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**Masters in Public Health Mini Dissertation:  
Acceptability of access to child health care, in the rural  
area around Zithulele Hospital in the Eastern Cape**

by

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Submitted in fulfillment of the requirements  
for the degree of Master of Public Health,  
specialising in Health Economics in the  
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## Declaration

I, \_\_\_\_\_,  
declare that the work that I have submitted is my own and where the work  
of others has been used (whether quoted verbatim, paraphrased or referred  
to) it has been attributed and acknowledged.

I further declare that this work has not been submitted for any other  
degree of examination to any other university.

Signed: \_\_\_\_\_

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University of Cape Town

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University of Cape Town

# Part I

# Protocol

## Executive Summary

This study is from the perspective of rural South Africa using the case of Zithulele Hospital as an area of interest. The research is qualitative in nature and will make use of both focus group discussions and key informant interviews, in order to assess the access to child health care provided at Zithulele Hospital. The focus will be on the acceptability of access to child health care and more specifically, the acceptability of treatment for diarrhoeal disease.

## 1 Introduction

While working at a district level hospital called Zithulele Hospital in the rural Eastern Cape of South Africa, I was faced with the challenge of making our physiotherapy department more accessible to the community. Our department attempted to engage with the community to try and ascertain what it was that individuals expected and wanted and how we could improve our services in order to achieve these needs. This proved difficult. However it left me interested in the problem of access and determining the reasons that individuals choose to either utilise available services or not. It also sparked my interest in how cultural beliefs influence individual's access to hospitals and clinics in contrast to seeking health care from traditional healers.

There are many factors that influence one's state of health and access to appropriate health care is just one of those components (Frost and Reich, 2008). Access in itself is a multi-factorial process which depends on the interaction of an individual with the health system in order to obtain and use health care when it is necessary (Frost and Reich, 2008; Gilson and Schneider, 2007; McIntyre, Thiede and Birch, 2009). McIntyre et al. (2009) argue that access depends on the empowerment of an individual so that they have adequate knowledge to decide on appropriate use of services. This empowerment facilitates an ability to benefit from the services available as well as aiding the trade of information between the provider and patient (McIntyre et al., 2009).

This empowerment can be further broken down into factors that influence access, by using an access framework such as the one described by Gilson and Schneider (2007). The framework consists of: 1.) *Availability* which refers to the geographical access, the hours an institution is open and the impact this has on utilization and the type of services offered by the staff. 2.) *Affordability* which refers to the financial implications of the health seeker's behaviour and the ability of the individual to pay for these services. 3.) *Acceptability* which looks at the cultural acceptability of services in terms of the individual's beliefs and the provider's attitudes (Frost and Reich, 2008; Gilson and Schneider, 2007; McIntyre et al., 2009).

Diarrhoea poses a significant health risk and is one of the leading causes of infant mortality. The socio-economic and environmental context play important roles in diarrhoeal disease. For instance in the access to safe, clean water. Studies indicate that cost-effective interventions exist. However South Africa is not reaching the Millennium Development Goals set for maternal and child health, due to the fact that coverage of those services is not sufficient. This will continue unless there is an immediate improvement in access to these services (South Africa Every Death Counts Writing Group, 2008; The United Nations Children's Fund, 2009; Hanson, Cleary, Schneider, Tantivess and Gilson, 2010).

This lack of coverage and decreased access leads us to look at which factors influence access to appropriate service.

In the Eastern Cape of South Africa, the incidence of diarrhoea in children who are under 5 years of age was 110 per 1000 children in 2009 (Health Systems Trust, 2009). An interesting pattern that I noted at Zithulele Hospital relating to children with diarrhoeal disease, was that mothers whose children suffer an attack of diarrhoea often first seek medical care for their children from a traditional healer. This is not surprising considering that approximately 80% of individuals, in developing countries use traditional medicine in their health care (Kim, 2005). In South Africa it is estimated that there are 200 000 practicing traditional practitioners comprising *Inyangas*, *Isangomas* and *faith healers* (Kim, 2005; Watson, 2005).

Occasionally the treatment received from the traditional practitioner aggravates the diarrhoea and results in severe dehydration. The child is then brought to the hospital to be rehydrated and treated.

It is interesting to think about what influences could be playing a role in

this sequence of events. It could be that there are social norms and expectations which put pressure on mothers to take their children to first seek health care from traditional healers. It could be that there is a difference in belief about the causative agents of diarrhoeal disease, based on the individual's belief system. It could be that seeking care from a traditional healer is considered the most effective form of treatment. It is necessary to first describe what is meant by the acceptability of health care.

## 1.1 Barriers to health care

As access considers human behaviour when assessing the factors involved in access, one has to look at the level of participation of individuals in their health. For example the reasons for utilising health care could be due to empowerment of individuals. Alternatively the reasons for non use could be due to the organisational structure of the health system creating a barrier to access, for instance if the institution has a fee for service structure which deters utilisation (Frost and Reich, 2008; Gilson and Schneider, 2007; McIntyre et al., 2009).

Another barrier could be that mothers are not empowered with the tools to prevent and treat diarrhoeal disease. If mothers are taught how to prevent diarrhoea through cleanliness, (for instance using soap and warm water for hand washing) and by breastfeeding (so that the child is provided with the necessary maternal antibodies to fight infection), then they may be made more responsible and involved in child health care. Also if mothers are taught the correct methods for preparing a rehydration mixture with salt, water and sugar the need to seek health care may be reduced.

Other reasons for inadequate utilisation of health service could be due to lack of continuity of care or poor quality of health care provision (Frost and Reich, 2008; Gilson and Schneider, 2007). Continuity of care is often lacking in a government facility, in that often a patient will be attended to by the first available doctor or sister and will not always be followed up by the same member of staff. Continuity of care refers to holistic care of a patient which results from a health care provider trying to solve problems that the patient may have and not simply behaving as if the provider's responsibility of the patient ends when they leave the health facility (The World Health Organisation, 2008).

However according to The World Health Organisation (2008) maternal

and child health services in low income countries have often been some of the first services to adopt a patient centered approach, emphasizing continuity of care. These relationships depend on trust and take time to develop and therefore need long term commitment. Providers are more likely to respect and understand patients when they have this type of relationship, which could ultimately lead to better acceptability for patients (The World Health Organisation, 2008). It is for this reason that the acceptability of access will be assessed in terms of child health services.

## 1.2 Acceptability

The focus of this study will be on the acceptability of child health care, in order to try and establish what the reasons are for utilising health care at Zithulele Hospital or not. Acceptability refers to the cultural suitability of the health care provided in terms of how well it fits with people's beliefs both cultural and religious. In addition individual's previous experience with health care providers and institutions will influence what is expected and what they deem acceptable (Gilson and Schneider, 2007; McIntyre et al., 2009).

Goudge, Gilson, Russell, Gumede and Mills (2009) describe acceptability as the 'appropriateness of the social interaction that accompanies care'. Goudge et al. (2009) go on to explain that acceptability can refer to the suitability of the communication between the patient and the provider in the transfer of knowledge about the condition and treatment options available. If the patient is unable to understand the information given by the provider, she may seek care from an alternate provider. Additionally if the patient is seeking care from multiple providers then the continuity of care and the effectiveness of care may be compromised (Goudge et al., 2009).

Another important issue raised by Gilson, Palmer and Schneider (2005) is the relevance of trust in the relationships between the provider and the patient and the role that this plays in the acceptability of the health care provided. This trust can affect the disclosure from the patient, adherence to the treatment prescribed and ultimately the utilisation of health care. In the same way a lack of trust can negatively impact on the interactions between health care providers and patients due to lack of respect, miscommunication and lack of focus on the patient (Gilson et al., 2005; Russell, 2005).

The acceptability of the health care provided can also be affected by the health provider's attitudes and beliefs. These beliefs can affect the provider's

tolerance when listening, the trust relationship between the provider and patient and to what extent the provider may blame the patient for their condition (Gilson and Schneider, 2007; McIntyre et al., 2009). In some cases providers' high workloads may also be responsible for decreased communication with patients, which impacts on the patients experience of health care provision as well as sometimes reducing the quality of care (Frost and Reich, 2008; Gilson and Schneider, 2007; Russell, 2005).

One of the ways that the acceptability can be improved is if the provider is aware of the patient's beliefs, his own beliefs and the impact that a discrepancy between the two may have on the provision of care. By being aware of these beliefs the provider can also be more open to offering alternative care that may be more suitable to the patient. If the patient's perceptions of effectiveness, health beliefs and expectations match those of the provider then the acceptability of health care may be improved (Frost and Reich, 2008; Gilson and Schneider, 2007; McIntyre et al., 2009).

Oliver and Mossialos (2004) touch on the need for access to be examined according to the specific context of an area and highlight that there are differences in access between countries, within a country and within smaller regions. For a better understanding of access one has to look at the barriers which delay or inhibit individuals seeking treatment (Frost and Reich, 2008; Gilson and Schneider, 2007).

### **1.3 Child health care services**

In South Africa the under five mortality rate has actually risen between 1990 to 2008 from 56 deaths per 1000 children to 67 deaths per 1000 children. This indicates that the country is not progressing towards the Millennium Development Goal (number four) of reducing the under five mortality rate to under 40 deaths per 1000 children or achieving a average yearly rate reduction of 4% or higher for the period 1990 to 2008. In terms of neonatal mortality the trends have remained constant, however approximately 260 women, babies, and children die daily in South Africa (South Africa Every Death Counts Writing Group, 2008; The United Nations Children's Fund, 2009).

In post apartheid South Africa children's rights are protected by several acts and include the right to 'greater access to health care for young people' (The United Nations Children's Fund, 2009). However bridging the gap between the rights of children to health care and the receiving of health care

still remains a challenge. In low and middle income countries, such as South Africa, pneumonia and diarrhoeal diseases are responsible for approximately 40% of deaths in the under five age group for children. The access to the necessary treatment to these diseases which have been proven to be effective, is still inadequate (The United Nations Children’s Fund, 2009).

In order to improve the access to quality child health care provided there needs to be ‘investment in health information and referral systems, equipment, medical supplies and infrastructure’ (The World Health Organisation and The United Nations Children’s Fund, 2010). Without this investment it is likely that in the future, children in low and middle income countries may face even greater lack of access to health care (The World Health Organisation and The United Nations Children’s Fund, 2010; The United Nations Children’s Fund, 2009).

In South Africa child mortality; stillbirths and neonatal mortality are audited respectively by two separate programmes. Auditing provides invaluable information however one needs to ultimately concentrate on reducing mortality (South Africa Every Death Counts Writing Group, 2008).

## 1.4 Treatment of diarrhoeal disease

It may be that there is a cultural difference in the belief of the causes of diarrhoea between western and traditional practitioners. For instance one of the illnesses most commonly treated by traditional healers is *ikhakhayi or ipleyiti [plate]* in IsiXhosa (*inyoni* in IsiZulu) which is described as diarrhoea in western terms but is attributed to witchcraft or ‘pollution’, from breast milk or during pregnancy or during the birthing process, which then needs to be cleaned out of the child’s system (Friend-du Preez, Cameron and Griffiths, 2009).

The primary way of traditionally treating *ipleyiti [plate]* is by giving an enema called *imbiza wenyoni or Muthi Wenyoni* which in effect purges the child of all that is considered ‘unclean’. This can lead to further dehydration (Friend-du Preez et al., 2009) and ‘can have disastrous consequences’ (Kale, 1995).

In addition *Muthi Wenyoni* has 3.74% alcohol which may be partly responsible for the perceived positive calming effect on the child (Bland, Rollins, Van den Broeck, Coovadia and Child Health Group, 2004). Alternatively a

plant called *Hermannia Incana* is used in enema form again to purge the body (Appidi, Grierson and Afolayan, 2008). Another one of the identified treatments for *ipleyiti* [*plate*] is that of making little cuts which leave scars, on the child (for instance around the umbilicus) and rubbing a black substance into the cuts to strengthen the child (Friend-du Preez et al., 2009).

In a study on the practices of mothers with children under 6 years of age in Johannesburg and Soweto in South Africa, it was found that up to three quarters of the survey group would give their child traditional medicine, despite the fact that government facilities provide health care to children under 6 years free of charge. The most commonly cited reason for this was that they went to a traditional healer for protection or felt that western medicine could not treat their child for the specific ailment. Conversely it was found that those who did not seek care from traditional healers mainly attributed this to the fact that they did not believe in the treatment (Friend-du Preez et al., 2009).

Similar findings were established in a study in the Eastern Cape around Umtata (approximately 90km from Zithulele Hospital) where 57.2% of the participants responded that they had given their child traditional medicine in the previous year (Dambisya and Tindimwebwa, 2003). At Umtata General Hospital the mortality of children brought in for herbal intoxication is as high as 40% according to Tindimwebwa and Dambisya (2002) as cited in Dambisya and Tindimwebwa (2003). These traditional medicines were most commonly used to treat diarrhoea. When asked why they were used the most frequent answer was that the treatment is effective. Of those who had used traditional medicines on their children 79.7% respondents stated that they had no negative side effects. However of those that reported negative side effects, these were classified as death, dehydration, diarrhoea, over dosing and other problems.

It was found by Friend-du Preez et al. (2009) that it was the belief in the traditional medicine that drove caregivers to seek this form of health care. Interestingly they found that practicing Christianity did not hinder the use of traditional medicine for some individuals. In addition it was found that where grandmothers were the decision makers, that individuals were more likely to seek traditional medicine. Social norms also play a role in that individuals are told, through social networks, which healer is a good healer from whom to seek. This social pressure means that often they would not go to another health care provider in case they were seen as deviating from the norm (Friend-du Preez et al., 2009).

Only seven of the 53 traditional healers in the study by Friend-du Preez et al. (2009), mentioned the need for oral rehydration in children with *ipleyiti* [*plate*] although several knew the importance of sending severely dehydrated children to hospital to be rehydrated with intravenous fluid.

Diarrhoea is also treated orally in the Eastern Cape with a variety of different plants some of which have an antimicrobial effect (Appidi et al., 2008). Some of these oral treatments reduce spasms, suppress the motility of the gut and aid water retention (Palombo, 2006). There are now studies in progress which are trying to assess the active agents in these plants (Appidi et al., 2008). Kim (2005) suggests that instead of having a negative attitude towards traditional medicine this formalized testing will aid understanding of how the traditional medicines act to treat diarrhoea. It could additionally increase the safety of using traditional medicines and provide necessary proof of the efficacious agents in plants. Furthermore attention is needed to establish whether it is the dosages given to children or the intolerance of infants to the medicine which is causing herbal intoxication (Dambisya and Tindimwebwa, 2003).

## 1.5 Framework

From this literature an analytical framework will be developed in order to explore the acceptability of child health care at Zithulele Hospital. The reason for the use of this framework is that it allows one to look at the degrees of access and the actors involved in this process as well as permitting one to understand the barriers that delay or deter access (Frost and Reich, 2008; Gilson and Schneider, 2007; McIntyre et al., 2009).

The framework will focus on the *beliefs* of patients and how these beliefs act to influence the health care choices that caregivers make on behalf of their children. Beliefs can be either culturally ingrained or religious in nature. If for example it is believed that the cause of diarrhoea is due to an impurity from breastfeeding or witchcraft, treatment from a traditional healer may be seen as the only option for cleansing the child's body or providing protection from bad spirits for the child (Friend-du Preez et al., 2009). Furthermore belief can be based on the perceived *effectiveness* of traditional medicine, from past experience or other individual's advice.

Also included in this framework is the influence of *social pressures* which

could be playing a significant role in the health care seeking behaviour of caregivers. Friend-du Preez et al. (2009) found that many individuals rely on social networks to establish which traditional healer is a good healer to go to. This social pressure often results in individuals seeking care from a particular healer so that they are not seen to deviate from the norm.

The third aspect considered in this framework is that of a difference of belief in the *causative agents and appropriate treatment of diarrhoea* despite knowledge that there is a western explanation of the causes of diarrhoea.

The fourth and final aspect considered is that of *responsiveness*. Where there is a lack of responsiveness from a health care provider this could be a deterrent in seeking treatment from the provider or a high level of responsiveness which could be an incentive to seek care from the provider.

These four factors (*beliefs and effectiveness; social pressures and norms; causative agents and appropriate treatment; and responsiveness of the provider*) were chosen as they are felt to be the most pertinent in this study and cover a range of areas that can be explored. The concept of *empowerment* was excluded as it is a complex process in itself and should be examined in terms of all three components of access: *affordability, availability and acceptability*.

The aspect of *communication* was not included explicitly in the framework but instead *responsiveness* was included which involves *communication* and may give an indication of the quality of communication between a patient and provider. As *responsiveness* encompasses empathy, sensitivity and listening, trust can be formed from responsiveness. However *trust* was not included as a factor on its own as it is a very complex topic which could warrant separate research.

## **1.6 Interactions of the four main factors identified in this framework**

This section describes the possible interactions of the theoretical framework, stemming from literature and recent findings, as described above.

