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DEVELOPMENT OF A COMPETENCY-BASED FRAMEWORK TO STANDARDISE AFRICAN TRADITIONAL HEALTH KNOWLEDGE AND PRACTICES IN NURSING CURRICULUM IN SOUTH AFRICA.

BY

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"Life is a journey to be experienced, not a problem to be solved." - Winnie the Pooh

DECLARATION

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Declare that:

Development of a Competency-Based Framework to Standardise African Traditional Health Knowledge and Practices in Nursing Curriculum in South Africa.

is my original work. It has not been submitted to any other institution before for any degree or examination. All the sources used and quoted were acknowledged by means of complete references in the text and bibliography.

NOVEMBER 2023

Signature Date

DEDICATION

I dedicate this study to my father, Lucas Pheaha Moeta for being an inspiration and provider, who has always encouraged me to push all boundaries. May your soul rest in peace; I know you are proud where you are.

Secondly, my lovely wife Mmasepeke Rebecca, who has been a pillar of strength throughout the study. When the chips were down, she would pick me up and provide me with the support I much needed. Your love and support have made it possible. Thank you.

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ABSTRACT

BACKGROUND

The training of health professionals in South Africa remains fragmented, one-sided, and continues to disregard African Traditional Health Knowledge and Practices. Nurses are trained under the biomedical model, wherein the content of the curriculum hardly infuses the principles and practices inherent in African Traditional Medicine. Nurses possessing knowledge about African traditional health knowledge and practices can provide holistic care to patients and practice ethically in the communities where majority of the population still opts for the services of Traditional Health Practitioners. Nurses spend more time with patients and are well-positioned to advocate for them, including for patients who opt to use alternative therapies, including consulting traditional health practitioners. However, there is no existing standard or framework in South Africa regarding what should be included in the curriculum concerning African Traditional Health Knowledge and Practices. Nurses are expected to develop competencies for nursing patients from all cultural and social backgrounds. However, the content in the curriculum for preparing nurses for such a role is unstructured and implicit. This lack of clarity in the training of nurses on African Traditional Health Knowledge and Practices results in nurse practitioners ignoring, ostracising, and undermining the contribution made by the African traditional health system. Ultimately, the use of African Traditional Health Knowledge and Practices may go unnoticed or not interrogated during health assessments, with adverse health outcomes for patients.

AIM

The study aimed to develop a competency-based framework for standardising African traditional health knowledge and practices in the nursing curriculum in South Africa.

RESEARCH DESIGN AND METHOD

This study adopted an explorative sequential mixed method design underpinned by a pragmatic paradigm. The study was conducted in three phases. In Phase 1, a qualitative, explorative, and descriptive design was adopted to collect data from Traditional Health Practitioners about their views on African Traditional Health Knowledge and Practices, and their roles in the provision of health services. Snowball sampling was used. The

themes and subthemes that emanated from the interviews were used to develop a self-administered questionnaire in Phase 2. Phase 2 adopted a quantitative, non-experimental descriptive survey design where questionnaires were distributed to public nursing education institutions, including universities, universities of technology, and public nursing colleges. The objective of this phase was to identify the level of teaching ATHKPs and determine the content of ATHKPs that is being taught in nursing curricula for the R425, R171, and R174 nursing programs at public NEIs. Based on the merged data from Phases 1 and 2, a competency-based framework was developed in Phase 3, guided by the South African Nursing Council's generic competency framework for professional nurses.

FINDINGS AND RESULTS

In Phase 1, eighteen Traditional Health Practitioners were interviewed, with seven females (39%) and eleven males (61%) practising in various categories such as *Sangomas*, herbalists, and diviners. The themes that emerged were: 1) The features of African Traditional Health Knowledge and Practices, 2) Elements of practice in African Traditional Health Knowledge and Practices, 3) Challenges encountered by traditional health practitioners in practice, 4) Competencies of traditional health practitioners and 5) Views of THPs on the training of nurses on African Traditional Health Knowledge and Practices. The direct quotes, definitions, and descriptions from the qualitative findings or themes were used to design the survey measurement items.

In Phase 2, a total of 408 nurse educators completed the questionnaires. The survey questionnaire yielded overall internal consistency and reliability of 0,9589. Although the response rate was high, there was a high level of disagreement with most items in the questionnaire by respondents. Results demonstrated that the teaching ATHKPs remains unstructured, or nurse educators do not necessarily know what needs to be taught and how as evidenced by 70,59% of respondents reporting that in their discipline, ATHKP is not taught. About 56,6% of the respondents indicated that ATHKP is not taught at any level of the nursing programme in their NEIs. Concerning the practical teaching ATHKPs, only 5,% agreed that Traditional Health Practitioners teach their nursing students in the institutions. The use of herbal medicine is the most prevalent content being taught, scoring a 5,00% level of agreement. Notably, 61,03% of respondents indicated that it is important to teach students about ATHKPs.

In Phase 3, the developed competency-based framework was based on the merged data, where themes from Phases 1 and 2 were integrated. The SANC competency framework was adopted to cluster the competencies into five domains that encompass ATHKPs, namely 1) Professional, ethical, and legal practice, 2) Care provision and management, 3) Personal development and quality care, 4) Management and leadership, as well as 5) Research. Therefore, the competencies are clustered within each of the domain based on the relevance and similarity of themes from the merged data to each subdomain. Further, the competencies are divided into core competencies and specific competencies within the subdomains of the SANC framework.

Components that were included in the competency-based framework include 1) the nature and purpose of the competency-based framework for nurses, 2) the scope and context of the framework, 3) the philosophical underpinning for the framework, 4) the benefits of the competency-based framework and, 5) the domains and subdomains.

CONCLUSION

The findings of the study and the developed competency-based framework are a positive move towards breaking the barriers to teaching ATHKPs in the nursing curriculum in South Africa. The developed competency-based framework will help facilitate an understanding and tolerance between nurses and THPs as they will have a broader view and appreciation of the similarities and differences between ATHKPs and the biomedical health system. The findings of the study confirmed that ATHKPs is a unique system of health care and nurses who are aware of the principles and ways of doing things within this system are better equipped to manage patients' problems. Nonetheless, the study established that no structure existed on how nurses can be taught about ATHKPs as evidenced by the high level of disagreement and uncertainty among nurse educators on the content of ATHKPs being taught in curriculum. The developed competency-based framework can serve as a guide for NdoH and NEIs in recognising the importance of nurses having knowledge and skills on ATHKPs. Curricula reformations should consider how this framework can be integrated into the teaching of nurses at various levels of their training.

Keywords: Curriculum, Competency Framework, Nursing, Traditional Health Practitioner, Nursing, African Traditional Health Knowledge, and practices

ABBREVIATIONS/ACRONYMS

Abbreviations/Acronyms	Meaning
AIDS	Acquired Immunodeficiency Syndrome
ATHKPs	African Traditional Health Knowledge and Practices
CAM	Complementary and Alternative Medicine
COVID	Coronavirus disease
DHET	Department of Higher Education and Training
DHEST	Department of Higher Education, Science and Technology
HEIs	Higher Education Institutions
HIV	Human immunodeficiency Virus
IKS	Indigenous Knowledge Systems
NDOH	National Department of Health
NQF	National Qualifications Authority
NEI	Nursing Education institution
SANC	South African Nursing Council
SAS	Statistical Analysis System
SDGs	Sustainable Development Goals
TTAM	Thai Traditional and Alternative Medicine
TCM	Traditional Chinese Medicine
TCAM	Traditional, Complementary, And Alternative Medicine
THPs	Traditional Health Practitioners
UNESCO	United Nations Educational, Scientific, and Cultural Organization
WHO	World Health Organisation

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CHAPTER 1

INTRODUCTION AND OVERVIEW OF THE STUDY

1.1. Introduction

Nurses are essentially the backbone of health systems globally. The ever-increasing importance of nurses in ensuring healthy communities has been acknowledged by the World Health Organisation (WHO State of Nursing 2020). In essence, nurses render services to the poorest and most vulnerable in communities where there may be a lack of access to resources, health information, and poor infrastructure (Nkoane & Mavhandu-Mudzusi 2020). This is an indictment on Nursing Education Institutions (**NEIs**) to create comprehensive, responsive, and culturally sensitive programmes that will prepare and equip nurses with the knowledge and skills to manage traditional health challenges that may arise when they render health services in such communities. The nursing education system should consider the environment and context within which nurses operate, such as in communities where most people still utilise other health care alternatives such as the African Traditional Health Knowledge and Practices (**ATHKPs**), which are provided by Traditional Health Practitioners (**THPs**). It is apparent that nurses still experience challenges in identifying and interpreting the language, symbols, and names used within the ATHKPs (Krah, de Kruijf & Ragno 2018). The challenges become a barrier in the rendering of care as it may affect how the patient perceives the care being provided by such nurses should they overlook the importance of the patient's health belief system. Nurses should never feel uncertain in dealing with problems presented by patients, including those patients who prefer the services of THPs (Lampiao, Chisaka & Clements 2019). Consequently, there is a need for curricular reformation to design new programmes to teach nurses about ATHKPs, so that they may be supported in their advocacy and caring role and become receptive to patients who prefer to consult their THPs.

It is therefore important for nurses to be knowledgeable and competent about matters pertaining to ATHKPs because according to the WHO (2019) and Ekor (2014), an estimated 88% of global citizens rely on traditional medicines as their first-line healthcare service to meet their health needs. More than 86% of the population in countries with low

socioeconomic status use traditional herbs for health and other healing purposes (van Andel & Carvalheiro 2013). Evidently, traditional health services remain an important and widely available service to the global population regardless of geographical location or socioeconomic status (WHO 2019). Within the African continent, ATHKPs include the incorporation of healing techniques, spiritual therapies, and the application of medicines derived from animals as well as plants (Fokunang et al. 2011). The primary purpose of such traditional approaches to health problems, like western medicine, is to diagnose, treat, and manage illnesses whilst ensuring that well-being is maintained. Therefore, collaborative partnerships between THPs and nurses will be possible if the practitioners understand and respect one another (Mokgobi 2013). However, the partnerships cannot happen spontaneously, they require a concerted effort from the practitioners in both ATHKPs and biomedical systems. Training programmes must be introduced to facilitate the acquisition and exchange of knowledge by both nurses and THPs on how each system of health works.

Higher education institutions offering training for health professionals, such as nursing science, have an important role to play by facilitating the exchange of knowledge as well as encouraging collaborative partnerships between nurses and THPs. This, in turn, will ensure that nurses and nursing students are socialised and trained to be aware of other modalities of health care such as the ATHKPs and various roles of THPs (Gyasi, Abass, Adu-Gyamfi, Accam & Nyamadi 2018). This is especially vital because increasingly, people are opting for traditional health services and treatments of ailments using herbs and medicinal treatment as an alternative to modern biomedicine, which has dominated the healthcare sphere for centuries (Abdullahi 2011). Therefore, nurses must be skilled and knowledgeable about the common diagnostic and treatment modalities to be able to intervene appropriately, timeously, and with sensitivity. Although attempts are made in Africa to integrate traditional health into the biomedical system, there seems to be no uniform way of doing this owing to the absence of a competency framework, especially in nursing.

Countries such as Ghana have initiated means to integrate traditional medicine in health science curricula through the occasional training of healthcare professionals on indigenous medicine (Asante & Avornyo 2013). This initiative is reportedly yielding

positive results and improved collaboration between healthcare professionals and THPs. Additionally, health professionals in Malaysian hospitals are also reported to be in favour of traditional health practices being part of the curriculum for the training of future health professionals (Abuduli, Isa, Eker & Aljunid 2016). Accordingly, to ensure the inclusion of knowledge on traditional health practice, formal curriculum should be designed and implemented to address the context under which such practices take place (Innocent 2016). Seemingly, more needs to be done to orientate the allopathic practitioners and expose them to such information to ensure respectful and productive interactions with THPs or with patients who are eager to utilise ATHKPs.

Collaboration spaces are required to ensure that the available traditional health services and resources are effectively used in a world plumbed by increasing global health challenges. Such transformative spaces will not be possible if nurses are not taught or convinced to appreciate, through educational programmes, the nature of ATHKPs. When nurses are more informed about the knowledge, skills, and roles of THPs, their attitude may change to the benefit of patients. The focus of healthcare delivery will henceforth, be patient-centred care and consider the patient and their holistic needs. Traditional health needs include being allowed to consult THPs, using of traditional remedies and other non-dangerous healing practices as permissible. In turn, this will increase patient autonomy, satisfaction, and comfort with the service which they deem sensitive to their unique needs. The aim of this study was therefore to develop a competency-based framework to standardise the education and training of nurses on ATHKPs. In the competency framework, the knowledge, skills, and behaviours required by allopathic practitioners on ATHKPs will be determined and designed in a way that will facilitate the assimilation of traditional practice and mutual respect between THPs and the allopathic practitioners.

1.2. Background and Rationale

According to the Sustainable Development Goals (**SDGs**) adopted in 2015 by the United Nations, universal health coverage is a key goal whose target is to improve the health and well-being of global citizens. However, the current global health care systems, and South Africa have been collapsed by the emergence of new health problems such as pandemics (Covid-19) and epidemics (HIV/AIDS), emerging resistance in infectious diseases as well as depleting human and natural resources that are necessary for

supporting health efforts (Maphumulo & Bhengu 2019). The new trends have in most cases pushed health systems in many countries to their brink of collapse, making universal health coverage a goal for the distant future. Traditional health practice, as a community-oriented service, falls within the area of primary care which is the intended target for the universal coverage initiative (Kasilo, Wambebe, Nikiema & Nabyonga-Orem 2019). Unfortunately, the role of THPs in combating health problems has not been thoroughly quantified and appropriately qualified (Mothibe & Sibanda 2019). Of particular importance is the hostile relationships that exist between THPs and allopathic professionals such as nurses and doctors (van Rooyen, Pretorius, Tembani & Ten Ham 2015). Although there is some progress in facilitating their collaborations, there are still a lot of stumbling blocks that need to be overcome. However, the contribution of THPs can no longer go unnoticed and unrecognised as witnessed by the increased demand for such services during the surge of the Covid-19 pandemic. Programmes to manage modern health problems should also consider the role traditional health practice plays and thereby target areas where nurses can learn from and collaborate with THPs.

During the Covid-19 pandemic outbreak, many Africans in particular, sought health services from THPs in the form of drinking remedies such as Artemisia afra (*Lengana*), steam inhalation and eating of traditionally prepared herbs such as *Aloe ferox (Asphodelaceae), Harpagophytum procumbens, Sutherlandia frutescens and Kiggelaria African* (Dwarka, Agoni, Mellem, Soliman & Baijnath 2020). A lot of contradictions arose from these practices as reported in the mainstream media; with allopathic practitioners, mostly nurses and doctors, discouraging the use of most traditional health interventions. However, most patients have been using such remedies to manage other health problems, therefore deemed as the immediate treatment available in a situation where no effective treatment was reported. It is also reported that many Covid-19 patients were successfully treated by using traditional Chinese medicine (Zhao, Li, Zhou, Zhou, Xie, Zhang & Sun 2021). However, the use and general acceptance of traditional medicine in China is relatively high as compared to other regions of the world (Shi, Zhu, Nicholas, Hong, Man & He 2020). Evidently, the ease of use was facilitated by the knowledge and acceptance by the allopathic practitioners and their endeavours to find common grounds between the different health systems. However, in South Africa, the misunderstanding among nurses and doctors regarding the use of such African healing practices is partly

because they did not possess adequate knowledge about such traditional health practices. Moreover, their biomedical education may have not facilitated such collaborations. Criticism on patients, for using traditional health remedies by allopathic practitioners may have deterred many patients from wanting to consult in hospitals and clinics. This raises a concern regarding who can choose what is in the best interest of the patient, especially when a practitioner does not have adequate knowledge to identify, diagnose and interpret symptoms of traditional medicine use.

