of a focus group, ethical considerations, limitations of focus group research, the roles of the research assistant/s, planning and conducting the focus group, data management, data analysis and the reporting of the results. The manual also contains various forms

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that will be signed by research participants together with interview schedule guides that are attached as appendices at the end of this document.

3. Description of a focus group

Focus groups are also called group interviews or group conversations. A focus group is a group of people who engage in a discussion guided by a set of questions and moderated by a facilitator. The objective of the focus group is to gather qualitative data from human research subjects. The kind of data collected in a focus group usually relates to the participant's: beliefs, perceptions, opinions, views, values, experiences.

There are two criteria that could make group discussions focused namely; a clear and defined topic and a common set of characteristics among participants (e.g., demographic, and/or other commonalities). For a focus group to be conducted there should be participants, a facilitator and recording devices for capturing the group discussions. These focus groups should be scheduled and organized. Participants should be informed prior the discussion groups about the date, time and the venue/location of the group discussion. Ideally, focus groups last from 45 to 90 minutes. In case where the focus group exceeds more than 90 minutes, the facilitator of the focus group should either plan a break or schedule another meeting with the participants. Participants after 90 minutes will likely be restless, hungry and may not want to continue with the group discussions.

A focus group that would be conducted by a research assistant should not exceed eight (8) participants. These focus groups should be conducted in a venue that would be suitable for participants to be heard by each other, the facilitator and the recorder. Recording of the responses ensures that every participant's contribution is being captured for future data analysis. Focus groups may be used as the sole source and/or can be combined with other methods of data collection. The specific roles of the research assistant/s may include either assisting or running the focus group. Research assistant/s may be asked to facilitate the discussion, be in charge of recording data or assist with other related duties pertaining the discussions. Each of these elements are further discussed in detail in this manual.

4. Ethical Considerations

The researcher or Principal Investigator (PI) would apply for ethical approval of the study with the University of Stellenbosch Health Research Evaluation Committee, Ethics Committee, Faculty of Medicine and Health Sciences and Department of Health in the Eastern Cape Province. Prior to the

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first phase of the Community-Based Participatory Research (CBPR) cycle, the researcher would explain to participants the consent form which will be translated from English into IsiXhosa a primary language of the study area. The researcher will diligently acquire the necessary skills and knowledge to implement the study design appropriately and rigorously to ensure trustworthiness of the findings. The process of explaining ethical considerations would be undertaken in all four sampled villages.

Consent to participate in the study within a CBPR study is quite complex and includes different layers of gaining consent (Bergold & Thomas, 2012 & Gelling & Munn-Giddings, 2011). For example doing community entry and gaining permission in the study-setting to conduct the study from the Chiefs will be the first layer of getting consent. During group discussions though each member of the group will sign a consent form, there will be a need for collective agreements and shared responsibilities on how the study will be conducted. In the case when the research conducted in these areas will be published the researcher will consult and discuss with the key stakeholders of Bomvana about the intention to publish the results of the study. The WHO/AFRO has been also promoting training involving traditional health practitioners, collaborations and researchers on Intellectual Property Rights (IPRs) relating to traditional medicine. Adeniji (2002) argues that it is important to empower people especially on issues relating to accrued benefit sharing and royalties in collaborative research involving researchers, communities and development partners.

4.1 Focus Group Questions

The researcher or PI would formulate an interview guide with semi-structured questions in both English and isiXhosa to gather data from the sample. The research questions are designed based on the objectives of the research study. The research assistant/s would be provided with an interview guide which is attached on this manual to assist the research assistant/s oh how to ask questions that are relevant to this research study.

4.2 Study Sampling

The study sample would be drawn from the clusters of villages of Hobeni, Madwaleni, Nkanya and Xhora. The researcher will purposefully divide the study sampling into two groups namely the Imbizo and the Imbumba YamaKhosikazi Akomkhulu (women from the chief kinship) to allow women a platform to freely voice their concerns in the absence of their male counterparts/figures. The chief from the respective villages would be in the forefront to organize an Imbizo with the assistance of the chieftains and Imbizo would be predominantly males namely from aged +60 years, the middle-aged,

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the youth, traditional leaders (sangoma and/or herbalists), religious leaders and key stakeholders such as educators from the schools, health care workers from the clinics and the hospital.

The study sampling that would be represented by the Imbumba YamaKhosikazi Akomkhulu would be predominantly women from the older women (+60 years), middle-aged, the youth, elite women, traditional and/or herbalists, religious leaders, educators and clinical nurse practitioner from the clinic and the district hospital. There are indicators that there is a split in the youth of this area because of English usage by some youth in the community. The youth that express themselves in English are regarded as modern and then they are beaten and insulted by their counterparts who still maintain and use their traditional/indigenous language. The researcher will enhance a working relationship where both will be represented in the sample and also negotiate communication channels that will not undermine differing views. It is expected that snow balling techniques will also be used as a sampling strategy as the researcher continues to engage with key informants and consensus agreements will be developed on who to include as part of the engaging team.

5. Limitations of Focus Group Research

Focus groups have particular limitations that must be considered as part of the research design:

5.1 Generalizability: Results from focus groups cannot be generalized. Researchers must be careful not to assume that what is said in a focus group represents the opinions, beliefs or perceptions of an entire population. While the objective is to have a focus group that represents the diversity of beliefs, views, and opinions of the larger population, this may or may not actually be the case.

Influence of other participants: This can occur when participants begin to agree with one another due to peer pressure or the perception that agreeing with others is preferable to raising an opposing viewpoint.

6. Research Assistant Roles

Research Assistant may or may not be registered with the institution that the Principal Investigator is part of during this research. However, there are several issues to consider as roles for the research assistant to consider. These duties may include but are limited to:

Attend and actively participate in research team meetings.

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Assist with participant recruitment, obtain informed consent, and keep accurate records for the research study. RAs must keep data confidential and not discuss what was said in a focus group with anyone outside the research team.

Collaborate with the Principal Investigator and other research team members to implement and maintain protocols for secure storage of data

Conduct focus groups

Maintain detailed and organized project documentation, including reports, data, etc.

Assist with administration work as needed

Assist with collaborative knowledge dissemination activities

Other duties as assigned

7. Planning for the Focus Group

The planning of the focus group may include among other things the following namely; how to access space for conducting the focus groups and payments:

How to access space for conducting the focus groups: The Researcher/Principal Investigator (PI) would meet with the Chiefs of the clusters of villages that are linked to the clinics and during this meeting the Research Assistant would be introduced to the chiefs. The purpose of this meeting is to get permission from the Chiefs to conduct focus groups and gather data for the research study. Each Chief from the cluster of villages would determine the suitable venue or space where the focus groups should be conducted. Once the respective Chief has approved the venue then the RA would commence with the focus group. This would also be applicable for the discussion with Amakhosikazi Akomkhulu.

Payments or purchases: There may be a need for items to be purchased as part of the planning process for the focus group and the responsibility of purchasing of equipment and services during data collection lies solely on the PI, the Research Assistant should not use their own funds. In case of petty cash, the PI should explain its use in details and the expectations of its use should be outlined clearly.

8. Conducting the Focus Group

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There are several factors to consider while running the focus groups itself, including who does what. Ideally, two research assistants will run a focus group. One research assistant will generally be the facilitator and also moderates the discussion with the participants. The other research assistant will be responsible for recording the focus group discussion. This second/other research assistant is in charge of ensuring data are recorded properly using approved recording devices and taking notes during the focus group.

8.1 Recording the focus group

The person assigned to the role of the recorder is in charge of ensuring that data are captured effectively and accurately. Focus groups may be recorded either by using an audio, video or field notes. In the case when the focus group is the sole source of data for the research study, then it is advisable to use a video or audio recording as the primary source of data for analysis. Note taking is usually considered as a secondary or a back-up recording device in case one fails or a recording might be accidentally erased. The type of recording devise that will be used during the focus group is approved by the institutional ethics review board for a particular research study.

In the case when the session is recorded via an audio recorder, a high-quality digital voice recorder should be used with a back-up recorder available. The PI should provide the RAs with a recording device used for focus groups. RAs should practice setting up and using the audio recording device before the focus group starts. This practice should include whether the recording device is working properly, memory card is stored and there are extra batteries. The audio recording device should be running until the last participants has left the room. There could be slackers in the group who would like to make contributions after the main discussion has concluded, in that way the facilitator can still capture their input with the recording device.

In the case when field notes are also used as a recording device, this should be introduced at the beginning of the session maybe the same person responsible for the audio recording would the same person as the note taker. The note taker should be sure to include the following; date and time of the focus group, full name of the research team member conducting the focus group and their role/s, location of the focus group and names of participants / pseudonyms. (See Appendix H as a template guide for note taking).

Research assistant/s should remember that field notes become part of the permanent element of the data collection for the research study. This is not just note taking for the individual but for the entire

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research team. The following could assist research assistant/s to produce high quality notes: writing of complete words, writing out complete sentences. Use quotations marks to denote direct quotations from participants. Use brackets to indicate additional comments such as gestures and/or body language etc. Be mindful to limit the number of editorial comments on the field note record. Finally, avoid vague indicators such as "he/she said" rather use names, pseudonyms as per research protocol.

The recorder should try to be as specific as possible with note taking. As a recorder, one is not meant to be a silent observer unless the PI specifically asked not to engage with participants. Otherwise, the recorder can ask participants to slow down if they are talking too quickly. In other instances ask for clarification if recorder is having a hard time taking notes on what a participant is saying. The recorder could also assist the facilitator when a question is missed or skipped.

8.2 Facilitating the discussion: Leading a group discussion requires skill and insight. The facilitator should listen to the participants and keeps the discussion moving forward, while remaining completely objective/neutral throughout the discussion. This does not mean that the research assistant would be emotionless, but would also be pleasant, warm and welcoming for participants.

Before the research assistant starts asking the focus group questions, the research assistant should introduce herself/himself with the recording device/recorder to participants. Ensure that everyone has signed the consent form. In the case where other participants are unable to read or write, read the consent form and after reading and everyone has understood, allow participants to place a sign that indicates that they have understood the consent form. Research assistant may also assist participants to make name tags. If they have chosen a pseudonym, they should write their pseudonym on their name tag rather than their real name. The research assistant should refer to the participants by their pseudonym but not their real name while conducting these focus groups.

Before or after the group discussion could commence, the research assistant should offer participants with water and/or refreshments. There should be a negotiated discussion between the research assistant and participants about the expectations during the focus groups. Participants should allow each other to take turns when speaking and be reminded that all discussions will be recorded. It is the responsibility of the research assistant to ensure that the focus group starts and ends on time and that there is enough time for each of the key discussion questions. The research assistant should indicate to participants at the beginning how long the focus group is scheduled for.

There tips that could help the research assistant namely:

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8.2.1 Managing of the time – This is the responsibility of the research assistant to indicate how long the focus group is scheduled for. And also ensures the focus starts and ends on time and that there is enough time for all discussion questions.

8.2.2 Keeping participants focused – There will be instances that some of the participants would dwell much on a question and at times the discussion will not be aligned with the questions. It is the responsibility of the research assistant to keep the discussion focused.

8.2.3 Ensure everyone participates – It is possible that the focus group would consists of participants that are reserved and others would dominate the discussion. The research assistant should ensure that each participant gets a fair chance to participate in the focus group. It is advisable that in this case could ask probing questions to the reserved by saying: "I noticed that (participant) has not yet commented on this issue. Let us give him/her a chance to contribute." In the case of participants who try to dominate the group discussion, do not be afraid to say, "Thank you (participant), can we now give others to comment on this issue." Sometimes this dominant participant would cut off some other participants in the middle of a sentence. The research assistant is allowed to say: "Please let (participant) finish."

8.2.4 Moderating disagreement – There will be times that during the focus group, participants would have opposing views on the same question. There could be a disagreement, but the research assistant should not take sides but rather allow participants to exchange ideas in a candid, comfortable and safe environment. It is the responsibility of the research assistant to keep the discussion moving forward and ensuring group members that there are no right or wrong answers, every contribution to the discussion is valuable.

During this process, the research assistant should also be mindful of the recorder as a full partner in the process. Every response during the focus group should be recorded and the recorder may need clarity to some questions.

8.2.5 Probing for further details – Although it is advisable to stick with the questions as approved by the institutional research ethics board, the research assistant is allowed to probe for deeper insights by using questions and/or phrases such as; kindly give us an example, is there anyone else who wants to add on this point?

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8.2.6 Paying attention to slackers – Some people may wait until the end of the discussion to speak up. In this case, take time to pay attention. The research assistant may supplement the filed notes after the focus group to capture this particular individual's contribution.

8.3 How to deal with interruptions and people leaving early?

There will be times that participants may need to leave the discussion early. This is allowed but the research assistant should thank them for participating and also allow them to exit. In the case when the discussion is being interrupted by an outsider, the research assistant should attend to the outsider immediately and make every effort to protect the identities of the participants. In case of a health hazard, ensuring participants' safety is priority number one than data collection. Therefore, the research assistant should ensure all participants vacate the place and/or space safely.