The *beliefs* of the caregivers could be integrated in their beliefs concerning the *causative agents and appropriate treatment of diarrhoea*. That is caregivers may believe that the cause of diarrhoea in their children is due to *ikhakhayi* or *ipleyiti [plate]* and not due to an infection (as believed in

western medicine). This could be further intertwined with the belief that the treatment received from a traditional practitioner is the most *effective* treatment available. In turn this belief in *effectiveness* could be emphasized by advice given by social networks of peers or respected and trusted individuals in the community (*social pressure*).

Furthermore *social pressures* could be playing a role in emphasizing that one must believe what is culturally acceptable. For instance a grandmother could place *social pressure* on her daughter to take the child to a traditional practitioner despite the daughter's wish to take the child to a western practitioner. *Social pressures* could result in groups of mothers seeking health care for their children exclusively at traditional practitioners based on their combined experience and belief in the provided treatment's *effectiveness*. Conversely groups of mothers could seek care from a western health care facility based on their experience of the facility and the perceived *effectiveness* of treatment.

Religious *beliefs* such as Christianity could mean that individuals do not seek care from a traditional practitioner but rather from a western practitioner. Confusion of beliefs in the *causative agents of diarrhoeal disease* could result from the influences of Christianity which often see traditional medicine as a form of witchcraft which should not be used. This could have the spin off effect that those seeking care develop different beliefs in what they deem to be the most *effective* treatment and may also change their belief in the *causative agents and appropriate treatment* of diarrhoeal disease (for example to a belief that the cause is due to a bacterial infection and should be treated with antibiotics).

High levels of *responsiveness* from a traditional practitioner could provide a reason for seeking health care from him rather than from a less responsive western practitioner. However the lack of *responsiveness* of the western practitioner may be due to a difference in beliefs between the caregiver and the practitioner. For instance if the caregiver believes that the cause of diarrhoeal disease is due to *ikhakhayi* or *ipleyiti* [*plate*] and the western practitioner believes the cause is due to an infection, the disharmony between the two may result in the treatment given not been seen as effective or not being taken.

Furthermore if a western practitioner has seen children who have been treated by a traditional healer with the result that the child has dehydration, herbal intoxication or shock due to 'cutting', then the provider may be opposed to traditional practices or may deem the treatment from a tradi-

tional healer as harmful.

## **1.7 Aim**

The aim of this study is to qualitatively examine the acceptability of access in the area around Zithulele Hospital in the Eastern Cape with a focus on access to child health services, specifically diarrhoeal diseases, by utilising a framework, which highlights patients' beliefs, and other reasons for individuals utilising services or not, in order to better understand the access of these services.

## **1.8 Objectives**

Specifically, the study aims to explore the factors influencing the health seeking behaviour of people in the community in terms of delay in seeking care from formal health facilities when their children suffer from diarrhoea. This will be achieved by examining:

1. People's belief in or the perceived effectiveness of traditional medicine
2. People's belief in or perception of causative agents and appropriate treatment of diarrhoea
3. Existing social pressure regarding certain types of health care services
4. Perceived responsiveness of traditional and formal health care providers
5. Attitudes of formal health care workers towards patients beliefs (regarding the effectiveness of traditional medicine and causative agents and appropriate diarrhoea treatment).

## **1.9 Justification**

There have been numerous studies which focus on access in terms of availability and affordability, however much less research has been done around the topic of acceptability which Gilson and Schneider (2007) describe as the 'often ignored dimension of access'. There is a scarcity of information regarding the reasons for using traditional medicine versus western medicine (Friend-du Preez et al., 2009). Further research on the reasons for the use of traditional medicine especially in infants and children may provide necessary

information which will aid in the adoption of practices of hospital staff which improves the acceptability of treatment at a hospital level due to a greater understanding of why a combination of health care practices are sought in the rural Eastern Cape.

As I have previously spent a year in the area around Zithulele working in the hospital and am well know to the community and health professionals (Zithulele Hospital has a stable community of health care professionals), I plan to use this access point to aid the collection of data and recruitment of participants. Additionally part of the services that our department provided in the area were weekly clinic outreaches, meetings with the community and home visits. Furthermore a colleague and I were invited and attended the day long initiation of a young Isangoma. This invitation indicates a level of acceptance and mutual respect which resulted in relationships being formed with the local traditional practitioners in the area.

## **2 Methods**

### **2.1 Study setting**

The setting in which this study will take place is Zithulele a rural area in the Eastern Cape of South Africa. Zithulele comprises pastoral landscapes, with most housing being in the form of rondavels (round huts built with clay bricks, cow dung and thatch) which are not connected by a network of roads but rather small walking paths on the hilly countryside. Around the area of Zithulele Hospital there are numerous sangoma's and traditional healers, several satellite government clinics and then the district level government hospital of Zithulele. The nearest tertiary hospital is approximately 90km away at Umtata which is the closest urban area. There are several gravel roads connecting Zithulele Hospital to its satellite clinics and a tar road (very badly potholed) connecting Zithulele Hospital to the urban area of Umtata.

### **2.2 Study design**

This study will be a descriptive qualitative study focused on health services research, using a purposive sampling technique. After obtaining departmental approval, University of Cape Town Ethics' approval and approval from management at Zithulele Hospital and the surrounding clinics the data col-

lection will commence.

### **2.3 Methods for data collection**

Focus group discussion and key informant interview outlines will be used as data collection tools. The principal investigator will facilitate the focus group discussions and undertake the key informant interviews. The objective of the discussions and interviews is to allow participants to share their experiences and views on the acceptability of health care at Zithulele Hospital and express the reasons for utilising health care or not.

Using focus group discussions in two clinics areas and at two residences of traditional practitioners in the area surrounding Zithulele, a comparison will be made between those who seek access (patients) and those that do not seek access (non patients) at Zithulele Hospital in order to establish why services are sought or not sought and the reasons for their choice. These focus groups will involve community members (both patients and non patients) and will focus on reasons for utilising services or not, their cultural and religious beliefs, their beliefs in the causes of diarrhoeal disease, the perceived responsiveness of the health care providers, as well as social pressures. Verbal informed consent will be obtained prior to the focus group discussions commence.

The discussions will be between one and two hours long beginning with two ice breaker activities. The format of the discussions will be that of a scenario which describes the actions of a mother whose child suffers from an attack of diarrhoeal disease. The participants will then be asked questions about the mother's actions and reasons for her health seeking choices. It is hoped that study participants will talk openly about their beliefs and views by superimposing them on the hypothetical caregiver. The questions in the focus group discussions relate to the objectives and study framework (see appendix 4). Prior to the start of the focus group discussions, the objective of the discussion will be explained, the anonymity of participants will be assured and agreement will be requested for recording the discussions.

Additionally using a semi structured questionnaire, key informant interviews will be conducted in the area around Zithulele Hospital during a three week period in February. This will possibly comprise ten interviews with health professionals, the chief at Ngcwanguba and a community based development official, in order to try and establish a group of interviewees rep-

representing the interests of the whole community and obtaining information from the multidisciplinary health care providers of the health services being sought as suggested by Green and Thorogood (2009). The key informant interviews will focus on looking at the beliefs of the key informants, their tolerance of patients' beliefs and the degree of fit of their beliefs with those of the community members. Written informed consent will be obtained prior to the interviews.

Key informant interviews (see appendix 2) will be based on the framework and study objectives formulated for this study. The interviews will be approximately one hour in length. Prior to the focus group discussions commencing the objective of the interview will be explained, the anonymity of participant will be assured and agreement will be requested for recording the interview.

The key informant interviews will be undertaken primarily in English with the assistance of a IsiXhosa translator who is fluent in both English and IsiXhosa. Where necessary participants will be able to converse in their own language with the aid of a translator. The focus group discussions will be undertaken primarily in IsiXhosa with the translator assisting the facilitator. The translator will be present in all the interviews and discussions to maintain consistency and trust. The principal investigator is also able to converse in IsiXhosa and will be aware of simplified translations or misunderstandings. Interviews will be recorded electronically using an audio recorder and downloaded onto a password protected personal laptop computer.

The interviews and focus group discussions will then be transcribed word for word in English using the audio recordings. As the interviews and discussions will be translated during the data collection period it is the English translations that will be transcribed and not the untranslated IsiXhosa .

## **2.4 Subjects**

### **2.4.1 Inclusion Criteria and exclusion:**

Female adults, above the age of 18 years, in the geographic area surrounding the clinics of Wilo and Ngcwanguba will be considered for inclusion (in focus groups), subject to obtaining verbal informed consent (see appendix 3) as it is felt that obtaining written consent would be inappropriate in this setting with low levels of literacy and that paperwork may be associated with gov-

ernment involvement (Green and Thorogood, 2009).

The reasons for only including females are that firstly child health primarily relates to females and secondly to encourage participation of women as they are often dis-empowered in terms of voicing their opinions in the Eastern Cape. It is hoped that holding focus groups comprising only women will facilitate discussion. The therapists, chiefs and traditional healers of the area will be involved in recruitment to assist the trust relationship of the women participants with the researcher (Green and Thorogood, 2009). These female adult participants will be included whether they are able to converse in English or in IsiXhosa and furthermore whether they are patients at Zithulele or not.

Interviewees must be above the age of 18 and have completed informed written consent (key informants) to participate in the study (see appendix 1). To be included in the interviews they will be deemed to be key informants in the area by the researcher with the assistance of the community.

There will be no exclusion criteria, except if informed consent is not obtained or if the individuals do not live in the geographic areas that are being sampled.

#### **2.4.2 Recruitment strategy**

Eight groups will be purposively sampled. These groups will comprise women who seek access to child health services and those that do not seek access at Zithulele Hospital, at two respective clinics (Wilo and Ngewanguba) and at two traditional healers in the area surrounding Zithulele. Each group will be composed of approximately 10 individuals. There will be four groups of individuals who have attended Zithulele hospital (patients) and the other four groups will comprise caregivers who have not attended Zithulele hospital (non patients). Four groups of subjects will be recruited by the chief of the area and focus group discussions will be held in a community building or at the chief's residence if space and privacy allows. Four separate groups of subjects will be recruited by two traditional healers in the area surrounding Zithulele and these focus groups will be held at their residences if the traditional practitioners allow.

Furthermore a mix of approximately 8 health professionals (two doctors, two therapists, two nurses, and two sangomas or traditional healers) as well

as the chief at Ngcwanguba and a community based development official will be selected to participate in key informant interviews.

As the aim is to understand whether the access to Zithulele Hospital is acceptable or not and why this is the case, qualitative data collection will be used in a manner deemed appropriate by Etter and Perneger (1997). As the data will not be statistically analyzed one does not need to perform sample size calculations to obtain an indication of the number of subjects needed. Rather by performing key informant interviews as well as focus group discussions, an understanding of the overall impressions of the community will be sought.

## **2.5 Pilot test of the data collection tools**

A pilot study will be conducted in the Zithulele area with two or three participants in order to establish whether or not the questions asked in the focus group illicit answers or not. The same will be done for the key informant interviews with one or two interviewees. If the questions are not deemed suitable or the order of the questions is not conducive to a flowing discussion then the questions will be modified accordingly prior to data collection.

# **3 Analysis**

## **3.1 Data management**

After transcription and translation of the interviews, thematic content analysis will be done to highlight relevant themes. Coding will be undertaken across the transcripts (focus group discussions and key informant interviews) and the themes arising from the transcripts will be considered together for further levels of coding to be applied. This will be done to present the significant elements from the key informant interviews and focus groups. Anonymity will be maintained. From this analysis, beliefs in the causes of diarrhoea, perceived responsiveness of the health care provider, social norms and beliefs and hence the acceptability of the health care services provided will be assessed in terms of the association they have with either accessing or not accessing care. Comparisons will be made between those individuals in the focus groups and key informants respectively in order to assess how the themes inter-relate as suggested by Green and Thorogood (2009). NVIVO

software will be used to manage the transcribed data.

After the dissertation is written up paper copies will be sent to Zithulele Hospital and the traditional practitioners involved and will be made available to those who partook in the study or who show an interest in the study.

## **4 Ethics and Communication**

### **4.1 Ethics**

This study aims to assess the acceptability of health care with regard to diarrhoea and in the process contribute to the improvement of public health, increase health care access for individuals in the community and result in enhanced health status and a greater understanding of the reasons for utilising formal health care services and traditional practitioners. This research aims to be culturally sensitive and will make use of relationships that were formed in the year that the researcher worked at Zithulele Hospital.

Each subject's transcribed interview will be encoded to ensure confidentiality and the study results will be presented in such a way as to ensure the anonymity of the participants. Subjects will be fully informed about the rationale for this study and will receive sufficient information about the study prior to deciding whether or not to participate. Study participants will then be given a choice as to whether or not to join the study. Additionally it will be made known to the participants that they may withdraw from the study at any stage. Once the study is written up, feedback of results will be available to participants on request. There will be no risks, benefits nor cost involved for the participants in this study. In addition there will be no insurance cover for participants in this study should harm come to any subjects.

### **4.2 Stakeholders**

There are no competing interests declared in this study. Furthermore there is no funding from external organizations with any interest in the subject matter.

## 5 Logistics

### 5.1 Budget

#### Printing and photocopying:

- Journal articles: 500 pages at R0.50 per page: **total R250.00**
- Dissertation (including drafts): 100 pages at R0.50 per page: **total R50.00**
- Questionnaires: 10 pages at R0.50 per page: **total R5.00**

#### Accommodation:

- One night accommodation in Coffee Shack Backpackers: **total R120**
- Other nights: free (in friend's guest room)

#### Food:

- Food for three weeks: **total R2000**

#### Transport:

- Return plane ticket with South African Express Airlines from Cape Town to East London: **total R2540**
- Baz Bus from East London to Umtata: **total R210**
- Shuttle from Umtata to Coffee Bay: **total R60**
- Shuttle from Coffee Bay to Umtata: **total R60**
- Baz Bus from Umtata to East London: **total R210**
- Taxi from Bus Stop to Airport: **total R200**

#### Translation:

- Approximately 20 hours at R50.00: **total R1000**

**Equipment:**

- NVIVO Software: free trial package
- Electronic audio recorder: free (borrowed from Zithulele therapy department)
- Batteries from electronic audio recorder: 3 packs at R25 each: **total R75.00**

**Total expected budget:**

- **Total expenditure: R6780**

**5.2 Timetable****June:**

- 14th June 2010, Establish research question.

**July:**

- 7th July 2010, First meeting with potential supervisors Ayako Honda and Lucy Gilson.

**August:**

- 5th August 2010, Meeting with Ayako Honda to discuss completed outline of research topic.
- 31st August 2010, Progress meeting with Ayako Honda.

**September:**

- 27th September 2010, First draft of protocol to Ayako Honda and Lucy Gilson (co-supervisors).
- 28th September 2010, Meeting about protocol and necessary changes.

**October:**

- 25th October 2010, Updated draft of protocol to Ayako Honda.
- 26th October 2010, Meeting about protocol and necessary changes.

**November:**

- 15th November 2010, Complete protocol and submit to Ayako Honda, meet with Joy Fuller to discuss the research budget, ensure all necessary application forms are signed and completed.
- 22nd November 2010, Make final changes to protocol. Submit protocol, synopsis and application forms (with signatures) to The Faculty of Health Sciences Human Research Ethics Committee.

**January:**

- 10th January 2011, Three weeks of data collection in the Eastern Cape.

**February:**

- 1st February 2011, Begin transcription and analysis of data.
- 21st February 2011 Establish search criteria and key words for structured literature review and begin writing up literature review and dissertation.

**August:**

- 10th August 2011, Final draft to Ayako Honda and Lucy Gilson for review.
- 15th August 2011, Submit final dissertation.

## Part II

# Literature Review

## 1 Introduction

The present study explores the factors that are involved in the health care choices that caregivers make when their children are suffering from diarrhoeal diseases. In particular I focus on the acceptability aspect of health care access. In essence, why is it that caregivers continue to seek care from traditional practitioners in the rural Eastern Cape, when health care for children under the age of six years is free of charge at public health facilities. This literature review hopes to highlight relevant studies regarding access to traditional healers and western medicine and to expose areas where further research is required.

The aim of this review is to shed light on what research has been performed surrounding this topic by encompassing four broad areas: Access to Health Care, Acceptability of Health Care, Use of Traditional Medicine, and Child Health in South Africa.

## 2 Methodology

In order to find relevant literature on the above mentioned topics, various search strategies were undertaken as well as consultations with experts in the field. In this search I focused on the key topics of Access to Health Care, Acceptability of Health Care, Use of Traditional Medicine, and Child Health in South Africa.

The search strategies undertaken involved a systematic search of the database platforms of PubMed and EBSCO Host using key words relating to the relevant topics. Examples of these keywords are: “acceptability”, “access”, “child”, “health”, “Africa”, “rural”, “availability”, “affordability”, “costs”, “out-of-pocket payments”, “transportation” and “geographical”.