Therefore, there is a need for the identification of commonalities and the involvement of nurses in efforts to integrate and acknowledge the existence and contribution of ATHPKs. Nurses are key in this regard and should possess the knowledge and skills necessary to manage patients' health problems from all facets of lives, including those who consulted THPs (Habtom 2018). These nurses play an important role in communities; in the prevention of diseases, promotion of health, treatment of health conditions, and should therefore have the knowledge to work hand in glove with THPs as healthcare team members. Nurses are also important in making sure that patients' needs are addressed in line with patient-centred care. An example of meeting patient's needs is when patients request to consult THPs then nurse can advocate for these services (Ehlers 2000). However, because the training of nurses has historically not included the alternative modalities of care, especially modalities commonly used among indigenous populations in South Africa, these nurses are often unwilling or unsure how to manage patients who have been to THPs (Mokgobi, 2014). Due to the lack of knowledge and awareness among nurses on ATHKPs, the use of traditional medicine often goes unnoticed or is not even interrogated during health assessments of patients. There are no competencies against which nurses can be assessed for their willingness to work with THPs and their attitude towards the use of ATHKPs. This points to a need for preparation and training of nurses for them to be aware of the knowledge, skills, roles of THPs as well as principles that underpin ATHKPs. It is envisaged that development for nurses and the inclusion of ATHKPs in the nursing curriculum will lessen the tension between nurses and THPs and support efforts by government to integrate ATHKPs into the health system.

1.3. Problem Statement

Nursing education and training in South Africa has undergone massive reformation since the dawn of democracy. The calls were made because of the changing landscape and

existing legacy qualifications which have been declared to be unsuitable and unresponsive to modern health trends and developments in government policies. The South African National Department of Health has heeded to calls for the WHO to recognise and support efforts for integrating traditional medicine into mainstream health system (WHO Traditional medicine strategy 2013). However, such efforts to promote and integrate ATHKPs have not been made exclusive in policies such as the Department of Health Strategic Plan for Control of Non-Communicable Diseases and the National Development Plan Vision for 2030. There seems to be no tangible strategy on how this will happen (de Lange 2017). This is despite the observations that THPs are preferred by many indigenous African populations despite the domination of Western medicine. This slow progress has also affected the collaboration and acceptance of THPs by nurses in the communities where both practitioners serve. Nursing Education Institutions and regulating bodies such as the South African Nursing Council (**SANC**) have also not responded with enthusiasm to the rise and increasing recognition for the contribution of ATHKPs by the South Africa. Analysing the new nursing curriculum for undergraduate nursing, reveals that there is little mention of ATHKPs. Clearly the role of THPs and ATHKPs as a health system, as recognised by the WHO and National Departments in South Africa has not cascaded down to education and training institutions. Training programmes to educate nurses on ATHKPs are scarce despite reports that some nurses are willing to work with THPs (Mutola, Pemunta & Ngo 2021).

Nevertheless, within most communities, THPs and ATHKPs play important roles ranging from treatment of ailments, mental health problems and counselling. It is highly likely that nurses will be in contact with patients who have utilised the services of THPs or who subscribe to some African value belief system and such nurses should have the necessary knowledge to manage problems presented by such patients. Particularly, most health professionals, such as nurses and health sciences students, still lack knowledge on the roles of THPs and have negative attitudes towards the use of ATHKPs by patients (van Rooyen et al. 2015; Nemutandani et al. 2015). Notably in South Africa, no competency framework or documented structure exists upon which ATHKPs can be taught to nurses and the content that needs to be included in their curriculum. The educational programs for preparation of nurses have not adequately included the knowledge on roles of THPs and skills inherent in the ATHKPs as well as the principles, values and beliefs underpinning African traditional health practice (Nemutandani et al.

2015). Most healthcare professionals such as nurses and health sciences students still ostracise and delegitimise THPs (Busia & Kasilo 2010). Common justifications for the undermining and exclusion are related to the apparently "unscientific" methods and processes of rendering care associated with ATHKPs. This happens because of a lack of structure for teaching ATHKPs in institutions of higher education (Abdullahi 2011). This results in one-sided, monolithic approach to healthcare management of patient's health problems.

Nurses still require training on ATHKPs to ensure they understand and appreciate the knowledge and skills possessed by THPs. Not only will this benefit the patients, but the entire health care system as most patients will be treated for certain ailments within the communities where THPs reside. There is a need for formal, standardised educational programmes and competency-based framework for nurses to address the context under which ATHKPs is practiced. This will ensure competence among nurses in not only recognising but also advocating for the use of other health care modalities such as the ATHKPs in line with patient-centred care.

1.4. Research Question(s)

Based on the identified problem, the following research questions were therefore posed:

- What competencies are required to standardise African Traditional Health Knowledge and Practices in nursing curriculum?
- What does a competency-based framework that standardises a nursing curriculum for African Traditional Health Knowledge and Practices into a nursing curriculum in South Africa include?

1.5. Aim and Objectives of the study

The aim of the study was to develop a competency-based framework for standardising the African Traditional Health Knowledge and Practices in nursing curriculum in South Africa. The aim and objectives of the study were achieved in 3 phases:

PHASE 1

This phase composed of a qualitative method where individual semi structured interviews were conducted with THPs.

Objectives:

- Explore and describe the views of THPs on African Traditional Health Knowledge and Practices.
- Explore and describe knowledge and skills of THPs in the provision of healthcare in South Africa.

PHASE 2

This phase adopted a quantitative, cross sectional descriptive design. Based on the information gathered in Phase 1, a questionnaire was developed from the themes to determine the content of ATHKPs by nurse educators in the disciplines they teach. Furthermore, the questionnaire assessed the level of inclusion of ATHKPs in the curriculum from accredited public nursing education institutions offering R425, R171 and R174 nursing programme in South Africa. Therefore, the themes that emanated from phase 1 were used to construct items in Section A of the questionnaire.

Objectives:

- Identify the level of teaching for ATHKPs in nursing education institutions in South Africa.
- Determine the contents of ATHKPs taught in the nursing curriculum in public nursing education institutions (NEIs).
- Assess how ATHKPs is being taught in public NEIs.

Data analysis took place in three stages: after the qualitative phase, then the secondary quantitative phase. The last stage is for the merge or integration findings from the qualitative and quantitative strands (Fetters, Curry & Creswell 2013). The merge was done at the interpretation level of the study.

PHASE 3

The merged data from Phases 1 and 2 was then be used in Phase 3 of the study to develop the competency-based framework.

Objective:

- Develop the competency-based framework to standardise the African traditional health knowledge and practices in nursing curriculum.

1.6. Contribution to the Body of Knowledge

This study proves to be an important milestone within the South African higher education landscape, especially within nursing education and training, where efforts to decolonise and transform curricula are underway. The study made a significant contribution to facilitating the exchange of knowledge between THPs, nurses, and other health professionals, who must work together in the interest of recipients of health services from different cultural backgrounds. The competency-based framework provides a structural format within which nursing education institutions and other health science institutions can design their curricula and train nurses, that is comprehensive and inclusive of alternative methods of health care such as ATHKPs.

1.7. Paradigmatic Perspectives

A paradigm represents a worldview, a set of beliefs, or a general perspective on the complexities of the world (Polit & Beck 2017). According to Chilisa (2012), research paradigms refer to ways of knowing and interpreting value systems and ethics as used in a study. This study adopted an exploratory sequential mixed method approach underpinned on a pragmatic paradigm, which is deemed relevant when a practical and pluralistic approach is needed to resolve societal problems (Feilzer 2010). Pragmatists advocate for more alternatives and frameworks that provide new insights and that which challenge the status quo (Feilzer 2010). This mixed method study takes the pragmatic stance because practical solutions to the integration and standardisation for teaching and assessing ATHKPs in nursing curricula may be achieved through a multi-stakeholder, problem-oriented and real-world practice focused interventions. The current situation in the training and education of nurses needs to be reviewed and challenged, especially on why the nursing curricula is designed the way it is, to suite the Western medicine perspective alone within an African health context. It remains the duty of pragmatic researchers to advocate for solutions that are people oriented and that which provides real-time solutions.

Additionally, exploration of more responsive programmes and alternatives should be prioritised as advocated for by pragmatists. Undertaking a study using the mixed method research design overcomes the setbacks and capitalise on the strengths of both qualitative and quantitative methods. A pragmatic stance provides a lesser amount of

influence to philosophical assumptions thereby limiting biasness (Brierley 2017). Pragmatists believe that science should facilitate problem-solving and not only be concerned with reality and the truth as both are dynamic (Pansiri 2006). In this current study, the lack of standardisation in teaching ATHKPs is associated with various factors such as western hegemony, indoctrination, misunderstanding of ATHKPs and many others which require exploration, contextualisation, and practical solutions.

Pragmatism is relevant in this study as it offers opportunities to solve societal educational problems. In most cases, pragmatism is concerned with what works best within a given situation. Thorough engagement with the phenomenon under study generated data that explained and describes the possible enablers or limitations to transformation and change in nursing curricula. In turn, a comprehensive view of the phenomenon was uncovered and contributed to efforts to transform the education and training of nurses in relation to ATHKPs in South Africa.

1.8. Philosophical Assumptions

Polit and Beck (2017) describe philosophical assumptions in research as the basic principles that are believed to be true without validation. These assumptions may therefore influence an individual or groups' understanding of reality. The shared assumptions about knowledge and reality within research include ontology, epistemology, and methodology.

1.8.1. Ontological Assumptions

Ontology is the study of existence as well as of what there is in the world. Ontology refers to the multiple and subjective nature of reality (Polit & Beck 2017). Therefore, one's ontological assumptions define what research objects and phenomena one focuses on based on what is regarded as the reality. The reality, as premised in this study, is that ATHKPs is not comprehensively and exclusively integrated in curricula at NEIs. This lack of integration means that there is less interest among nurses about ATHKPs and most of the nurses trained at NEIs in South Africa are not aware of what knowledge, skills, and various roles THPs play in provision of healthcare. In this study, stakeholders from different backgrounds gave their inputs on the reality of the phenomenon in their contexts, in the different phases of the study. Various methods of engaging the reality were deployed to identify, explore, describe, and determine the reality as experienced by

THPs, Indigenous Knowledge Systems (**IKS**) knowledge holders, nurse educators and other participants who were eligible for inclusion.

1.8.2. Epistemological Assumptions

Epistemology is concerned with knowledge, what constitutes that knowledge, as well as how the knowledge is obtained (Botma, Greeff, Mulaudzi & Wright, 2010). Additionally, epistemology refers to an individual's knowledge of reality and how to get to that reality (Polit & Beck 2017). Epistemology is therefore concerned with how the researcher and the participants co-created knowledge to the knowledge, skills and attitudes required among nurses to standardise ATKHPs in nursing curricula. Within this study, the researcher and all participants shared knowledge and experiences to facilitate a thorough understanding of why things are the way they are without trying to influence the outcomes. The study created opportunities for new ideas and better explanations that were previously not clear. Outcomes of engagements therefore contributed to the dialogue around the integration of ATHKPs, which has at its core the principle of Africanisation and decolonisation of nursing curricula.

1.8.3. Methodological Assumptions

Methodological assumptions are techniques and guidelines that direct how the researcher and the tools deployed can achieve scientific rigour during an investigation or study (Botma et al. 2010). According to Polit and Beck (2017), differing interpretations can be developed through interaction between the researcher and participants. Therefore, to minimise this, the researchers must be clear about the methods they choose and the rationale thereof in terms of why the methods are the best to investigate the phenomenon. In this exploratory sequential mixed method study, data was gathered using multiple tools and methods from multiple participants. The data collection techniques the researcher utilised include one-on-one face-to-face semi structured interviews, telephonic interviews, self-administered questionnaires, and consensus group discussions. The collected data was recorded on multiple sources such as audio recorders and fieldnotes to ensure credibility, authenticity and provide evidence of the study having been conducted.

1.9. Concept Clarification

1.9.1. African

The concept of African refers to characteristic of the continent of Africa or relating to its indigenous black people who live in it (Merriam Webster Online Dictionary 2019). This includes the ethnical groups, languages, knowledge systems, and practices that are of African ancestry. In this study the concept African refers to the knowledge, skills and practices related to health, that have originated and valued within the continent of Africa.

1.9.2. Standardise

To standardise, according to the Oxford Online Dictionary (2019) is to make an activity, object, or procedure to be similar in terms of characteristics and quality. In educational terms, the term standard refers to registered statements of desired education and training outcomes and their associated assessment criteria that highlight the quality of the expected performance (South African Qualifications Authority 2000). The aim of standardising is to ensure that there is consistency and conformity in how things are done, or procedures are performed. In this study, the concept standardise means adopting a structured approach in designs and methods on how ATHKPs are taught and assessed in nursing education institutions.

1.9.3. Healthcare Professionals (Allopathic Practitioners)

Healthcare professionals are individuals who are formerly trained to offer health services within a scientific paradigm, who apply scientific medical knowledge and technology to the health problems presented by patients (Kreitzer, Kligler & Meeker 2009) In this study healthcare professionals refer to all practitioners registered with their respective regulatory councils as such. These healthcare professionals are employed in private or public sectors offering diagnostic, treatment and rehabilitative health services and include nurses, doctors, pharmacists, psychologists, physiotherapists etc.

1.9.4. Competency Framework

Competency framework is a model that lists and describes the expected knowledge, skills and attitudes that enables a person to perform the expected role or duties successfully (Chartered Institute for Professional Development 2019). It is a means by which

institutions communicate with individuals on which behaviours are required, valued, recognised, and rewarded with respect to the specific roles they occupy (United Nations Educational, Scientific and Cultural Organization 2016). Competency frameworks are developed through consultative, comprehensive processes with multiple stakeholders who will be affected by the framework. In this study, a competency framework refers to a model that outlines or highlights a variety of knowledge, skills and attitudes that promote and measure the targeted learning related to African traditional health knowledge and practices by nurses.

1.9.5. Curriculum

A curriculum refers to a programme or course designed by an education institution highlighting the structure and content that will be presented within a programme (Bruce, Klopper & Mellish 2011). In this study, a curriculum refers to all the planned learning experiences, theoretical and clinical, that the educational institution intends to provide for its nursing students to enable them to achieve the outcomes of the programme. In nursing, this includes how students will be taught, assessed, supported, and guided through their learning by the nurse educators in the NEI.

1.9.6. Traditional Health Practice

According to Section 1 of the Traditional Health Practitioner's Act, Act no 22 of 2007, this concept means the performance of a function, activity, process, or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practices to diagnose, manage and rehabilitate persons with health problems. In this study, the concept means a system of health care that treats diseases using African traditional medicines, herbs, ointments, and any other prescription instituted by THPs.