8.4 How to conclude the focus group?

During conclusion, the research assistant should ensure that the following steps are completed:

All questions have been asked. Double check with the recorder that all questions have been asked because it is possible that as a facilitator one might miss a question. Checking with the recorder ensures all data has been captured. All consent forms have been signed. Take time to thank all participants for their attendance and contributions. Emphasize on how valuable their contributions to the research study. Reinforce that there is nothing for them without them. Remind, participants about the confidentiality of the discussion and that the focus group should not be discussed with anyone. The dissemination of the results will be made available via reports, presentations and other means necessary for participants to have access. The respective Chiefs of the villages will have firsthand information about the results and all people would be welcomed to attend the presentations. In the case of follow-up groups, this would be a suitable time to remind participants. At the end, participants should leave the focus group feeling valued and appreciated.

9. What to consider after the Focus Group?

After all participants have left, the research team may vacate the place and/or space where the group discussion was held. The research team should take some time to debrief immediately after the focus group. This could be done in the place and/or space where the focus group was conducted provided the briefing would be strictly the research team. In some cases, the research team would move to another venue which is private and may involve the PI in this discussion via telephone. During the

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debrief, the research team would discuss what worked and what did not. All aspects of the focus group can be included in the debrief including the place and/or space, the recording, the participants (could everyone see or hear), understanding of the questions, the usability of the data, what areas to pay focus on next focus group and any other elements that are worth noting. The recorder should jot down some notes from the debrief as part of his/her field notes for that session, but should also have a chance to actively contribute through the conversation.

9.1 How to prepare for Data Analysis?

This should be done after the data has been collected. The field notes should legible and comprehensive. Anonymity of the data is ensured. Participants' real names should not appear anywhere except on the consent forms. There should be a back-up copy that would be kept in the project archive and the other copy should be used for transcription. Transcriptions of the recorded data may be sent away to a professional transcriptionist or may be done by a member of the research team. This decision/approach for the research study would be communicated with the PI.

The process of data analysis would be led by the PI, with assistance of research assistant/s. The PI will lead the research team through the data coding and analysis process. The focus group analysis involve systematically identifying and summarizing themes, patterns, perspectives, perceptions and experiences.

Finally, focus group results can be reported in the format that the PI deem fit to report them and are to be kept confidential until PI is ready to release them.

9.2 Intellectual Property Statement for Research Assistants

The purpose of this statement is to ensure clarity and transparency among all members of the research team. According to the University of Stellenbosch Intellectual Property Policy of ??? year, Section ??? the work that the persons is paid for belongs to the employer, unless that work is related to the academic development of a particular individual, that individual may gain access to the work through the relevant channels. Research Assistant/s are hired to perform specific duties and tasks in relation to the research study but this does not entitle RAs to intellectual property rights. RAs may not copy, publish or publicly share results and/or any other work relating to the research study without the explicit written permission of the PI. There would be certain instances where RAs may be invited to contribute to collaborative dissemination of research results namely; conference presentations or

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publication. Research assistants are encouraged to have open and frank interactions with PI about what constitute a substantive intellectual contribution to a research study.

10. References

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STUDY INTERVIEW GUIDE

Study objectives	Linking questions
Explore the development of partnerships with the community key stakeholders through community entry.	How can researchers access Bomvana community to conduct a research study? How could the community and the researchers develop partners? What is the importance of partnerships between the community and researchers? How could these partnerships function?
Participate with the study participants in exploring and describing existing health care providers in the study area.	What are the existing health care providers in this area? How do these existing health care providers function within the community?
Engage with the study participants in describing the existing communication	Describe communication channels between health care providers and community

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channels between health care providers and community.	How can these communications channels between health care providers and community be modified? What could be the role of the community to modify these communication channels? What could be the role of the health care providers to modify these communication channels?
Engage with the study participants on the idea and process of developing CHFs with the study sample.	Do you think an idea of CHFs would be useful for the community? What could the ideal process to develop these forums model be developed to serve as a bridge between health care providers and community?
Engage with the study participants in describing and developing a model that maps out how communication channels and CHFs will function as a bridge between health care providers and community.	Describe ways in which a model of communication can be developed for this community. How will this model be adapted as a channel of communication between health care providers and the community?
Discuss with study participants indicators for monitoring and evaluating the newly formed CHFs and communication channels.	How will this model be monitored? How will this model be evaluated? What indicators will be put in place to ensure monitoring and evaluation of this model?
Recommend a model on how the development of Community Health Forums (CHFs) can be used as a strategy to improve communication between	Do you think that there are two different health care systems that exist in your community?

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biomedical health professionals and an indigenous community.	Do you think both health care systems could learn to coexist? What would be your role to ensure the coexistence and tolerance of these two health care systems? What do you think will be the outcome of this coexistence for the wellbeing of the community?

APPENDIX E: Copy of final proposal

An exploration of the development of community health forums as a strategy to improve communication between biomedical health professionals and an indigenous community: A Rural Participatory Action Research Study

1. Introduction

The focus of this study is on indigenous health knowledge carried by the people in the study site and biomedicine offered by health facilities that provide health services in the study area. The main aim of this study is to explore the development of Community Health Forums (CHFs) as a strategy to improve communication between biomedical health professionals and an indigenous community. It is hoped that the CHFs would assist in playing the role from the point of view of the family-based management of the sick member, to the interventions of non-professional healers and to referral stages outside the home environment when the sickness could no longer be managed at home. This would also include referral back at home of the patient after the patient has been treated by the health practitioners in the health facilities.

The point of departure for this study is based on Kleinman's conceptual framework (the popular (the home), the folk (indigenous community) and the professional (the district hospital and the 9 clinics). The three held arenas in Kleinman's health belief model are similar to what is happening in the study area but Kleinman did not explain how communication would happen in the three arenas and also how they would work together and complement each other, hence this study. Another important model that will be used in this study is the asset model. The asset model is an approach that uses

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embedded assets within the communities to determine and improve health systems. In this model, people jointly identify problems, as well as the assets that exist to solve these (Morgan & Ziglio, 2007).

Since in South Africa the Clinical Nurse Practitioner (CNP) was given the status of being a mini doctor in primary care services such as the clinics (Mash, 2004), in caring for the health and well being of the people in the study area, the role of the CNP and the bio-knowledge that this professional acquired in the nursing practice is important for these communities. It is seen that the CNP is the mediator in the health care facility between the doctor and the patient (Mash, 2004). The negative attitude and the secrecy of practicing indigenous health knowledge build a gap between the western healing and the indigenous healing (Bodeker, 1999). The revelation about usage of alternative medication by the patient prior visit to the health care facility could be beneficial to the CNP. This could inform the CNP about the phase of the sickness and therefore advise the CNP on proper diagnosis and futher treatment of the illness. On the other hand, the positive community interventions of experienced women in the community that Mji (2013) classify as elite women due to their knowledge of supporting sick community members, traditional healers and herbalists, who at times assist the older Xhosa woman when she is unable to manage the minor health ailments at home should be included and integrated in the primary health care model for the people in the study area. There should be no exclusion and imposition but an inclusion and integration of both knowledge systems in terms of what works and does not work. Unfortunately that is not the situation in the study area as patients that have utilised indigenous medicines prior visit to the health facility are chastisized by health professionals in the health facilities of the study area (Mji, 2013). This undermine communication and creates a vale of secrecy between patients that have used indigenous medicine and health professionals in the health facilities. This study then hopes to improve communication channels between health professionals in the health facilities and the patients from this indigenous community.

Since 1994, Primary Health Care (PHC) was rolled out throughout South Africa, including in the rural areas, such as those in the Eastern Cape Province. It was, thus, expected that such care would provide people with general access to PHC and health services, and that such care would impact on what illnesses are managed in the home and what illnesses are managed in public health centres. At present, it appears that the South African government was only able to implement selective primary health care and primary care and not the comprehensive primary health care strategy of 1978 that was horned in Alma Ata (Gaede & Versteeg, 2011). These policies appear to only cover institution-based health care management, the home environment where illness starts and communities were

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left to fight the social health battle on their own (Gaede & Versteeg, 2011). It also appears that the health care system only focused on the current bio-medical model neglecting a socio-political and spiritual model where health care again becomes an organic part of community care as it once was in the traditional society (Dennil et al., 2007 and Edelman & Mandle, 2002). It appears that there is a need to develop bridges of care that connect the home and its ability to maintain health and health determinants with the existing health facilities in the study setting.

2. The identification of the study setting

Based on the findings and recommendations that Mji made in her study setting the area that is identified as the site for this doctoral study would be KwaBomvane in Xhora (Elliotdale) in the Eastern Cape Province (see Figure 2.1 below) (Jansen, 1973, Mji, 2012). The people who reside here are called AmaBomvana and are one of the most interesting tribes in South Africa (Jansen, 1973). They speak Nguni-Xhosa, a Bantu language spoken by more than 3.9 million South Africans. As one of the social health determinants that have affected the Bomvana person, education has a major impact on this area as indicated by Mji in her study and had managed to divide people of this area into two groups: the “red” illiterate people (amaqaba = people who paint themselves with red ochre and are classified as traditionalists), and the “school” people (amagqobhoka: abantu basesikolweni = people who have left traditional life and are usually Christians and to some degree are Westernised (Jansen, 1973).

The breakdown of their tribal economy forced the traditional Bomvana towards the turmoil of rapid cultural change. This is the process of acculturation in South Africa which affected thousands of Africans to mainly work as labourers in mines (Jansen, 1973, Mji, 2012). The impact of migrant labour on Bomvana life cannot be overestimated; their manpower in the vital period of life (18-50 years) was continuously withdrawn from their tribal society and mobilized for the labour market (Jansen, 1973). Migrant labour practices have left these villages with absence of the middle-aged generation. The older Xhosa woman has a dual responsibility of assuming the role of the head of the household and the primary caretaker of the sick relative with an extra burden to discipline and teach respect to the grandchildren. 9 clinics and a district hospital provide biomedical health services for the Mbhashe municipality.

Below in Figure 2.1 is the map of part of Elliotdale, showing Madwaleni hospital, the nine surrounding clinics, the villages, Mbhashe and Xhora River and part of the Indian Ocean.

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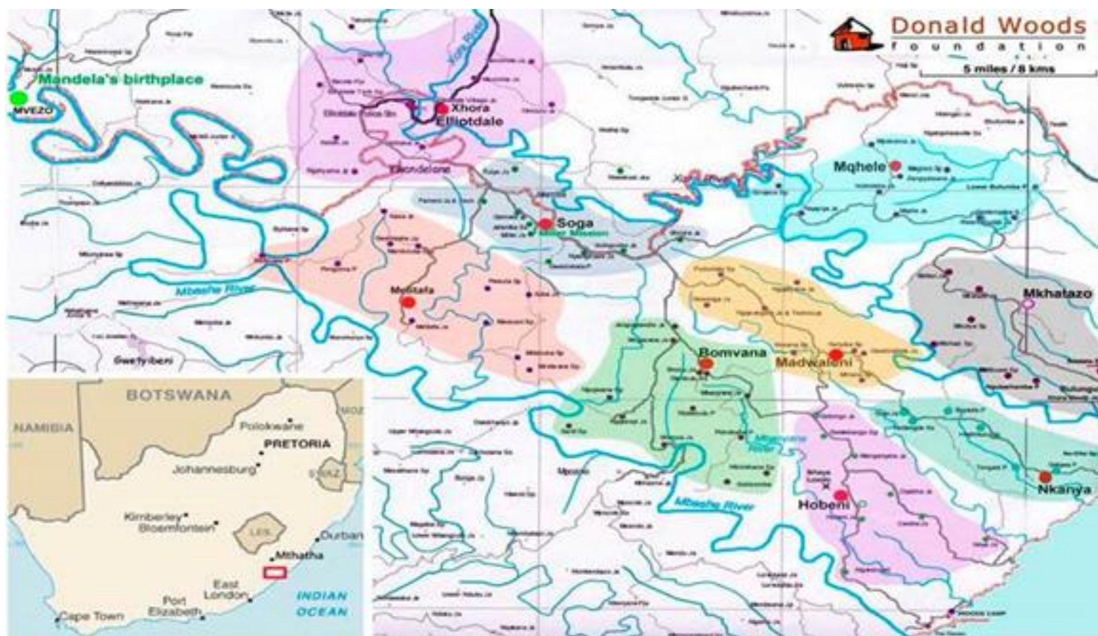

Figure 2.1: Map of part of Elliotdale, showing Madwaleni Hospital, the nine surrounding clinics, the villages, Mbhashe and Xhora rivers and part of the Indian Ocean.

3. The Statement of the Problem

Mji's study highlighted four critical problems that are highlighted in this proposal and these were:

3.1 The gap between western healing and indigenous knowledge:

Firstly, the existence of nine (9) clinics and a district hospital in Bomvaneland has been seen by people of this area as both a blessing and a problem as the health workers of these two health systems had a tendency of marginalizing the practice of indigenous knowledge and the older Xhosa women who practice their indigenous healing normally do so in private. Clients are reluctant to mention any other form of alternative care that they may have used before visiting the Community Health Centres (CHCs). The notion is that the older Xhosa elite woman has a fear of being chastised by the health care professional and being accused of practicing muthi that would result to increase the health ailment from minor to major sickness. The negative attitude and the secrecy of practicing indigenous health knowledge build a gap between the western healing and the indigenous healing. The former regards itself as the better way of healing whereas the latter is regarded as backward and worsening the ailment of the clients.