Through these searches and the references within, as well as certain key papers suggested by experts in the field, literature was obtained. In order to ensure the literature was current and topical I generally favoured articles

published in the past ten years. However I limited the inclusion to publications in English that provided access to full text.

In this document the terms *modern*, *conventional*, *western* and *formal* are all used interchangeably to denote medical professionals that have undertaken training at a university (or training college) and are registered with the Health Professionals Council of South Africa.

The terms *traditional healers* and *traditional practitioners* are also used interchangeably to depict a collective group of practitioners that may be sangomas, inyangas, traditional healers, diviners, faith healers or other practitioners utilising traditional medicine.

### 3 Literature review

Section one regards **Access to Health Care** and comprises three subsections namely “An access framework for health care”, “Findings of a national household survey” and “Barriers to health care access in South Africa”.

Section two encompasses the area of **Acceptability to Health Care** and is discussed using the subsections “Culture”, “Other studies regarding the dimension of acceptability” and “Demand side barriers”.

Section three regards **Use of Traditional Medicine** and comprises the subsections of “Traditional medicine and practitioners”, “Factors that influence use of traditional health care” and “Regulation of traditional practitioners”.

Section four discusses **Child Health in South Africa** in relation to progress towards the Millennium Development Goals (MDG) in particular MDG four: reduction of child mortality.

Finally other factors impacting on health care access are explored before concluding the literature review.

## 3.1 Access to Health Care

There are several models that can be used to evaluate access, however the focus of this review will be a current model that assesses access within the three dimensions of: affordability, availability and acceptability.

### 3.1.1 An access framework for health care

There are many components which influence the state of an individual's health, including the factor of access to appropriate health care (Frost and Reich, 2008). Access involves an individual interacting with a health system in order to utilise health care when necessary (Frost and Reich, 2008; Gilson and Schneider, 2007; McIntyre et al., 2009). This course of action requires sufficient knowledge to decide on appropriate use of services. Thus if an individual is empowered with information the ability to benefit from available services, as well as have productive interactions with a provider, is facilitated (McIntyre et al., 2009).

The three dimensions of access are: 1.) *Availability* which refers to the geographical access, the hours an institution is open and the impact this has on use of health care, and the type of services offered by the staff. 2.) *Affordability* which refers to the financial implications of the health seeker's behaviour and the ability of the individual to pay for these services. 3.) *Acceptability* which looks at the cultural acceptability of services in terms of the individual's beliefs and the provider's attitudes (Frost and Reich, 2008; Gilson and Schneider, 2007; McIntyre et al., 2009). Issues surrounding acceptability will be covered in more detail in the next section.

**Availability** Examples of availability which can impact on the use of these services, are distance from a health care facility and the inconvenience of long queues or waiting times (Ensor and Cooper, 2004). The following studies have researched the impact on access to health care from an availability perspective by evaluating the distance to a health care facility and services available at that facility.

Some studies (Dummer and Parker, 2004; Ray and Ebener, 2008; Rosero-Bixby, 2004) assess access to health care by selectively evaluating the geographic distance from peoples residences to a health care facility (part of the dimension of availability). The technique used by Ray and Ebener (2008) is

particularly interesting as their study uses a computational system to model the terrain of an area according to the physical accessibility to health care. By combining this data with the relative availability of the facility and the mode of travel of the patient the authors are able to establish the “geographic coverage”.

Rosero-Bixby (2004) in their research on Costa Rica use a geographic information system which assimilates an indication of physical accessibility taking into account the distance to a health care facility, the population characteristics and size and resources of the health care facility. These two studies (Ray and Ebener, 2008; Rosero-Bixby, 2004) present one way of evaluating where the need for more health care facilities is greatest and which households are vulnerable in terms of limited physical accessibility to health care facilities. However one needs reliable sources of information in order to apply these techniques.

**Affordability** Affordability issues include the associated cost of traveling to the facility as well as additional costs in the form of indirect costs to the individual and family, such as time taken off work to aid a family member in seeking health care, which can further impede access to health care (Ensor and Cooper, 2004). Several studies (Falkingham, 2004; Jutting, 2004) focus predominantly on the financial implication of seeking health care (the dimension of affordability) and the affect this has on access.

Jutting (2004) examines whether community run insurance schemes benefit the population in an area of Senegal. While they found community based insurance to aid some of the population, with members more likely to seek hospital health care services (with reduced cost to their families), the poorest groups in the area were still excluded from the medical insurance schemes for various reasons.

In this line, attention is draw to the fact that out-of-pocket payments and other costs of health care not only create major barriers to health care but also put families at risk of becoming poverty stricken (The World Health Organisation and The United Nations Children’s Fund, 2010). In order to improve efficiency, out-of-pocket payments should be reduced or if possible eliminated as has been done in South Africa for primary health services (Mathauer, 2009; McIntyre, Okorafor, Ataguba, Govender, Goudge, Harris, Nxumalo, Moeti, Maja, Palmer and Mills, 2008). In addition to removing ser-

vice fees, pre-payment and risk-sharing (such as a community run insurance schemes) should be encourage to protect the poorest groups from impoverishment due to the financial costs of health care (Jutting, 2004; McIntyre et al., 2008).

Although studies on affordability and availability provide useful information, in isolation they do not present a true representation of access without the additional information regarding acceptability of health care services. McIntyre et al. (2009) address the concern that access needs to be evaluated in terms of all three dimensions (affordability, availability and acceptability), “only then can we develop policies and plans that promote real improvements in access”.

### **3.1.2 Findings of a national household survey**

In order to better understand the statistics surrounding use of various forms of health care in South Africa as well as the perceptions towards health care, I investigate findings from a recent study by McIntyre et al. (2008).

In this study reporting the findings of a national household survey based on information from 4800 households in South Africa, McIntyre et al. (2008), present very useful data regarding statistics of health care use and perceptions of the health care system.

The least wealthy individuals in South Africa are likely to live in a rural area (76% of the poorest 20% of the population (poorest quintile)), have no education (27%), nor tapped water (77%), nor flushing toilets (97%) (McIntyre et al., 2008). This has major implications for a disease such as diarrhoea of which the cause is often water borne illness and contaminated water, and which is made worse by lack of cleanliness.

Health care barriers to seeking health care were found to be the highest in the rural areas with 12.9% of those in need of health care not seeking care. These barriers include availability, affordability and acceptability limitations. McIntyre et al. (2008) describe acceptability issues as relating “to the fit between provider’s and patients attitudes towards and expectations of each other and how this affects patient-provider interactions”.

Barriers to health care described by respondents include distance (availability) to the health care facility; cost of transport (affordability) (particu-

larly in the Eastern Cape); and waiting time (acceptability or availability). Respectful treatment seems to impact on where individuals seek health care. Of those who had previously been admitted to a hospital, 75%-90% reported being satisfied or very satisfied, with a greater level of satisfaction being noted in district hospitals. However the authors found that “there appears to be greater satisfaction with services provided by traditional healers than by bio-medical health professionals in either the public or private sectors” (McIntyre et al., 2008).

### **3.1.3 Barriers to health care access in South Africa**

As alluded to in McIntyre et al. (2008), barriers exist between patients and their health care providers. Research by Goudge et al. (2009) focuses on the provider-patient relationship and the shortcomings that lead to impeded access to health care in South Africa. A combination of quantitative and qualitative methodologies was used in this study, highlighting the barriers to chronic care provision. It is suggested by the authors that an ineffective interaction between providers and patients leads to misunderstandings regarding illness and treatment; lack of co-operation; and patients seeking health care elsewhere or choosing to renounce the public health sector. In turn, utilizing an array of providers can impede chronic health care services.

Importantly having adequate resources for seeking health care did not equate to habitual treatment and management of symptoms. This was due to flaws in the health system, such as disrupted drug supplies (Goudge et al., 2009).

Many of the respondents were unsure of their illnesses and could not explain them to the researchers. Furthermore patients appear to not seek clarification or ask questions for instance regarding referral (Goudge et al., 2009). This combined lack of questioning and poor understanding can lead to disempowerment of patients.

Goudge et al. (2009) suggest that poor understanding is a problem on the part of the provider as information is not adequately conveyed, however it could also be that the patient does not believe the explanation that the health care professional provides or they have had inadequate education regarding the body and are therefore unable to fully understand explanations provided by the health care professional.

This reveals a social and cultural distance between patients and providers which can result in decreased patient satisfaction due to the discrepancy between the traditional and formal explanations for illness. Consequently treatments may be seen as ineffective (Goudge et al., 2009).

However Goudge et al. (2009) found that constructive interactions between patients and providers resulted in patients being active in their treatment, believing it to be efficacious, and enabling them to justify medical expenses and explain their illnesses to their support networks.

**Equitable access** An important concept is that of equitable access to health care for all individuals in a country. Common principles of equitable access are: individuals with the same need for health care should have an equal level of access to health care services; furthermore use of health care should be equal for individuals with the same level of need; and health care outcomes should ultimately be equitable in that when they are quantitatively measured they are equal (Oliver and Mossialos, 2004). The World Health Organisation and The United Nations Children's Fund (2010) intimate that access levels are reduced for women and children in poorer families which can lead to inequitable access. Furthermore poverty in families can have the effect of reducing access to information regarding health care services and altering care seeking habits (The World Health Organisation and The United Nations Children's Fund, 2010).

**Empowerment** This leads us to the topic of empowerment. Although in theory if a service is affordable, available and acceptable it should be deemed accessible and therefore utilised, this will not be the case if a caregiver is not empowered. McIntyre et al. (2009) argue that access depends on the empowerment of an individual so that they have adequate knowledge to decide on appropriate use of services. This empowerment facilitates an ability to benefit from the services available as well as aiding the trade of information between the provider and patient (McIntyre et al., 2009). Thus health consumers need to be empowered with information about prevention and what courses of action are available to them if the child requires treatment from a practitioner.

Furthermore if a caregiver lacks education it may not be possible to make informed decisions based on their current knowledge. Thus it is necessary to

be educated, have adequate knowledge about health care services and health as well as be empowered.

**Education** Education is a complex consideration as a factor in health care access. “Education provides the consumer with the basis for evaluating whether they or a dependent require treatment” (Ensor and Cooper, 2004). Education impacts on an individuals lifestyle choices and health care use, and has been previously shown to correlate with good health. Coupled with education, is the need for information about health prior to making decisions in order to make informed choices. Ensor and Cooper (2004) suggest that as health consumers patients are active in seeking their health practitioner of choice. Mothers who are educated may be more able to voice their own opinions, especially if their education has lead them to contributing financially to the household (Ensor and Cooper, 2004).

If information is lacking, patients may not be aware of what services are available to them or how they will be cared for at a health facility. Further information can provide reassurance for example of culturally acceptable practices, (which is a demand-side barrier) aided by the provision of culturally aware and appropriate services (supply-side barrier). Lack of information and education can negatively impact on access by postponing the seeking of care (this can also be impacted on by lack of availability of services or lack of funds), whereas monetary problems are often the primary reason that travel to a health care facility is delayed (Ensor and Cooper, 2004).

## **3.2 Acceptability of Health Care**

As the dimension of acceptability is the main focus of the present study it is covered in more detail in the following section.

### **3.2.1 Culture**

It has previously been argued (Airhihenbuwa and DeWitt Webster, 2004), that health behaviour in Africa is greatly affected by culture and the values of the surrounding community. Thus it is through culture that health is communicated and it should be seen through this lens when trying to express, comprehend and define health (Airhihenbuwa and DeWitt Webster, 2004). With this idea in mind it is not difficult to see why it is that conventional

health care is not always seen as acceptable. Western health care with its focus on the illness and the body often neglects culture, and health behaviour typical to a culture, in its quest to provide care (Airhihenbuwa and DeWitt Webster, 2004).

With culture comes tradition and particular socially respected ways of behaving. In order to be more socially and culturally aware it has been suggested (Airhihenbuwa and DeWitt Webster, 2004) that western health care practitioners dismiss the idea that conventional medicine is the only truth and adopt a culturally sensitive model that addresses the particular society in which they find themselves practicing. For instance a particular culture may consider traditional medicine to be the most suitable approach to treating a particular disease (McIntyre et al., 2009). Other examples of issues around acceptability may be that it is socially inappropriate for mothers to be away from homes for extended periods; or mother in laws (or husbands) may make decisions in the family setting, dis-empowering mothers in their ability to make their own health care choices (Ensor and Cooper, 2004).

Western practitioners need to find ways of understanding this cultural belief especially in the case of patients seeking mixed health care. McIntyre et al. (2009) suggest that if health care providers hold patients responsible for their health concerns (for example if a child suffers complications following use of traditional medicine) they may be less obliging in their care of a patient.

Airhihenbuwa and DeWitt Webster (2004) discuss the adoption of a health care model that attends to “cultural identity, relationships and expectations, and cultural empowerment”. Ideally cultural empowerment should entail shifting focus so that it is not only the negative aspects of culture or health behaviour that are focused on.

### **3.2.2 Other studies regarding the dimension of acceptability**

In order to accurately explore acceptability, in the present study, other research needs to be examined in order to compare methodology and results. The study by O’Gorman, Nyirenda and Theobald (2010) explores the acceptability of the prevention of mother-to-child transmission (PMTCT) service in Malawi. The study is qualitative in nature with a purposive sampling method. Their findings were that PMTCT services are “not currently accessible, acceptable and affordable for all rural women.” Although barriers

to health care at hospitals were found (such as proximity, affordability, and negative health worker attitudes), trust in the hospital remained strong. Additionally it was found that mothers choose to frequent traditional birth attendants (TBAs) primarily as they believe that the quality of care is equal or better than a hospital. The TBAs were deemed more experienced and able to cure illnesses that the hospitals are powerless to treat, for instance curses.

In order to make PMTCT services more acceptable the authors of the study suggest that as TBAs are incorporated in the community, they are in an ideal position to facilitate counseling and testing services for HIV/AIDS (O’Gorman et al., 2010).

A rural study from Uganda utilising both focus group discussions (FGD) and key informant interviews assessed the acceptability of evidence based health care practices for newborns. Acceptability of the evaluated health care practices, was good, however several barriers were found. One of the barriers is that antenatal care is perceived to be for sick women, which is thought to be due to a cultural understanding different from that of modern medicine. Barriers to hospital delivery were “health worker’s rudeness, corrupt tendencies and absenteeism from work” (Waiswa, Kemigisa, Kiguli, Naikoba, Pariyo and Peterson, 2008).

Interestingly the following practices regarding newborns were accepted by the community: maintenance of warmth and cleanliness, exclusive breastfeeding and skin on skin birth contact. Although breastfeeding is considered acceptable, colostrum was felt to not be good for one’s baby (Waiswa et al., 2008).

In South Africa it was found that breast milk can be “polluted” requiring that the child’s body be purged (Friend-du Preez et al., 2009). One of the methods used to purge the child is that of an enema. Unfortunately these days household detergents are sometimes one of the ingredients in the enema, which are thought to have “cleansing properties” (Friend-du Preez et al., 2009). Other ingredients that are used may not be toxic in small dosages but the informal way in which they are measured may mean that the dosage makes them toxic to children.

In the Ugandan study those practices that were not deemed appropriate were: “delayed bathing and putting nothing on the umbilical cord (Waiswa et al., 2008). The perception of the TBAs were that they provide more per-

sonalized health care than the hospital, and have the advantage of being able to treat conditions with their “magical effects”, which hospital staff cannot offer.

### **3.2.3 Demand side barriers**

Demand-side barriers refer to the barriers which impact on individuals, households and communities seeking health care. It has been suggested by Ensor and Cooper (2004) that demand-side barriers may play a very important role in patients’ health seeking behaviours. “Demand is influenced by factors that determine whether an individual identifies illness and is willing and able to seek appropriate health care” (Ensor and Cooper, 2004). Factors for individuals and households include: “age, sex, income, education and knowledge about the characteristics of, and need for, medical treatment”. Community factors include: “cultural and religious influences and other social factors that affect individual preferences” (Ensor and Cooper, 2004). Importantly cultural barriers often hinder poor and vulnerable groups gaining from public spending.

Apart from the commonly cited reasons of availability and affordability (which are usually supply-side barriers, such as maintaining drug supplies or exemption of fees), acceptability of health care services often plays a role in why people choose to not utilise public health care services. “Often, health services of a reasonable quality exist, but few use them” (Ensor and Cooper, 2004).

Belief and attitude towards health and health care can affect the outcome of a treatment to some degree (as can be the case in some placebo treatments) (Bodeker and Kronenberg, 2002). This has important implications in ensuring that patients feel that they have been cured and has the potential for much more extensive research, especially in light of The World Health Organisation’s component regarding the spiritual side to health care.

## **3.3 Use of Traditional Medicine**

### **3.3.1 Traditional medicine and practitioners**

It is estimated that in low and middle income countries, such as South Africa, 80% of the population utilises traditional medicine in their health

care (Kim, 2005; The World Health Organisation, 2002). While McIntyre, Bloom, Doherty and Brijlal (1995) suggest that the public health sector provides free basic primary health care to approximately 80% of the population. This indicates that there must be a substantial use of conventional health care services in conjunction with traditional health care (Meissner, 2004). There is a lack of literature on the reasons for this trend (of using the two health care systems in parallel) however several of the articles published which touch on this topic, have been included in this literature review. Through assessing the reasons that traditional practitioners are sought, it is hoped that light will be shed on how to improve accessibility to formal health care services.