1.9.7. Traditional Health Practitioners

A Traditional Health Practitioner (THP) refers to a person registered under the Traditional Health Practitioner's Act, Act 22 of 2007, in one or more of the categories of traditional health practitioners. The categories registered under this THP Act include herbalist, traditional birth attendant, traditional surgeon, and diviner. In this study, THPs are African indigenous health practitioners who ceded to the ancestral calling and went through training. These THPs provide a variety of health services to citizens within a particular

geographic location using indigenous knowledge and skills African traditional medicines and practices.

1.9.8. Nursing Education Institution

Section 42 of Nursing Act 33 of 2005 defines a Nursing Education Institution (NEI) as institutions accredited by the SANC to offer programmes leading to registration in one of the categories stipulated in terms of this Act. In this study, NEI refers to public institutions offering nursing education and training to individuals and includes public and private colleges, universities of technologies and universities.

1.10. Delineation

The study was conducted within a South African context wherein a competency framework for standardising ATHKPs in nursing is developed for nurses. Phase 1 included interviews with THPs from the City of Tshwane Metropolitan Municipality. Phase 2 included nurse educators from public nursing education institutions that were offering courses leading to registration as a professional nurse and midwife practice under South African Nursing Council regulations such as R425, R171 and R174. Within the South African context, regulations are abbreviated (R) then followed by a number such as 425. Therefore, R425 represents regulation underpinning the training of student nurses who will be professional nurses and midwives upon completion of training.

1.11. Classification of Chapters

Chapters in the thesis are the following:

Chapter 1: introduction and overview of the study

Chapter 2: Literature review

Chapter 3: Research design and methods

Chapter 4: Presentation of qualitative results Phase 1

Chapter 5: Interpretation and discussion of qualitative results

Chapter 6: Presentation of quantitative results Phase 2

Chapter 7: Interpretation and discussion of quantitative results

Chapter 8: Integration of qualitative and quantitative results

Chapter 9: Development of competency-based framework

Chapter 10: Limitations, recommendations, and conclusion

1.12. Summary

In Chapter 1, the researcher introduced the study and provided a detailed background outlining the importance of the study. A brief description of the research design and methodology was given with its alignment to aims and objectives. In Chapter 2, the researcher outlines the literature that was reviewed to support the study.

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

Chapter 1 introduced the study and outlined the purpose of the study as well as the objectives through which the purpose was achieved. The primary aim of this chapter is to outline the body of knowledge on African Traditional Health Knowledge and Practices, which includes perspectives about health, between Western biomedicine and African traditional health practice. Additionally, the training and regulation of biomedical and traditional health practitioners will be discussed. A literature review was conducted on the competencies and competency frameworks for nurses on ATHKPs and traditional medicine regionally and globally.

2.1.1. Purpose of literature review

In the literature review, the researchers provide a systematic appraisal of the available peer-reviewed studies to analyse and synthesise the outputs of those studies (Efron & Ravid 2018). Such findings are then utilised to rationalise the importance of the current study. According to Aveyard (2014), researchers are involved in literature review to develop new knowledge and understanding of a phenomenon from various angles. The researcher put forward scientific arguments that provide a comprehensive view of the study, where the pros and cons of the study are interrogated and reported upon (Hart 2018). Further analysis of the study can be achieved by critiquing the literature to get a clearer picture of why the phenomenon under study is a problem.

2.1.2. Scope of the literature review

The literature review covered accessible, relevant literature that was published and referred to regarding the development of competency frameworks and competencies of nurses on African Traditional Health Knowledge and practices in South Africa. Relevant studies published in English from 2010-2023 were searched using various electronic search engines.

2.2. Methodology

The methodology used for conducting the literature review is discussed under the strategy for searching in peer-reviewed journals followed by the search strategy for grey literature. Lastly, the inclusion and exclusion criteria, as well as data extraction will be presented.

2.2.1. Search strategy for peer-reviewed journals and grey literature

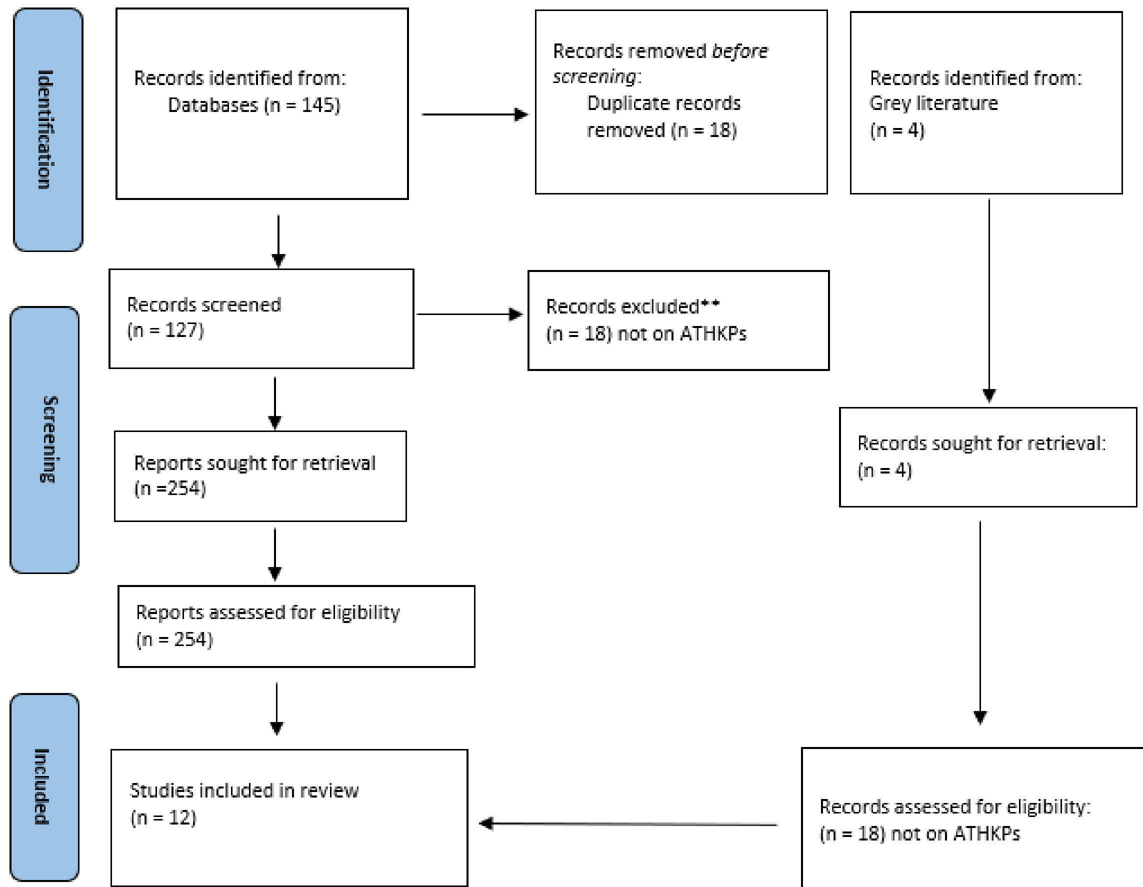
Search strategies were developed to include search concepts/terms, databases, duration, language used as well as the type of sources (Levac et al. 2010). The publication dates extend from 2000 until 2023 due to the scarcity of publications in this field of research in Africa. The researcher searched for literature in peer-reviewed journals in databases such as PubMed, Web of Science, Scopus, and EBSCOhost (CIHNAL), while grey literature search was done through research platforms such as Google, Google Scholar, ResearchGate as well as non-governmental organisations such as the WHO and International Council for Nurses in case additional literature may have been missed.

Key terms were developed and customised to suit the search strategies for the different databases. The following key terms were used in the study: *competence, competency-based framework, nursing, knowledge, skills, attitude, traditional medicine, indigenous, African traditional practices, and curriculum.* Salient concepts that emanated from the initial search terms included traditional healing, traditional medicine, traditional health practice, cultural competency. This was done because the concept of ATHKPs encompasses all elements of traditional health practice, including culture and spiritualism. The chosen articles were first screened by title and abstract to check if they are relevant. Subsequently, the researcher analysed the titles and abstracts of the articles that were not selected. If the title and abstract contained potentially relevant key words about nurses' competencies, competency framework and African traditional health practices, the article was included.

From the search concepts used in more than 957 articles that were yielded, about 145 articles were related to the topic or title of the study. Only articles included that presented original findings were included. The limited number of articles in the field of ATHKPs on competencies and nursing necessitated that the search list be refined to include

international studies conducted on the topic of traditional medicine. Librarians were consulted to also assist with the literature search to ensure wide coverage for the literature search. See Figure 2.1 for an illustration of the selected publications.

Figure 2.1: Prisma flow chart



2.2.2 Inclusion and exclusion criteria

The included literature criteria were:

- Must be published in English.
- Years of publication 2010–2022.
- Studies to be included can be quantitative, qualitative, and mixed methods studies.
- Focusing on traditional medicine and African traditional health practice.
- Competencies and competency frameworks for nurses on ATHKPs.

2.3. Discussion on Findings of the Literature Review

The section discusses the results of the literature review to support the current research study.

2.3.1. Definition of health in African traditional health system and Biomedical system (Western medicine)

Much debate exists globally on the definition of the concept health or a state of being healthy. While common elements can be elicited from the breakdown of the concept of health, disparities still exist in whether an individual can be fully healthy at any given time. For example, globally, health authorities define health by referring to the definition endorsed by the WHO. According to the WHO, health is state of complete physical, mental, and social wellbeing and not merely the absence of disease or illness (WHO 1984). This definition of health by the WHO has remained and been adapted by many countries. It tends to somehow support the definition superficially in the traditional health practice realm, where spiritual well-being is recognised as a dominant force in determining a person's health and well-being. Habersack and Luschin (2013), points out to the need to standardise the definition globally, as a matter of addressing human rights. Definitions of concepts in legislative documents such as the WHO constitution are by their very nature, normative and enforceable by law.

However, such definitions should be contextualised to the health needs of indigenous populations who primarily also rely on traditional health practice to meet their neglected needs such as spiritual therapies (Fokunang, Ndikum, Tabi et al. 2011). There is a need for common understanding, which will facilitate the knowledge exchange between biomedical health system and traditional health system. Hereunder is a discussion of the African traditional health and the biomedical systems, outlining principles and processes adopted in providing healthcare in each system.

2.3.1.1. African traditional health system and underlying principles

African traditional medicine is recognised as the oldest health system in the history of mankind (Mahoomodally 2013). According to the WHO (2021), traditional medicine encompasses the knowledge, skills and practises that are influenced by value belief systems of indigenous populations. The knowledge, skills and practices are based on

people's experiences on what may have worked over a period, either used in the prevention, diagnosis and of treatment of health problems. African traditional medicine is a holistic health system using indigenous health practices in managing health problems and differs from one community to another. (Dzoyem & Kuete 2013). Africa, as a predominantly rural continent, has a abundance of traditional health practitioners who offer traditional health services within the vicinity of the local communities. Not only are the services physically accessible, but they are also affordable in line with the primary health care approach adopted by many continents (Mahoomodally 2013). Traditional health practitioners or as commonly referred to as traditional healers in many communities, are respectable members of their communities who often are consulted when people need counsel or advice on matters that require wisdom from a spiritual realm.

The African traditional health system is characterised by its focus on holistic care, which encompasses the body, mind, and the soul (Mothibe & Sibanda 2019). Across many African countries, the utilisation of traditional medicine has been on the rise (James, Wardle, Steel & Adams 2018). However, due to colonialism and dominance of Western medicine, many Africans have been utilising both systems concurrently to treat illnesses that are sometimes deemed incurable by Western medicine or those unmanageable in the African traditional health system, a phenomenon referred to as dualism (Mothibe & Sibanda 2019). According to Ozioma and Chinwe (2017), African traditional health system is structured in terms of the type of service rendered, however falls within the specialties of herbalism, spiritualism, and divination. Within each specialty, traditional health practitioners typically render health care services that include consultation, assessment of physical and spiritual well-being as well as prescribing oral and topical herbs (Zuma, Wight, Rochat & Moshabela 2016). Similarities can be noted however between African traditional health system and biomedical system in terms of the process involved in providing healthcare services such as assessment of problem, diagnosis, prescription, and possible referral and follow up on health problems that require such (Zuma et al. 2016). Table 2.1 below outlines the specialties within the African traditional health system.

Table 2.1: Specialisations in African traditional health system

Specialty	Type of Practitioner	Services
Herbalism	*Inyanga* (Traditional medicinal remedies)	• Use ancestral spirits during consultations to determine causes, sources of illness. • Uses traditional medicinal herbs to treat disease
Spiritualism	*Umthandazi* (Faith healer)	• Receives instructions from messengers of God by connecting with ancestors in the spiritual realm. • Assist to interpret people's problem and offer counselling
Divination	*Sangoma* (Diviner)	• Uses plants, herbs in traditional medicinal remedies. • Connect with ancestors to activate healing powers
Surgery	Traditional surgeons	• Preform circumcisions and other surgical procedures such as drainage of abscesses
Traditional Midwifery	Traditional birth attendants	• Provide maternal and child services using traditional methods.

The WHO has been actively involved in supporting member countries in Africa and advocating for complete inclusion of the African traditional health system into modern system of healthcare. The call is important amid the expanding utilisation and recognition of traditional health as an equal partner in solving some of the health problems that have prevailed over long periods of time without tangible solutions from the biomedical health system. For example, HIV/AIDS was first discovered over 40 decades ago and the approach to its management seems to be conservative and not curative. However, one of the most treated diseases among THPs is reportedly HIV/AIDS or are patients presenting with similar symptoms as those of the pandemic (Audet, Ngobeni & Wagner 2017). Still, there is sceptics about the treatment of such patients by allopathic practitioners despite THPs having received training on HIV/AIDS management (Zuma et al. 2016). The possible areas of collaboration, such as in the management of HIV/AIDS, between THPs and allopathic practitioners demonstrate that the African traditional health system has a place in modern health system and should be prioritised.

2.3.1.2. Biomedical health system

Biomedical health system, also known as Western medicine or allopathy, is currently the most dominant system of healthcare, offered more recognition and support across Africa and the entire world. In the biomedical system, healthcare professionals such as nurses, doctors, pharmacists, and therapists treat symptoms and diseases using drugs, radiation, or surgery. The domination of the biomedical health system has over time been perpetuated by colonialism in Africa, which vilified the practice of African traditional health practices for over four centuries. Biomedical health system may be regarded as superior to other systems of healthcare because of the support the system from a political and legal point of view. Despite efforts to reconcile the biomedical and African traditional health system, there seems to be some level of resistance, from allopathic practitioners who cannot seem to conceive what they refer to as a primitive, abstract system of healthcare that lacks objectivity (Oseni & Shannon 2020). Consequently, the widening gap between the two health systems in terms of the approaches to health care is perpetuated by the intolerant education and training system for allopathic practitioners. The professional socialisation of allopathic practitioners situates them as to be having superior knowledge and skills. This becomes an impediment in closing the gap and facilitating collaboration among THPs and allopathic practitioners.

Literature associates the birth of biomedicine to Hippocrates whose philosophy on health disease focuses on scientific evidence for the cause and effect of disease on the human body (Sandeck 2017). However, a closer look at the initial philosophy of Hippocrates demonstrates that in fact, he believed that the body has an innate ability to heal itself, which considered disease as a multifactorial phenomenon (Hazelbaker 2013). The biomedical system, like all other alternative systems has evolved over time, however evolution in Western medicine has been closely linked to advancement in technology and its ability to provide evidence or links between disease and human existence (Grosz 2011). The biomedical health system is characterised using scientific medical knowledge and technology to facilitate the management diseases and facilitate healing in hospitals and clinics (Kreitzer, Kligler & Meeker 2009). Much focus in the modern biomedical system is on the physical aspects of disease, however in recent times, many aspects which are present in traditional medicine such as music therapy and spirituality have been infused, in response to patients demands for such services. It therefore demonstrates

that some of the practices between the different health systems have been borrowed and are utilised to advance the science in each system of health care.