3.2 The different lenses and approaches used by both indigenous and western medicine in identifying health and illness:

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Secondly, the complexity of understanding indigenous health and that indigenous people have a concept of health that is eco-social and often communal, rather than individual. This has several implications for indigenous interpretation and understanding of social health determinants. For example, many indigenous peoples have a complex socio-cultural and spiritual relationship with their lands and the ecosystem and isolation or destruction of land is not just a question of a change of location or occupation, but a profound socio-spiritual change with consequent health implications. In addition as it is confirmed by Bradshaw (2008), it is important to understand that the very definition of indigenous is substantially socio-cultural. It includes elements of identity that may also be classed as important determinants of well-being. This also means that being isolated from aspects of this identity may have direct negative impacts on health. In other words self and group identity may be important social determinants of indigenous health. Since from the older Xhosa women of this area by the time you see sickness, the disease has been festering for some time and to them the main cause of disease is in fighting and broken relationships. To the older women of this area the existing bio-medicine is not approaching sickness and disease from this perspective i.e. by also investigating and identifying the cause of illness and finding mediating factors in this regard; to them this is a problem.

3.3 The lack of institutional spaces where both Indigenous Health Knowledge (IHK) and Biomedicine could be discussed:

Thirdly, the lack of institutional spaces where both Indigenous Health Knowledge (IHK) and Biomedicine could be discussed for promoting wellness and quality of life is a paucity in the health system of this area. Similar to Bodeker (1999) and Mishra et al., 2003 thinking, the influences of education and religion that do not respect the essence of one's cultural existence and, to this community the cultural identity of what makes one a Bomvana is very important. There further appears to be a general neglecting of the contribution that young people of Bomvaneland can make to their own culture. Instead, once the youngsters finish their schooling locally, they tend to leave the villages for the cities. Those left behind either ignore the Bomvana culture or chastise those who appear to be aligned with it. The lack of a critical mass for the development of the Bomvana culture is a threat to the continued existence of indigenous health knowledge in this area (Mji, 2012).

3.4 The need for the dissemination of Mji's research findings:

Lastly, Mji (2012) presented critical research findings from her PhD study on the indigenous health knowledge carried by older Xhosa women on the management of health problems in their home

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situation with focus on indigenous health knowledge. Within a community-based participatory research approach, The researcher used the dissemination process of these research findings as an activity to initiate the process of developing community health forums with the goal of clarifying roles and pathways of care with regard to the management of health problems (social health determinants, minor health problems and major health problems) including the rural health model that was suggested by Mji (2013). These four critical aspects have stimulated the researcher to explore the development of CHFs as a bridge that could improve the understanding between indigenous health knowledge holders of this area and health professionals from the district hospital and the 9 clinics with the goal of improving communication between service providers and people from the area.

4. Motivation and rationale for the study

All cultures and races of people have particular knowledge systems that are embedded in their ways of being and existing (Maila & Loubser 2003). They further assert that the culture of the people is equally its civilization and carry its indigenous and as well as its modern knowledge systems. This is not different in Africa as well as in South Africa. Studies in Africa and South Africa have indicated that indigenous knowledge as well as bio-medicine have been practiced and existed in our communities although they both have been practised in parallel to each other.

In the study conducted in Tanzania by Mbwambo et al., 2007, they argue that traditional and allopathic or conventional health care systems have coexisted since colonial times but operating in parallel circles although their main objective is to serve the same people. Colonialists, with their intension to rule Africa had to find a way to discourage all sort of activities which would have provided an opportunity for developing Africans. The whole process was calculated to ensure that the key features of African culture were captured and eroded and hence dis-empower the Africans. Traditional Health Practitioners (THPs) used to play vital role in the doctrine of chiefdoms that existed during pre-colonial era. They were part of the ruling system assigned specifically to advise the chiefs on social and health wellbeing of their communities.

Colonial masters equipped with education and religious beliefs, brainwashed the African elites, which later led them to despise Traditional Medicine (TRM) and the role of traditional health care system that was embedded in the African traditional culture. This attitude allowed for penetration of foreign culture marking the beginning of mismatch between African traditional medicine and the orthodox or western-style medical care system and hence creating gaps between the two health care systems. The

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negative attitude towards traditional medicine and her practitioners created during the colonial rule is however, still lingering in many African scientists even today.

This view above is even confirmed by Mulaudzi (2001) in her South African study on synergy between indigenous knowledge systems, modern health care system and scientific research which is a vision for the 21st century. She talks about this integration of South Africa into the global community to be considered as an indication that South Africa and other Third World countries have to learn and adopt the so-called global standards. However, she says that the time has come when the world is challenged to acknowledge the significance of African medicine. This acknowledgement has greater implications in the development of a new paradigm shift in the culture of health care and nursing. Accordingly, a South African approach in this sphere should be guided by the perception of the clients around health issues, e.g. illnesses and health problems and the treatment thereof as well as care giving.

While not undermining the contribution of western medicine, the power of African medicine has led to the birth of new conceptualisations in medicine. As a result, one of the subjects of focus in primary health care is how to establish a synergy between indigenous knowledge systems, modern medicine and scientific research. The new paradigm questions the predominance of western medicine over the years. In agreement, Airhihenbumwa (1995) points out that health promotion and disease prevention practices continues to operate under the strong and direct influence of the westernised medical model. He argues that although benefits are derived from such influence, it seems unquestionable that a profession that anchors its reason in the ability to influence human behaviour has consistently undermined and in most cases ignored the centrality of culture. Mulaudzi (2001) advocates for a synergy that could be the interaction of the two existing knowledge so that their combined effect is greater than the sum of their individual effects.

The argument by Mbwambo et al, 2007 & Mulaudzi (2001), is confirmed by one of the key informants a Chief residing in the study area where the Chief believes that the Christian religion, education and the health have weakened and eroded the Bomvana culture and their indigenous health knowledge (IHK) in the 18 villages of the study area. The three aspects have a clear institutional presence amongst the 18 villages of this area, in the form of the hospital and the nine clinics, the Dutch Reformed Church, and over 20 primary and high schools present in the area. None of the institutions according to the Chief draws its underpinnings from the Bomvana culture and their indigenous knowledge systems. Instead, it appears that each one attempts to erase from the minds of the Bomvana people their own culture and the knowledge they have learnt from the cradle of their homes.

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The existence of Public Health Care Centres (PHCCs) should be viewed as an addition to improve the quality of health of the people of this area. The role of PHCCs is to provide health care that does not marginalize communities irrespective of their education level. PHCCs must ensure that the health system is improving the health of all in an equitable, accountable, and affordable manner. This can only be ensured by involving community members in health-related issues because they are the people who have a better understanding of practices in managing minor health ailments within the homes where the older Xhosa woman plays a pivotal role as first line practitioner in the home environment.

The importance of developing CHFs would assist the researcher, her team together with the stake holders to begin taking action in the community by linking the community with the health institutions existing in the area (9 clinics and a district hospital) and vice versa. The formation of CHFs would assess the community needs and resources. In this regard the forums would develop a plan for identifying local needs and resources and also identifying community assets. Through planning, CHFs would develop a framework or model of change by creating strategies for the action plan. Since this study has identified a need for developing CHFs on issues that the community care about and it is time to act and respond to those issues by creating a platform where dialogue between the community and health care providers can happen. This involves mobilizing people around the effort of contributing to solutions about strategies to reclaim their health and well–being and implementing some sort of intervention with them participating in that intervention process. The implementation of the intervention would include developing such an intervention, increase participation and membership and ultimately conduct a direct-action campaign.

From the onset of implementing CHFs, it is important to monitor and evaluate what the CHFs are doing and adjust as necessary. After the evaluation process has been completed, sustainability of the CHFs is of vital importance. There should be strategies for sustaining the CHFs and planning for long-term goal of these forums. It is hoped that the CHFs would uncover and integrate both biomedicine and IHK including the levels of care (home, clinics and hospital including other levels of community-based health care services) that this health knowledge can be used. The CHFs would also assist the people by providing necessary support and creation of advice; provide solutions especially in cases where a person falls sick in the middle of the night where there is scarcity of paramedical vehicles to transport a sick person to the nearest public health care centre. The intention therefore for this study is to bridge

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the gap between the existing health knowledge and practice in these villages with the goal of improving the health and well-being of the AmaBomvana people.

5. Critical Research Questions

The questions are divided into main question and sub-questions:

5.1 Main question

How can the development of Community Health Forums improve communication channels between the district hospital, the 9 clinics and the indigenous community of Bomvaneland?

5.2 Sub-questions are as follows:

What are the critical research findings that emerged from Mji's study that require dissemination and consensus agreement?

What are the communication channels between health care providers and the community?

How can a bridge be developed between biomedicine and IHK existing in this area?

What type of communication model will emerge from the process of developing CHFs?

6. Aim, purpose and objectives

The main aim of this study is to explore the development of Community Health Forums (CHFs) as a strategy to improve communication between biomedical health professionals and an indigenous community.

The main purpose of the study is to improve the health and well-being of the AmaBomvane people.

Objectives of the study

As this is a participatory action research it is envisaged that the researcher will share and discuss the objectives of this study with the study participants. During this discussion, these objectives might change and one or two extra objectives might be added to the study objectives. The first objective will be used to open and facilitate this discussion focusing on Freire (1968) approach of enquiry and the reflective cycle of PAR methodologies (Bergold & Thomas, 2012 and Gelling & Munn-Giddings, 2011). The objectives of the study are divided into short-term and intermediate-term.

Short-term objectives are to:

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Explore the development of partnerships with the community key stakeholders through community entry.

Disseminate and explore consensus agreement on Mji's critical research findings on the indigenous health knowledge and use a community-based participatory action research cycle to implement and improve these study findings.

Participate with the study participants in exploring and describing existing health care providers in the study area.

Engage with the study participants in describing the existing communication channels between health care providers and community.

Intermediate- term objectives are to:

Engage with the study participants on the idea and process of developing CHFs with the study sample.

Engage with the study participants in describing and developing a model that maps out how communication channels and CHFs will function as a bridge between health care providers and community.

Discuss with study participants indicators for monitoring and evaluating the newly formed CHFs and communication channels.

Pilot the model in 4 chosen areas.

Recommend a model on how the development of Community Health Forums (CHFs) can be used as a strategy to improve communication between biomedical health professionals and an indigenous community.

7. The conceptual framework and significance of the study

This study is proposing how the development of community health forums can be used as a strategy to improve communication between biomedical health professionals and an indigenous community. The conceptual framework of this study would be based on Kleinman's model and the community-based models (Mji, 2013). The three arenas that Kleinman mentioned are the popular, the folk and the professional. The *popular* arena is known as the lay, non-professional domain of the society, where ill health is first recognized and defined, and health care activities are initiated. The popular arena within the CHF can be seen as the older Xhosa women who would play a pivotal role as first line

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practitioners in the home environment. The older Xhosa woman manages and treats the ill person at home where the ill is not physically removed from their familiar surroundings with the support of the family and to a larger extent the community.

The *folk* arena is defined as certain individuals who specialize in forms of healing that are either sacred or secular, or a mixture of the two. These healers are not part of the official or public medical system, and they occupy an intermediate position between the popular and professional arenas. Most folk healers share the basic cultural values and world view of the communities in which they live, including beliefs about the origin, significance and treatment of ill health (Kleinman, 1980). The folk arena within the CHFs would be the elite older Xhosa women, herbalists and traditional healers. Elite women are other older Xhosa women in the community with higher IHK and are consulted by older Xhosa women when their health management strategies have failed within the home situation. Herbalists and traditional healers are also consulted by the older Xhosa women when at times are unable to manage the Minor Health Ailments (MHA) at home. The healing of the ill person is sometimes conducted within the home environment or in the community but not far away from the family support.

The *professional* arena comprises the organized, legally-sanctioned healing professions, such as modern Western scientific medicine. It includes not only physicians of various types and medical specialties, but also the recognized allied professions such as nurses, midwives or physiotherapists. Healers in this arena have the power to question or examine their patients, prescribe powerful and sometimes dangerous treatments or medication, and deprive certain people of their freedom by confining them to hospitals if they are diagnosed as psychotic or infectious. When consulting a professional, the ill person is removed from family, friends and community, at this time of great personal crisis. Patients undergo a standardized ritual of “depersonalization”, and become a numbered “case” in a ward full of strangers. The relationship of the health professionals with their patients is often characterized by distance, formality, brief conversations, and often the use of professional jargon (Jansen, 1973).

The three held arenas in Kleinman’s health belief model are similar to what is happening in the study area but Kleinman did not explain how the three arenas would work together and complement each other, hence this study. It was noted that rural South Africans swing between the three arenas, due to a lack of availability of health services. Maelene, 2002 and Liddell et al., 2005 were drawn for a review of African health belief model. Maelene (2002) explains that traditional Africans do not believe in chance, bad luck or fate. They believe that every illness has a specific intention and a cause. This

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was supported by Liddell et al, 2005 in his description of three categories of illness in Sub-Saharan African culture. These authors emphasise the need to consider African beliefs and practices when dealing with rural African people (Mji, 2013).