In South Africa it is estimated that there are 300 000 traditional healers in comparison to the 32 000 doctors registered with the Health Professionals Council of South Africa (Meissner, 2004). The comparison in numbers of doctors and traditional healers indicates that traditional healers are able to provide access that conventional doctors are unable to compete with. Furthermore the distribution of traditional healers enables their services to be geographically available (Gbodossou, Floyd and Katy, 2005). Traditional practitioners are respected in their surrounding societies with their advice being “sought, believed and acted upon by community members” (Gbodossou et al., 2005).

Traditional practitioners are often the health practitioners of choice despite the fact that they are not inexpensive (Leonard, 2000). In a South African study (Nxumalo, Alaba, Harris, Chersich and Goudge, 2011) it was found that 64% of respondents spent 10% or more of their monthly expenses on traditional healers, compared to 13.6% of respondents spending more than 10% on government hospital services (while only 2% of respondents spent more than 10% on government clinic services). Spending of this proportion can lead households previously above the poverty line into poverty or advance the levels of poverty for families below the poverty line (Nxumalo et al., 2011).

Traditional medicine is defined by The World Health Organisation (2002) “as including diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness.”

Of the poorest 20% of the population the rate for visiting a traditional healer was 0.25 consultations per person per year (McIntyre et al., 2008). However nearly all outpatient consultation by the poorest 40% of the pop-

ulation in the public sector, take place in clinics, community health centres or district hospitals. Those in the poorest 20% of the population make most of their out-of-pocket payments to district hospitals in comparison to other public health facilities. When looking at the private sector, out-of-pocket payments to traditional healers account for 40.3% of all out-of-pocket payments by the poorest 20% (and over 20% in the next two poorest quintiles). In looking at all those surveyed, with regard to private outpatient services, “the greatest burden for households are those from traditional healers (31% across all quintiles)” (McIntyre et al., 2008).

Traditional healers have a high motivation to exert effort due to the way in which their fees are paid. The patient and provider often agree on a fee that will be paid if the service is successful with a reduced rate if it is unsuccessful. In this way it is in the best interests of the provider to successfully treat the patient (Leonard, 2000; Nxumalo et al., 2011).

This payment system, called a contingent-fee scheme, encourages the traditional healer to shroud the illness and treatment in a veil of mystery. This in turn causes the patient to be very honest about their condition in part due to fear that if they are not truthful they may be affected by the supernatural. As the provider relies on the information given to him by the patient this results in a mutually beneficial relationship (Leonard, 2000).

One area where there is more research regarding conventional medicine and traditional medicine working alongside is in the area of HIV/AIDS. Wreford (2008) suggests that traditional practitioners have a accompanying role to play with formal facilities, where traditional healers perform rituals to decrease stigma and psychological stress associated with HIV/AIDS. In this domain particularly, collaboration between conventional and traditional practitioners could prove beneficial.

Wreford (2008) illustrates that in the case of HIV/AIDS (which could be cautiously adapted to other health conditions) if conventional health staff found that a patient blamed the cause of their symptoms on the supernatural (for example witchcraft) they could then refer the patient to a known, regulated traditional practitioner. If the formal health professional and traditional practitioner had agreed to work together the advantages would be that the formal health care worker could minimize or at least be aware of possible drug interactions (instead of a patient concealing traditional medicine use); the formal health care worker would feel that the traditional healer would respect the conventional treatment; and most importantly the patient could

be confident that all the possible options had been exhausted.

### 3.3.2 Factors that influence use of traditional health care

A study, that reveals very valuable findings about factors that influence use of traditional health care for children under six years of age, was performed by Friend-du Preez et al. (2009), using a sample from the Birth to Twenty cohort. This included five FGD with mothers from the Birth to Twenty study and 18 in-depth interviews with a variety of participants including caregivers, traditional and western health care professionals. Furthermore quantitative data was gathered in survey form from 206 participants, using a sample of convenience.

It was found that the most commonly cited reason for seeking care from a traditional practitioner for a child (under 6 years) was for protection against so called “abantu illnesses” (such as *ibala* and *ipleyiti*) which conventional medicine is powerless to treat. These illnesses include witchcraft, spirits and ancestors. Furthermore belief in the treatment given by a traditional healer represented 40% of the rationale for seeking health care from traditional practitioner (Friend-du Preez et al., 2009). Nxumalo et al. (2011) suggest that apart from belief in the effectiveness of traditional medicine (which represented 52.6% of the reasons for seeking a traditional healer in their study) patients in South Africa also utilise traditional practitioners in order that they are seen by one practitioner throughout a treatment (continuity of care represented 37.2% of the reasons for seeking a traditional healer).

It was felt that social influence from family, including the husband’s family, impacted on the caregivers beliefs. Social pressure or advice from friends also plays a major role in which health care practitioner one will seek care from (Friend-du Preez et al., 2009). Other reasons which were found to impact on participants accessing services included previous efficacy of traditional medicine, respectful treatment, proximity of care and medicines being available (Friend-du Preez et al., 2009; Nxumalo et al., 2011).

When Friend-du Preez et al. (2009) asked where respondents would go if money was not an object, more than half said that they would continue to seek care from traditional healers due to their trust and knowledge of them. Interestingly respondents in the study felt that newborns require protection due to their perceived fragility and vulnerability to the supernatural. In addition it is the presenting symptoms which indicate to a caregiver where it

is that the child should be taken for treatment (i.e. a traditional healer or conventional health care facility) (Friend-du Preez et al., 2009).

The authors found that education is a good indicator for where a caregiver will take a child for health care. “93.8% of caregivers with primary school education or less having given their child traditional medicine compared with 56.1% of those with post-secondary education” (Friend-du Preez et al., 2009). In a recent South African study by Nxumalo et al. (2011) it was found that there was a decline in seeking care from a traditional healer with an increase in wealth.

The most commonly cited reasons for not seeking care from a traditional healer were that the caregiver did not believe in traditional medicine and for religious reasons (Friend-du Preez et al., 2009). It was found that some traditional healers do refer to conventional health care facilities in order for children to obtain a drip, however the child still needs the help of the traditional healer to cure the underlying ailment.

Friend-du Preez et al. (2009) put forward that “regardless of provider characteristics, caregiver beliefs are at the heart of the decision-making process...”. In this they mean that in South Africa, belief in traditional medicine is still strong which leads caregivers to consult with traditional healers in preference to obtaining care from a public sector facility which provides free care to children under the age of six years (Friend-du Preez et al., 2009).

Friend-du Preez et al. (2009) suggest that caregivers are aware of the negative feelings that practitioners at conventional health facilities have towards traditional medicine, but due to caregivers’ unwavering, strong belief in traditional medicine and its effects, they do not take the advice that is given to them (to not use traditional medicine).

Seeking health care can be a time consuming process, hence the convenience of hours can play an important role in decision making (Ensor and Cooper, 2004). Traditional practitioners see fewer people per practitioner as there are greater numbers of traditional practitioners than formal practitioners. This also has the added benefit of shorter waiting time for their patients in comparison to formal institutions. Friend-du Preez et al. (2009) add that as traditional practitioners’ medical services dictate their income it is expected that they will make themselves more available.

### 3.3.3 Regulation of traditional practitioners

Traditional practitioners are an ingrained part of society in South Africa however currently in South Africa they are unregulated. It has been suggested (Meissner, 2004; Gbodossou et al., 2005) that by utilising the huge man power that traditional practitioners represent, South Africa could provide adequate health care services for the population which are culturally appropriate. The role that regulated traditional practitioners could fill would mean that patients could be educated about diseases and prevention, and treated with acceptable health care practices. This in no way negates the role of the conventional health care facility, but rather would be a complementary service, where the traditional and conventional health care sectors support each other (Meissner, 2004).

Unfortunately regulation is a resource intensive process and the “very nature of traditional medicine with its strong religious, magical, spiritual and other supernatural dimensions ... mitigate against any formal structuring of knowledge in the way professionalism may require” (Meissner, 2004). Thus creative methods will be needed in order to enforce regulation.

In addition to regulation “support, education and cooperation” is needed from the conventional health system (Richter, 2003). A problem area regarding access is the lack of collaboration between formal and traditional health care workers, which is perpetuated by lack of communication and understanding (Bodeker and Kronenberg, 2002). Currently many conventional medical practitioners feel frustrated with traditional medicine and this is an area that needs to be addressed before the two parallel health systems (traditional and conventional) are able to complement each other.

Validated treatments, and quality research into safety and efficacy will go a long way in easing the friction between the two health systems. Also by separating the physical treatments and spiritual treatments traditional healers may be able to explain more fully what their treatments entail to formal health care professionals (Richter, 2003). Formal health care professionals need to express their concerns to traditional practitioners in an effort to decrease agitation and increase understanding (Wreford, 2008). Additionally steps need to be taken to maintain the intellectual property rights of traditional practitioners especially in light of the expense of patenting products (Richter, 2003).

The The World Health Organisation (2002) make several suggestions re-

garding traditional medicine. These include: identifying and researching the safest and most effective traditional medicines in particular with regard to relevant high prevalence diseases; identifying the health care roles of traditional practitioners in low and middle income countries and encouraging upgraded skills; preserving and defending local traditional practitioner knowledge as well as protection of medicinal plants through sustainable use.

It has been suggested by The World Health Organisation (2002) that national policies are developed regarding traditional medicine with a focus on regulation, safety and efficacy issues. However currently only 25 of the 191 World Health Organisation member states have national policies of this nature in place (Bodeker and Kronenberg, 2002). Bodeker and Kronenberg (2002) put forward that it is the family influence, availability, affordability and familiarity on a cultural level that ensures a continuation of seeking care from traditional practitioners.

Nations that have achieved some level of traditional and conventional integration include New Zealand, the United States of America and China. Significantly in New Zealand registered Maori traditional healers (numbering approximately 600) must uphold standards which are set by the Maori traditional health practitioner associations. In America oriental medical practitioners must complete a national examination for traditional Chinese herbal medicine (Bodeker and Kronenberg, 2002).

If South Africa is to have success in incorporating traditional medicine into the national health system it is important that one realises that patients have the right to “medicines and treatment that are safe and efficacious” (Richter, 2003). To this end it is important that traditional practitioners do not “overstate or misrepresent the efficacy of their medicines or treatment” (Richter, 2003). Furthermore traditional practitioners that do not uphold certain standards should be reported to an official regulatory traditional healers board (Richter, 2003).

In looking to see whether it is feasible for the primary health care team to include traditional healers, Meissner (2004) provides an analysis from the viewpoint of the four main stakeholder: the consumers (patients); conventional practitioners; traditional practitioners; and the government.

Patients and traditional healers have a recognized relationship in many South African communities as they speak the local language, understand cultural norms and are familiar to the community. Conventional practitioners

were found to be unconvinced of beneficial role of traditional healers. This was due to the lack of scientific information about the safety and efficacy of treatment, leading to skepticism regarding their treatment outcomes. Furthermore Meissner (2004) found that formal health care workers felt that traditional healers fail to recognise when a patient is outside their scope of practice and when referral is required. Due to the current lack of registration, it is also difficult to differentiate between charlatans and benevolent traditional healers.

Conversely traditional healers were often found to be in favour of improving relationships with modern health care professionals, and attend workshops to learn more about conventional medicine. However on this note traditional healers were cautious that their treatments should not be exploited by pharmaceutical companies (Meissner, 2004).

The government has stated that it is committed to supporting the inclusion of traditional practitioners in the health sector, and in 2004, The Traditional Health Practitioners Bill went before Parliament. However the very nature of traditional health care makes it very difficult to regulate due to the supernatural and spiritual characteristics it incorporates into healing. Presently “traditional medicine cannot be taught, assessed or subjected to standardised tests of competence and proficiency” (Meissner, 2004). However that being said it provides for the spiritual and social needs that conventional medicine often does not address, which are particularly pertinent to South African culture.

Regulation and research into the practices of traditional practitioners will hopefully halt the emergence of charlatans; preserve local culture and medicine; provide scientific rationale for why a treatment works; and ensure that patients are exposed only to safe and efficacious treatments (Gbodossou et al., 2005). However there is currently no incentive for large pharmaceutical companies to support research into traditional medicines, because if cheaper treatments were found (for instance in HIV/AIDS treatment) their profits may be reduced (Gbodossou et al., 2005). Furthermore scientific research that is vigorous and maintains high standards is expensive and time consuming. Gbodossou et al. (2005) and Richter (2003) recommend that government and bilateral donors pledge their support, infrastructure and resources to the process of regulation and research.

### 3.4 Child health in South Africa

South Africa is faced with many complex problems of which one is the provision of adequate maternal and child health care. The Millennium Development Goals attempt to tackle some of these issues with Development Goal number four seeking a reduction in the under five mortality rate to fewer than 40 deaths per 1000 children (South Africa Every Death Counts Writing Group, 2008; The United Nations Children's Fund, 2009).

The Millennium Development Goals are a set of goals that were developed in order to address worldwide societal problems. As Hanson et al. (2010) state "there is a substantial gap between what could be achieved and what is actually being achieved in terms of health improvement in low- and middle-income countries".

Although cost effective interventions exist, South Africa is not achieving targets set in the Millennium Development Goals for maternal and child health, due to the fact that coverage of those services is not sufficient. This will continue unless there is an immediate improvement in access to these services. The under five mortality rate has in fact risen between 1990 and 2008 from 56 to 67 deaths per 1000 children (South Africa Every Death Counts Writing Group, 2008; The United Nations Children's Fund, 2009; Hanson et al., 2010).

Millennium Development Goal number four addresses reducing child mortality. In order to fully improve child health in South Africa, for example a reduction in under five mortality from diseases such as diarrhoea, it is necessary to establish why it is that caregivers make the health care choices that they do regarding the seeking of care (South Africa Every Death Counts Writing Group, 2008; The United Nations Children's Fund, 2009).

One of the leading causes of child mortality in South Africa, is diarrhoea. Diarrhoea poses a major obstacle in health care in that it has environmental, social and economical components. For instance in the access to safe, clean water. In the Eastern Cape of South Africa, the incidence of diarrhoea, in 2009, among children who are under 5 years of age was 110 per 1000 children (Health Systems Trust, 2009).

Currently in South Africa many people make use of mixed care, seemingly without desire for continuity of care. For example use of a drip was noted in the study by Friend-du Preez et al. (2009) as being a reason for

utilising a hospital in conjunction with a traditional practitioner, although not all of the participants in their study understood the rationale for using a drip. Nxumalo et al. (2011) found half of the respondents in their study who had sought a traditional practitioner in the previous month had also sought conventional medicine, either simultaneous or in succession.

If there is continuity of care (in terms of patients seeing the same health care professional in follow up visits) it is more likely that patients will feel able to develop trusting, long-term relationships with staff, which benefits communication and open dialogue. However personal trust can be harmed by a face to face encounter where the patient-provider relationship is not productive. In general terms for trust in a public health system to be maintained it is pertinent that facilities provide patients with the services that are expected, such as tolerant staff and required medicines (Russell, 2005).

Kale (1995) elaborates on three aspects that western practitioners could learn from traditional healers. The first is that enough time must be allocated to a patient so that they feel that their concerns have been heard. The patient should also be completely satisfied that they have been taken seriously. Secondly the patient should be treated holistically in that the body and the mind should both be jointly considered. And thirdly the patient should be considered in the context of the community in which they live with family members being included in treatment as needed.

### **3.5 Other factors impacting on health care access**

Other areas of interest to this study regard two identified health economic concepts which play roles in health care access.

The first is that of asymmetry of information, meaning that the health care provider is in control of health information, leaving the patient relatively uninformed (Ensor and Cooper, 2004).

Patients would ultimately like to purchase quality health care which will restore them to health, but as health skill and effort (proxies for quality) are not observable, this is not possible. Thus patients are unable to buy the particular health care that they desire as they lack the necessary information to evaluate if the treatment they have received is the health care that was needed. Instead they must make a choice as to which health care provider they access according to who they feel is appropriate (Leonard, 2000).

A provider who does not involve a patient in decision making process, maintaining information asymmetry and dis-empowering the patient, may additionally reduce the acceptability of health care to the patient (McIntyre et al., 2009).

The second is the factor of uncertainty in health care, which refers to the fact that one is uncertain when a health concern will arise which often means that finances need to be mobilised quickly with short notice (Ensor and Cooper, 2004). Due to the inherent uncertainty in health care, patients are compelled to trust health practitioners intentions and decisions. Furthermore trust assists communication between patients and providers facilitating patient centered treatment. Trust can either be placed with a provider or simply with the institution on a more intangible level (Russell, 2005).