2.4. Training and regulation of biomedical practitioners versus African traditional health practitioners

One area of common purpose that will facilitate mutual respect for the knowledge and skills possessed by practitioners, is related to the processes of training and regulation for such practitioners from the different systems of healthcare. Training and regulation of both THPs and allopathic practitioners should accordingly clarify their roles within the formal and informal healthcare systems so that the formalisation and recognition of African traditional health and practice, as mandated by law in South Africa, is not undermined (Traditional Health Practitioner's Act 22 of 2007).

2.4.1. Training and regulation of biomedical practitioners

Education and training of allopathic practitioners South Africa is the role of the Department of Higher education, Science and Technology (**DHEST**). All training at higher education institutions (**HEIs**) is regulated by the Higher Education Act 101 of 1997, whose preamble mandates the DHEST to restructure and transform higher education, redress past inequalities, respect freedom of belief or religion and respond to current needs of communities being served (Higher Education Act, Act 101 of 1997). This is important in the context of South Africa, where higher education sector experienced eruptions from student unrest across the country, demanding decolonisation of the curriculum. Education and training for allopathic practitioners, nurses in particular, in South Africa offered at universities, private and public colleges. Qualifications being offered are Doctoral degrees, Masters degrees, bachelor's degree, and diplomas. The formal training in this sector is well established and is carried out in terms of rules and regulations prescribed by quality assurance bodies such as the Council on Higher Education, South African Nursing Council, Health Professionals Council of South Africa, and the South African Pharmacy Council. The mandate to redress and transform higher education in the HEIs, is a shared responsibility among all stakeholders in contributing to the development of responsive curricula that integrate the indigenous knowledge systems and advocate for inclusion of ATHKPs in curriculum in line with demands of the black majority population of South Africa.

Some nursing education institutions in South Africa have initiated the teaching ATHKPs in their curricula, however, how ATHPKs is taught remains fragmented, one-sided, and monolithic as evidenced by the lack of clarity and structure in terms of what should be taught and by whom (Chitindingu, Geroge & Gow 2014). It is reported that nurses often lack the knowledge and confidence to discuss or document the use of alternative methods of healthcare (Hall, Leach, Brosnan & Collins 2017), demonstrating the one-sided teaching approach and philosophy which regards Western medicine as the only legitimate science. Guidelines for formal training were recommended as a good starting point in South Africa and Australia to improve the nurses' competencies on ATHKPs and Complementary and Alternative Medicine (CAM) respectively (Shorofi & Arbon 2010; Sibiya, Maharaj & Bhagwan 2017). Therefore, as purported by the study, the presence of competencies will ensure that nurses acquire the necessary knowledge, skills, and attitudes to be able to respond holistically to patient's biomedical and traditional health needs in line with patient centred.

2.4.2. Structure of nursing curricular in Africa and globally

The integration of traditional health knowledge and practices into nursing practice will first require curricular reformation to ensure that nurses and health sciences students from other professions are trained about traditional health practice and its different methods of managing health problems (Egharevba, Ibrahim, Kassam and Kunle 2015). However, Chitindingu, George and Gow (2014) noted that South African health sciences institutions still lag and are reluctant to incorporate traditional health practices and complementary medicine fully into their curriculum. According to Singer and Adams (2012), incorporating Complementary and Alternative Medicine (**CAM**) and traditional health practices into modern biomedical curricula pose challenges related to lack of approaches that are "evidence-based" in traditional health practice. Another aspect that could impact the inclusion and teaching of ATHKs in institutions of higher learning is possible curriculum overload. This perspective however demonstrates the subtle views some western scholars still hold about African knowledge systems. Other scholars (Innocent 2016; Krah, de Kruijf & Ragno 2018) also reported the lack of resources required to train health practitioners in ATHKPs. Whether the concerns should not supersede the importance of a responsive patient-centred care and Africanised nursing curriculum or not remains a point of debate.

In South Africa, the minimum standards and requirements for training are prescribed by the South African Nursing Council, as the statutory body regulating the profession (Nursing Act 33 of 2005). The scope of practice for various categories of nursing determines the curriculum for such categories in terms of the regulation. One example of the structure (shown in Table 2.2) of the nursing curriculum in terms of R425, is such that student nurses will be trained on the following:

Table 2.2: Subjects and duration of training for professional nurses in South Africa

Subject	Duration
Fundamental Nursing Science, ethos, and professional practice	At least one (1) academic year.
General Nursing Science	At least three (3) academic years.
Psychiatric Nursing Science	At least two (2) academic years.
Midwifery	At least two (2) academic years.
Community Nursing Science	At least two (2) academic years.
Biological and natural sciences	At least two and a half (2½) academic years.
Pharmacology	At least half (½) an academic year.
Social Sciences	At least to (2) academic years.

The training of nurses in South Africa is structured in such a way that most content related to ATHKPs are aspects of cultural competency and diversity. Having said that, the emphasis on culture and its influence on health seeking behaviour is limited to Western interpretations. According to Balcazar, Suarez-Balcazar and Taylor-Ritzler (2009), most available cultural competence models being taught in health sciences professions are in nursing (72%), followed by counselling (22%) and social work (6%). While many higher education institutions are recognising the need to start integrating African perspectives into curricula or decolonising western theories are still preferred as a basis for such integration. The Western context in which the cultural competence theories and most nursing theories were developed is obviously different from the African context, making integration of such theories into nursing in South Africa a challenge. The different cultural influences include body language, dress code and traditional accessories worn by patients in different demographic landscapes.

Efforts have been made to infuse ATHKPs into the health sciences curricular. For example, cultural competence theories such as Leininger's Culture Care Diversity and Universality Theory (1988), have been integrated into most nursing curricula. Nursing students are taught, trained, and required to contextualise the theories such as the Leininger's Culture Care Diversity and Universality Theory, which often creates confusion among students or portrays a one-sided narrative not inclusive of the perspective from African traditional health practice (Kaya & Seleti 2013). As such, nursing students are often socialised into believing and accepting that ATHKPs is primitive and is without a scientific base. This highlights the knowledge gaps within health science curricula and the distorted perception among some nurses towards alternative methods of care such as ATHPKs.

However, teaching nursing theories may not guarantee the conversion of knowledge into cultural competence among nurses, especially because of how culture is taught and assessed in nursing education institutions. Brosnan et al. (2017) commented on a need to develop guidelines for formal training of nurses regarding traditional health as one of the health care modalities that patients often use.

2.4.3. Regulation of training for allopathic practitioners

Regulation of practitioners is important as it provides a clear framework within which health professionals provide safe, efficient, and competent services to recipients of such a service (Kreutzberg, Reichebner, Maier, Destrebecq & Panteli 2019). Professional bodies such as the South African Nursing Council (SANC), Health Professionals' Council of South Africa, and government departments prescribe standards of practice for nurses. In nursing, the standards are in the form of regulations for training such as R425, R171, R174, the specific conditions such as where the training must take place, who must train the practitioners and knowledge areas (subjects) that must be covered. In most instances, these standards turn out to be biased only towards modern Western medicine. Competencies from the SANC do not include any aspect of ATHKPs. The prescripts from the professional bodies tend to indirectly disregard patient's value and belief systems as they inhibit certain traditional health and culture-oriented actions or practices such as involving THPs in management of patients by nurses. Some education institutions have reported that they include the use of alternative health care models in their curriculum

(Sibiya et al. 2017); it is still not clear what content is taught and against which competencies are this taught to ensure nurses understand the roles of THPs and principles underlying ATHKPs.

2.4.4. Training and regulation of traditional health practitioners

Traditional medicine has a long history of existence and its documentation dates as far back as 2000 years ago in China (Hsu 2008). The traditional health system in countries such as China is so well developed that it is now being utilised in specialised areas of health such as trauma, gynaecology, and paediatrics. According to the WHO (2019), the first official traditional and complementary medicine school was founded in 624 AD. On the other hand, in India, the system of life sciences, popularly known as Ayurveda, has been documented and practiced since 1500 BCE (Jaiswal & Williams 2017). The systems of training for traditional healers from these ancient countries have been well developed and formalised to such an extent that convergence has occurred. Traditional healers in the Traditional Chinese Medicine utilises assessment and diagnostic interventions borrowed from modern biomedical system, while allopathic practitioners also utilise and prescribe traditional medicine interventions (WHO 2019). Such progress is a good benchmark for other countries such as South Africa who are keen on integrating ATHKPs into modern the biomedical system.

Without a doubt, African medicine existed before the arrival of Western medicine and was established as an effective health system over millennials. However, in Africa, documentation and formalisation of traditional health practice has threatened its existence. This has been fuelled by the secrecy inherent in ATHKPs as well as the criminalisation of traditional health practice by colonial governments (Ozioma & Chinwe 2017). Some countries are however making progress in formalising the recognition and registration of THPs. In South Africa for example, the Traditional Health Practitioners Act 22 of 2007 was enacted for the establishment of the Traditional Health Practitioners' Council whose mandate is regulating, training, and the registration of practitioners and students. Within the THP Act, categories of practice are given to practitioners in terms of the role they will be carrying out. Acts and regulations are laws of a country and provide a framework which formalises the prescripts in the law. Therefore, the debate about the formality of ATHKPs should take a different direction and narrative. However, there have

been challenges in terms of the regulating mandate as there are a lot of logistical and procedural hurdles that must be overcome (Abrams, Falkenberg, Rautenbach, Moshabela, Shezi, van Ellewee & Street 2020). This includes creating a single coordinated framework for regulation among practitioners, who by their own right still want to maintain the independence.

Traditional health practitioners perform various roles within communities such being the guardians of the traditional African religion and customs, teachers on cultural practices, offer counselling services (Mokgobi 2014). The rise in the utilisation of traditional medicines, and the acknowledgement of the important role played by THPs by global and regional organisations such as the WHO, has also put ATHKPs on the spotlight for scrutiny. Issues emanating from efforts to formalise the practice of THPs involves the sharing of sacred information (Ozioma and Chinwe 2017), which according to THPs, should not be made public. The secrecy inherent in ATHKPs regarding the processes involved in their training and methods used to source healing practices has placed much pressure on the ability to legitimise the practice (Kanu 2018). Although, the process of recognising and certifying THPs in South Africa has been ongoing for some time, little progress has been made in this regard.

Traditional health practitioners, like in the mainstream education system, undergo an intense programme of training for them to be certified as competent practitioners before they start to practice. Within the African traditional health system, being a traditional health practitioner starts with an ancestral calling which may manifest as illness or visions. Often, this illness is diagnosed in Western medicine as Schizophrenia, while in many South African ethnic groups it is termed a*mafofonyane*. The concept of mafofonyane represents unusual behavioural and psychological state of mind (Niehaus et al. 2004). Upon patients seeking help from spiritual practitioners, it is often diagnosed and confirmed that there is a calling to become THP in whatever specialisation (Mokgobi 2015). The calling is referred to as "*ho thwasa"* in Sesotho; *"ukuthwasa"* in isiXhosa and isiZulu in the South African dialects (Mensele 2011; Booi 2004). However, Zuma et al. (2017) reported that to be an *Inyanga* may be an individual choice, but still requires training by an expert. The trainee THP is led by the ancestors or the consulting diviner to the more experienced THP who will initiate the trainee as guided by ancestors. Notably,

not everyone who is initiated becomes *Isangoma;* others go through "*ho thwasa"* (initiation) due to ancestral issues or life challenges, however, still maintain their livelihood.

The training of THPs in their various disciplines varies, as well as the period of training. On average, in Nigeria, as far back as the late 80s, the training of herbalist and traditional birth attendants is about 7 years (Oyebola 1980). Literature in South Africa on the training of THPs does not specify the period, however it is estimated to be years (Mensele 2011). During the period of training, the trainee is expected to live with the trainer and family for the period of their training, being observed, assessed, and taught how to perform the duties of a traditional health practitioner (Mokgobi 2015). This period of apprenticeship is used for preparing the trainee for the independent role and comes with rules of conduct such as how to communicate with people, learning appeasing of ancestors, identification, and preparation of herbs as well as cleansing rituals (Zuma et al. 2017). At the end of the training, a ceremony is performed in the presence of community members to confirm if the initiate has mastered the art and science of traditional healing, like summative examination leading to a graduation ceremony in the mainstream education system.

However, Louw and Duvenhage (2016) argues that the level of training for THPs is "elementary" and cannot be compared to the level of qualifications for allopathic practitioners on the National Qualifications Framework (**NQF**). The view shared by Louw and Duvenhage (2016) in this literature review study, as indicated in the limitations of their study, may be influenced by a lack of a documented structure within which training for THPs can be provided. Having said that, Nompumelelo, Gomo, Gqaleni and Ngcobo (2019), in their study, identified the following eleven competencies to be developed during training for THPs: "*consultation, diagnoses, holistic patient care and treatment, integrative and holistic healing, application of healing procedures and cultural rituals, spiritual development, ethical competencies, problem solving, herbalism, ancestral knowledge and end of life care*". Therefore, regarding such training as elementary is in fact arguable as the competencies above are similar, in all aspects, to what would be included in the scope of practice for allopathic practitioners during their training. African views and methods of validating indigenous practices must be prioritised and utilised to come up with conclusive evidence on the elementary nature of training for THPs; hence, the need for a competency-based framework in this current study.

2.5. Competency frameworks for nurses

Competence entails the knowledge, skills and attitudes that are required for a practitioner to perform a specific task at a set standard (Dijkstra et al. 2021). In nursing, competency is associated with the ability to carry out tasks assigned to a professional practitioner in line with their scope of practice and expectations of the role (Fukada 2018). This is confirmed by the SANC, which describes competencies as "*a combination of knowledge, skills, judgement, attitudes, values, capacity and abilities that underpin effective performance in a profession"*. While many competency frameworks exist in nursing to provide support and structure within which nurses can be taught and practice, in South Africa, there is paucity of literature in terms of frameworks to guide in the teaching ATHKPs. This leads to an unstrutured approach to teaching and hinders the ability of nurses to render context specific, culturally-responsive and acceptable nursing services to clients,in turn affecting the quality of care provided.

2.5.1. Definition and purpose of a competency framework

A competency framework is a broader structure describing and explaining different competencies. Within a competency framework there are set of cognitive, psychomotor, and affective sets of indicators and standards against which performance will be measured. Competency frameworks are used by organisations to standardise and align organisational performance with work expectations and goals (UNESCO 2015). Competency frameworks outline the structure within which common assessment of behaviours and use of language may be required related to the occupational duties and performance behaviour. Accordingly, a competence framework is necessary so that education institution can develop educational programs that are competency-based and tailored to meet the needs of society (Dijkstra et al. 2021). This demonstrates the challenges an organisation or a profession such as nursing may experience when there is no existing framework to measure performance and standardise practices.