This study then would explore the development of CHFs that would be a bridge between the arenas that have been stated by Kleinman. CHFs would determine how communication channels can be described and improved between the two existing health systems (IHK and Bio-medicine). Another important model that will be used in this study is the asset model. The asset model is an approach that uses embedded assets within the communities to determine and improve health systems. In this model, people jointly identify problems, as well as the assets that exist to solve these (Morgan & Ziglio, 2007). For example, the CHFs would consist of key stake holders (chiefs, community leaders, traditional healers, herbalists and older Xhosa women), people that have a vital role to play in the upliftment of quality of health in their area. In this way the esteem of individuals and communities is stimulated, and this leads to reduced dependency on professional services.

The contribution of the study especially the invaluable knowledge from these older Xhosa women would be a benefit in modifying health care policy for a multi-cultural and dimensional society. It is hoped that the results from this study could be an introduction of culturally-appropriate health science education programme which could assist in the revival of the AmaBomvana culture and their IHK.

8. Researcher's stance

The researcher chose the study because of her career background since she has worked in community projects around Cape Town especially in the informal settlements. In this study the researcher will engage with community stakeholders to identify a need for developing CHFs. These CHFs would create a platform where dialogue between the district hospital, the 9 clinics and the indigenous community can happen. It is evident from the study that has been conducted in the area that there is lack of communication between bio-medicine and indigenous knowledge that seem to exist in Bomvaneland. The bio-medicine and the indigenous community seem to operate in opposing directions whereas they have a common goal of health and well-being of Bomvana people.

There are concerns regarding both bio-medicine and indigenous health knowledge on how each knowledge provides health care to its users. In relation to bio-medicine, the medical language that is used is not user friendly and is not easily nor readily explained to health users. According to Jansen

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(1973) the relationship of the health professionals with their patients is often characterized by distance, formality, brief conversations, and often the use of professional jargon. It appears that bio-medicine has failed to treat individuals as human beings with minds, emotions, and spirits and this can result in the denigration of systems or viewpoints that attempt to address these facets. This can be seen in the manner in which the medical and scientific establishments have looked down upon treatments and technologies not developed by their method (Waldstein and Adams, 2006).

Another limitation is the reliance on, and belief in, the scientific method as the sole source of information and the directing force for innovation (Ngokwey, 1995). By focusing only on those aspects or facets of individuals and diseases that can be measured, observed, or reproduced in a laboratory, a large blind spot emerges in which the medical model has nothing, or little, to contribute when considering the individual as anything other than a collection of parts.

With the indigenous knowledge there is concern about its vulnerability where this knowledge is under threat because it is carried by word-of-mouth from generation to generation. However, WHO acknowledges dearth of information and documentation on practices and utilization of different health care systems in the world today and especially for traditional medicine and for some of the complementary and alternative systems of medicine (WHO, 2002). Traditional Medicine (TRM) has attained increased international popularity and demand but yet its efficacy, safety, quality and practice have not been thoroughly well established. This set back has become major concern for both health authorities and the public in general. Therefore, WHO has been strategically advocating worldwide for scientific validation of TRM with regard to efficacy, safety, quality and its practice. WHO 2002-05 strategy on TRM was formulated specifically to address issues relating to policy, safety, efficacy and quality, access and its rational use globally.

The safety, efficacy and quality of the methods used in traditional healing is also mentioned by one of the Chiefs in Bomvana where he suggested a backward and forward approach a development strategy to be used when a modern concept has emerged. He said, before its implementation, that there is a need to connect the concept with the older traditional concepts to determine what should be integrated and what should be left behind, because of lack of relevancy to current development (Tinky – Penny in Mji 2013). This view of the Chief is supported by Mbwambo et al., 2007 that there should be deliberate efforts directed towards increased awareness and advocacy on TRM to the public, policy-makers, researchers, THPs and end users through mass media, tailored radio/television

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programmes, flyers and other educational materials to ensure the two health care systems find a way to complement rather than competing with each other.

It has also been a concern that there seem to be an influence of foreign knowledge in indigenous communities as indicators that can lead to the evolving of IHK and to have a direct impact on this change (Fabrega, 1997 & Ngokwey, 1995). Hence there should be a revival of this knowledge to assist indigenous people to guard against completely letting go of IHK because of foreign entries which lead to rural communities becoming undecided about what to learn. The researcher would then use an approach for this study to both explain and understand the gap that exists between bio-medicine and indigenous health knowledge. This would allow the researcher to think about what kind of knowledge is valid and how the research team and the research partners would make sense of this existence and reality. This approach will include methods such as interviews and group discussions with the sample size that is discussed in detail in the section of study sampling where the research team would be present during these engagements. Any difficulties and potential limitations during this process would be discussed by all the research partners in relation with the proposed research objectives.

9. Study Methodology

9.1 Study Design

The research design for the study would be built around four distinct features of methodology namely: exploratory, community-based participatory action research, ethnography and qualitative reflective research. The selection of these designs is purposeful because they are not seen in isolation but are interlinked and relating to each other. The use of such designs allows the research team a platform to engage, collaborate and explore with participants in their natural setting. Although the study will be using these designs the main design will be the qualitative method because the research study will engage with indigenous communities in their natural setting, with PAR as an approach to assist the process of engagement between the research team and the stakeholders in the research area.

9.1.1 Exploratory study design

Exploratory research intends to explore the research questions and does not intend to offer final and conclusive solutions to existing problems (Babbie, 2007), hence this methodology is regarded to be descriptive in nature. Conducted in order to determine the nature of the problem, this type of research is not intended to provide conclusive evidence but helps us to have a better understanding of the problem (Cargan, 2008). When conducting exploratory research, the researcher ought to be

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willing to change his/her direction as a result of revelation of new data and new insights (Saunders, Lewis & Thornhill, 2012). Therefore, exploratory research is used to define and/or clarify a problem and subsequent research is expected. Exploratory study designs are essential when breaking new ground because they afford space for reflection about events and facilitate the probability of yielding new insight and understanding of the area in the research process (Cargan, 2008, Babbie, 2007, Somekh & Lewin, 2005, Katzellenbogen et al., 1987).

There are 4 ways to implement exploratory research into a research plan; namely: focus groups, secondary research, expert surveys and open-ended questions. Focus groups discussions which will be the focus of this study continue to be one of the most common uses of exploratory research, providing researchers with a great foundation on where people stand on an issue. The open and natural discussion format of focus groups allows for a wider variety of perspectives in a shorter period of time. Secondary research such as the research that was conducted in KZN about CHFs will be reviewed for all research strategies and learn from their results. The community engagement and consultation with the relevant people for this study (traditional leaders-sangoma and/or herbalist, older elite Xhosa women, religious leaders, health practitioners) will allow the research to gain information from specialists in a field that the research team is less qualified or knowledgeable in.

In Mji's study, the IHK carried by older Xhosa women in their care of health problems within the home situation has been described. And most importantly an attempt was made to present the interpretation of these practices through the eyes of the older Xhosa women (Mji, 2012). The older Xhosa women and the elite women are the carriers of the IHK this study seeks to disseminate critical research outcomes that emerged from Mji's study with the goal of engaging with the community in gaining a consensus on these findings and explore from participants existing communication channels between the community and health facilities in this area.

9.1.2 Community-Based Participatory Research (CBPR)

The term 'community participation' is commonly understood as the collective involvement of local people in assessing their needs and organising strategies to meet those needs (Zakus & Lysack, 1998:1). Community-Based Participatory Research (CBPR) approach is qualitative in nature. CBPR methods are geared towards planning and conducting the research process with those people whose life-world and meaningful actions are under study (Coghlan & Brannick, 2014, Reason & Bradbury, 2008). CBPR is intended to result in some action, change or improvement on the issue being

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researched (Bergold & Thomas, 2012; Gelling & Munn-Giddings, 2011). CBPR is a collaborative at every stage, involving discussion, pooling skills and working together and a partnership approach to research that equitably involves community members, organizational representatives and researchers in all aspects of the research process (Altman, 1995; Israel et al., 2001). Partners contribute their expertise and share responsibilities and ownership to increase understanding of a given phenomenon, and incorporate the knowledge gained with action to enhance the health and well-being of community members (Israel et al., 1998a; Padarath & Friedman, 2008). CBPR involves conducting research that recognizes the community as a social and cultural entity with the active engagement and influence of community members in all aspects of the research process (Hatch et al., 1993; Schulz et al., 1998a).

Community participation is widely accepted as a desirable feature of any health system and is considered to be an important aspect of developing and fostering effective governance at various levels of the health system (Paradath & Friedman, 2008). CBPR allows the study sample and the researcher to be equal partners in terms of the decisions that would affect the development of the CHF. Using the exploratory method the researcher will facilitate problem solving and bringing change through a process of collaboration which will be driven by stakeholders of the Bomvaneland (Gelling & Munn-Giddings, 2011). CBPR work will be captured using a diary and fieldwork notebook and all data will be analysed. For the purpose of this study CBPR would be conducted by proposing seven phases that would be explained into details under the section of data collection.

9.1.3 Ethnographic study design

Ethnographic research is both a study of interactive strategies in human life and analytical descriptions of social scenes, individuals, and groups that recreate their shared feelings, beliefs, practices, artifacts, folk knowledge, and actions (Mayan, 2009, Hammersley, 2006, Foley & Valenzuela, 2005). In other words, it is both a process and product of describing and interpreting cultural behaviours. Ethnographic study design methods will be selected to ensure that a suitable approach will be utilised to explore and describe the study setting, sampling strategy and methods of data collection. The way ethnographic methodology will be used in this study is within an exploratory participatory, descriptive qualitative paradigm.

The researcher will try to understand the participant culture (ethnographic) from the point of view of the people who inhabit and inherit that culture. The human community, as opposed to the rest of the environment, is seen to have social characteristics that are the product of the interaction between its

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members. It is assumed that the features of social organisation that are significant in community life are known to its members and discoverable by the investigator (Miles & Huberman, 1994; Rubie & Babbie, 1993; Marshall & Rossman, 1995).

An ethnographic study requires a close examination of the context in which the participant culture lives, to discover and understand how this has influenced the actions of the participants. In December 2014, the researcher has stayed with the Bomvana people to observe their culture. This experience has allowed the researcher to be embedded within this culture to understand and be sensitive towards practices by the Bomvana people. Because of this, different ethnographic research methods will be used in this research study to collect data, such as: FGDs with the study sample, in-depth interviews with key informants, participant observation, audio-recording and journal documentation (using diary and a notebook).

9.1.4 Qualitative reflective research design

The qualitative design will be the over-arching approach for this study because both exploratory and ethnographic methodologies in community based participatory action approach are to explore from participants their understanding and interpretation of their lives and the health challenges they face (ethnographic) and creating solutions on how to work together to improve the health status and indicators of the community (community based participatory action research). The primary goal of qualitative research is to interpret and document an entire phenomenon from an individual's viewpoint or frame of reference (Denzin & Lincoln, 2011, Ortlipp, 2008). Etherington (2004) and Irvine & Gaffikin (2006) contended that researchers who employed qualitative research sought deeper truths while aiming to study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings that people bring to them.

Similarly, Ortlipp (2008) and Etherington (2004) maintained that qualitative researchers aspire to uncover the world through another's eyes, in a discovery and exploratory process that is deeply experienced. Qualitative features of the individual's feelings, views, and patterns are revealed without control or manipulation from the researcher (Leininger, 1985 & Willis, 2007). The researcher would be aware of her bias and maintain objectivity to ensure the authenticity of the data collected. She would be mindful of the sample's viewpoint and keep references and records all the time. The engagement and the consultative manner with the various stake holders would allow the researcher to reflect on the outcomes of the study.

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9.2 The study setting of the research

The study will be undertaken are in the district of Elliotdale in the Eastern Cape Province of South Africa. Elliotdale lies between Umtata and East London and between Umtata and Bashee River in the South West and Xhora River in the East (see Figure 1). Part of the Mbhashe municipality lies directly on the Wild Coast of the Eastern Cape. Enclosed by the boundaries of the sea and the two rivers, the area stretches inland for about 18 miles. The people that reside in this area classified as the AmaBomvana tribe. This area is sometimes called Bomvaneland. The AmaBomvana tribe spreads over two thirds of Elliotdale district and includes the neighbouring Mqanduli district. Bomvaneland has numerous rolling hills, meadows, rivulets and rivers where bushes and trees grow. The roads are gravel with *dongas* (large potholes) that make travelling by car difficult. Spring and summer rains bring reasonably high rainfalls that assist subsistence farmers with green pastures and with grazing fields for stock (cattle, sheep and goats) as well as growing mealies (maize) and vegetable for family use (Mji, 2013).

This district is purposefully chosen for the study to implement the research objectives and the critical research outcomes that emerged from Mji's doctoral thesis with the goal of developing CHFs. There are various layers of the study setting namely; the 9 community areas with their clusters of villages and with a residing Chief and Chieftains for each cluster; the 9 clinics that have cluster of villages linked to each clinic and the secondary hospital.