## 4 Conclusion

There is evidence in countries such as Bangladesh that where services to treat diarrhoeal disease are made more accessible to the community that there is a subsequent reduction in child mortality (The World Health Organisation and The United Nations Children's Fund, 2010). Coverage of health care services (such as those for diarrhoeal disease) rely on both the people accessing the services, as well as the services reaching out to individuals in an effective and satisfactory manner (The World Health Organisation and The United Nations Children's Fund, 2010). Thus in order to improve uptake of diarrhoeal disease services, quality, effectiveness and access all need to be addressed.

In the past, few studies have been undertaken to investigate various aspects relating to access to traditional healers and western medicine. The focus in terms of access is often on the availability and affordability of health care, however there is a scarcity of data regarding the acceptability of health care. Of those studies that do tackle the issue of acceptability, the spotlight is frequently on HIV services. More research is needed in relation to acceptability of access to other health care services such as child health care.

South Africa is falling short of the Millennium Development Goal number four of reducing child mortality. Although cost effective interventions for diseases, such as diarrhoea, currently exist, due to the low coverage of numerous services, set targets are yet to be met (Hanson et al., 2010). One

of the components in Millennium Development Goal number four is that of reducing the under five mortality rate to under 40 deaths per 1000 children or achieving a average yearly rate reduction of 4% or higher for the period 1990 to 2008 (South Africa Every Death Counts Writing Group, 2008; The United Nations Children's Fund, 2009).

In order to address the problems associated with not meeting the Millennium Development Goals, it is important to understand why it is that these goals are not being met. In South Africa, there is currently a parallel health care system of traditional practitioners and public sector facilities. In understanding why the coverage of services is low one needs to understand the rationale for the public's health care choices. McIntyre et al. (2009) suggest that access needs to be evaluated in terms of all three dimensions (affordability, availability and acceptability), in order to truly understand barriers and enablers of health care use.

“Patients seek quality health care because it improves not only their experience of visiting a health care provider, but their health as well” (Leonard, 2000). It has been proposed that “the benefits of health care come not just from the ability of a health care provider to produce health but from the provider's motivation to do so” (Leonard, 2000).

In some ways this quotation sums up the most important aspects of health care. Patients are not passive in their choice of health care but rather have many internal and external factors playing roles in their decisions. Patients choose what they feel is the best quality health care as they see that this will be the most beneficial choice for their health. However a patient's choice of quality health care may not correspond to health care of the highest quality. Thus empowerment is needed in the form of education and information regarding health and health care in order for South Africa's health care system to be wholly utilised. Furthermore a health care provider is impacted on by various choices, one of which is motivation. Motivation is an aspect which can determine the quality of health care due to its result on the attitudes and behaviours of health care staff.

Although in the past studies have been completed with regard to access in terms of affordability and availability, acceptability still requires more intensive research. Demand-side barriers and acceptability in general are difficult topics to research as they must be studied in a natural environment where many confounders may be present (Ensor and Cooper, 2004). Thus one should limit the other factors by selecting a suitable study area if possible

or more importantly acknowledge that dimensions within the access framework (acceptability, affordability and availability) should not be studied or considered in isolation.

Furthermore data regarding the rationale of patients utilising traditional practitioners either in tandem or in parallel to conventional health care services is lacking. The advantages of incorporating traditional healers into the national health system would be that of enabled use of local knowledge, which treats both the physical and spiritual aspects, providing psychological support (Richter, 2003; Wreford, 2008).

Resources need to be allocated, so that policy can be made with regard to traditional practitioners. Only then can regulation of traditional practitioners take place, ensuring safe and efficacious treatments for society. Furthermore studies from a public health perspective are needed to assess cost-effectiveness, quality of health care and patient satisfaction when using traditional and/or conventional health care services.

## Part III

# Journal Manuscript

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### Abstract

**Background:** Diarrhoea presents a considerable health risk to young children and is one of the leading causes of infant mortality. Although proven cost-effective interventions exist, South Africa is falling short of reaching the Millennium Development Goals set for maternal and child health. The rural area surrounding Zithulele in the Eastern Cape of South Africa, like many rural areas, continues to have a parallel health system comprising traditional practitioners and formal health care services. Historically this is the area of the AmaXhosa People who speak IsiXhosa and practice traditions pertaining to their culture. It is in this setting that this study aimed to qualitatively examine the acceptability of access to Zithulele Hospital.

**Methods:** Using a purposive sampling technique, 8 focus group discussions (FGD) and 11 key informant interviews were chaired by the primary investigator in January 2011. These FGD and interviews explored the reasons that mothers seek health care for their children with diarrhoea, either from a traditional practitioner and/or a formal facility.

**Results:** It was found that seeking health care from a traditional practitioner is deeply ingrained in the culture of the rural society around Zithulele. People's beliefs about the causative agents of diarrhoea are at the heart of seeking care from traditional practitioners, often in order to treat curses, witchcraft and bad spirits. A combination of care is acceptable to the community, but not necessarily to the formal health care staff. This is due to areas of concern such as the inclusion of detergents in some traditional medicines and the unknown ingredients which could be toxic to children. These factors highlights the complexity of the task of regulating traditional

practitioners.

**Conclusion:** Traditional practitioners can be seen as a valuable human resource in South Africa, especially as they are culturally accepted in the communities they practice in. However if allopathic and traditional practitioners are to work towards a common goal of providing safe health for all, standards of practice that provide safe, efficacious treatment should be supported. Additionally more communication is needed between formal and traditional practitioners to aid mutual understanding.

## Highlights

1. Seeking health care from traditional practitioners appears to be profoundly ingrained in culture of the rural society around Zithulele.
2. A deep unquestioning belief in traditional practitioners ability to treat curses, bad spirits and witchcraft is central to their involvement.
3. A combination of formal and traditional health care appears to be acceptable to the community surrounding Zithulele Hospital.
4. Regulation of traditional practitioners is needed prior to formalised referral between western and traditional practitioners.
5. At a local level intervention is needed regarding the use of detergents in some traditional medicines for infants.

## Keywords

Acceptability, access, child-health, South Africa, rural, traditional practitioners

# 1 Introduction

South Africa has a very unique situation when it comes to health care due to its history and the implications of this history. The particular features that make it unique are, the longstanding use of traditional practitioners, as well as a history of previous colonial rule, previous apartheid policies and discrimination, and post apartheid health care reform (Coovadia, Jewkes, Barron, Sanders and McIntyre, 2009). Although not all these factors directly relate to health care, to a degree, they are intertwined with South African health care. There are, however, other low and middle income countries that one can cautiously compare South Africa's health situation to, in an attempt to suggest possible strategies for improving the health care system. For instance one can draw parallels between South Africa; Ethiopia; India and Bangladesh (Balabanova, McKee and Mills, 2011; Mahmood, Iqbal, Hanifi, Wahed and Bhuiya, 2010; Talukder, 2011).

Like South Africa the rural population in Bangladesh is served by government health facilities, as well as utilising forms of non-allopathic medicine. It was found in Bangladesh that patients often seek non-allopathic medicine prior to attending a government health facility where the patient load per physician is very high (Talukder, 2011).

Balabanova et al. (2011) imply that Bangladesh like South Africa, needs to maintain effort to decrease child mortality in an attempt to reach Millennium Development Goals. Unlike South Africa, Bangladesh is considered to be 'on track' to meet the Millennium Development Goal number four, regarding reducing the under five mortality (Balabanova et al., 2011).

In Tamil Nadu in India, the government has made a concerted effort to incorporate indigenous medicine in its primary health care services. Additionally support of indigenous service has been provided by promoting research into indigenous medicine (Balabanova et al., 2011).

As discussed in a paper by Coovadia et al. (2009) South Africa's history has played a prominent role in the current health situation. In order to meet the Millennium Development Goals set for South Africa, focus is needed to rectify 'income inequality, improve access to the full range of social services, introduce a broad ranging development policy, and promote gender equity' amongst other problems (Coovadia et al., 2009).

Diarrhoeal diseases are an important problem to address if the Millen-

Millennium Development Goals are to be achieved in South Africa, specifically, the reduction of child mortality. The environmental context, as well as social and economic factors, play an important role in diarrhoeal disease, for instance in the ability to access clean, safe water. In low and middle income countries such as South Africa, pneumonia and diarrhoeal diseases are responsible for approximately 40% of deaths in the under five age group for children (The United Nations Children's Fund, 2009).

In South Africa the under five mortality rate has actually risen between 1990 to 2008, from 56 to 67 deaths per 1000 children. This indicates that the country is not progressing towards the Millennium Development Goal (number four) of reducing the under five mortality rate to under 40 deaths per 1000 children or achieving a average yearly rate reduction of 4% or higher for the period 1990 to 2008 (South Africa Every Death Counts Writing Group, 2008; The United Nations Children's Fund, 2009). In the Eastern Cape of South Africa, the incidence of diarrhoea in children who are under 5 years of age was 110 per 1000 children in 2009 (Health Systems Trust, 2009). There are relatively cost-effective interventions available to prevent or treat diarrhoeal diseases but the low uptake of these interventions is problematic (Waiswa et al., 2008; South Africa Every Death Counts Writing Group, 2008; The United Nations Children's Fund, 2009; Hanson et al., 2010).

Consequently, the issue of access to those interventions needs to be addressed. One way to conceptualise access is by using a model which encompasses three dimensions: affordability, availability, and acceptability. Availability refers to the geographical access, the hours an institution is open and the impact this has on utilisation and the type of services offered by the staff. Affordability refers to the financial implications of the health seeker's behaviour and the ability of the individual to pay for these services. Acceptability looks at the cultural acceptability of services in terms of the individual's beliefs (both religious and cultural) and the provider's attitudes (Frost and Reich, 2008; Gilson and Schneider, 2007; McIntyre et al., 2009).

A review of current literature has revealed that little study has been undertaken on the issue of acceptability, while there are a relatively large number of studies that address the issues of affordability and availability.

In South Africa, where traditional medicine is commonly practiced (particularly in rural communities), when children suffer from diarrhoeal diseases, mothers frequently take them to traditional practitioners rather than to for-

mal health facilities. This is despite the fact that formal health facilities provide free services to children under six years of age. This pattern (of utilising traditional practitioners) leads to a low uptake of formal health care services or delayed treatment of diarrhoeal diseases in children (Friend-du Preez et al., 2009; Kim, 2005).

Similarly in Bangladesh Mahmood et al. (2010) found that more than half of the participants in their study (who suffered a bout of illness and sought care) chose to seek care from a 'village doctor'. Talukder (2011) suggests that following traditional medicine, if the medication fails to help, or the progression of the illness is rapid, patients go to a government facility at which time they are usually very sick. "Free consultation and an intimate social relationship are two reasons that inspire their actions" in seeking care from a village doctor or drug seller (Talukder, 2011).

Talukder (2011) suggests that this course of action puts the patient in a vulnerable position. They are at the mercy of the doctor's decision with regard to cost and due to the progression of their illness the decisions need to be made promptly. Hence this situation can produce a 'paternalistic' patient-doctor relationship (Talukder, 2011).

Unlike in Bangladesh where traditional practitioners belong to a regulatory board and study at a teaching college (Balabanova et al., 2011), South African traditional practitioners are currently unregulated and receive no formal training.

Historically the land around Zithulele Hospital belongs to the AmaXhosa People, who converse in IsiXhosa and follow certain traditions relating to their culture. Prior to the arrivals of missionaries in the Eastern Cape there would have only been traditional practitioners who conversed with the AmaXhosa's Godlike Supreme Being via their ancestors. In this way traditional practitioners are able to establish the cause of a person's misfortune or illness (Broster, 1981). Traditional medicine can be defined as treatment practices that were established in rural areas before the advent of western medicine in the area and that continue to bear a resemblance to these techniques (Leonard, 2000).

It is estimated that in low and middle income countries, such as South Africa, that 80% of the population utilise traditional medicines (Kim, 2005). Although it is often thought that traditional practitioners are sought as they are inexpensive, it was found (Leonard, 2000) that this was not the case.

Leonard (2000) ascertained that payments vary depending on the outcome of the care provided (as agreed to, prior to treatment, by the patient) in that a successful treatment results in a higher payment than an unsuccessful treatment.

In the past 15 years there has been a shift to improve access to health care in South Africa. This has included “a clinic building programme, free primary health care, exemptions for hospital fees for the poor, cash transfers, and a patients’ rights charter” (Goudge et al., 2009). The mix of western and traditional culture can be seen in other areas of peoples lives in the area around Zithulele Hospital, thus it is understandable there exists a mix in health care too.

This study explores the reasons why mothers more frequently seek care from traditional practitioners than formal health facilities when their children develop diarrhoeal diseases, with a particular focus on the acceptability aspect of health care access.

The study aims to explore factors affecting the acceptability of seeking treatment from formal health care facilities among caregivers of children with diarrhoeal diseases in comparison with seeking care from traditional practitioners.

Specifically, the study examines:

1. People’s belief in or the perceived effectiveness of traditional medicine
2. People’s belief in or perception of causative agents and appropriate treatment of diarrhoea
3. Existing social pressure regarding certain types of health care services
4. Perceived responsiveness of traditional and formal health care providers
5. Attitudes of formal health care workers towards patients’ beliefs (regarding the effectiveness of traditional medicine and causative agents and appropriate diarrhoea treatment).

Conceptually this study attempts to expose the acceptability of services provided by formal and traditional practitioners. Through the acquisition of greater understanding of health care choices one hopes that the health care statuses of individuals in the community are enhanced. Greater understanding of the processes involved could aid decision making as to where

focus should be placed, how to proceed from the current situation we find ourselves in, what policy making is needed and whose support is required.

The study also attempts to draw policy implications on how to bring about mutual understanding between western and traditional medicine and extract insights on the appropriate balance between two types of health care services in terms of health care access.

## 2 Methodology

### 2.1 Study setting

Zithulele is a Missionary Hospital in the Eastern Cape of South Africa, which was established in 1956 and is now a government run District Hospital (Gaunt, 2010). It is approximately 90 Kilometers from Umtata (the nearest city) where patients are generally referred for secondary and tertiary hospital services, and 260 kilometers from East London (the second closest city). The road from Umtata ends in a cul de sac at Zithulele Hospital, there is no formal village except for a small shop, church and hospital. The area around Zithulele comprises pastoral landscapes, with few roads between dwellings. Most of the population resides in mud huts with thatch roofs. Most households do not have electricity or running water, but rather collect water from rivers.

The O.R Tambo District in which Zithulele falls is one of 18 identified priority health districts within South Africa. These health districts have been selected according to maternal and child health and socio-economic indicators so that focus is placed on those districts most in need of improvement (Multisectoral HIV and AIDS Support Programme, 2011). The incidence of diarrhoea in the district in 2007 and 2008 was 173.5 per 1000 (Day, Barron, Monticelli and Sello, 2011) in comparison to the provincial incidence of 110 per 1000 children in 2009 (Health Systems Trust, 2009).

Although interviews were formal in nature it should be noted that due to the setting, interviews tended to be undertaken in non-ideal situations. There were often children, chickens and dogs coming in and out of the houses. Sometimes people were cooking or cleaning during the interviews.

## 2.2 Perspective

The primary investigator's (PI) perspective is that of a white South African female, who was brought up in a western culture with western medicine. The PI then worked as a physiotherapist at Zithulele Hospital in the Eastern Cape for one year, in a multidisciplinary team. Thus she is familiar with the area both geographically and socially, having spent a year working, treating patients, conversing in IsiXhosa and engaging with the community at Zithulele Hospital, in the surrounding clinics and homesteads. Although the PI did live in the rural area around Zithulele for a year and was known to the community, the majority of her life has been spent living in a city.

## 2.3 Data collection

Data was collected in the area surrounding Zithulele Hospital, during three weeks of January 2011. Data collection methods included both key informant interviews and focus group discussions (FGD). Both the key informants and FGD participants were recruited purposefully. The FGD participants were recruited with the help of health professionals and traditional practitioners practicing in the area as well as other community members.

A small pilot study was undertaken prior to starting the formal study to briefly assess the data collection tools (semi-structured questionnaire and an agenda for the FGD). This comprised one key informant interview with a health professional at Zithulele hospital in a private room, and one FGD with two consenting mother's at Wilo Clinic (approximately 28km or 45 minutes drive from Zithulele). These participants were asked directly if they would take part in the pilot study. After listening to the answers elicited from the questionnaire and agenda, it was felt that modification was unnecessary as the participants had provided valuable insights in their answers. And so the formal study ensued. Data from these two sessions was not included in the analysed data.

There were 11 key informant interviews undertaken (see *table 1*). Participants that were interviewed (using semi-structured questionnaires) were health professionals (doctors, a nurse and therapist) a community member, a minister and traditional practitioners (sangomas and a traditional healer). This was done in order to obtain information regarding why caregivers utilise traditional practitioners in preference to formal health care services when their children suffer from diarrhoea.