2.5.2. Competency frameworks in nursing related to traditional medicine

Competency frameworks are designed to facilitate a common understanding of critical elements that would be used to measure success or failure in providing a service. In other words, the ability to assess if the nurses are providing services that meet the needs of patients is measured by how well they collectively understand and interpret the

expectations. Competencies therefore standardise how practitioners perform duties, communicate, and conduct themselves within the parameters and scope of the framework. In a profession such as nursing, competency frameworks are necessary to promote patient-centred care, to prevent working in fragments (Englander & Carraccio, 2018) and to promote collaboration in the multidisciplinary healthcare setting (Zumstein-Shaha & Grace 2021). In nursing, competency frameworks have been used to enhance the ability to communicate between nurses and to ensure that nurses have a comprehensive understanding of their profession and their contribution to the broader healthcare facility. However, many competency frameworks globally focus on generic competencies or are specific to disciplines in nursing such as community, midwifery, geriatric, childcare nursing, and others (Zumstein-Shaha & Grace 2021). While some countries have managed to develop competency frameworks for nurses in traditional medicine in the specific geographical locations such as Asia, Australia and some part of America, most frameworks are applicable to nursing practice in the region. Table 2.3 highlights some of the global competencies on traditional medicine.

Table 2.3: Global competencies on traditional medicine for nurses

Region/country	Title of study	Authors/year	Identified competencies related to traditional medicine
Asia/China	A clinical care competency inventory for nurses in Traditional Chinese Medicine: Development and psychometric evaluation	Chang et al, 2020	• Basic Traditional Chinese Medicine related knowledge and skills. • Diagnostic questioning • Traditional Chinese Medicine assessment in special conditions • Patient education about Traditional Chinese Medicine nursing
Asia/India	Post Basic Diploma in Ayurveda Nursing - Residency Program) Regulations, 2022	Indian Nursing Council	• Knowledge on concepts, principles, and standards of Ayruveda • Patient education and counselling • Assessment, diagnosis, and treatment • Principles of treatment • Understanding drug administration and maintenance • Develop competencies in rehabilitative techniques. • Promote collaboration and teamwork.
Asia/Thailand	Nurse's roles in a Thai traditional medicine and alternative medicine unit	Atthayasai & Oumtanee 2019	• Patient care of Thai Traditional and Alternative Medicine (TTAM) • Informant and counsellor • Risk management regarding TTAM and conventional medicine. • Coordination of patient care • Self-development on TTAM
Asia/Korea	Developing a best practice framework for clinical competency education in the traditional East-Asian medicine curriculum	Han et al, 2022	• The procedures and methods for keeping the clinical setting clean and sterile. • The accurate practice of physical examination. • The correct administration of traditional medical diagnosis and appropriate explanation of its results to the patients. • Safe and effective performance of acupuncture, • moxibustion, cupping, and pharmaco-puncture. • Proficient preparation, processing, and prescription of medical herbs
Australia	Working together in Aboriginal health: a framework to guide health professional practice	Wilson et al, 2020	• Using appropriate processes in traditional medicine • Demonstrating commitment to building relationships and relinquishing control • Having an awareness of Aboriginal history • Communication, commitment, flexibility, humility, honesty, and persistence.

The above literature on the competencies also supports most of the findings from Phases 1 and 2 of this study regarding the knowledge areas and competencies in traditional medicine. Across the different countries or regions, common competencies that are identified include history taking and assessment, knowledge on diagnosis and treatment modalities as well as ability to collaborate with other practitioners. The competencies therefore must be integrated into the nursing process so that ATHKPs is not seen as a separate entity from nursing care provided. Nurses, while acting within their scope of practice, must be clear on their roles so that they can provide care to patients, considering their value belief system in line with ethical principles of beneficence, justice and maintaining the patient's autonomy. A summarised list of all the above competencies in the table include:

- Basic knowledge and skills (assessment, diagnosis, and treatment)
- Knowledge on concepts, principles, and standards
- Patient education and counselling
- Understanding drug administration and maintenance
- Promotion of collaboration and teamwork.
- Risk management
- Coordination of patient care
- Self-development (continuous professional development)
- Proficient preparation, processing, and prescription of medical herbs
- Using appropriate processes in traditional medicine
- Demonstrating commitment to building relationships and collaborations
- Communication, commitment, flexibility, humility, honesty, and persistence as values for practice

In South Africa, the SANC developed a competency framework generic to all nursing specialisations. The competency framework may be used in a variety of settings but does not highlight issues of traditional health practice. The development of the framework by the SANC has paved a way for NEIs to adopt and contextualise elements of nursing in their curriculum. Nonetheless, there is paucity of literature regarding competency frameworks for nurses on traditional medicine or specifically ATHKPs in Africa or South Africa. Competencies that have been reported in literature include those reported by Nompumelelo et al. (2019), which focused on THPs, not

nurses. This demonstrates the challenges faced when nurses must practice in health environments where most of their patients' understanding of health and disease is informed by indigenous knowledge systems. As a result, patients are either misunderstood, misdiagnosed, or even shamed for demonstrating signs of using ATHKPs by nurses. This phenomenon has been reported in South Africa.

2.6. Summary

This chapter focused on relevant literature related to the study. The concepts of Africa traditional health knowledge and practices and biomedicine were elaborated on, citing similarities in both systems of health care. Furthermore, the differences in terms of training and regulation of practitioners were outlined. Chapter 3 will highlight the methodology for the study which includes data collection methods, data analysis and trustworthiness.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1. Introduction

In this chapter, the research design and methods adopted to achieve the aims and objectives of this study are discussed. The chapter discusses the research design, data collection methods, data analysis, and process for the development of the competency-based framework. The study was conducted in 3 phases:

- Phase 1: To explore the knowledge, skills, and roles of THPs in the provision of healthcare services.
- Phase 2: To determine the current teaching of nurses on ATHKPs; and
- Phase 3: To develop a competency-based framework to standardise ATHKPs in nursing curriculum.

The chapter will then be concluded by explaining the ethical principles which were considered throughout the study.

3.2. Research design for the study

According to Polit and Beck (2017), a research design is the plan for addressing a research question and includes all the conditions for enhancing the rigor of the study. Research design refers to a road map that outlines the research process in terms of who the data was collected from, the data collection instrument (how data was collected) as well as how the data was analysed to come up with a conclusion about the findings (Hair, Celsi, Money, Samouel & Page 2011). Research design provides an actual implementation plan in terms of the nature of the study and a justification of the approach that brings about in-depth information using the best available tools and sources. In this study, an exploratory sequential mixed method design was employed to explore, describe, document, and ultimately develop a competency-based framework to standardise ATHKPs in nursing the curriculum. The findings of Phases 1 and 2 were merged for interpretation and guided the development of the competency-based framework in phase 3.

3.2.1. Exploratory sequential mixed method

According to Cresswell (2013), an exploratory sequential mixed method research design firstly deploys a qualitative design to collect and analyse the data. Thereafter, a quantitative design is undertaken based on the themes, ideas or items that emanated from the qualitative design to collect subsequent data quantitative data (Tariq & Woodman 2013). Creswell (2016) recommends that researchers who opt for mixed method designs justify the value of collecting qualitative and quantitative data as well as the importance of integration. Using mixed method research ensures validity across many dimensions as well as an in-depth understanding of the phenomenon at hand (Schoonenboom & Johnson 2017). Mixed methods can be used for a variety of purposes such as converging, complimenting, expanding, or initiating a conversation from a variety of methods (Creswell 2013). The purpose for using a mixed approach in this study was developmental, where the results from Phase 1 (qualitative design) were used to inform Phase 2 (quantitative). Results of Phases 1 and 2 then informed the development of a competency framework in Phase 3.

Within the context of this study, using a mixed method design gave a better description and understanding of the knowledge, skills, and roles of THPs as well as the principles underpinning healthcare system of ATHKPs from a qualitative perspective. Furthermore, a quantitative approach ensured that this study determines the knowledge of nurses on ATHKPs as well as the teaching of nurses on ATHPKs. The findings of Phases 1 and 2 were merged and contrasted for similar patterns and meaning. The common ground that was established from Phases 1 and 2 then laid the ground for the development of the competency-based framework.

In line with mixed method design, collecting data from multiple sources, utilising a variety of methods (triangulation) provided a comprehensive view on the multiple realities and interpretations that exist between various stakeholders. Adopting a mixed method design also maximised strengths and minimised the weaknesses of qualitative and quantitative designs (Creswell, 2013). The qualitative data in Phase 1 informed the data collection instrument that was used subsequently in Phase 2. The resulting data from Phases 1 and 2, formed the basis for the development of the competency-based framework in Phase 3. The qualitative data from the individual interviews enriched the subsequent quantitative survey and provided a deeper understanding of

the context within which ATHKPs are located. According to Jones-Harris (2010), using the findings of a qualitative study to inform a quantitative study greatly improves and strengthens the subsequent quantitative data collection method, which in this case, was a self-administered questionnaire. The following discussion clarifies the phases in terms of the research methods used for each of the three phases.

3.3. Phases of the study

According to Creswell (2016), when using mixed methods, the researchers must provide a clear illustration of the procedures for handling data such as the sequence of methods and emphasis on qualitative or quantitative deployed methods. In this current study, data was collected in three phases. Figure 3.1 below illustrates the sequence of study phases.

Figure 3.1: Illustration of study designs according to phases

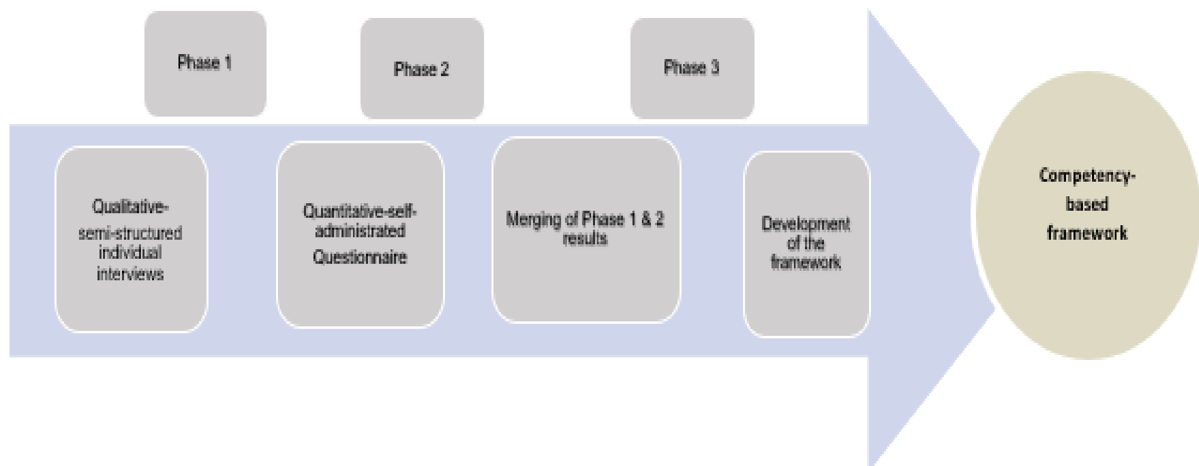


Figure 3.

3.3.1. Phase 1 (Qualitative Design): Exploring the knowledge, skills, and role of THPs.

3.3.1.1. Qualitative design and methods

Qualitative data was collected in Phase 1, as part of exploring the reality of ATHKPs as experienced THPs. A qualitative, explorative, and descriptive design was used. Qualitative research design offers a qualitative approach where the data about a given phenomenon is explored comprehensively and has detailed aspects about

behaviours, actions, and beliefs (Reeves, Peller, Goldman & Kito 2013). This qualitative design explored knowledge and understanding of ATHKPs from the THPs within the natural setting of the participants. The qualitative design is mostly applicable when little is known about a phenomenon. The researcher aimed to explore how THPs define and perceive their practice of ATHKPs. There is a paucity of literature regarding how THPs believe nurses should be taught about ATHKPs. The researcher and participants co-created meaning and shed light on some of the grey areas in the underlying principles of ATHKPs such as properly defining what ATHKPs are and their challenges. Therefore, a constructivist perspective influenced this study because not much was known about ATHKPs from a nursing perspective, as described by the custodians of such information (THPs).

Constructivism as a philosophical approach, is closely linked to qualitative design because it seeks to explore the phenomenon from the lens of the participants who rightfully are the custodians of the information or experiences researchers seek to explore (Adom & Ankrah 2016). Within the constructivist paradigm, learning takes place outside the traditional didactic situation where the researcher is supposedly the more knowledgeable person, and the participants are intended recipients of the knowledge being imparted. To be more specific, in research terms, constructivist theorists believe that previous experience moulds subsequent knowledge and little should be done to influence the interpretation of such knowledge. The qualitative design therefore allowed the exploration of knowledge, skills, and beliefs from THPs on ATHKPs, which is proven not to be common knowledge among many nurses.

3.3.1.2. Context of study for Phase 1

The first phase of the study was carried out with THPs in the City of Tshwane Metropolitan Municipality of Gauteng Province. The province of Gauteng has rural, urban, and semi-urban areas with diverse cultural and traditional practices. There are about 11 district municipalities in Gauteng Province, the City of Tshwane included, which has a land size of 6,298 km². The total population of residents in the City of Tshwane Metropolitan Municipality is estimated to be 3, 555,741 million people. According to the Census Report (2020), about 75,4% of residents in Gauteng Province are Africans. Most THPs are in rural areas and townships where the dominant residents are black Africans. However, there are THPs who are also located in the

urban areas of the province, and therefore accessing THPs as participants was possible because people who use their services commonly reside within the surrounding communities, be it rural or urban. Within these communities, THPs have organised themselves and formed local THP associations where members are affiliated to support and empower each other by sharing experiences and expertise. These associations form committees by its members in their various area of practice such as diviners, herbalists, and *Sangomas*, which looks after the interests of its members. The chairperson of the committee then keeps records of all the members and becomes the contact person for the association.

3.3.1.3. Population

Population is a whole set of individuals that have similar features and who meet the criteria for inclusion in the study (Polit & Beck 2017). In a study, the target population can also include objects or events that are to be sampled to participate in the study (Burns & Grove 2011). The population for this phase of the study were the independent THPs and THPs from local THP associations located in Mamelodi and Soshanguve townships in the City of Tshwane Metropolitan Municipality of Gauteng Province. The researcher made enquiries about THPs in the university, from academics who had prior experience with working with THPs. The researcher was referred to one independent THP collaborating with the nursing department who then made referrals to THPs belonging to different associations for recruitment and data collection.

The THPs had to have at least 2 years of experience in practice and be known to other THPs as a legitimate practitioner. The THPs in this study were comfortably conversant in English, although some would mix the languages and include isizulu, Setswana and Sepedi during the interviews. The researcher was fluent in the three languages as they are local languages. English fluency was not a determining factor as to whether a THP was invited or not. During recruitment drive, the researcher reassured participants that they should feel comfortable to use African languages if they feel it will make clear their inputs.

3.3.1.4. Sampling and sampling size

Sampling is a process of selecting a portion of the population to represent the entire population (Polit & Beck 2017). The sample of the study could only be determined by saturation of data. In this phase, the researcher used snowball sampling method to include participants who would provide their knowledge and experiences on their roles as THPs. The researcher was referred to an independent THP who had a collaborative relationship with the university nursing department. The independent THP was the first point of referral to other independent THPs and those belonging to local associations. From these initial interviews, the researcher requested the participants to provide a network connection with other THPs who may also be able to provide the researcher with other prospective THPs who meet the inclusion criteria for the study. The contact details and addresses of the independent THPs and of the leaders in the association were requested. Snowball sampling was done until data saturation, after 18 interviews were conducted.