9.3 Sampling of the study setting

The study sample would be derived from four clusters of villages namely; Hobeni, Madwaleni, Nkanya and Xhora. These four clusters of villages represent some of the villages in the Mbhashe municipality with some village cluster closer to the hospital and others being far away. The purpose of choosing such villages is to gather information relating to accessibility of the hospital as the point of referral and establish whether the distance plays a role in accessing health care services. The relationships that have been developed between the health professionals that are delivering health services in this area and the villages that receive health services from the secondary hospital and the four clinics.

9.4 Study sampling

The study sample would be drawn from the clusters of villages of Hobeni, Madwaleni, Nkanya and Xhora. The researcher will purposefully divide the study sampling into two groups namely the Imbizo and the Amakhosikazi Akomkhulu (women from the chief kinship) to allow women a platform to freely

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voice their concerns in the absence of their male counterparts/figures. The chief from the respective villages would be in the forefront to organise an Imbizo with the assistance of the chieftains and Imbizo would be predominantly males namely from aged +60 years, the middle-aged, the youth, traditional leaders (sangoma and/or herbalists), religious leaders and key stakeholders such as educators from the schools, health care workers from the clinics and the hospital.

The study sampling that would be represented by the Amakhosikazi Akomkhulu would be predominantly women from the older women (+60 years), middle-aged, the youth, elite women, traditional and/or herbalists, religious leaders, educators and clinical nurse practitioner from the clinic and the district hospital. There are indicators that there is a split in the youth of this area because of English usage by some youth in the community. The youth that express themselves in English are regarded as modern and then they are beaten and insulted by their counterparts who still maintain and use their traditional/indigenous language. The researcher will enhance a working relationship where the youth will be represented in the sample and also negotiate communication channels that will not undermine differing views. It is expected that snow balling techniques will also be used as a sampling strategy as the researcher continues to engage with key informants and consensus agreements will be developed on who to include as part of the engaging team.

9.5 Researcher’s community entry and development of community partnerships

The researcher would meet with the Chiefs of the clusters of villages that are linked to the clinics. And get permission from them to implement the study, share ideas and establish whether a Community Health Forum does exist in these areas and how to strengthen it if it does exist. An explanation to the outcomes of Mji’s study would be tabulated; ask for suggestions on how to disseminate Mji’s study findings. And finally present to the Chiefs the facilitation process to develop the Community Health Forum. In a participatory action research cycle, the chiefs’ response to the methodology would be used to further improve the methodology of the study.

Each chief would then gather people in the form of *Imbizos* where the community leaders and other dominant people in the community discuss pertinent matters regarding the social sphere of the community. Imbizos are the meetings that are attended by chieftains and other community leaders where the chief resides and are chaired by the chief.

9.6 Data Collection Process

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The researcher intends to engage with key informants in the early stages of the research with regard to some reflection about appropriateness of the methodology. Consensus collective agreements will be developed for shared responsibilities with the participants. Interactive cycles of planning including action, observation and reflection, revised planning and renewed action will be done (Bergold & Thomas, 2012 & Gelling & Munn-Giddings, 2011). Freire (1968) approach of enquiry and the reflective cycle of CBPR methodologies Bergold & Thomas (2012) whereby the researcher envisaged that they will be a process reflection on the health situation of the AmaBomvane people, why it has deteriorated and what can change this status. Data collection would then proceed along the following four main lines namely; the Imbizo data gathering instruments, training of research assistants and data collection procedure. Workshops will be conducted to speak about the use of the herbs and address issue of healthy versus unhealthy, dangerous, alternative, unconventional methods of poor practices. And these workshops will be directed to sangomas, traditional healers, herbalists, older Xhosa women and elite women.

9.6.1 The Imbizo

The chief would be the point of entry for each cluster of villages. The researcher together with the help of the two research assistants would approach the chiefs from each cluster of villages to organise an Imbizo which would include the study sample. The chiefs gather people in the form of Imbizos where the community leaders and other dominant people in the community discuss pertinent matters regarding the social sphere of the community and create solutions for community upliftment and health. Imbizos are the meetings that are attended by chieftains and other community leaders where the chief resides and are chaired by the chief. The Imbizo is dominated by males but the Paramount Chief of this area is a female and all male chiefs of Bomvane respect their Paramount Chief. This encourages the balance of power and discouraging the oppression of gender to gender.

9.6.2 Amakhosikazi Akomkhulu Forum

This is a meeting which is constituted by the wives of the chiefs, chieftain and other women leaders in the community, is chaired by the chief’s wife where the chief and his wife reside. The wife of the chief gather these women in the form of a meeting to discuss matters that women would be more comfortable to share with other women in the absence of their male counterparts. The outcomes of the discussion would then be presented to the chief and the chieftain in a report format. The chief, chieftains together with the representatives from the Amakhosikazi Akomkhulu forum would

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deliberate on the report outcomes and where a need arises amend some outcomes with the aim of implementing the report outcomes.

9.6.3 Data gathering instruments

The researcher would formulate an interview guide with semi-structured questions in both English and isiXhosa to gather data from the sample. The tool of research would consists of four sections that will include the following; a) summary of the key findings from Mji's doctoral thesis, b) discussion questions that would explore and describe heath care providers in these areas including the communication channels they use, c) determine whether CHFs exist and strengthen those, and in the absence of CHFs facilitate the development d) design a model through participatory action cycle. During this stage the research team would also gather data by using a method of participant observation, make use of journal documentation (diary and notebook) as well as audio-recording of significant events and these will be conducted with the consent of the study sample.

9.6.4 Training of research assistants

Two research assistants would be trained on the various aspects of data collection and both research assistants would be Xhosa-speaking and would be from Bomvaneland. In the initial stages of the study, the two research assistants would conduct discussions in the presence of the researcher. And as the study develops the researcher would assess when the two research assistants need further research training. The research training would be conducted in isiXhosa. The research team would discuss concepts and phrases that seem to be different from each area. There would be a written agreement that the research team would have a similar standard on asking pertinent questions.

9.6.5 Data collection procedure

The data collection procedure would proceed along the seven following phases namely:

Phase 1: Community entry and establishment of relationships

This is community entry where the researcher introduces herself, the research team and the research study to the various chiefs of the respective villages. Ask for the chiefs' permission to consult the relevant stakeholders (sample) for this particular research via Imbizo. An invitation to these Imbizos would be extended to community health providers, health professionals from the 4 clinics and from the district hospital.

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Phase2: Dissemination and obtaining consensus on Mji's findings

During the Imbizo the researcher would disseminate and facilitate a process of gaining consensus on the findings and addition of extra aspects that were not documented in the critical research findings from Mji's doctoral thesis as the foundation of this study since this is an implementation stage.

Phase 3: Asset mapping of health care providers

Through a CBPR cycle together with the key stakeholders, the researcher would explore, identify community-based assets such as indigenous healers and herbs, resources and availability of different health care providers in the study area (this includes IHK health care providers).

Phase 4: Establishment of communication channels

The researcher would find out from the key stake holders whether communication exist between health care providers of this study area and further establish which channels do these health care providers use to communicate.

Phase 5: Importance of Developing Community Health Forums

During this phase the researcher will explain and describe the process of developing CHFs as possible bridge between biomedicine and IHK and further develop a plan and gain input from participants with regard to the nature of these forums and how they will run. In the event where the CHFs are existing the researcher will then again ask the participants to paint a picture of the state of these forums and in a participatory interaction consensus should be reached on how these existing forums will be revived. The researcher will also suggest workshops on dangerous traditional practices which are seen as unsafe and unhealthy by the western knowledge.

Phase 6: Checking on process and progress

Methodology for checking the process and progress whether the developed CHFs are working and to make adjustments as necessary will be discussed with the CHFs with regard to how key activities of the village are checked for process and progress and a consensus will be reached between participating stakeholders. The engagement during this stage would be communicated and deliberated in consultation with the community when it seems that the CHF have failed to meet its goal of bridging the gap between the two existing health systems in Bomvaneland.

Phase 7: Sustain

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It is the responsibility of the CHFs to define the roles and responsibilities of each member for the long-term sustainability of the CHFs. The Rural Health model developed by Mji (2013) will be discussed as the last phase of research and together with the CHFs would engage with the Rural Health Model regarding its suitability for the management of health problems in Bomvaneland.

These seven phases would be replicated in the respective cluster of villages for this research study. And within these four areas the same methodology will be repeated. There will be similarities and differences although the four areas seem to be distinct; they are the same Bomvane people. Triangulation will be conducted in order to achieve saturation. Diary and fieldwork notebook will be captured and all collected data will be analysed.

10. Ethical considerations

The researcher would apply for ethical approval of the study with the University of Stellenbosch Health Research Evaluation Committee, Ethics Committee, Faculty of Medicine and Health Sciences and Department of Health in the Eastern Cape Province. Prior to the first phase of the Community-Based Participatory Research (CBPR) cycle, the researcher would explain to participants the consent form which will be translated from English into IsiXhosa a primary language of the study area. The researcher will diligently acquire the necessary skills and knowledge to implement the study design appropriately and rigorously to ensure trustworthiness of the findings. The process of explaining ethical considerations would be undertaken in all four sampled villages.

Consent to participate in the study within a CBPR study is quite complex and includes different layers of gaining consent (Bergold & Thomas, 2012 & Gelling & Munn-Giddings, 2011). For example, doing community entry and in the study-setting, gaining permission to conduct the study from the Chiefs will be the first layer of getting consent. During group discussions though each member of the group will sign a consent form, there will be a need for collective agreements and shared responsibilities on how the study will be conducted. In the case when the research conducted in these areas will be published the researcher will consult and discuss with the key stakeholders of Bomvane about the intention to publish the results of the study. The WHO/AFRO has been also promoting training involving traditional health practitioners, collaborations and researchers on Intellectual Property Rights (IPRs) relating to traditional medicine. Adeniji (2002) argues that it is important to empower people especially on issues relating to accrued benefit sharing and royalties in collaborative research involving researchers, communities and development partners.

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11. Quality Assurance

Strategies for quality assurance will focus on the strengthening of credibility, dependability and confirmability of data, and the transferability of findings.

11.1 Strengthening of credibility

The researcher would double-check the accuracy of transcriptions by presenting participants' viewpoints accurately and adequately. Selection of participants would be purposeful. All transcripts will be checked during field note-taking, themes and categories be organized during follow-up interviews. Verbatim quotes will be presented in the research report and observational data will be systematic by recording field notes in the field, audio taping and also using video recordings.

11.2 Dependability and confirmability of data

Peer debriefing would assist with the process of examining all documentation and processes, and this would act as an auditing process. The researcher for this study would review the raw data and analyse it, perform data-reduction and data-analysis products, data-reconstruction and data-synthesis products. According to Babbie & Mouton 2009, if the auditing process is managed adequately, it can be used to determine dependability and conformability.

11.3 Transferability of findings

Extensive field notes would be taken on the environment in which the study would take place. The notes would give the researcher an opportunity to compare observations with the researcher's original theoretical ideas and this process would allow the researcher to pick-up contradictions from the initial assumptions.

12. Data Analysis

This section provides an overview of data management and the methods of data analysis that will be used for this study.

12.1 Data Management

Data management is as crucial as data analysis. During the early stages of data management for this research study, the researcher would personally manage the data. All discussions with the stake holders will be recorded on a digital voice recorder and the data will be entered into a computer. Pseudonyms will be used to maintain anonymity and confidentiality. All files will be code-locked so as

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to prevent ant person from gaining access to the information (Weiss, 1998). According to Weiss (1998) in the case where there is only one primary researcher, it is important that he/she develops a systematic and consistent way of carrying out and analysing the research. And in the case where the research is being carried out by an entire team, developing a systematic approach and maintaining consistency throughout the process is essential to having good data. This would be applicable during this study when the researcher would be assisted by two research assistants.

12.2 Qualitative Data Analysis

The data analysis comprised of an informal ongoing stage of data analysis within data management, as well as a formal stage of data analysis.

12.2.1 Informal ongoing stage of data analysis within data management

This is the process of bringing order, structure and meaning to the mass of collected data. It is a messy, ambiguous, time-consuming, creative and fascinating process, and does not proceed in linear fashion (Westhues et al., 2008, Rubie & Babbie, 1993, Khanlou & Peter, 2005).

Qualitative data analysis methods will be utilised to analyse all the phases of data collection during this study. The researcher will organize and trace the outcome of each objective developing a systematic approach that is underpinned by the phases that the study will cover, ultimately a framework will emerge through the CBPR which will assist in answering one of the key research questions, which is how the process of developing CHFs as a bridge between an indigenous community and health care centres/providers in the area can assist in improving health of the AmaBomvane people (Miles and Huberman, 1994).