They were interviewed at Ngcwanguba Clinic (approximately 23km or 40 minutes drive from Zithulele); Wilo Clinic (approximately 28km or 45 minutes drive from Zithulele); Zithulele Hospital; residences of staff on hospital property; and residences of traditional practitioners within walking distance from Zithulele Hospital.

FGD comprised 8 FGD, with 2-9 participants in each group and a total number of 30 participants (see *table 2*). These FGD were held at Ngcwanguba Clinic; Wilo Clinic; and residences of traditional practitioners and others within walking distance from Zithulele Hospital.

Data collection tools included a semi-structured questionnaire for the interview and an agenda for the FGD respectively, which were created using existing literature. By performing a literature review during the initial stages of this study, findings from other studies were assimilated to form a list of probable factors which might influence where a mother would take her child if her child had acute diarrhoea. The PI must note that although these factors stem from literature and prior findings, they assume that mothers around Zithulele may act in a similar way to those individuals previously studied. Although other factors such as geography, economic circumstances, organisational and bureaucratic components may (and in all likelihood do) play a role in the accessibility of health care at Zithulele Hospital, these were not incorporated into the questionnaire or agenda as the focus of this study centered on acceptability of health care.

The topics covered in the interviews were beliefs (in relation to the causative agents of diarrhoea, spiritual beliefs and belief in traditional medicine) of the key informants, their/ nurses and doctors tolerance of patients' beliefs and the degree of fit of their beliefs with those of the community members.

The agenda for the FGD, utilised a scenario about a woman whose child is sick with diarrhoea. The participants were then asked questions regarding the choices she makes and asked what they might do in her situation. The FGD covered the agendas concerning the reasons for utilising services or not, participants cultural and religious beliefs, their beliefs in the causes of diarrhoeal disease, the perceived responsiveness of the health care providers, as well as social pressures.

Data collection was administrated by the PI, who facilitated the interviews and FGD. Interviews were held in English where possible, otherwise

translation was aided by a translator fluent in English and IsiXhosa. All FGD were held in IsiXhosa and questions and answers were translated by a translator. An electronic audio recorder was utilised in all the interviews and FGD. Data was gathered from consenting participants in a variety of locations as indicated in *table 1 and table 2*.

Due to financial and time constraints it was felt that FGD would enable contact with a wide audience of participants with first hand knowledge of the community, interacting as a group to produce insights that might not have been elicited in a one-on-one interview. It was further hoped that FGD would illicit a common voice for mothers from the area. The use of a scenario in the FGD was hoped to enable mother's to give their opinions freely about the scenario without feeling that they were exposing too much of their personal experience in front of the group, stimulating them to talk openly amongst the group.

Key informant interviews were undertaken with a select few, who were felt would represent aspects of allopathic and traditional health care, and the community as a whole. It was hoped that key informant interviews would probe and question the participants in order to obtain information about the topic at hand, from a quite a diverse range of community 'experts'.

Mothers who were younger than 18 years of age were excluded as ethical clearance was only obtained to question those participants who were legally able to give informed consent to take part in the study.

*Table 1: Participant information regarding key informant interviews*

Title	Location of interview	Code
Community member	Wilo Clinic	Community member
Doctor	Private residence	Doctor One
Doctor	Private residence	Doctor Two
Doctor	Private residence	Doctor Three
Therapist	Private residence	Therapist
Minister	Private residence	Minister
Nurse	Office room at Zithulele	Nurse
Sangoma	Ngcwanguba Clinic	Sangoma One
Sangoma	Private residence	Sangoma Two
Sangoma	Private residence	Sangoma Three
Traditional Healer	Private residence	Traditional Healer

*Table 2: Participant information regarding focus group discussions*

Number of participants	Age	Location of FGD	Code
9 women	18-50	Wilo Clinic	Wilo FGD
2 women	18-19	Ngcwanguba Clinic	Ngcwanguba FGD One
5 women	19-40	Ngcwanguba Clinic	Ngcwanguba FGD Two
4 women	40-60	Ngcwanguba Clinic	Ngcwanguba FGD Three
2 women	18	Sangoma's residence	Sangoma FGD One
3 women	23-30	Private residence	Sangoma FGD Two
3 women	40+	Grant pay point	Sangoma FGD Three
2 women	28-32	Traditional Healer's residence	Traditional Healer FGD

## **2.4 Data analysis**

A qualitative exploratory approach was used for data analysis. Both inductive and deductive processes were utilised to analyse the data. Themes were developed based on a literature review, leading to study objectives, however other themes identified during the process of data collection and analysis were explored.

The electronic audio files were transcribed word for word in English in a quiet environment. It was felt that the translations by the translator provide cultural interpretation and insight into the subtle nuances of IsiXhosa dialogue and hence these translations were used in the analysis. Quality of translation was ensured by the PI personally verifying the IsiXhosa translations.

Coding was done manually (using Microsoft Office Word 2003), by firstly identifying recurrent ideas, grouping these systematically into broader themes, reducing the themes into concepts and then seeing how they applied to the framework objectives developed prior to the study. To ensure that the interpretation is sound a framework based on current literature was developed prior to the study, however the interpretation and understanding is that of the PI.

## **2.5 Limitations of the study**

As this was a small, unfunded study, it had both time and financial restrictions. These restrictions may have limited the study as the PI was unable to fund word for word translation of the interviews and FGD, after they had been recorded, by someone whose mother tongue is IsiXhosa. However the PI hopes that by personally verifying the translations, that translation errors have been kept to a minimum.

These restrictions may also have limited development of the questionnaire as the PI was only able to visit the site once for three weeks and so only tested the quality of the interview and FGD in the pilot study in the days leading up to the formal study. However time was taken to listen to the pilot interview and FGD in order to establish if it prompted interesting and insightful discussion, which it did, and hence there appears to be a richness to the data obtained in this research.

The PI acknowledges that there may have been limitations in the questionnaire. These limitations may have resulted as the questions at times elicited responses that were very basic in nature, only scratching the surface of the 'whole story'. Language barriers occasionally meant that meaning was lost in translation sometimes resulting in a line of questioning becoming stunted or abandoned. This can be seen as a limitation of working with a translator, however the translator was able to add cultural perspective that would have been lacking if PI had translated the interviews and FGD alone. In order to mitigate short answers, both the PI and the translator made a great effort to pursue a line of questioning to its completion. Additionally the fact that the PI can converse IsiXhosa meant that translation errors were kept to a minimum.

The framework although based on current literature may have incorporated the PI assumptions in that it predicted some of the expected themes that were thought may emerge. However by utilising an inductive approach to the data analysis the emergence of themes and ideas other than those explored in the framework was possible. A deductive approach was then utilised to detect if these ideas, when compared to the framework, were similar in nature.

The use of FGD may have meant that the less vocal participants did not express their opinions. Furthermore those who had opposing views may not have voiced their opinions in order to keep the peace. However as the FGD were facilitated, those women who were particularly quiet were encouraged to voice their opinions. By making use of the scenerio women were able to express their opinions through the actions of a fictional character.

The PI also recognizes that the focus of this study has fallen more heavily on mothers' interactions with traditional healers and although this is an important part of access in this area it is only a part of the whole story. However this was found to be an interesting area of focus in the setting of Zithulele Hospital, and was a topic that those in the key informant interviews and FGD discussed freely.

The methods used for recruitment (aided by health practitioners, traditional practitioners and community members) may have meant that certain groups of individuals were excluded. For instance mothers that tend to treat their children at home, mothers that take their children to general practitioners that are not working in a hospital setting, or mothers that are socially outcast. Although this may have been the case, no mothers were

purposefully excluded. Furthermore, the use of several people aiding with recruitment meant that there was a wider base of participants.

The perspective of the PI may have altered the interpretation of the data, however as a systematic approach was taken bias was hopefully kept to a minimum.

## 2.6 Theme relationships

*Attitudes of formal health care workers towards patients' beliefs*, (both cultural and religious beliefs) especially with regard to tolerance can be seen to dictate the patients' *perceived responsiveness of traditional and formal health care providers*. The *perceived responsiveness of traditional and formal health care providers* can also be impacted on by a patients previous experience or *existing social pressure regarding certain types of health care services*.

*Attitudes of formal health care workers towards patients' beliefs* also have to do with patients' expectations; trust; and knowledge of what type of health care should be provided. Another dimension is that of tolerance or lack of tolerance between traditional practitioners and formal health care workers. This again can be based on previous experience; personal beliefs (cultural or religious); lack of understanding when it comes to knowing what is done in the diagnosis and treatment stages; disharmony between belief systems and not trusting the provision of health care.

*People's belief in or perception of causative agents and appropriate treatment of diarrhoea* is likely to affect *people's belief in or the perceived effectiveness of traditional medicine* as people generally make health care choices based on their knowledge or belief of a causative agent and hence have preconceived ideas of how they should be treated.

**Text box 1: Explanation between traditional practitioners**  
(From participants responses)

**Sangoma**

A sangoma or an iqgirha is a person who has been called to ukuthwasa, become a sangoma, by their ancestors. A sangoma is said to 'dream' prior to becoming a sangoma. It is important that a sangoma does rituals as well as treating people. As long as a sangoma is doing the necessary rituals she is even able to work in another job such as a pharmacist observed at one of the clinics visited by the primary investigator.

Interestingly it was mentioned by several people that it is not something that people want to do because it is hard work and is not always pleasant. Prior to becoming a sangoma the person becomes 'sick' for example some sangomas feel that their entire body aches. Once they have accepted that they are being called to become a sangoma then this 'sickness' disappears.

**Traditional healer**

A traditional healer or inyanga or iqwele trains to be a traditional healer at a 'school', however they also receive visions in which their ancestors instruct them. For example their ancestors may tell them where to go to collect the necessary ingredients for their medicines and how to make the medicines or perform certain rituals.

The Community Member explained that some traditional healers will be able to treat one problem and not another. The example which was given was that of throat cancer, because traditional healers are sent to find ingredients for their medicines by their ancestors some will not be able to cure throat cancer while another may be able to.

### **A Prophet**

Prophets or prophetesses or abathandazeli are people who have been called to be sangomas but they have a strong affiliation with a church.

*“She can see the things that a sangoma can see but the difference is she has got a church or she works for the church.”* Traditional FGD

### **A herbalist**

A herbalist trains in a similar way to that of a traditional healer. The participants in the Traditional FGD said that some herbalists have visions just like a sangoma does. Although sometimes they can sense what is wrong with a person, they cannot always treat the problem. If this is the case they will refer a patient to a traditional healer for treatment in a analogous way to that of a district hospital referring to a secondary hospital.

## **3 Findings**

In this section the PI presents the primary findings of the study with regard to why mothers/caregivers choose to take their children, suffering from diarrhoea, to traditional healers rather than to clinics or hospitals. These findings are discussed in terms of various recurrent themes identified both in the pilot study and throughout this study.

### **3.1 Perceived effectiveness of modern medicine**

The first theme is that of the perceived effectiveness of modern medicine in the community and the possible implications this has for how a caregiver will respond to a case of diarrhoea.

It was found in general that the community held mixed feelings towards hospitals and clinics. Several respondents stated they would gladly utilise clinics and hospitals because they knew that they would be afforded help there, in some cases community members willingly stated that there is indeed “no place like a hospital”. Other respondents utilised modern facilities less out of faith in modern medicine but rather because they either did not believe in traditional medicine or they did not know of a good traditional practitioner.

*“You know where to go if your child is sick and because now there is a lot of people getting sick. So there is no place like hospital you know your child is going to be helped at the hospital.”* Wilo FGD

Another common reason for caregivers taking their children to hospital, or indeed for a traditional healer to refer a child to the hospital, is that of an intravenous drip. There exists an understanding in the community that an intravenous drip will strengthen a child. Giving a child strength is something that in general traditional practitioners are unable to do and therefore is a common reason for children to be taken to the hospital. It is perhaps important to note that the hospital is not necessarily seen to be curing the child, but rather to just strengthen it.

With regard to health education it was found that Zithulele in particular has a reputation in the community for providing basic education to caregivers. However it was found that there still exist inconsistencies in the community’s cultural beliefs. Some of those interviewed spoke of the first milk (colostrum) not being good for babies as it can cause illness (*amalaze*, a traditional illness). More concerning was the belief that if the colostrum is ingested it should be purged from the child, for example by giving the child milk of magnesium.

Contrary to this finding some respondents did say that they had been treated and discharged from the hospital without the hospital staff explaining the problem to their patients. This could be due to the discrepancy of beliefs between traditional and modern medicine (see section 3.3).

**Text box 2: Definitions of traditional illnesses**  
(From participants responses)

**Plate (ipleyiti)**

Ipleyiti is thought to be a problem in the child's stomach which affects all children. Although no one interviewed was able to tell the primary investigator if it affects all races. The symptoms are that the child is listless, there are prominent veins on the abdomen, the stomach is bloated, the tongue is white (there can also be sores in the mouth) and the diarrhoea is green or alternatively the child has 'air' in the stomach. The belief is reinforced by the observation of black faeces passed by infants (meconium).

Plate is treat prophylactically by giving the child such things as milk of magnesium, gripe water, muthi wenyoni, drops like hernurses and staldropples or with medicine purchased from a traditional practitioner.

If this is not done then the child will develop the problem of ipleyiti which then needs to be treated by a traditional practitioner.

**Ibala**

Ibala is something that is caused by a bad spirit before the child is born for instance if the pregnant mother was cursed by standing on a bad spirit. The child has a writhing neck and does not sit up straight.

The primary investigator was told that one can sometimes see a red mark on the neck which spreads up the head. It is important that this red mark does not spread to the fontanel.

*"Because if its here [on the fontanel] you can't heal the child the child is going to die." Community Member*

*"They get healed, because those that have got Ibala you just cut [with a blade often on the neck], do the cuts so they get help. Then they give them medicine. Yes it's the herbal medicine. Ja, it's the natural herbs, that they get from the bushes and they put... when they do the cuts they put that black powder. We call it Insisa I dont know how you call it in English. Yes Insisi. Then after they burn something. Ja then the child can smell [inhale] that thing, then the medicine. Traditional medicine after that."*

Sangoma One

### **Inxeba**

Inxeba is a bad spirit that affects a baby after they are born. It either affects the anus or the fontanel. It is not necessarily that the baby is cursed but rather that they are affected by a bad spirit, as seen in the following quotation regarding a 'snake'.

*“Inxeba also is bad spirit that...maybe goes to the baby...its like maybe if...lets say the father of this house has got a snake...like he's a witch...so he's using the snake...so like that snake is maybe going to face that baby and he catches inxeba that way.”* Sangoma Two

## **3.2 Perceived effectiveness of traditional medicine**

The second theme which is interlinked with the first theme discussed in section 3.1, is that of people's belief in traditional medicine and its perceived effectiveness in regard to the actions of caregivers.

The most prominent idea with regard to belief in traditional medicine is that in the case of 'bad spirits', doctors at a formal institution are unable to help and the child should be taken to a traditional practitioner in order to be healed. *Ibala*, *inxeba* and *ipleyiti*, are all examples of conditions that several of those interviewed felt are best treated by a traditional practitioner rather than at a formal institution. Some other reasons identified as leading one to seek care from a traditional practitioner were that of proximity particularly relating to urgency in treating one's child and that previous experience or habit has led one to first think of a traditional healer when facing disease.

Several respondents stated that seeking care from a traditional practitioner relates purely to the beliefs (regarding the causative agents of diarrhoeal diseases) of the caregiver and her understanding of disease rather than the beliefs of the community as a whole. If the caregiver attributes her child's diarrhoea to a curse for some reason then it is highly likely that she will request help first from a traditional healer.

The Therapist interviewed shared this view in that the reason that a mother chooses to seek care at either a traditional practitioner or at formal health care facility is essentially the same.

*“Because every mother wants to do what's best for the child and they believe it's good and helpful.”* Therapist

These two ideas, of seeking care from a traditional practitioner being purely related to beliefs and mothers choosing where to take their children being based on where they believe they will find the best care, illustrate to us that a mother's underlying belief system influences what actions are deemed to be 'good and helpful' to the child.

Another recurrent idea was that of previous help. In general if one has received satisfactory assistance for a particular ailment in the past, from either a traditional practitioner or a formal health care facility, then one should return there. However if the illness displays different symptoms, and one has no previous experience to rely on, the caregiver will instead rely on their underlying beliefs (in the causative agents of diarrhoeal diseases).

Although some of the participants believed strongly that traditional medicine works, others modestly stated that they are aware that it only works some of the time.

*"...if you take your child there, in a belief that she is going to be healed, she gets healed most of the time."* Sangoma One

A FGD participant, who happened to be a sangoma, told her tragic story which includes a series of choices illustrating the complex decisions that people make in terms of their health care. Furthermore her course of action illustrates how traditional and modern health care is used in tandem.

Her child had *ipleyiti*, was vomiting and had diarrhoea. Initially she took her child to the clinic to treat the child but then went to the traditional healer to get medicine for *ipleyiti*. She said that the medicine helped initially (it was not ascertained what the medicine consisted of), but she then took the child to an unregistered doctor, who did not take her money but urged her to go to Zithulele as soon as possible.