3.3.1.5. Inclusion and exclusion criteria

Inclusion criteria refers to the conditions stating characteristics that a target population should have to be included in a study (Polit & Beck 2017).

In this phase the following participants were eligible for inclusion:

- THPs older than 18 years with at least 2 years' experience in practice.
- Independent THPs or belonging to a THP organisation.
- Both males and females older than 18 years.
- Consented to participant.

Exclusion criteria

- Less than 18 years.
- Presenting with flu-like symptoms at the time of data collection (Covid-19 precaution).
- Participants with less than 2 years' experience.

3.3.1.6. Data collection

Data collection denotes the techniques adopted by the researcher to collect data provided by participants in response to the research questions (Polit and Beck, 2012). The process of data collection involves gathering information to address the research

problem (Polit & Beck 2017). In the qualitative phase, the researcher conducted semi structured individual interviews with THPs. The questions that guided the individual interviews, aimed at exploring important features of ATHKPs including knowledge, skills, and the roles of THPs are outlined in Annexure C.

3.3.1.6.1. Access to participants

The researcher made all the procedural requests for approval and permission to conduct this study. Participants who met the criteria were approached, using the snowball sampling method (Polit & Beck 2017). Both independent THPs and those belonging to local associations were contacted as the snowball network expanded and their contact details were made available. Due to the Covid-19 restrictions that were in place during the data collection, the data collection had to be postponed until some restrictions were lifted. The researcher was informed of the local traditional healers' association by an independent THP who resides in the Mamelodi township. The researcher interviewed THPs who are practicing within the sphere of ATHKPs. The contact details of the THPs and their physical addresses were shared the chairperson of the associations and key informants. The researcher then contacted the THPs as per referral to request appointments to discuss the study, its purpose and to request their participation. After agreeing to participate, the dates, times, and place of interviews were agreed on between the researcher and participants. Therefore, data was collected over two sessions: information session and actual data collection session.

3.3.1.6.2. Information sessions

The purpose of an information session was to establish rapport and build trust with the participant as well as recruitment (Brink, van der Walt & van Rensburg 2018). The researcher contacted the THPs and requesting time to discuss the study and its purpose. Interviews were conducted at a place preferred by participants, mostly at their practice site. The researcher provided THPs with a participation leaflet explaining the processes to be followed, their rights and then sought consent. The THPs who were interested were asked to sign the consent form with the guidance of the researcher.

The researcher conducted the interviews after obtaining approval from relevant institutions and individual THPs. Interviews were conducted in a private place and in English, and intermittently Isizulu, Setswana and Sepedi languages were used by participants to clarify their view. The services of the language expert were also sorted to translate some aspects of the interviews where vernacular terminologies were used

by THPs. Transverse translation was also used to enhance the correctness of the translations.

3.3.1.6.3. Actual data collection process

The researcher initially contacted the THPs to establish a trust relationship. An appointment was then arranged to meet in person and to understand the context in which they work. Upon establishing rapport and explaining the aims and objectives of the study, the researcher was then allowed to view, do walkabouts in the practices, and participate in certain activities to broaden the researcher's understanding of ATHKPs and broadly, traditional health practice. After the initial meeting and consent to participate, the date, time and venue for the actual interviews was selected according to the participants' preferences and availability. This was challenging as the nature of the work of THPs is not routine, patients can come in at any time and therefore the researcher had to wait for long periods on days of interviews or postpone to future dates, depending on the nature of the ailment of the patient. Most interviews took about 45 minutes; however, data saturation determined the actual time of the interview. Semi structured interview guide was used during the interviews, where probing questions were also asked in between and after questions to ensure rich data is collected until no new information was coming forth. The following are the questions that were asked during the interviews:

- How would you define African traditional health knowledge and practice?
- What are the unique features of ATHKPs?
- What are the values and beliefs informing African traditional health practice?
- What knowledge and skills are required for traditional health practitioners?
- What do you suggest nurses be taught about ATHKPs?

Field notes were taken, and data was also collected using an audio recorder and participants were informed of that and gave consent.

3.3.1.7. Pilot study

For scientific rigor, pilot study is necessary to evaluate the feasibility of the study as well as possible refinements to data collection tools (In 2017). In this qualitative phase, the researcher conducted two pilot interviews with THPs on progress. The first and

second interviews were used to gain experience of the context and feedback and to make some changes on subsequent interviews when there is a need for such. The pilot study was also used to assess the time allocated for interviews, language issues, clarity of questions as well as any other potential problem that could emerge during the interviews. Ethical principles as in the main study, were upheld. The researcher explained the study and objectives, thereafter informed consent was sought. Participants were informed that the data may be used for the main study and consent for this was also sought. The information from the pilot study was included in the findings of the main study.

3.3.1.8. Data analysis

According to Polit & Beck (2017), data analysis in research encompasses the breakdown of data into smaller and manageable components or ideas. Qualitative content analysis process was undertaken in the qualitative Phase 1 (Bengtsson 2016). This data analysis method is employed in qualitative research to make sense and to identify consistency and meaning derived from response of participants (Ali 2021). The researcher purposively selected the text or wording in the responses that were likely to be related to the research question being explored. Raw data was categorised and then themed based on the interpretations that the researcher gave to the data. The prominent ideas that came out of the interviews and discussions were identified to group common themes that emanated. After all the data was captured, participants were still approached to validate the results (Chilisa 2012). The participants therefore also served as co-coders to ensure consistency and to reduce biasness (Botma et al. 2010). A rigorous process of engaging the data during the interviews was ensured. The independent coder also conducted an audit trail of the themes and subthemes that emanated. Then the findings were used to develop the survey questionnaire which was administered to nurse educators in different nursing education institutions.

3.3.1.9. Trustworthiness

Trustworthiness within a research study is the extent to which the researcher believes the data and methods used in ensuring that quality is maintained (Connelly 2016). Furthermore, Botma et al. (2010) define trustworthiness as the degree of confidence researchers have in their data. Trustworthiness was ensured by employing the

following strategies as suggested by Lincoln and Guba (1985): credibility, dependability, conformability, transferability, and authenticity.

3.3.1.9.1. Credibility

Credibility in qualitative research, also known as internal validity, seeks to ensure the true value of data collected (Polit and Beck 2017). Credibility was ensured by prolonged engagements with participants to ensure rich data is generated. The researcher spent time with THPs in their practices to understand the context and gain clarity on why certain things in THP are done the way they are. Different data sources such as the recorded interview and field notes were also used as part of triangulating multiple views. Data was also audio recorded and field notes taken as raw evidence and to facilitate member checking (Botma et al. 2010). The research processes and methodology are made transparent and open for scrutiny by other researchers.

3.3.1.9.2. Dependability

Researchers are expected to give an account on the methods or techniques used throughout the study so that if this study could be repeated using similar data collection methods, subjects and contexts, similar results would be obtained (Polit & Beck 2017). The researcher provided a dense description of the methodology and data collection tools to ensure consistency should the study be conducted at a different time with the same participants in a similar context. Multiple participants were also interviewed.

3.3.1.9.3. Confirmability

Botma et al. (2010) refers to confirmability as the extent to which the results are a true reflection of the participant’s views and not an outcome of bias or subjectivity of the researcher. Therefore, researchers are obliged to be neutral and objective in collecting and interpreting data (Polit & Beck 2017). Member checking was done to verify the meaning and context from participants during and after interviews. Additionally, the participants’ actual words were used without changing meaning to ensure that their voice is heard. An independent coder was used to assess the analysis and interpretation of the findings. The independent coder is experienced in coding and has previously coded several research studies. The researcher initially listened to the recorded audios and re-read the transcripts as initial coding to assess for similarities in the concepts, phrases, and participant’s actual words. Thereafter the ideas that

came out were formulated into themes and subthemes. This data was then shared with the independent coder, for audit trail, who then arranged a meeting with the researcher to discuss the themes and subthemes and to come to a common understanding and consensus.

3.3.1.9.4. Transferability

Transferability, also known as external validity, means the extent to which findings of a study can be applied in other settings or groups (Polit & Beck 2017). In this study, a dense contextual description of the participants, setting and methods was provided to enable transferring of data to other contexts. A thorough interrogation of how THPs view ATHKPs and their roles was ensured until data saturation.

3.3.1.9.5. Authenticity

Authenticity requires that researchers fairly and truly report on wide range of realities emerging in a research report. Therefore, the researchers must convey the feeling and tone of participants (Polit & Beck 2017). All the participants' viewpoints as described during the interviews were reported upon without giving interpretation from the researcher's point of view.

3.3.2. Phase 2: Current teaching of nurses on ATHKPs

A quantitative, cross sectional, non-experimental descriptive survey design was used as part of a situation analysis in nursing education institutions in Phase 2. According to Cresswell (2013), quantitative research focuses on the process of collecting numerical data. The data collection instrument was developed from the data resulting from Phase 1 interactions with THPs.

3.3.2.1. Quantitative research design and methods

In the quantitative research, data is collected, analysed, and interpreted using statistical procedures and for reporting the result of a study (Creswell 2013). This quantitative, cross sectional, non-experimental descriptive design aimed at investigating and determining the extent to which a phenomenon occurs by using measurements and quantifying results in a controlled manner (Polit & Beck, 2017). Quantitative cross sectional, non-experimental descriptive design was used in this

phase of the study to quantify and determine how much ATHKPs is being taught in nursing curricular for the R425, R171 and R174 nursing programme at public NEIs.

3.3.2.2. Research question for Phase 2

To what extent is ATHKPs integrated into nursing curriculum in public NEIs in South Africa?

3.3.2.3. Objectives of Phase 2

A questionnaire was developed to elicit information regarding ATHKPs in the curriculum from accredited public nursing education institutions offering R425, R171 and R174 nursing programme in South Africa.
Objectives:

- To determine the knowledge of nurse educators on ATHKPs.
- Identify the level of teaching for ATHKPs in nursing programmes.
- To determine the contents of ATHKPs taught in the nursing curriculum in public nursing education institutions (NEIs).
- To assess methods of teaching ATHKPs in public NEIs.
- To determine other alternative traditional health practice taught in nursing curricula.

3.3.2.4. Context of the study in Phase 2

Study setting may be any physical location or the circumstances in which data is to be collected during study (Polit & Beck 2017). Nursing education in South Africa is offered at public and private nursing colleges, Universities and universities of technology located in urban and rural communities. All NEIs in South Africa are accredited with the SANC to offer undergraduate and postgraduate programmes such as Diplomas, Postgraduate Diplomas, Bachelor's degrees, Masters, and Doctoral degrees. All nursing programmes in South Africa are expected to be in line with curriculum prescripts by the SANC. The educators teaching in the NEIs and the clinical placement sites such as hospitals and clinics, are all registered with the SANC as nurse educators. Each NEI however is responsible for designing its curriculum and content which must be in line with the programme it is accredited for. For example, R425 is a 4-year undergraduate programme, whereas R118 is a regulation for postgraduate

nursing education programme. The total number of public NEIs accredited to offer undergraduate nursing programmes, according to the SANC website, was 26; including universities, universities of technology and nursing colleges.

3.3.2.5. Population and sampling

Sampling is a process of selecting a portion of the population to represent the entire population (Polit & Beck 2017). The population for this study was nurse educators from the accredited NEIs offering the R425, R171 and R174 nursing programmes at the point of this study.

3.3.2.5.1. Population and sampling for Nursing education institutions

Total population sampling method was used to include all the NEIs who met the criteria for inclusion. Total population sampling is typically used when the size of the population with common characteristics is very small. Probability sampling ensured that all NEIs have the same chance of being included. The SANC website was used as a reference to obtain the list of all NEIs accredited for R425, R171 and R174 nursing programme. The list with names and contact details of NEIs is available and was extracted from the SANC website. Table 3.1 below is a breakdown of public NEIs in South Africa eligible for inclusion:

Table 3.1: Number of accredited public NEIs

Type of institution	Number of institutions
Universities	14
Universities of Technology	3
Nursing colleges	9
Total	26

3.3.2.5.2. Population and sampling for nurse educators

The researcher aimed to collect data comprehensively across all the nursing disciplines within the nursing programmes namely general nursing, midwifery, mental health, and community nursing. Purposive sampling was conducted as the researcher only selected nurse educators within certain disciplines who had more expertise and experience of teaching their discipline. The researcher therefore sent a survey via email and hard copy to eligible institutions who demonstrated interest in participating.

The nurse educators were contacted via the principals' or HOD offices, so that those who are interested in various disciplines can share their knowledge and practices regarding teaching ATHKPs.

3.3.2.5.3. Sample size determination

In this study, the population consisted of 2141 (N) educators from 26 educational institutions that offer nursing curriculum. These educational institutions were divided into three groups: universities, universities of technology, and colleges, with 303, 50, and 1788 educators, respectively. Yamane's (1967) sample size formula, as cited in Islam (2018), Israel (2013) as well as Sarmah and Hazarika (2012), was used to calculate a representative sample size for this study. Assuming a 95% confidence level and an estimated population proportion *p* of 50%, i.e., p= 0,50, as well as a sampling error, e = 5% = 0,05, the sample size is given by:

$$n = \frac{N}{1 + N(e^2)}$$

where n= sample size, N = population size and e= (0,05) the acceptable sampling error. Using the Yamane sample size formula for the given population of 2141 educators, the sample size for this study was 337 educators. In addition, stratified proportional sampling was used in determining the sample size proportional to each stratum (subgroup of educational institutes). Subgroups were divided into stratums using stratified proportional random sampling. The Barreiro and Albandoz (2001) study were adopted in determining the sample size of each stratum (subgroup of educational institutes), which is given by the formula below.:

$$n_i = n.\frac{N_i}{N}$$

where, n_i = required sample size for each stratum, n = sample size (337), N_i = population size for each stratum and N = size of the population (2141). Applying equation 2, the proportional sample size for within each stratum (subgroup of educational institutes) to be used in this study is illustrated in Table 3.2 below.

Table 3.2: Summary of the sample stratum (subgroup of educational institutes)

EDUCATION INSTITUTIONS	N_i	n_i
1. University 1	22	3
2. University 2	20	3
3. Univerisity3	43	7
4. University 4	17	3
5. University 5	43	7
6. University 6	17	3
7. University 7	17	3
8. University 8	16	3
9. University 9	16	3
10. University 10	15	2
11. University 11	15	2
12. University 12	20	3
13. University 13	14	2
14. University 14	28	4
15. University of Technology 1	13	2
16. University of Technology 2	12	2
17. University of Technology 3	25	4
18. Nursing College 1	284	45
19. Nursing College 2	164	26
20. Nursing College 3	128	20
21. Nursing College 4	174	27
22. Nursing College 5	245	39
23. Nursing College 6	293	46
24. Nursing College 7	191	30
25. Nursing College 8	83	13
26. Nursing College 9	226	36
TOTAL	**2141**	**337**

3.3.2.5.4. Sampling method

To achieve a representative sample, 337 educators were chosen using simple random sampling without replacement (SRSWOR) (Rose, Spinks & Canhoto 2015). This process ensured that each educator in the population had a known and equal chance of being chosen and participating in the study. This was accomplished by assigning each educator to a unique computerised number using random number generation in the Microsoft Excel program. Following randomisation, 337 educators constituted the sample for the study.