12.2.2 Formal stage of data analysis

This stage of data analysis is where the researcher tries to reflect on her own biases and tries to separate, drew boundaries before interpreting the data as to protect infection with her own assumptions. Transcriptions from both the Imbizo and Amakhosikazi Akomkhulu discussions would be read and re-read until the researcher comprehends what the discussions conclude. From the text, a list of significant statements expressed by the participants would be drawn up. These statements would be grouped into ‘natural meaning units’ (Denzin & Lincoln, 1998) expressed by the study sample. Where analysis of data is narrative, (Denzin & Lincoln, 1998) the process would involve the grouping together of themes. This process requires a substantial amount of intuition and judgment on

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the part of the researcher. The categories would be weighed against the research questions and subsequently further analysed and interrogated resulting in a process from which 'central themes would be determined' (Denzin & Lincoln, 1998). These units would be grouped and further analysed for similarities and differences to create clusters of themes. The categorization of common themes would unfold from the experiences of the participants. The aim is to assemble the essential, non-redundant themes and to formulate a descriptive statement which captures the essence of meaning units within the holistic context. This process assists in constructing biographies and could be understood as the second level of analysis.

The researcher would also keep and use reflective journals while conducting the qualitative process of this participatory action research study (Ortlipp, 2008). Researchers are urged to talk about themselves, "their presuppositions, choices, experiences, and actions during the research process" (Mruck & Breuer, 2003:3). This enables the researchers to make their experiences, opinions, thoughts, and feelings visible and acknowledge part of the research design, data generation, analysis, and interpretation process (Ortlipp, 2008). Keeping and using reflective research journals can make the messiness of the research process visible to the researcher who can then make it visible for those who read the research and thus avoid producing, reproducing, and circulating the discourse of research as a neat and linear process.

Gold (1997) maintains that in ethnographic and exploratory research, rather than relying on a preconceived framework for gathering and analysing data, ethnographers use their interactions with informants to discover and create analytical frameworks for understanding and portraying that which is under study. Early in the research process of this study, the researcher will develop an analytic strategy that will be an ongoing analysis throughout the different stages of the study. Hence, observation strategies will be adjusted, and the emphasis shifted, tested and re-tested to avoid bias. Categories that will characterise the Imbizo and Amakhosikazi Akomkhulu engagements in developing Community Health Forums will be identified. These categories, together with the selection of conceptually intriguing phrases from the audio-tapes, will assist in suggesting patterns. From these patterns, the researcher will then start to draw up tables based on the key themes of the study objectives. From these further key themes will start to emerge and the data will develop its own direction.

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APPENDIX F: Copy of Mji's critical findings

The critical aspects that underpin the health and sickness definition produced by the current study

Definition of health	Determinants of health	Definition of sickness	Determinants of sickness
Absence or presence of disease Healthy pregnancy and healthy children Food a key contributor of health to the home Presence of peace, happiness, wellness and support for one another in the village	Positive: Happiness and wellness Connected to ancestors and God Food production Production of Xhosa beer Negative: Presence of worry Subjection to being troubled by men/husbands Subjection to being troubled by children	Interpreted within a perspective that is both physical and emotional Absence of the following: money; sanitation; running water; and electricity Migration of adult children to work in the cities	Doing poorly at maintaining the following: body; spirit; children; mother; and other family members, due to: the absence of work; loneliness; the migration of children to the cities; substance abuse by children (smoking and drinking);and the inability to produce food and Xhosa beer No time for ancestral reverence

Using functionality as a yardstick for wellness

For the older Xhosa women in the study, like the Maori (42), by whom health was measured according to their participation in tribal activities, being included in family celebrations and the ability to make Xhosa beer for ancestral reverence served as a yardstick for wellness. (30,93–97) Being healthy

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entailed being fully engaged in the functions of the Amabomvane people. This is the yardstick that they used for measuring the health status of an individual in their villages.

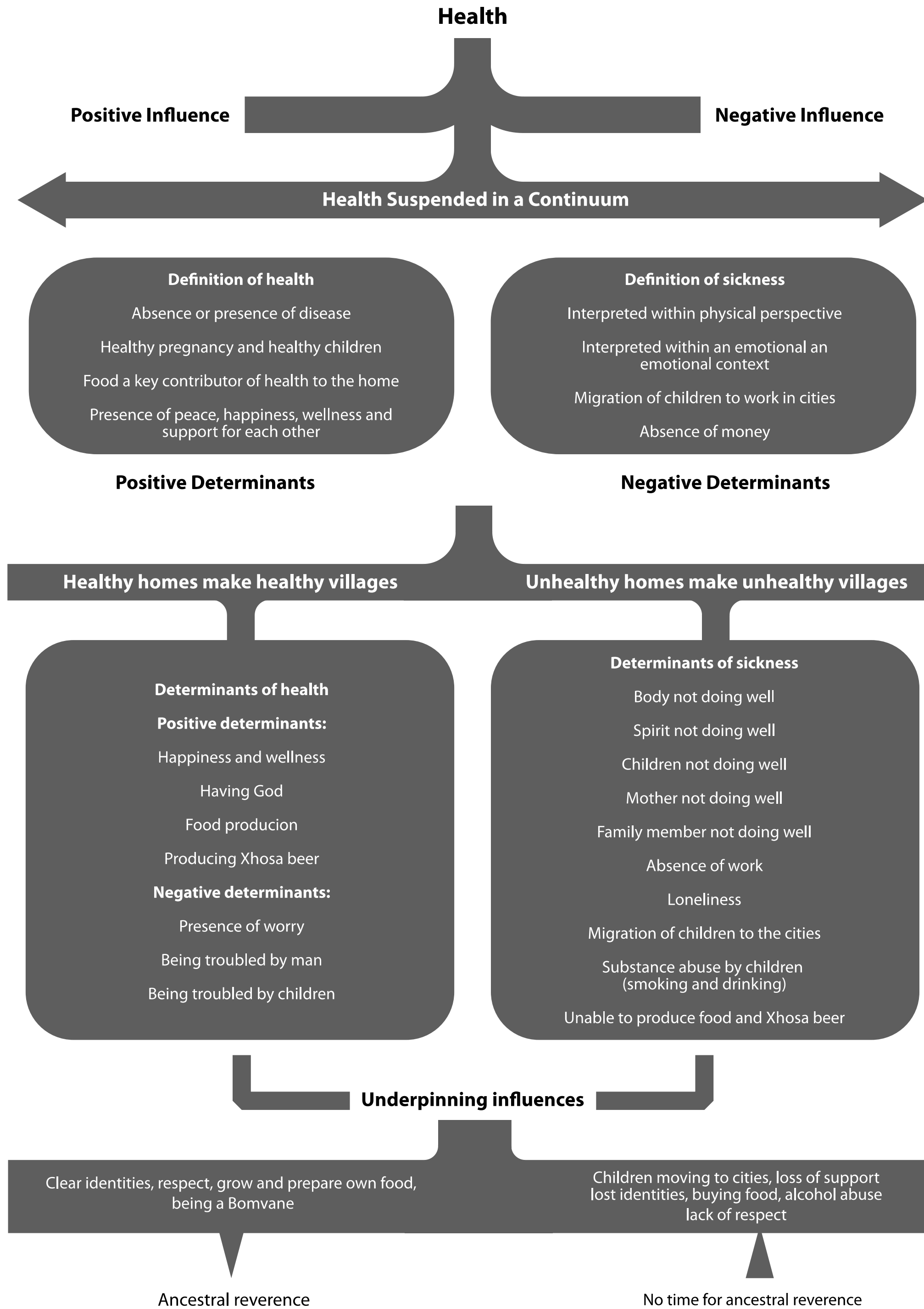

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Figure 6.1 The model of health and sickness from this study.

The health problems that are managed by the older woman within the home

The current study identified three categories of health problems that were managed within the home situation, which are:

social health problems;

minor health ailments that can be managed at home; and

other health problems that require referral outside the home.

The three categories are discussed below.

Social health problems

Globally, there is a problem regarding the implementing of PHC as a strategy in its entirety, especially in low-income countries, where it is most needed;(10, 11,12) instead, selective primary health care has been an interim chosen strategy. Such health care is mainly what is offered at present by the primary care services that are common in low-income countries and in such rural areas as the villages of Gusi. Not implementing PHC to its fullest has challenges of the revolving door syndrome, as social health problems that are commonly the cause of disease are left unaddressed. (17,18) Primary and secondary social health problems emerged from the findings in this study, as are outlined in Table 6.2 below.

Primary and secondary health problems identified in the study

Primary and secondary health problems
Primary social health problems
Lack of respect
Substance abuse
Alcoholism
Not planting and ploughing food
Poverty in households
Presence of struggle
Lack of peace and security.
Lack of motivation

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Unruly children
Money problems (financial concerns)
Absence of health
New diseases
Not brewing Xhosa beer
Making neither sufficient time nor resources available for purposes of ancestral reverence
Secondary health problems
Absence of work
No projects on which people can work
Absence of clean running water and sanitation
No electricity
Lack of money
Non-receipt of old age pension

List of minor health ailments that could be managed within the home

Facial pimples	Amaqhakuva obuso
First stool of an infant	Ituwa yokuqhala yomntwana
General cough	Ukukhohlela okungephi
Head lice	Intwala zentloko
Blocked nose	Umfinxane
Mouth blisters	Amandyunguza omlomo
Childbirth	Ukuzala
First baby rash	Ishimnca

A list of herbs and approaches used by the older Xhosa women to treat the health problems that they experienced within the home

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Umkhamelo; itshungu; inkondlane; umuncane; unogangatshange; umncephe; unohawuzela; mthene; mpinda; umsobo wehlathi; mafumbuka; amanzi olwandle; uthuli lengca; ubuhlungu; isichakathi; isikhikhi; ingxozela; tsasela; impuzi zethanga; ukuthonjiswa; umhlonyane; isindiya-ndiya; sampontshane; Imputshi yehashe; umthombothi; impepho; ityholo; amafutha ehagu; umafumbuka; isihawu-hawu; isivumba mpunzi; ixolo lo umnga

.

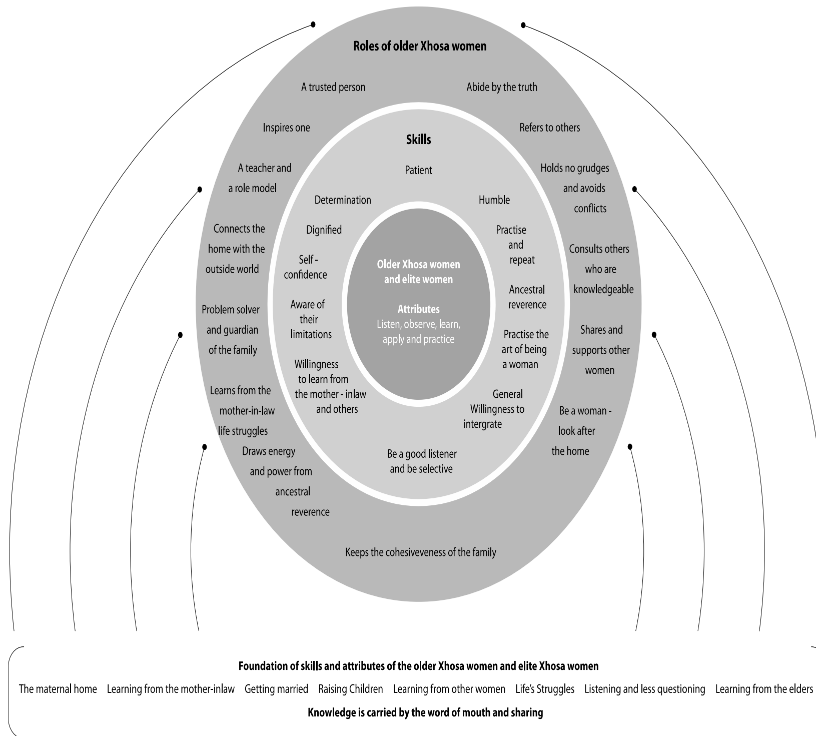

Figure 6.2 A flowchart showing the caring skills and attributes of the older Xhosa women

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The rural primary health care model envisaged for the 18 villages of Gusi

A rural primary health care model for the management of health problems in the 18 villages of Gusi

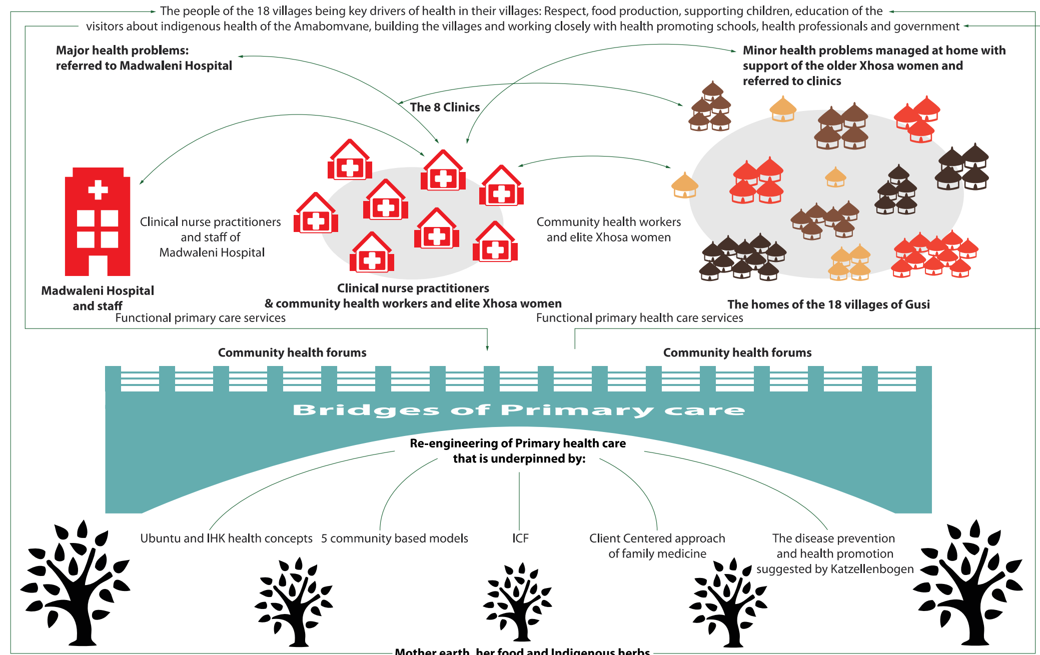

Figure 6.3: The rural primary health care model for the management of health problems in the 18 villages of Gusi

A brief description of the functioning of the rural primary health care model

The above-mentioned model envisages the following:

The people of the 18 villages of Gusi are the key drivers of the model.