At Zithulele she said the formal practitioners were upset that she had given her child herbal medicine. The child was put on a drip but unfortunately it was too late for the child and he passed away.

We do not have all the necessary information in order to draw conclusions as to the cause of this child's passing, however one can assume that to some extent the act of seeking multiple treatments may have delayed the child from seeking the care that she needed to be treated. This particular case is an illustration of how one's beliefs about the causative agents of diarrhoea

and where the best place to take a child for treatment can conflict, and have terrible consequences. Despite being a sangoma, the caregiver realised the danger her child was in and took her to a clinic. However believing the child had not been cured of the underlying ailment she then administered herbal medicine.

### 3.3 Causes and treatment of diarrhoea

It was found throughout this study that cultural belief was central to people's perception of the causative agents and appropriate treatment of diarrhoea. The community around Zithulele attributes many of the causes of diarrhoea to curses, witchcraft and evil spirits (although causes such as: diet, unclean water, and lack of cleanliness were mentioned by some participants).

*“Mostly because they believe in witches. They...want to know the cause of this diarrhoea, they don't regard things like water and diet and stuff like that. They don't want to know if the child is being fed in the right way. They just want to know who's trying to kill my child.”* Community member

As mentioned above, previous experience could also play a role in decision making as suggested by the three doctors. Past experience coupled with belief (about the causative agents of diarrhoeal diseases) could perpetuate the use of traditional medicine.

Interestingly a number of participants including the Nurse, blamed teething for causing diarrhoea. One of the doctors (Doctor One) interviewed said she would strongly hesitate to blame teething for diarrhoea that requires hospital attention.

Other causes of diarrhoea identified by those interviewed were: heat from the sun, herbal medication, worms, not breastfeeding and incorrect mixing of formula.

The three doctors interviewed felt that their understanding of the causative agents and appropriate treatment of diarrhoea is very different to those who seek health care from a traditional practitioner as they do not relate diarrhoea to curses or evil spirits. As alluded to in section 3.1, this discrepancy of beliefs between traditional and modern medicine could result in a lack of understanding between patients and modern practitioners as well as between modern and traditional practitioners.

There was an identified lack of knowledge of bodily systems and conventional models of disease which could be blamed on low levels of education in the community or on strong belief in the explanations given by traditional healers and the effectiveness of traditional medicine.

### **3.4 Social pressure in health**

In designing the analytical framework for this study it was thought that social pressure would play a prominent role in caregivers health care decision making. However it was found that although social pressure does play a role in decision making, it is not a driving factor in comparison to cultural belief. Social pressure, norms and culture do however factor into decision making as they reinforce belief in the causative factors and appropriate treatment of diarrhoea.

The Nurse and Therapist suggested that pressure from family in particular one's elders (such as a grandmother or mother in law) will alter where one decides to take a child with diarrhoea.

### **3.5 Responsiveness of health care providers**

Although the doctors interviewed appear tolerant of their patients beliefs (regarding the use of traditional medicine and the causative agents of diarrhoea) they seem to be perplexed. Their patients beliefs and the medical model in which they are taught to reason do not fit well together. A further confounder amongst the doctors interviewed was that of their own personal beliefs (in line with the missionary hospital in which they work) which do not sit well with traditional beliefs.

Doctor One acknowledges that traditional healers play an important role in society as they often spend more time with their patients than formal health workers and they recognise the spiritual side of their patients. Conversely she also expressed her concerns about the interaction of traditional medicine with formal medicine. One of her worries is that some of the herbal remedies could be toxic. Additionally she raised the concern that household detergents are sometimes included in treatments given by traditional practitioners.

This disharmony leaves the staff feeling bewildered as they want the best for their patients however they cannot overlook the fact that they are not able to accept, or do not believe in traditional medicine, and at times even feel strongly opposed to it.

On the other hand, the community responds to the responsiveness of the traditional practitioners who are felt to provide holistic care.

*“... the reason why people like to go to the traditional healers, they give full care to the people, they care a lot about the people and there are things that they know that you can't go to the hospital having this thing.”* Sangoma FGD Two

These findings seem to illustrate that despite the formal practitioners living and practicing in the community it is possible that they are not fully accepted into the community and that patients feel more comfortable seeking help from one of their own community members.

### **3.6 Attitudes and tolerance**

One area where there seems to be an identified lack of tolerance is that of mixing traditional and formal medicine. Some of the caregivers and traditional healers interviewed stated that the hospital staff can tell that a child has been given herbal medicines and that the staff do not like this. This could be in part due to the unknown reaction of traditional and conventional medicine as mentioned in section 3.5. Thus some of the traditional practitioners refer children prior to giving traditional medicines (for example if the child needs to be rehydrated with a drip) and then asks the caregiver to return for traditional treatment.

Several of the traditional practitioners spoke about the idea of traditional and formal health professionals working alongside in close proximity. Although two of the doctors suggested that there may be scope for working more closely with traditional practitioners, particularly in regard to issues of stigma and psychological concerns, they were hesitant at the idea of referral as traditional practitioners are unregulated at present.

Some of the participants felt that the personal beliefs of the staff at Zithulele do not influence their actions in that they treat patients in an equal manner with clear clinical judgment. For example Doctor Two expressed her

feelings that the staffs' strong belief in breastfeeding has positively impacted on the community.

The Community Member felt that the doctors and nurses at Zithulele are tolerant of patients beliefs while the three Sangomas interviewed disagreed. Sangoma One interviewed at Ngcwanguba Clinic had the following to say:

*"...they become rude, they become arrogant... they can judge her by telling her about these [white bead bangles on wrists and ankles] maybe this is not good. And she knows why she has got these things, so the doctors don't like them, don't like these things."* Sangoma One

Doctor One and Three were undecided on whether or not the nurses and doctors are tolerant, articulating that tolerance maybe inconsistent. Doctor One expressed that on the whole the staff are interested and concerned for their patients, but sometimes the circumstances of the day make them slightly intolerant. Doctor Three pointed out that doctors are only human and he feels that it weighs heavily on him seeing children dying from herbal intoxication.

When key informants were asked if their personal beliefs opposed those that seek health care from traditional healers Sangoma One, the Therapist and the Minister said that people are free to make their own choices.

When the Sangomas and Traditional Healer were asked if their personal beliefs oppose those that seek health care from a clinic or hospital, Sangoma One said that her personal beliefs do not oppose those that seek formal health care. She sends patients to the hospital if they look weak and she added that she takes her own children to the clinic. Sangoma Three did not see anything wrong with utilising formal health care in addition saying that she thinks that it is good.

Conversely two of the doctors interviewed (Doctor Two and Three) said that they are completely against the use of traditional medicine. However Doctor Two expressed great insight by saying:

*"I don't think that we've listened enough and heard enough and I don't think we walk with our patients enough. I think we are quick to judge but it's because we have seen so much damage from what they believe."*

## 4 Discussion

In this study I have attempted to address the issue of the acceptability of access to child health care in the rural Eastern Cape, with a particular focus on diarrhoeal diseases. I find that: belief (about the causative agents of diarrhoea and traditional medicine) is central to the decision making process of caregivers with children suffering from diarrhoea; mixed (traditional and formal) health care is common in the Zithulele area; intravenous drips are seen as a draw card to attend a formal health facility often without knowing the rationale for their use; detergents have recently been introduced into some traditional practitioners treatments for their cleansing properties; social pressure is found not to play a prominent role in decision making; and although seeking care from both traditional healers and conventional facilities is acceptable to the community it is not necessarily to health care professionals.

In this section I briefly discuss the key results of this study in comparison with current literature and suggest possible policy implications resulting from these findings.

The central finding emanating from this study is that the belief system of the community dictates how caregivers access child health care in the rural Eastern Cape. Seeking health care from a traditional practitioner is deeply ingrained in the AmaXhosa culture. Traditional practitioners are perceived to be able to treat “traditional illnesses” which result from supernatural causes while conventional facilities are believed to be unable to treat these illnesses. Correspondingly Friend-du Preez et al. (2009) found that the most common reason stated for seeking a traditional practitioner was protection from so called *abantu illnesses* which are related to witchcraft, spirits and ancestors (such as *ibala* and *ipleyiti*) which formal health care facilities are powerless to treat. Furthermore it was found that belief in the treatment given by traditional practitioners represented 40% and 52.6% of the reasons for choosing them as the health practitioner of choice respectively in studies by Friend-du Preez et al. (2009) and Nxumalo et al. (2011).

Although some individuals are moving away from using traditional medicine the majority of the rural population are still utilising traditional medicine either in isolation or in tandem with formal health care services. Indeed mixed care seems to be common in the Zithulele area.

Friend-du Preez et al. (2009) has the following findings in common with this study: the symptoms often dictate where the child is taken; and efficacy

of previous treatment added to the trust of traditional practitioners and the continued utilisation of traditional medicine. Interestingly converse to this study's findings, Friend-du Preez et al. (2009) found that the vulnerability of small children was seen as a reason to seek care from a traditional practitioner as the need to protect them from bad spirits is higher. In the current study I found that some participants feel that infant's vulnerability is a good reason not to administer unknown dosages of traditional medicine, but rather take a child to a clinic or hospital.

The use of a drip was also noted in the study by Friend-du Preez et al. (2009) as being a reason for utilising a hospital in conjunction with a traditional practitioner. Similarly not all of the participants in their study understood the rationale for using a drip.

An additional problem is that household detergents have been integrated into some traditional treatments due to their cleaning properties. Friend-du Preez et al. (2009) point out that "...morbidity related to the incorrect use of medicines and poor management of childhood illnesses represents a sizable proportion of injury, disease, and mortality burden which could potentially be eliminated."

In opposition to these arguments, Airhihenbuwa and DeWitt Webster (2004) proposition that some formal health care concepts are flawed in that the medical model considers "health behaviour to be a-cultural". This is contrary to the idea that health should be defined and understood through culture. This idea challenges formal health care to find more culturally appropriate ways of taking care of the community without presenting the western health care model as the "universal truth".

Contrary to suggestions in previous studies (Friend-du Preez et al., 2009), social pressure does not appear to be as prominent a factor as belief (about the causative agents of diarrhoea and traditional medicine) in health seeking behaviour. Due to the pronounced belief in traditional illness and medicine in the community formal health care workers are seen as unable to adequately explain and treat health problems. Furthermore staff at conventional institutions are often seen to not wholly understand the perceived underlying ailment. In contrast, however, caregivers do not always grasp the conventional medical understanding of an illness, its causative agents, and the necessary treatment.

In addition, as found McIntyre et al. (2008), the responsiveness and at-

tentiveness of traditional practitioners makes them particularly appealing to the community whereas in formal institutions tolerance is, in some instances, lacking and needs to be addressed. With the regulation of traditional medicine, respect for traditional practitioners may increase.

In 2003, Ethiopia, introduced a 'Health Extension Programme' where women served their communities as health ambassadors, seeking to improve health through the knowledge that they had acquired in various health areas, thereby improving access to health information and some services (Balabanova et al., 2011). This is a good example of how one can utilise a group of individuals within a community to improve access to basic health information. One possibility in South Africa is that by utilising the manpower (and womanpower) that traditional practitioners represent, it might be possible to follow Ethiopia's example and improve access to basic health information.

Mahmood et al. (2010) suggests that village doctors in Bangladesh play a vital role in coping with the sheer numbers of patients that need to be seen and treated. South Africa finds itself in a similar situation where doctor patient ratios lead us to look for new solutions in order to reach the Millennium Development Goals. Mahmood et al. (2010) indicate that "...making use of the available pool of under-skilled providers, particularly the Village Doctors, can be a feasible option". One of the ways that village doctors in Bangladesh can be valuable is in appropriate referral of patients to more qualified health care professionals (Mahmood et al., 2010). Mahmood et al. (2010) suggests that kind of system "warrants building a productive network where the services of Village Doctors and the physicians would complement each other". In South Africa, traditional healers could potentially play a similar role, however as in the case of the village doctors in Bangladesh, they would need training in order to adhere to practice standards.

There seems to exist a great disharmony between traditional and conventional health practitioners in the rural Eastern Cape. I have seen that many community members have mixed feelings toward hospitals and clinics leading them to, in many cases, prefer to consult a traditional practitioner. The successful results of using both informal doctors and formal doctors in Bangladesh relied on the provision of care being complementary in nature (Balabanova et al., 2011). If South Africa is to have similar success, then the root cause of this identified disharmony needs to be addressed, prior to expecting the formation of symbiotic relationships in South Africa, similar to those found in Bangladesh.

Balabanova et al. (2011) in their research into the health progress of five low and middle income countries, found that health improvements were due to factors over and above health system strengthening, such as political sincerity, increased literacy and development of road infrastructure. Notably in Thailand contributing factors to health performance success included ‘economic growth and poverty reduction, a high level of female literacy and a fall in the gender literacy gap’ (Balabanova et al., 2011).

Thailand can be seen as a great role model for low and middle income countries to emulate, as it was very successful in reducing under five mortality, among other health objectives that it reached. Its success in health system strengthening meant that in the early 2000’s all the Millennium Development Goals had been met. In order to meet the Millennium Development Goals the following actions were taken: ‘free antenatal care, skilled birth attendance, family planning, and immunization’ for all; provision of medical staff to rural areas through government bonding schemes; ‘financial risk protection’; continuity through the years in government leadership and vision; involvement of the ‘Royal Family’ in projects aimed at rural development; and evidence based policy formation (Balabanova et al., 2011).

In Tamil Nadu in India, it is thought that the inclusion of indigenous medicine and treatments into the primary health care system has expanded the access to health services (Balabanova et al., 2011). This is something that South Africa may want to consider in the future, once regulation has been introduced.

If we are to improve the uptake of services at modern health care facilities in South Africa several factors need to be addressed. Firstly, formal health care staff need to become more aware of the cultural beliefs and understandings of illness in order to better serve the community. Secondly, the community needs to be informed of the conventional causes and treatments of diarrhoea and how they operate, this requires improved education aimed particularly at women who are the primary caregivers. Finally, the role of the traditional practitioners needs to be regulated and respected, and possibly restricted if the health care provided is hazardous for small children.

Some policy implications of these findings are as follows:

- In this study a high level of acceptance of traditional practitioners was revealed. Other countries such as Bangladesh and India have success-

fully utilised 'lay' doctors trained in basic health care to improve the dispersion of health care information, and this could be beneficial in South Africa, by utilising traditional practitioners as a valuable human resource.

- Although traditional medicine appears to be highly accepted among the community around Zithulele Hospital, it is not seen as completely acceptable to the allopathic health care staff. Two of the major reasons found in this study that traditional medicine is not accepted by formal health care staff are, its potential toxicity to children and the use of detergents in some medicines. At a local level there is a need to address the use of detergents in traditional medicines. However on a national level there is a need to regulate traditional medicine in order that traditional practitioners provide safe, efficacious treatment, which satisfy a set of standards that are equal in their rigor to formal principles, in line with patients' human rights (as is also suggested by Richter (2003)).
- Regulation will require commitment from the government to invest in establishing the safety of traditional medicines, promoting relevant research and the passing of the Traditional Health Practitioners Bill. As was the case in other low and middle income countries, things over and above health system strengthening are needed. These include (among other things): vision, quality leadership, centers of excellence, economic stability, continuity in ideas and higher levels of female literacy.
- In order that traditional practitioners are not exploited, care is needed to protect the intellectual property rights of traditional healers when it comes to pharmaceuticals that prove to be safe and efficacious.
- There was an identified lack of bodily understanding by the participants in this study, which could in some cases lead mother's to not question the treatment given by traditional healers or formal health care workers. Improved quality of education is needed in the area around Zithulele with an emphasis on female literacy so that the rural population are better equipped to make informed choices about their health.
- Communication channels need to open between traditional and formal health care practitioners so that common understanding can be reached. Formal facilities could possibly meet with the community to develop more culturally appropriate services.

It was hoped that this study would gain an holistic overview of why people make the health care decisions that they make, however realistically due to the large influence of the hospital on the area the ideas represented are quite specific to the region and caution should be taken when trying to generalize it to a larger area.

Future studies of acceptability in the Eastern Cape as a whole could highlight commonly occurring issues in the integration of modern health care into rural areas and facilitate a more holistic and culturally suitable health system. Furthermore research will be needed regarding the regulation of traditional practitioners in their provision of safe and effective treatments.

## 5 Conclusion

Through the experience of other countries' health situations one can learn a great deal. South African needs vision, support, inspiration and commitment in order to achieve the Millennium Development Goals, in particular goal number four, reducing under five child mortality. Ideas such as utilising 'village doctors' (traditional practitioners in our case) as was done in Bangladesh can be adapted cautiously for our own health system, provided training and management is at a high level.

It appears that seeking health care from traditional practitioners is profoundly ingrained in AmaXhosa culture. Central to this health seeking behaviour is the belief in the traditional practitioners ability to treat curses, witchcraft and bad spirits which hospitals and clinics, are powerless to treat.