3.3.2.5.5. Data collection

A survey, using a self-administered, anonymous questionnaire was developed from the qualitative data, and distributed to different NEIs across South Africa to assess content of ATHKPs that is integrated into nursing curricular at those institutions. The questionnaire was developed by the researcher in consultation with the statistician based on the themes and constructs from Phase 1 as well as predetermined objectives of Phase 2. Refer to Annexure D for the questionnaire.

Development of survey questionnaire

A structured questionnaire was used as the instrument to collect primary data from the respondents. The researcher also used both hardcopies and an online survey due to the coronavirus pandemic where movement restrictions and other restrictions were in place countrywide. The online survey was developed using Qualtrics ® software and set to prevent multiple responses from the responders using unique and dedicated links per respondent. The questionnaire was constructed by the researcher with the help of supervisors, the statistician and consulting existing literature. The questionnaire was developed in English while the accuracy and credibility of the instrument was ensured throughout the study period. This survey questionnaire was based on the predetermined objectives and constructs in the following themes that came out of Phase 1 of the study:

- Traditional Health Practitioners defined the features of African Traditional Health Knowledge and Practices
- Elements of practice in African Traditional Health Knowledge and practices
- Challenges encountered by Traditional Health Practitioners
- Competencies of Traditional Health Practitioners
- Views of Traditional Health Practitioners on the training of nurses on ATHKPs

Survey design process

The questionnaire was developed following recommendations by Mamabolo and Myres (2019). Firstly, the qualitative findings were finalised by clearly labelling the codes and categories. Secondly, the research question for the quantitative phase was clarified. Codes and categories were then converted to variables, where they were then assigned to variables. The direct quotes, definitions and descriptions from the

qualitative findings or themes were used to design the survey measurement items. In the next step all the items were brought together to develop a questionnaire. A pilot study was conducted to test the validity and reliability of the questionnaire as well as to assess if the research question is being answered. The pilot study was important as it contributed to improving the questionnaire and clustering of codes and similar variables.

Structure of survey questionnaire

The survey questionnaire had four sections for the nursing educators to respond to:

Section A: Demographic data of respondents

Demographic profile of the respondents included six items (1–6), namely, institution type, age, gender, discipline of nursing taught, programme offered at the NEI and years of experience as nurse educators.

Section B: Assess the structure of the module/s for teaching ATHKPs.

This section includes five items (7–11), to assess the level of teaching for ATHKPs in the respective nursing college, university, or University of technology nursing department.

Section C: Evaluating the content of ATHKPs taught in the module/s.

This section had a total of eight sub-sections (12–19), to evaluate the content of ATHKPs taught in the modules the educators teach.

Section D: Methods of teaching and assessment of ATHKPs in the module.

This section consisted of 5 items (20–24), with both closed and open-ended questions to assess the method of teaching and assessment of ATHKPs in the module/s.

Distribution of the questionnaire

The questionnaires were distributed physically to institutions and sent online via email with instructions on how to complete and sent back electronically. The researcher sent an email to the head of the NEI for recruitment of participants in the four nursing disciplines offered in the R425, R171and R1714 namely, General nursing, Community

nursing, Psychiatric Nursing and Midwifery to ensure comprehensiveness. The contacts number of the researcher were included on the questionnaire so that the participants can contact the researcher should they require any clarity. The researcher made follow-ups with the participants to remind them of completing the survey questionnaire.

Pilot study

According to Polit and Beck (2021), a pilot study is a trial that researchers conduct to assess the feasibility of the methods or procedures that will be used in the main study. Furthermore, a pilot study may provide valuable information regarding the ease of use and complexity of the questionnaire as well as time required to complete the survey. The questionnaire was pretested with a sample of 12 nurse educators from universities to determine if there are errors that need to be attended to. The pilot study was conducted three weeks before the actual study. There were no changes that were made to the questionnaire; however, the findings of the pilot study were not used.

Data analysis

From the distributed questionnaires, quantitative data was analysed statistically to yield numeric data on the various aspects of integration of ATHKPs in nursing curriculum at nursing education institutions. The resulting data was coded and captured using the Statistical Analysis System (**SAS**). Bar charts, frequency tables and percentages generated by SAS was used to describe the institutional demographics as well as the extent to which ATHKPs is integrated into nursing curricula. This data is kept safe in a locked computer with a secured password that was accessed by the researcher and the statistician only as per University of Pretoria policy.

3.3.2.6. Validity and reliability

In quantitative phase, to guarantee quality control, reliability and validity was ensured.

3.3.2.6.1. Validity

Validity in quantitative research refers to the degree to which the internal content of the tool accurately measures what it is supposed to measure with precision (Polit &

Beck 2017). Four forms validity has been identified as content validity face validity, construct validity and predictive validity (Polit and Beck 2012).

3.3.2.6.2. Content validity

Content validity ascertains the accurate measurement of knowledge of the content domain, which the tool was designed to measure (Polit and Beck 2012). To ensure content validity in this study, the questionnaire was sent out to experts and piloted to ensure that content validity is addressed. The questionnaire also covered all aspects that were elicited by the interviews in Phase 1. Additionally, the questionnaire covered aspects related to integration of ATHKPs in nursing curricular at NEIs. Subject matter experts in research and nursing education were invited to do a rational analysis to review all items for readability, clarity, and comprehensiveness so that an agreement could be reached on what item to be included (Salkind 2010). Furthermore, the statistician's expertise was sought.

Face validity

Face validity denotes the measurement of variables as they appear in the data collection tool (Sweet, Bazargan, McKellar, Gray and Henderson 2018). The variables that appeared and were seen at a face value of the questionnaire were all aspects of ATHKPs integration in nursing curricular at various NEIs. Experts in the field of indigenous knowledge systems and traditional health practice were consulted for inputs on the questionnaire and a sample from the respondents gave input on readability, comprehension, and language clarity.

Construct validity

Construct validity also focuses on whether the definition of a variable as operationalised, reflects the accurate theoretical significance of a concept (Sweet et al. 2018). The researcher developed the questionnaire, modified, and pretested it to ensure clarity of constructs and variables. In this study, construct validity was made certain by providing a clear description of the various variables such as ATHKPs and curriculum thereby ensuring that these concepts reflected the true theoretical meaning in a questionnaire.

3.3.2.7. Reliability

According to Polit and Beck (2017), a reliable instrument is that which consistently produces similar scores in repetitive measurements. Gray et al. (2021) described reliability as the consistency of the instrument in measuring what is aimed to measure. Internal consistency reliability was ensured through the following measures:

3.3.2.7.1. Internal consistency reliability

Tang, Ciu and Babenko (2014) describes internal consistency as the extent to which items within a scale measure the same concept. Cronbach's 'α' was used as the coefficient of reliability. Cronbach alpha has given the formula to find out the reliability by using standard deviations of the scores not only on odd and even items but also on the total number of items.
According to Kaiser (1974), the following values are used to determine the reliability of the questionnaire:

- to 0,49 unacceptable
- 0,50 to 0,59 miserable
- 0,60 to 0,69 mediocre
- 0,70 to 0,79 middling
- 0,80 to 0,89 meritorious
- 0,90 to 1,00 marvellous

The questionnaire yielded overall internal consistency and reliability of 0,9589, which was graded as a marvellous level, indicating excellent internal consistency. Additionally, scale of reliability for the sections were determined and confirmed further reliability of the data collection tool.

3.3.3. Phase 3: Development of the competency-based framework

This phase of the study entailed the development of the competency-based framework for standardising ATHKPs in nursing curriculum. The development of the competency-based framework was based on the integrated data from Phases 1 and 2.

3.3.3.1. Objectives

To develop a competency-based framework for standardising ATHKPs in nursing curriculum.

3.3.3.2. Research design and methods

Development of competency frameworks is a systematic process that should have a theoretical basis to guide the development. A comprehensive literature review was conducted to understand existing theories, models and best practices related to competency frameworks for nursing. This was done as part of literature review which was described in Chapter 2. The SANC competency framework for professional nurses was adopted to guide the development of the competency-based framework. The current developed competency-based framework has not been validated in the current study. This will be done as part of the post-doctoral project, where the framework will be extended to other stakeholders and subject matter experts to verify if the competencies resonate with nursing practice and context. To avoid duplication, a detailed description of the process and method followed in the development of the competency-based framework is provided later in Chapter 9.

3.4. Ethical consideration

Research ethics are fundamental in any research study involving humans and should be seen as an integral part of the study. Upholding the ethical principles and protecting the participants should be a deliberate undertaking by all researchers. To ensure compliance, the permission was be sought from the following:

- Departmental research committee (In-house)
- Faculty of Health Sciences Research Ethics Committee at the University of Pretoria
- Nursing Education Institutions
- Research participants

The following ethical principles were upheld in the study:

3.4.1. Beneficence and non-maleficence

The principle demands that participants be protected from any potential harm and hazards resulting from their participation in the study (Botma et al. 2010:20). A comprehensive description was given to participants on their rights, risks, and benefits of taking part in the study. Sensitivity was maintained throughout the study by not coercing participants to respond to questions that they did not want to respond to. It is anticipated that knowledge gained in this study may contribute to fostering collaboration and understanding between THPs and nurses.

3.4.2. Autonomy and respect for human dignity

An important element of conducting research involving humans is the respect for participants as capable of determining their destiny and the extent to which they maintain self-worth (Botma et al. 2010). This principle includes the right to self-determination and the right to full disclosure in the Belmont Report (Polit & Beck 2017). The researcher approached all participants and explained to them the aim of the research and the processes involved so that they could make informed decisions on whether to participate in the study. The researcher ensured that participants are not disadvantaged or exposed to situations or conditions which they have not been prepared for. Participants were given the opportunity to voluntarily participate and not coerced or compensated to elicit their buy-in. Additionally, participants were informed of their right to withdraw from the study at any time without fear of prejudice or victimisation. Subsequently the participants were given information about the purpose, potential risks, and benefits of the study, and then informed consent was signed (See attached information leaflet and informed consent in Annexure A).

3.4.3. Justice

The principle of justice requires that participants be treated fairly and be given an equal chance to partake in the study (Polit & Beck 2017). In this study, the participants were treated equally and fairly without discrimination. This means that participants were selected based on their eligibility and not their vulnerability. Participants who declined participation were not prejudiced or treated differently. All participants who met the criteria for inclusion were invited to participate in the study. Full disclosure of information was done to facilitate decisions to participate or not among participants.

3.4.4. Privacy and confidentiality

Participants in a research study maintain the right and prerogative to keep their personal information confidential. The safety and protection of the name and person is the primary responsibility of the researcher. Failure to do so may result in unintended harm and embarrassment (Polit & Beck 2017) shared with anyone. Data collection took place in private places to ensure that information is not disclosed to those who are not part of the study. The researcher ensured that any possible identifiers that could link the participant's name to the quotes were prevented. Codes were allocated to participants instead of names. The researcher is keeping the records of the study safe according to the policy of the University of Pretoria on safekeeping of research documents.

3.4.5. Veracity

Veracity refers to the extent to which the researchers represent facts and responses of the participants honestly and as described by the participants, not as the researcher's view or partialities (James 2016). The participants were informed about the aims of the study and not mislead on any issue pertaining to the research. A detailed clarification regarding any new deviations we discussed with the participants throughout the study. The researcher used quotes as facts, without altering intended meaning by participants.

3.5. Summary

Chapter 3 provided a detailed explanation about the research design and methods. Further clarity was given on mixed methods, its purpose and how it was applied to this study. Processes of collecting, analysing, and interpreting data were outlined for phases of the study. This chapter also included the ethical aspects that were observed throughout the study. Chapter 4 will present the findings of Phase 1, which adopted a qualitative explorative and descriptive design.

CHAPTER 4

PRESENTATION OF QUALITATIVE FINDINGS (PHASE 1)

4.1. Introduction

This chapter presents the findings of the Phase 1 for the exploratory mixed method design adopted for this study. The initial findings that will be presented are from the qualitative design, which was conducted as Phase 1 of the study. The findings will be discussed in terms of the demographic data and themes that emerged from the interviews with THPs.

4.2. Qualitative design findings : Phase 1

This phase of the study adopted a qualitative, explorative, and contextual design with aim of exploring and describing the knowledge, skills, and roles of THPs in the provision of healthcare in South Africa. In line with its objective, the study explored how THPs define ATHKPs and its unique features in their context of practice. This study went further and explored the values and beliefs informing ATHKPs as well as the knowledge and skills required for THPs to be regarded as competent. Lastly the study explored THPs perspectives on what they consider as important aspects of ATHKPs that nurses should be taught about. The findings of this phase of the study will be presented in terms of the themes that emanated from the interviews.

4.2.1. Data collection and analysis for Phase 1

Data was collected through individual in-depth semi structured interviews from the THPs. While most interviews were conducted in the home of the practitioners, some were conducted telephonically due to Covid-19 restrictions which were in place at the initial time of data collection. After establishing rapport and building of a good relationship with the THPs, the researcher made an appointment with the THP on when the interview can be conducted. The researcher allocated the participants their confidential codes according to the interview numbers. For example, THP 1 represents the first THP to be interviewed. On the day of the interview, the researcher confirmed with the participants if the interviews were still scheduled as agreed. The researcher started the interviews by explaining the study, its purpose, and objectives to the

participants, and then consent was obtained either verbally or in writing, depending on the nature of the interview. The researcher proceeded the interview by asking the following predetermined questions:

- How would you define African traditional health knowledge and practices?
- What are the unique features of ATHKPs?
- What are the values and beliefs informing African traditional health practice?
- What knowledge and skills are required for traditional health practitioners?
- How do you suggest nurses be taught about ATHKPs?

Participants were guided through the questions where they did not understand. Probing was also done to clarify responses and questions. Interviews were transcribed and translated to English where participants used African vernacular. Qualitative content analysis process was undertaken (Bengtsson, 2016:01), where prominent ideas that came out of the interviews and discussions were identified to group common themes that emanated. The service of an independent coder was sought, who together with researcher reached consensus on the themes. After all the data was captured and transcribed, participants were still approached to validate the transcription and results as recommended by Chilisa (2012). As a result, the participants also served as co-coders to ensure consistency and to reduce biasness (Botma et al. 2010). The themes were used to develop the survey questionnaire in Phase 2. The themes that emanated from the discussions are discussed below.

4.2.2. Demographic data of participants

There were 18 THPs interviewed, with seven (7) females (39%) and 11 males (61%). In their specialisations as THPs, nine (9) identified themselves as *Sangomas*, seven (7) as herbalists, four (4) as diviners. However, four of the THPs indicated that they practiced in more than one of the above-mentioned specialisations, while two also identified themselves as *Gobela* (certified trainer of the THPs). Three of the participants are in dual practice, where they practice as professional nurses and THPs at the same time. Three (17%) THPs are under the age 40, 10 (55%) are between 40 and 64 years, while five (28%) are 65 or older. The oldest THP participant was 74years old followed by a 70-year-old participant. The youngest was 38 years old. The participants' years of experience as a THP ranged from 6–46, with an average of 19

years. The majority of the THPs, (nine, [50%]) stated that they have 11–20 years of experience in this field. While five (28%) THPs indicated that they have more than 20 years of expertise in this field, with reporting to have 46 years of experience. The remaining four (22%) had less than 10 years of experience, with the lowest being six years. Table 4.1 below highlights the demographics of the participants using their confidential codes.