The community health forums serve as a link between the various stakeholders,

The 18 villages of Gusi are responsible for the management of minor health ailments, social health determinants and the early detection of other health problems.

The eight clinics supervise minor health ailments and social health determinants, and help with the early detection of other health problems, with proper referrals.

The hospital provides prompt intervention in the case of other health problems and in the monitoring of the smooth running of the suggested rural primary health care model

Mother Earth, the sea and two rivers supply the people of Gusi with water, food and herbs, including grazing land for the animals.

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The external agents are the government, academics, researchers and international partners.

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APPENDIX G: Conference invite for 2016 conference and report

Let us all fight for our health

Conference on Indigenous Health Knowledge 1 – 2 July 2016: held at the Donald Woods Foundation.

Report from the Donald Woods Foundation, accessed 07/07/2016: http://www.donaldwoodsfoundation.org/marrying-western-medicine-with-indigenous-knowledge/

Marrying western medicine with indigenous knowledge

Dr Gubela Mji of Stellenbosch University leads a village elder to the Indigenous Health Conference at the Donald Woods Centre at Hobeni.

Almost 100 traditional healers, village elders, chiefs, community leaders and residents took part in an Indigenous Health Conference at the Donald Woods Centre at Hobeni over the weekend.

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Doctoral research undertaken in the area by Dr Gubela Mji, an Associate Professor with Stellenbosch University's Faculty of Medicine and Health Sciences, revealed that elderly Xhosa women use their extensive knowledge on a range of social and health issues to manage illnesses in their homes and the wider community.

The two-day conference was jointly hosted by the Donald Woods Foundation, Stellenbosch University and the University of Cape Town. It was aimed at reporting back to the Bomvana people on Dr Mji's research findings and providing a platform for the community to chart a way forward for incorporating local health concerns into rural health interventions.

Mji found that elderly Xhosa women do not view disease in terms of mere symptoms and their treatment but were of the view that each disease is linked to a wider social determinant, and such determinants must be included when considering the overall health of a community.

Managing health is "about the health of the home and not just about the management of disease. They believe that healthy homes make healthy villages, and that the prevention of the development of disease is related to the strengthening of the home," said Mji.

Xhosa women's health concerns include food security, healthy children and families, peace and security in their homes with anxiety and worry seen as the greatest threat and contributor to ill health in their communities.

"Worry is seen as the greatest negative contributor to ill health, with troublesome men and children being the greatest cause of worry," she added.

This concern was uppermost and was identified by participants during the second day of the conference when Hobeni community members convened to chart a course to address such concerns.

Following the event, Dr Mji said discussions had revealed a community in deep distress, with many social components such as unemployment, the absence of adequate sanitation, running water and electricity adding to the burden borne by rural communities.

"This includes social ills such as isolation and loneliness, substance abuse, the loss of traditional values among the youth (including the ability to produce food and traditional beer) and a loss of ancestral reverence."

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Mji said the conference had been successful in that it gave local residents a voice and it further highlighted the need that health professionals should take the deep knowledge and wisdom held in communities into account in the day-to-day provision of overall health care to ultimately foster meaningful well-being in rural communities.

Let us all fight for our health

Conference Invite:

Join us for a presentation and a discussion on research findings that emerged from a PhD study that explored indigenous health knowledge (IHK) utilised by older Xhosa women amongst the Amabomvane people in a rural research site in the Eastern Cape Province. The purpose is to pilot a rural health model that the previous study suggests which will promote the working together of the indigenous health healers and the community together with the health professionals within the health facilities.

We hope that the conference will start a dialogue with every stakeholder in this community to understand that health is bigger than a disease in an individual and that there is a need for a continuous community engagement that will address the social health determinants. We envisage a future where there is an interchange of both indigenous and biomedicine knowledges and assets towards the health and well-being of people and their communities.

Date: 1st-2nd July 2016

Venue: Donald Wood Foundation Conference Centre

Programme:

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Day 1: Friday, *1 July 2016*

09:00 - 10:00 Arrival and registration

10:00 - 10:15 Opening remarks: Associate Professor Gubela Mji and Dillon Woods

10.15 - 1030 Opening speech Paramount Chief Nobangile Gwebindlala

10:30 - 11:30 Presentation on Indigenous Health Knowledge research findings: Associate Professor Gubela Mji and Dr. Nondwe Mlenzana

11:30 - 12:00 Presentation on food security project: Professor Xikombiso

12:00 - 13:00 **Lunch**

13:00 - 14:30 Responses, discussion and way forward

14:30 - 15:00 **Closing remarks:** Dillon Woods

Day 2: Saturday, *2 July 2016*

The focus of this day will be on Hobeni Community to get responses from the previous day with regard to the implications of the findings to the Hobeni community.

9:00 – 10:30 **Item 1:** Focus group discussions with different age groups with regard to challenges they are facing and assets that they have to address some of their challenges.

Item 2: Prioritise issues to be engaged with

10:30 - 11:00 **Tea**

11:00 - 12:00 **Item 3:** Coming together as a group to share discussion outcome

12:00 - 13:00 **Item 4:** Identify key leaders for each focus area and develop a committee and way Forward

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13:00 - 14:00 **Lunch**

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APPENDIX H: Conference invite for 2018 conference and report

INVITATION TO

SUMMITT BETWEEN ELLIOTDALE TRADITIONAL HEALTH PRACTITIONERS & HEALTH PRACTITIONERS.

PURPOSE

SEEK TO FIND COLLABORATIVE EFFORTS IN HEALING THE SICK BETWEEN TRADITIONAL HEALTH PRACTITIONERS & HEALTH CARE PROFESSIONALS.

WHO'S INVOLVED

ALL TRADITIONAL HEALTH PRACTITIONERS FROM ELLIOTDALE & MADWALENI HOSPITAL AND ALL ITS FEEDER CLINICS AT EXHORA

DATES: 3rd and 4th July 2019 (08h00-15h00)

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VENUE: QATYWA HALL (NKANYA LOCATION – ELLIOTDALE)

COME JOIN US AS WE TRY TO UNDERSTAND EACH OTHER MORE; IMPROVE THE HEALTH OF OUR PEOPLE AND DEVELOPING BETTER WAYS OF WORKING TOGETHER

THANK YOU - RSVP

MAKUKHANYE TRADITIONAL HEALERS OF MADWALENI

MR TONGA; 0633962877

MADWALENI HOSPITAL MANAGEMENT

Ms MNYANDA-: 073096 8396

SUMMIT BETWEEN ELLIOTDALE TRADITIONAL HEALTH PRACTITIONERS & HEALTH PRACTITIONERS -

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PROGRAMME DAY 1

Program Director: Mr Thonga & Mrs Mnyanda

7:30- 9:00--- Arrival & Registration

9:15-9h30 Welcoming – Chief Ngubechanti)

9:30-9:40 - Indigenous opening Ceremony

9:40-9h45-- Purpose of the Summitt - Mr Conjwa

9:45- 9h50 – Introduction of guests (Traditional Healer & Health Professional)

9:50-10h00- Background of the Conference – Stellenbosch Researcher

10h00 -11h00 – Who are indigenous traditional healers & their work (expertise)

TEA TEA TEA 11h00-11h30

11:35-12h00 – What are Xhora DOH institutions; their roles; work and expertise

12h05- 12h30 -- Challenges faced by Traditional Practitioners at the face of Health Practitioners

12h35- 13:00- Challenges faced by Health professionals needing support from traditional practitioners

13h00- Closing remarks; way forward – (Stellenbosch- Facilitator)

1400- Lunch closure….

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DAY TWO (4 July 2019)

9:00- 9:15 Opening remarks

9:15- 9:45 How can we unite as "healers" and support our community? Report back from group discussions.

9:45-10:30 Program for collaboration

10:30-11:00 Tea & Coffee

11:00-12:00 Signing of the Memorandum of Understanding (MOU)

12:00-13:00 Closing remarks

13:00 – 14:00 Lunch - Closure

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APPENDIX I: Conference invite for 2019 conference and report

LET US ALL FIGHT FOR OUR HEALTH: MARRYING WESTERN AND INDIGENOUS HEALTH KNOWLEDGES

Indigenous knowledge about medicinal plants and managing or curing illnesses particularly in rural communities is rife with rapidly growing interest in health care systems throughout the world. Despite proven validity, accessibility, affordability and the value that medicinal herbs hold amongst various populations worldwide, this indigenous knowledge is still undermined and often criticized in favour of allopathic (bio-medicine). In recognition of the vital contribution of this indigenous knowledge in the field of health and in line with the World Health Organisation' strategy to address issues of policy and rational use of traditional medicine (WHO, 2002-2005), in 2016, Stellenbosch University together with Indigenous Health Healers and DOH, Elliotdale initiated a community of practice "marring western and indigenous health knowledges". This article reports on a recently held conference (July 3-4, 2019) in Madwaleni Xhora/Elliotdale with the theme: Let us all fight for our health. The main goal of the conference was to forge a way forward on how Western Medicine can reconcile and work together with indigenous healers.

Western medicine, although changing through policies such as universal coverage through a primary health care approach, it is still largely institution based and focusses on diagnosis of diseases, treatment and cure. Minimal attention is placed on promotion of health and it is disconnected from the land, plants and animal. In contrast indigenous people's concept of health and survival is both a collective and individual inter-generational continuum, encompassing a holistic shared dimension of life that includes the conservation of people, plants, animals and the land. By breaking the interconnectedness of life, a fundamental source of disease erupts and can progress to different

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stages of illness, and due to the fact that disease has found fertile ground (the broken interconnectedness) it can spread to epidemic levels.

Doctoral research undertaken in the area by Dr Gubela Mji, an Associate Professor with Stellenbosch University's Faculty of Medicine and Health Sciences, revealed that elderly Xhosa women use their extensive knowledge on a range of social and health issues to manage illnesses in their homes and the wider community. Mji found that elderly Xhosa women do not view disease in terms of mere symptoms and treatment but were of the view that each disease is linked to a wider social determinant of health, and such determinants must be included when considering the overall health of a community.

Managing health is "about the health of the home and not just about the management of disease. They believe that healthy homes make healthy villages, and that the prevention of the development of disease is related to the strengthening of the home," said Mji. Xhosa women's health concerns include food security, healthy children and families, peace and security in their homes, with anxiety and worry being seen as the greatest threat and contributor to ill health in their communities. "Worry is seen as the greatest negative contributor to ill health, with troublesome men and children being the greatest cause of worry," she added. This worry has deepened with the bringing in of social grants whereby older people find themselves deep in their knees through schemes run by loan sharks.

Carriers of this indigenous knowledge are older people who are dying without the documentation of this knowledge. This knowledge will be lost for future generations. Hence the need to bring together western and indigenous health knowledges and practices.

Three conferences on indigenous health knowledge have been held in Xhora/Elliotdale in the Amatole District since July 2016. The first conference, held at the Donald Woods Foundation, was reported on by Zisanda Nkonkobe in the Daily Dispatch of Tuesday the 12th of July 2016. It highlighted the need to build closer future relationships between indigenous healers and biomedical health practitioners.

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Picture1: First conference held at the Donald Woods Foundation

The second conference was held in September 2018 and focused on disability and moral regeneration on the first day. On the second day, the need highlighted in the first conference, focused on the work of indigenous healers and collaboration between traditional and western health knowledges and practices.

Picture 2: The second conference held in Qatywa hall in Nkanya village

The third conference was held in July 2019 and this article focusses on the third conference.

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Picture 3 – 5: Third conference held in Qatywa hall in Nkanya village

The **purpose** of this conference was to seek and create collaboration between traditional health practitioners & health care professionals from the DoH, Elliotdale. The people **involved** were all traditional health practitioners from Elliotdale & health care professionals from Madwaleni hospital and all its feeder clinics at eXhorha/Elliotdale, and community members. Stellenbosch University played a facilitatory role. At the core of this conference, the aim was to understand each other more, so as to improve the health of our people through developing better ways of working together between traditional health practitioners & western educated health care professionals.