That been said a combination of formal and traditional health care appears to be acceptable to the community and traditional practitioners, although not necessarily to the formal health care staff.

This leads to the recommendation that traditional medicine should be regulated in such a way that it provides safe, efficacious treatment for patients in line with their human rights, prior to formalised referral between western and traditional practitioners. As regulation is a resource intensive process, in the mean time, traditional and formal health care professionals should try to improve communication in order to aid mutual understanding.

Furthermore in order to improve the health system in South Africa, an

inter-sectoral approach is needed which incorporates the education sector. Emphasis on quality education is required in order to empower women, so that they are better able to make informed decisions about their and their dependents health care.

As in most cases, acceptability of health care, is a complex issue. Perhaps even more complex and intriguing are the reasons that mothers make the health care choices that they do. This study has revealed that in general the community around Zithulele continue to have a profound belief in traditional medicine, although some have a preference for attending Zithulele Hospital. Reasons for choosing a particular form of child health care appear to be clear to the mothers involved, however the course of action chosen does not always result in the desired effect of successfully treating a child for diarrhoeal disease.

University of Cape Town

## Part IV

# Policy Brief

## South Africa's dual health care system

*Why and how do caregivers make use of both the conventional and traditional health care systems when their children suffer from diarrhoea?*

**Source:** This policy brief is based on the article “Acceptability of access to child health care, in the rural area around Zithulele Hospital in the Eastern Cape” written for dissertation purposes at the University of Cape Town.

**Author:** Lucy Shillington, Masters in Public Health, Health Economics, candidate 2011.

**For more information about this policy brief:** please email Lucy Shillington, (lucyshillington@gmail.com).

**Introduction:** Although proven cost-effective interventions exist for diseases such as diarrhoea, South Africa is still falling short of reaching the Millennium Development Goals set for maternal and child health due to low coverage of services. One existing issue is that caregivers in the rural (and some urban) areas of South Africa continue to utilise both traditional and formal health care services, either separately or in conjunction, when their children suffer from diarrhoea. As effective interventions have not been used by those who have the potential to most benefit from them, progress towards the Millennium Development Goals has been undermined.

**Research objective:** Formative research into the reasons mothers seek health care for their children with diarrhoea, either from a traditional practitioner and/or a formal facility.

**Methods:** Qualitative research methods were used with a purposive sampling technique. 8 focus group discussions (FGD) and 11 key informant interviews were chaired by the primary investigator in January 2011.

**Findings:** Health care choices, made by caregivers with children suffering from diarrhoeal disease, were found to be based on a complex variety of factors including cultural belief, social pressure, belief in particular treatments and previous experience. Curses, bad spirits and witchcraft are considered (believed) by many in the area around Zithulele to be causes of diarrhoea. It

was found in the current study that seeking health care from traditional practitioners, who are currently unregulated in South Africa, is deeply ingrained in the culture of the rural society, with belief in traditional practitioners ability to treat curses, bad spirits and witchcraft, being central to this choice. The profound belief and utilisation of traditional medicine highlights the difficulty in regulating traditional practitioners, as the rural society around Zithulele continue to seek their care and treatment even though they are unregulated.

Interestingly it was found that a combination of care, accessing both formal and traditional health care, is largely acceptable to the community, however this was not necessarily the case for formal health care staff. A disturbing trend is that detergents have recently been introduced into some traditional practitioners treatments for their cleansing properties. What this study has illustrated is that rural South African's will continue to access traditional care despite the availability of free care at formal facilities for children under six years of age.

**Policy implications:** In light of the findings there is a clear need for a change in policy regarding the integration of traditional beliefs and medicine into the public health care model. In order for this to be achieved one recommendation would be that traditional health care workers need to be regulated in order to maintain standards of practice that provide safe, efficacious treatment in line with patients' human rights. Regulation is also required in order to facilitate formalised referral between western and traditional practitioners. This would result in culturally acceptable health care for the general public. Thus government support and resources are required to ensure this regulation is effective. In addition:

- A regulatory framework needs to be provided within which traditional medicine and formal medicine can work together in order to avoid delays in access to health care for children with diarrhoea.
- On a local level, intervention is needed to address the use of detergents in some traditional medicines.
- Dialogue between formal care providers and traditional practitioners needs to be facilitated so that they can understand each other and collaborate to promote good health care and disease prevention.
- As found in previous studies this intervention requires an inter-sectoral approach to empower women for instance through improved education and information with regard to health care.

## Part V

# Appendices

## Appendix 1: Written informed consent for Key Informant Interviews

*Acceptability of access to child health care, in the rural area around Zithulele Hospital in the Eastern Cape.*

This study is conducted by Lucy Shillington from the University of Cape Town, Health Economics Unit, Masters in Public Health Department for a Masters Dissertation. It may be published in the future.

The purpose of the study is to investigate the acceptability of care of patients at Zithulele Hospital. The significance of this study is to see what affects the acceptability of accessing Zithulele Hospital in terms of access to child health care services, in particular for the treatment of diarrhoeal disease.

Key informants from the area around Zithulele Hospital who give informed consent will be able to take part in the study. Questions will be asked and the answers will be recorded using an electronic audio recorder. A translator will assist in translation if key informants speak Xhosa. These interviews will then be transcribed and written in English.

Interviews will begin on the 10th January 2011 and will cease on the 29th January 2011. The interviews will take approximately one hour. There will be no follow up interview.

Each subject's transcribed interview will be encoded to ensure confidentiality and the participants may withdraw from the study at any stage. Feedback of results will be available to participants on request. There will be no risks, benefits nor cost involved for the participants in this study. There is no insurance cover for participants in this study should harm come to any subjects.

Ethical approval for this study will be secured from Zithulele Hospital and The Faculty of Health Sciences Human Research Ethics Committee. All the research will adhere to the *Declaration of Helsinki* (2008).

If there are any further questions with regards to the study feel free to contact Lucy Shillington at lucyshillington@gmail.com or cell number 0763928367. In additional, participants can contact the Human Research Ethics Committee (Professor Marc Blockman) if there are any questions regarding their Rights and welfare as research subjects.

### **Informed Consent Form**

University of Cape Town, Health Economics Unit in the School of Public Health and Family Medicine, Faculty of Health Sciences.

I ..... have read (or had read to me by ..... ) the information sheet. I understand what is required of me and I have had all my questions answered. I do not feel that I am forced to take part in this study and I am doing so of my own free will. I know that I can withdraw at any time if I so wish without any repercussions.

Signed:

Participant ..... Date and place .....

Researcher ..... Date and place .....

Witness ..... Date and place .....

## **Appendix 2: Key Informant interview**

- Key Informant interview will last approximately 1 hour.
- Key informant title or role: e.g. Doctor .....

### **Questions about acceptability of child health care: approximately 50 minutes**

People's belief in or the perceived effectiveness of traditional medicine.

1. Why do mothers seek care from a traditional practitioner when their children have diarrhoea?
2. Why do you think a mother whose child has diarrhoea would go to Zithulele Hospital for treatment?

People's belief in or perception of causative agents and appropriate treatment of diarrhoea.

3. Do you think that mothers who take their child to a traditional practitioner when they have diarrhoea, have a different understanding of the causative agents and appropriate treatment of diarrhoea, compared to you?
4. Do you/doctors and nurses give information to mothers regarding cleanliness, the mixing of a rehydration solution and encourage mothers to breast feed exclusively in the infant's first 6 months of life?

Existing social pressure regarding certain types of health care services and perceived responsiveness of traditional and formal health care providers

5. Do you think your/ nurses and doctors' beliefs influence the way the patients are treated?

Attitudes (tolerance) of formal health care workers towards patients beliefs (regarding the effectiveness of traditional medicine and causative agents and appropriate diarrhoea treatment).

6. What do you think about using traditional medicine for children?
7. Do your cultural and religious beliefs oppose those who seek care from a traditional practitioner?
8. Do you consider yourself/ doctors and nurses tolerant of patient's beliefs?

- Conclusion: approximately 5 minutes.
- Ask the key informant if he has anything more that he would like to say.
- Thank him for participating and give him the thank you letter (appendix 6).

### **Appendix 3: Standardized Introduction to Focus Group Participants**

My name is Lucy Shillington and I am studying for a Masters in Public Health at the University of Cape Town. I am doing a project to try to find out what people around Zithulele think about going to Zithulele Hospital and why you want to or don't want to go to Zithulele Hospital.

I do not work for the government and I have no money for you. I am just asking you to talk with me in this group. If you don't want to talk you don't have to stay and you don't have to answer my questions. But it would help me if you talked with me so that I can understand. You are free to leave at any stage.

When I write my project I will not write down anyone's names. I will just write that I was told these things by a group of people from this area. This project might help people to understand better, why people go to the hospital or don't go to the hospital. I am not promising you that anything will change. Do you agree to talk with me?

## Appendix 4: Focus Group Outline

- Group discussion will last 1-2 hours.
- Introduction (appendix 3).
- Group task one (ice breaker): Communication.
- Line up oldest to youngest.
- Group task two (ice breaker): Trust.
- Two people blindfolded, one feeds the other person a sweet.

### **Ideas for group discussion: approximately 50 minutes.**

Outline scenario: A mother wakes up in the night and her child has diarrhoea and is very sick. She holds the child and then put him down to sleep. In the morning he still has diarrhoea and is very weak. She takes him to the nearby traditional healer.

1. Why did the mother go to the traditional healer? Prompt: Did someone tell her to go there? (People's belief in or the perceived effectiveness of traditional medicine).
2. What could have caused the diarrhoea in her child? (People's belief in or perception of causative agents and appropriate treatment of diarrhoea).

3. What does the traditional healer do for the child and does he explain the problem? (Perceived responsiveness of traditional and formal health care providers).
4. Do you believe it works? (People's belief in or perception of causative agents and appropriate treatment of diarrhoea).
5. Why did she not take him to the clinic? (Attitudes of formal health care workers towards patients beliefs).

The traditional healer gives the child an enema and the mother takes the child home. The diarrhoea gets much worse and now there are no tears when her child is crying. She takes him to Zithulele Hospital.

6. Why did she go to Zithulele hospital? Prompt: Did someone tell her to go there? (People's belief in or the perceived effectiveness of traditional medicine and existing social pressure regarding certain types of health care services).
7. If your child gets sick where do you go?
8. Does going to Zithulele fit with your cultural or religious beliefs? (People's belief in or perception of causative agents and appropriate treatment of diarrhoea).
9. Does the person that helps your child explain the problem to you? (Perceived responsiveness of traditional and formal health care providers).

The child is given a drip and some strong medicine and is much better. The child and mother go home. The next week the child again gets diarrhoea.

10. Where does she take the child this time? (Existing social pressure regarding certain types of health care services and perceived responsiveness of traditional and formal health care providers).
11. Why does she take him there? (People's belief in or perception of causative agents and appropriate treatment of diarrhoea and attitudes of formal health care workers towards patients beliefs).

- Conclusion: approximately 10 minutes.
- Ask each participant if they have anything more that they would like to say.
- Thank the group for participating (appendix 5).

## **Appendix 5: Verbal Thanks for Focus Group Participants**

Thank you very much, without your help I could not have done my project. Thank you for telling me your opinions and for talking to me. I have learnt a lot from you and hopefully other people can also learn from what you have told me. I may send my project to a journal so that other people will be able to learn from this talk and the other talks I have had with other people around Zithulele. But I will not write your names down or tell people who told me what.

I will send a copy of the final project in English to Doctor Ben Gaunt at Zithulele Hospital in August 2011 if you want to read it.

## **Appendix 6: Letter to Key Informants**

University of Cape Town,  
Observatory  
31st August 2010

Dear

I would like to express my sincere appreciation for your valuable participation in my research project. Thank you for making yourself available, giving of your time and committing yourself for the duration of my project.

As the results collected are very valuable for learning about acceptability of access, my Masters Thesis may be submitted for publication in the near future. Once again I would like to remind you that confidentiality has been preserved and no names have been mentioned.

A copy of the final write up will be sent to Doctor Ben Gaunt at Zithulele Hospital in August 2011 for your interest.

Yours sincerely,  
Lucy Shillington

Masters in Public Health in Health Economics Candidate 2010  
University of Cape Town

## **Appendix 7: Guidelines for authors - Social Science and Medicine**



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## Guidelines for Qualitative Papers

There is no one qualitative method, but rather a number of research approaches which fall under the umbrella of 'qualitative methods'. The various social science disciplines tend to have different conventions on best practice in qualitative research. However SSM has prepared the following general guidance for the writing and assessment of papers which present qualitative data (either alone or in combination with quantitative methods). General principles of good practice for all research will also apply.

### Fitness for purpose

Are the methods of the research appropriate to the nature of the question(s) being asked, i.e.

- Does the research seek to understand social processes or social structures and/or to illuminate subjective experiences or meanings?
- Are the settings, groups or individuals being examined of a type which cannot be pre-selected, or the possible outcomes not specified (or hypothesised) in advance?

### Methodology and methods

- All papers must include a dedicated methods section which specifies, as appropriate, the sample recruitment strategy, sample size, and analytical strategy.

### Principles of selection

Qualitative research is often based on or includes non-probability sampling. The unit(s) of research may include one or a combination of people, events, institutions, samples of natural behaviour, conversations, written and visual material, etc.

- The selection of these should be theoretically justified e.g. it should be made clear how respondents were selected
- There should be a rationale for the sources of the data (e.g. respondents/participants, settings, documents)
- Consideration should be given to whether the sources of data (e.g. people, organisations, documents) were unusual in some important way

- Any limitations of the data should be discussed (such as non response, refusal to take part)

## **The research process**

In most papers there should be consideration of

- The access process
- How data were collected and recorded
- Who collected the data
- When the data were collected
- How the research was explained to respondents/participants

## **Research ethics**

- Details of formal ethical approval (i.e. IRB, Research Ethics Committee) should be stated in the main body of the paper. If authors were not required to obtain ethical approval (as is the case in some countries) or unable to obtain ethical approval (as sometimes occurs in resource-poor settings) they should explain this. Please anonymise this information as appropriate in the manuscript, and give the information when asked during submission.
- Procedures for securing informed consent should be provided

Any ethical concerns that arose during the research should be discussed.

## **Analysis**

The process of analysis should be made as transparent as possible (notwithstanding the conceptual and theoretical creativity that typically characterises qualitative research). For example

- How was the analysis conducted
- How were themes, concepts and categories generated from the data
- Whether analysis was computer assisted (and, if so, how)
- Who was involved in the analysis and in what manner

- Assurance of analytic rigour. For example
- Steps taken to guard against selectivity in the use of data
- Triangulation
- Inter-rater reliability
- Member and expert checking
- The researchers own position should clearly be stated. For example, have they examined their own role, possible bias, and influence on the research (reflexivity)?

## **Presentation of findings**

Consideration of context The research should be clearly contextualised. For example

- Relevant information about the settings and respondents/participants should be supplied
- The phenomena under study should be integrated into their social context (rather than being abstracted or de-contextualised)
- Any particular/unique influences should be identified and discussed

## **Presentation of data:**

- Quotations, field notes, and other data where appropriate should be identified in a way which enables the reader to judge the range of evidence being used
- Distinctions between the data and their interpretation should be clear
- The iteration between data and explanations of the data (theory generation) should be clear
- Sufficient original evidence should be presented to satisfy the reader of the relationship between the evidence and the conclusions (validity)
- There should be adequate consideration of cases or evidence which might refute the conclusions

(Amended February 2010)

## Appendix 8: Letter of ethical clearance



Health Sciences Faculty  
Faculty of Health Sciences Research Ethics Committee  
Room E52-24 Groote Schuur Hospital Old Main Building  
Observatory 7925  
Telephone [021] 406 6338 • Facsimile [021] 406 6411  
e-mail: sumayah.ariefdien@uct.ac.za

23 November 2010

HREC REF: 557/2010

**Ms L Shillington**  
Health Economics Unit  
School of Public Health & Family Medicine

Dear Ms Shillington

**PROJECT TITLE: ACCEPTABILITY OF ACCESS TO CHILD HEALTH CARE, IN THE RURAL AREA AROUND ZITHULELE HOSPITAL IN THE EASTERN CAPE**

Thank you for submitting your study to the Health Science Faculty Research Ethics Committee for review

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above-mentioned study.

**Approval is granted for one year till the 30 November 2011.**

Please submit a progress form, using the standardised Annual Report Form (FHS016), if the study continues beyond the approval period. Please submit a Standard Closure form (FHS010) if the study is completed within the approval period.

Appendix 1: Written Informed Consent. Please remove “university of Cape Town Ethics Board” and please reference the Helsinki Declaration of 2008 (not 2000). Please add that participants can contact the Human Research Ethics Committee (Professor Marc Blockman) if they have any questions about their Rights and welfare as research subjects.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

**Please quote the REC. REF in all your correspondence.**

Yours sincerely

**PROFESSOR M BLOCKMAN**  
**CHAIRPERSON, HSF HUMAN ETHICS**

Federal Wide Assurance Number: FWA00001637.  
Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

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