The first day focused on: a brief understanding on who indigenous healers are & their work, including their expertise. This was followed by a description of the Xhorha Department of Health (DoH) including their institutions, their roles, work and expertise. This was followed by a discussion on challenges faced by both traditional health practitioners and western health professionals when needing support from each other.

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The second day focused on: how can we unite as healers and support our community and hospital (Traditional Healer), and how can we work together as health professionals in collaboration with indigenous healers (Health Practitioner) to improve health care services in the area? The key issues that came out of group discussions were communication, accountability, transparency, referral system, protective garments, ethics and lack of respect.

Though initially it was planned that the conference would lend itself to the signing of a Memorandum of Understanding (MoU) between the traditional health practitioners and biomedical health practitioners that exist in the area, the discussions focused on challenges of communication. This came out strongly during discussions and therefore it was seen as important for the conference to elect members from both western health care providers and traditional health practitioners to form an interim Community Health Forum (CHF) on the basis that some of the traditional health practitioners were not present in the conference due to community rituals that were happening at the time of the conference. This CHF would go ahead and commit to monthly meetings that would strengthen the existence and the functioning of the CHF and deal ultimately with the issue of communication and other related issues that affect the working together of both health systems. A more permanent structure would be elected at a later stage.

Interim Community Health Forum Committee:

The interim committee consists of representatives from the indigenous healers, western educated health professionals, facilitators from Stellenbosch University, local non-governmental organisations, community members and the local chief.

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Picture 6: Interim Community Health Forum Committee:

The first meeting of the Interim Community Health Forum which brings together western educated health professionals with indigenous healers is scheduled to take place on 21 August 2019.

http://www.donaldwoodsfoundation.org/marrying-western-medicine-with-indigenous-knowledge/

This project is supported by DST/NRF

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APPENDIX J: Draft MoU from indigenous health practitioners

Draft MoU: Document in Xhosa and English

UMHLANGANO OJENGENE NONTETHO YOKUDALA INCWADANA YESIVUMELWANO PHAKATI KWABAHLALI NABANTU BASE MBHASHE NESEBE LEZEMPILO ELIJONGE LENDAWO

MEETING THAT FOCUSED ON DISCUSSION ON THE CREATION OF A MEMORANDUM OF UNDERSTANDING BETWEEN THE MBHASHE COMMUNITY AND ITS PEOPLES AND DEPARTMENT OF HEALTH THAT RENDERS HEALTH SERVICES IN THE AREA.

Yenzeke nini/Date: 19 December 2019

Ngaxeshaphi/Time: 9:00 yaqala ngo/started 12:00 yayokugqitywa ngo/finished at 15:30

Indawo/place: Hobeni Kwa Nkosi UPhathisile Aah Mhlekazi

Abantu ababengene umhlangano/attendees: Zwelimangele Gwebindlala, Bafana Tonga, Themba Gwayiza, Nobejile Gwebindlala, Boniswa Volibi, Azipheli Siyaleko, Janet Howse, Boniwe Gcawuza, Thobeka Manxanyana, Akhona Mbhojithi, Nolatile Nondelemseleni.

Imvula nabangqaba ntshintshi phambi komhlangano wokuxoxa ngencadana yesivumelano/Opening and remarks before discussion of the MOU.

1. Kuyekwavulwa ngomthandazo/opened with a prayer.
2. Siyavuya ukuba kulo mhlangano ozokusikhumbuza ngalencwadana yokusidibanisa/we are happy that we are here to discuss the MOU.
3. **Abantu abaxolisayo ukungabikho emhlanganweni/Apologies**: Ntabezulu Ngubenchanti, Ubawo usiTwayi, Kholekile Gwebindlala, Nkosi Phathisile, Unosenzo, Umakhawutile Nonojase, Unomzawabantu Kijane, Tatu Ndlela, Nosinothi, Mamkwayi, Nolingene Ngxekana.
4. Abantu basho abakukhumbulayo okuza kunceda ukuza nomkhomba ndlela/people reflected on previous discussions that will assist in forging a way forward: Zwelimangele: uyothuka ukuba kanti sisa xoxa abaqgirha Akaka fumani into esesihlahleni ukusebenzisana nezibhedlele/ Zwelimangele expressed concern that we are still discussing and there is nothing concrete in agreements between hospital/clinics and indigenous healers. Bafana Tonga: Uyavuya ukuba side sadibana/ is very happy that we had the opportunity to meet. Tatu Gwayiza: Yena uvakalisa amazwi ombulelo kuGubela noThando ukubancedisa ngento ibixake inyanga zemveli/ expressed gratitude for the process – Gubela and Thando assisted in an area

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that has been a concern for indigenous healers. Nobejile: Izigulo zininzi, sifanele ukuzama ukusingatha imeko zethu fanele ngoko sikhumbuzane ngokwenzeka EQatywa/There are many illnesses, we need to start giving direction on our matters, we need to try and follow up the decisions made in the Qatywa conference. Thobeka Manxanyana: Siphele ndawoni, siza kuya eQileni sidibanenaye no Docctor Willie, Mrs Mnyande No Nkosi Phathekile siye nase ziclinic nase zikolweni. Boniwe Gcawuza: Eyona nto ibalulekileyo kukuregitalitsha sibenamakhandana abonisa ukuba sikulomhlangano/what is important is our registration and given cards that show that people are part of this group. Gubela: Uvile ngo Mr Tonga ngequbela eyenziwa ngulomhlangano nokukhula phakathi kwenyangi zemveli nesibhedlele, inye into ibimkhathaza kukuncanca ukuba uxubelelwano phakathi kwesibhedlele nenyangi zemveli luyakhula kodwa ayikho incwadi yesivumelano – lonto iyakhathaza ngakumbi ukuba kunokubakho iphutha ingekho lencwadi yentsebenziswano – uyavuya ukuba namhlanje sihlangene ukuzokweza idrafuti ngoba asinokugqiba ukuthetha ngalencwadi ngoba asiphelelanga/Heard from Mr Tonga that there is progress between indigenous healers and the hospital – what concerned her was for this relationship to deepen without an MOU especially if there could be a problem – she is glad that today we can start developing a draft as we cannot finalise the document as not everybody is present in the meeting.

5. Ubawo UTonga uye wanikezela kuGubela ukuba ancedise umhlangano ngezakhono zencwadana yokusebenzisana: Mr Tonga handed over to Gubela to guide the discussion on the MOU.
6. UGubela uyewacacisa ukuba lencwada iyakuba nezizavenge: Iquka bani, Ithini, Imephezu kwantoni, Uthini Umkhomba ndlela/ Gubela explained the different parts that will be contained in the MoU which were: Who is included, what is the MOU saying, underpinning values, way forward and signing.

INCWADANA YESIVUMELWANO PHAKATI KWABAHLALI NABANTU BASE MBHASHE NESEBE LEZEMPILO ELIJONGE LENDAWO

MEMORANDUM OF UNDERSTANDING BETWEEN THE MBHASHE COMMUNITY AND ITS PEOPLES AND DEPARTMENT OF HEALTH THAT RENDERS HEALTH SERVICES IN THE AREA

Icandelo LesiXhosa	English version
Iquka bani:	Who is involved:

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Phakathi ko: Uluntu lonke lwaseMbhashe luquka: Abemi basekuhlaleni, Inyangi zemveli eziquka: Amagqirha, Amaxhwele, Amatola, Onobumba, Abathandazeli, Amakhankatha, Ababelekisi, Abaphethe ukukhubazenga, Inkosi Zemveli. Ukwenzela zonke ezi zingentla zibenentsebenziswano namasebe ezempilo engingqi yaseMbhashe equka: Isibhedlele IMadwaleni nekliniki ezisingqongileyo ezilithoba	**Between:** People of Mbhashe Municipality comprising of: People from the villages/community, Indigenous healers inclusive of: Amagqirha, Amaxhwele, Amatola, Onobumba, Abathandazeli, Amakhankatha, Ababelekisi, Abaphethe ukukhubazenga, Inkosi Zemveli. To ensure that all the above have a working relationship with Department of health of Mbhashe Municipality which will comprise of: Madwaleni hospital and the 9 surrounding clinics.
Ithini: Masilwele Impilo Yethu Sisonke: Masihlangane, Masakhane, Masihloniphane, Masibe nemfesane	**What is it saying: Let us all fight for our health:** Let us unite, capacitate each other, respect each other and have compassion towards each other
Imephezu kwantoni: Umntu makaqale ngokuzihlonipha ukuze ukwazi ukuhlonipha omnye umntu: Masihambisane sibenomoya omnye, Masingafihli izinto (kwakhe kwaxoxwa kakhulu ngalendawo amagqirha aye afumane kunzima ukungcaza ezinye izinto ezimalunga nezinyaya ingeyiyo ukuba bayafihla nabo kuzeke bengazi), Makulinganwe, Masibenomonde, sithembane, sincedisane, ucingisise ngaphambi kokuba wenze.	**What are underpinning principles/values:** A person must start with self - respect so as to respect others, let us walk together in one spirit, let not hide things from each other (there was a lot of discussion on this area as the indigenous healers maintain that some of aspects from ancestral realm they to struggle to explain – not that they are hiding anything). Let us have equality, patience, assist each other and think before you act.
Isikhokela Njani lencwadana: Mininzi imiqweno yabahlali nenyangi zemveli	**What directions does MoU give:** There are many issues that still need to be discussed concerning

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ezidibanisa lentsebenziswano kodwa okwangoku singabalula oku: Abanyangi beveli bafanele xabefuna ukusa abantu ababebanyanga esibhedlele badibane no Mr Tonga abancedise – kukwanjalo nesibhendlele neclinic xazifuna umntu osesibhedlele okanye eKliniki ahajelwe yinyangi yemveli – bamaqakamshelane no Mr Tonga	the working together but for now: if indigenous healers want to refer a person to either the clinic or hospital, they must link with Mr Tonga – it is also the same with the clinics and hospital, if they want to refer somebody to an indigenous healer, they must link with Mr Tonga.
Intsayino: Umsayini wokuqala: Umsayini wesibini: Umsayini wesithasthu: Umhla…………………………………………….	Signatures: 1st Signatory: 2nd Signatory: 3rd Signatory: Date……………………………………………….

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APPENDIX K: Glossary

isiXhosa	**English translation**
Muthi	Botanical medicine prescribed by an inyanga or herbal healer is generally known as "muthi", but the term can apply to other traditional medical formulations, including those that are zoological or mineral in composition
Amafufunyane	Is an unspecified "culture-bound" syndrome named by the traditional healers of the Xhosa people that relates to claims of demonic possession due to members of the Xhosa people exhibiting aberrant behavior and psychological concerns. Mafofonyane - Sesotho/ Northern Sotho
Ababelekisi	Traditional birth attendants
Amagqobhoka	The literate people. Amagqobhoka was the main way that amaXhosa identified those who chose to leave behind their own faith in the ancestors to follow the way of Christianity
Umhlonyane	Artemisia afra (tropical traditional medicine). Umhlonyane has been used for decades by traditional healers to treat various illnesses, including respiratory symptoms, it can be consumed with water, used with steam to clear a blocked nose and chest, or inhaled in the plant form
Isihawuhawu	Stachys Aethiopica mixed with *umhlonyane* for flu
Sangoma/igqirha	The indigenous doctor
Inyangi/ixhwele	The herbalist
Umthandazeli	The Christian faith healer
AmaGqirha	Indigenous doctors
UMoya	A spirit
Iingcibi	Traditional surgeons
Amakhankatha	Traditional nurses
Sukuma Sakhe	Let us build
UThixo	God
Oomakoti/Makotis	Daughters in-law
Ukwakha umzi	Building a home
Ukutena	How to make bricks
Imbizo	Chief's meeting, presided by the Chief at his homestead
Oomakhulu/makhulus	Older Xhosa women
Ukuhlonipha	Respect
AmaTola	Elitist men
Makukhanye	Let there be light

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Ukuphahla	Connecting with ancestors (acknowledging their presence)
Ibhekile	Silver enamel bucket
Isilawu	The word is believed to have come from the Khoekhoen word laula, meaning to apologize. The white colour of isilawu is said to indicate that the medicine is clean and pure. Silene undulata is the most commonly used *ubulawu* plant in the Eastern Cape
Icamagu livumile	All is well
Ahlambuluke/ukuhlambuluka	Be of sound mind, no quarrels against other people pray and be humble, be at peace
UbuBomvane siyabuphila	Being a Bomvana is a state of mind
Impilo	Health
Umqombothi	African beer
Ikomkhulu	The royal homestead
Inyathi ibuzwa kwabaphambili	Xhosa idiom that translates as older people are the best for knowledge
Ikhaya Loxolo	Home of peace (NPO)
Ukuthwasa	Initiation is a process undergone by someone who has *ubizo* (calling) from their ancestors to become a healer
Ukubuka iindwendwe	Honouring the visitors
Khululani iibhatyi kusekhaya apha	Take off your jackets and relax, this is your home
Ubuntu	A quality that includes the essential human virtues; compassion and humanity