Table 4.1: Demographic data of participants

Participant code	Gender	Specialisation	Age	Years in Practice
THP 1	Male	*Sangoma*	73 years	46
THP 2	Female	Diviner	52 years	20
THP 3	Male	Herbalist	43 years	8
THP 4	Female	Herbalist	51 years	12
THP 5	Male	Diviner	54 years	15
THP 6	Male	*Sangoma*	65 years	28
THP 7	Male	*Sangoma*	38 years	6
THP 8	Female	*Sangoma*	70 years	34
THP 9	Male	Herbalist/*Sangoma*	62 years	16
THP 10	Female	Diviner	54 years	13
THP 11	Female	*Sangoma* (Nurse)	39 years	12
THP 12	Male	Herbalist	39 years	8
THP 13	Male	*Sangoma*, *Gobela*	65 years	40
THP 14	Male	*Sangoma*	68 years	25
THP 15	Male	Herbalist (Nurse)	43 years	12
THP 16	Female	Herbalist	46 years	8
THP 17	Female	Diviner, *Gobela* (Nurse)	56 years	19
THP 18	Male	*Sangoma*/Herbalist	47 years	11

4.3. Presentation of themes and subthemes

The researcher analysed the data in terms of the predetermined, semi-structured questions that were posed to participants. Therefore, semantic analysis technique was used to categorise the ideas that came from the THPs in terms of their similarities to come up with themes and subthemes. The themes that emerged were the features of African Traditional Health Knowledge and Practices, elements of practice in African Traditional Health Knowledge and Practices, challenges encountered by traditional health practitioners in practice, competencies of traditional health practitioners and views of THPs on the training of nurses on African Traditional Health Knowledge and Practices. The themes and subthemes are outlined in Table 4.2 below.

Table 4.2: Themes and subthemes

Themes	Subtheme
1. Traditional Health Practitioners defined the features of African Traditional Health Knowledge and Practices	1.1 African Traditional Health Knowledge and Practices is a way of life for Africans. 1.2 Traditional Health Practitioners are called by ancestors. 1.3 Ability to connect and maintain the spiritual connection with the ancestors
2. Elements of practice in African Traditional Health Knowledge and practices	2.1 Training of Traditional Health Practitioners on African Traditional Health Knowledge and Practices 2.2 Language as a medium in African Traditional Health Knowledge and Practices
3. Challenges encountered by Traditional Health Practitioners	
4. Competencies of Traditional Health Practitioners	4.1 Knowledge and Skills required in the traditional healing process. 4.1.1 Assessment and Diagnosis of patients 4.1.2 Prescription 4.1.2 Referral and follow up. 4.2 Supplementary roles of THPs 4.2.1 Counselling of patients 4.2.2 Exorcism 4.2.3 Plant harvesting
5. Views of Traditional Health Practitioners on the training of nurses on ATHKPs	

4.3.1. Theme 1: Traditional health practitioners defined the features of African Traditional Health Knowledge and Practices

Participants voiced their different views regarding the definition of African Traditional Health Knowledge and Practices. The nature of ATHKPs was described by participants regarding what it entails and its founding principles. The views expressed depended on their background and experiences. For example, a THP who is herbalist viewed treating illness with herbs as a starting point, whereas a diviner would explore spiritual causes to the problems being presented. Two subthemes emerged defining the nature of ATHKPs, namely, African Traditional Health Knowledge and Practices is a way of life for Africans, Traditional Health Practitioners are called by ancestors and spiritual connections with ancestors.

4.3.1.1. Subtheme 1.1: African traditional health knowledge and practices is a way of life for Africans

From the interviews, it emerged that participants view ATHKPs as a way of life for Africans. It involves every aspect of life throughout the stages of life, while describing the roles and responsibilities of African people within the cultural and social context. Participants indicated ATHKPs has existed over long periods of time and has been passed down from the ancestors immemorial. The following expressions were made:

"Traditional health is about how we lives our life as Africans, not about giving people muthi [herbs]. *It is how we grow up and learn the ways of our ancestors".* (THP 1, *Sangoma*)

"African traditional health practice is a very old system that relies on using muthi and throwing of bones to connect with the ancestral spirits." (THP 3, Herbalist)

Another participant spoke further about the importance of ATHKPs in society as part of an education system. The value and contribution of ATHKPs encompass how Africans should conduct themselves through the stages of life. Participants' views highlight their plight for Africans to trust and respect ATHKPs as a legitimate health system from which people can learn and be proud of.

The participant said:

"If you look at the world right now, everyone is doing things the western way. What about our ways of living? Even us as Africans, we had schools even back then, but our schools in the past were about how to live as a man who is a Venda, how to live as a woman who is a Venda. How to live as a girl who has reached puberty as a Venda, as a man that has reached puberty as a Venda... how to live as an old person who is gogo [old woman] *in Venda. And today we are saying everybody can live the same, that is why we are failing."* (THP 17, Diviner/ *Gobela*)

This participant, THP 17, went further and raised a concern regarding governance and how that has affected the way Africans live their lives and the food they eat.

"For example, democracy is a western concept, so you are therefore determining how Africans must live their lives. Now we all must eat bread. What about our umngqusho [mix of samp and beans]*, You know mabele* [sorghum]*? The foods of our forefathers our ancestors. Now you want Africans to learn, you want to teach them the western way. we have copied what Works for America, what works for the UK, you. If you look at UK, do you find Vendas and Sothos in their cabinet? They are all British. And that is why they are succeeding because they are pushing the way of life of the British person*" (THP 17, Diviner/*Gobela*)

It further emerged that ATHKPs encompasses all elements of life including physical and spiritual realms. According to one participant, in ATHKPs treatment is given to patients so that the problem they have can be eliminated and for life to resume like before the consultation.

"So, in African traditional health practices, we institute treatment so that everything can go back to normal... spiritually, physically and preventing ubuthakathi (witchcraft)." (THP 7, *Sangoma*)

THP 1, (*Sangoma*) said:

"It is a holistic approach in terms of therapy. What type of therapy, maybe spiritual therapy of some sort, you know…giving advice."

4.3.1.2. Subtheme 1.2: Traditional health practitioners are called by ancestors

According to participants, not everyone can be a THP, and you cannot choose which type of THP you want to be. It was reported that in some cases, the ancestral spirits may choose a person to be a THP before they are even born. Accordingly, there is no specific age at which the calling can present itself. Participants reported different diagnosing of a calling such as being ill, or having difficulties in your life, which are only diagnosed as a calling when you seek counsel with THPs. Participants had this to say about the calling:

"You do not just wake up and decide to be a healer. There must be a connection and a medium that connects you with the calling. Sometimes people ignore it, and it manifests as a disease or ailment. That's how different it is. "(THP 8, *Sangoma*)

"But as you grow there are these spirits that have already decided on you to say you must follow the calling. When you go for initiation, as any traditional healer, why did they become a traditional healer." (THP 5, Diviner)

"But to be a traditional healer, maybe as a child o nyaka go bina malopo (you want to perform an African traditional dance) *and say I want to be a traditional healer, when you grow up, you are a different person*." (THP 16, Herbalist)

A participant who is also a nurse said:

"At least with Western medicine, you are trained, you decide that you apply, you decide that you even like it or not. but this side whether you like it or not, if this is your calling, if your cells and your brains and your genetics and everything are connected such that you will be a healer, whether you like it or not you will be a traditional healer." (THP 17, *Gobela/Sangoma*)

Another participant went further and described the preceding events to becoming a traditional healer and said:

"For a person to be a traditional healer, they can tell you a very difficult story. Maybe they started by being sick, went for operations, doctors suspected this. Their history is very painful for them to be a traditional healer. Because at times there is denial, especially if you can look these days, the trend of people becoming traditional

healers, you find that this person has a PhD degree, this person is definitely learned, and being told that you need to go for initiation." (THP 10, Herbalist)

It was also reported that sometimes ancestors can bring minor ailments to warn a person who denies the calling. Should the person not cede to the call, there will be more serious consequences which may be life-threatening.

The participant said:

"At a hospital they will amputate his finger, saying he is diabetic. O na le swikiri [he is diabetic] *and if not, careful they will cut this hand. So, whilst he is still in denial, they keep amputating him slowly but surely. These are warning shots. Then when they start saying they need to now take out one of the members of the royal family, meaning heart, to insert screws, it is the time he realises that he has to go for initiation. He goes for initiation when he is now sick, but the particular person becomes better and powerful traditional healer."* (THP 1, *Sangoma*)

According to another participant, signs of a calling may also include having dreams about different things that sometimes may or may not make sense until you get clarity from a THP. The participant also cited connection between a calling and history of traditional healing in the family. The Participant said:

"People experience their calling in different ways. Like with me, I started with dreams about me wearing izangoma [beads] *and ingubo ezinye* [other garments]. *But when I started dreaming about abantu abanga sekho* [people who have passed on] *na manzi* [and water], *I realised ukuthi* [that] *ngine isipho* [I may have a gift]. *Ugogo wamiway' Isangoma* [my grandmother was a *Sangoma*]*."* (THP 13, *Sangoma/ Gobela*).

It is evident that for most THPs, a conceding calling in various forms was the first important step that they took to become THPs. Not accepting the calling as reported in this study caused many problems for THPs who had the gift of being a THP.

4.3.1.3. Subtheme 1.3: Ability to connect and maintain the spiritual connection with the ancestors

According to participants, the nature of ATHKPs is such that there is always a component of spiritual connection with the ancestors. It was reported by some participants that spiritual healing is an important element in the treatment of many ailments that brings the patients to consult with the THPs. Other participants indicated the value of spiritual alignment which may affect growth and prosperity in life.

Participants said:

"Here we connect with clients at their spiritual level. So, when you connect with clients you have to reassure them that there will be a connection even if they use their spiritual approach. Here what is more important is spiritual healing. The spiritual healing goes a long way." (THP 5, Diviner)

"Traditional health helps people in aligning properly with their spiritual sphere. Some people you find that they are in the roman catholic, but their spirit is that of a Zionist. When they are in the Zionist is like you being given fat cakes when your body can actually not stand fat cakes, then you will have stunted growth." (THP 2, Diviner)

Another participant added to the importance of alignment by indicating that consultation with the THPs includes other element of spirituality such as diagnosis regarding the genetic connection with spiritual realm or ancestors and how important this is for treating presenting problems.

"This is what I normally do in terms of my healing… I do mainly diagnosis, how is your genetic make-up, spiritually, your ancestors, we call them ancestors and so on, so that's what I normally do. Before we come to what can treat you. What can we now do for you, but this is where we start." (THP 18, Diviner).

It was also reported by some THPs in this study that there are different ways that could lead to a connection with the ancestors. According to one participant, often people have a spiritual problem that may present as a sickness and needs a person to connect with the spiritual world.

The participant said:

"In traditional healing, there are people who really it has got nothing to do with being ill, but it manifests itself as spiritual and you have to help them connect…" (THP 10, Diniver)

Findings also indicate that acceptance of ATHKPs requires Africans to think differently about how the past domination of apartheid and colonisation has influenced their views about ATHKPs. Traditional health Practice encompasses many aspects of life and should be recognised and legitimised. Spirituality is strongly entrenched in ATHKPs and forms part of the connection with the ancestors. Interestingly participants who are diviners focused more on the spiritual nature of traditional health.

4.3.2. Theme 2: Elements of practice in African traditional health knowledge and practices

The second theme that emerged from the interviews is about the process a person has followed to become a THP. Within ATHKPs, the initial step of being a THP requires one to be chosen by their ancestors for the calling. Like other systems of health care, ATHKPs involves training in a variety of disciplines, which are not exclusively permanent areas of specialisation or practice for THPs because they can transit from being in one of the specialisations. Two subthemes to be discussed in this theme are: training of THPs and language as a medium in traditional health practice.

4.3.2.1. Subtheme 2.1: Training of traditional health practitioners on African traditional health knowledge and practices

Participants reported training as a significant step towards being a THP. However, there seems to be trials that may be overcome during training, which may interfere with the initiation (*ukuthwasa/ho thwasa*) process. It was reported that training of THPs depends on the nature of their calling. Most of the training may even happen in the family, where parents who are THPs may teach their children. This was reported:

"Training is an important element of qualifying as a traditional healer. One has to go through the process of observing and slowly be shown how to do certain things. It is like an internship where students follow their mentor and learn by observing what is being done by their Gobela." (THP 17, *Sangoma/Gobela)*

Another participant said:

"It also depends on the nature of your calling. For example, the initial training will be tailored to assist the initiate in becoming, for example, a herbalist. Many people these days do shortcuts as they believe you can just know the herbs or plants for certain diseases and then you are qualified, no... you must learn how to do these things properly and know that you remain answerable to your ancestors and the Gobela." (THP 4, Herbalist)

Participants reported that the training of THPs involves shadowing and mentoring of the initiate at the home of the trainer *(Gobela).* To qualify to train other THPs takes a lot of experience and requires extensive knowledge and skills. Some participants raised their concerns regarding the nature of training and the increasing number of false THPs who are not properly trained. The challenges raised are the duration of training and incompetence after completing the training.

"They say someone went for initiation but is not successful. It is because of the quality type of the people who were in charge of the genuine way of doing things, they have passed on. I tend to question people who would say, no I can train you and ka o thwasisa [you can graduate] *within 3 months to be a doctor. So, the lifespan of being a traditional healer is decreasing."* (THP 1, Sangoma)

"There are many bogus healers, that if you may ask them where they have been trained, for example as an herbalist, they may not be able to answer you because to them everything is trial and error because most are not answerable to anybody so they may not have been trained properly." (THP 15, Herbalist)

Other participants supported importance of proper training of THPs by saying:

"Ho thwasa [initiation] *is not about the dancing, automatically…* [you become a healer] *you start learning by showing them gradually how to mix medications and how to perform certain interventions such as ho phalaza* [induced vomiting], *it is the practical at home, so when I die, the child knows almost everything, so… the handover of the practice."* (THP 7, *Sangoma*)

"I was telling my students that you can't tell me that you graduated in 2019 and already you are telling me that you are having students. You may have those that

are potential students, but you are not at a level where you may say you are ready to start training. What experience do you have? Because when you train them, you must also share some experience. At least 4 years to 5 years of practicing so that you have more knowledge to share with your students as well." (THP 17, *Sangoma/Gobela*)

THP 17 (Sangoma/Gobela) participant went further and emphasised that as the *Gobela*, you remain accountable to the students that you trained. Therefore, students must be taken through the process methodically. The participant said:

"The students that I trained, they're answerable to me. If anything happens there, they will say they were trained by so and so. Then people can bounce back and say, hey you did not train them properly. Can you check 1 2 3, what we see with your students they lack here and there. So, for one to say now I am a seasoned healer, it takes time. You develop, you will never know everything. It's also like some professions, you can't just be a basic nurse and that's it, no. you go through the stages you develop, you grow."

It appears that training plays an important role in the development and competence of a THP. Evidently participants were concerned about the fake initiation schools and trainers who promise vulnerable THPs that they will be competent without following proper processes of training for THPs. Lack of standards and regulation for training of THPs are identified in this study as key determinants to emergence of bogus practices.

4.3.2.2. Subtheme 2.2: Language as a medium in African traditional health knowledge and practices

Some participants described the influence and importance of language in ATHKPs. According to participants language serves as a medium for communicating with the ancestors and a tool used in the training of initiates. The use of different language may create interferences when the THP is communicating with the ancestors. Participants said:

"Remember when we talk about the ancestors, the composition of the language of the person who will participate in initiation, Nka se thwasise ke morafe o mongwe [I cannot be trained by another ethnic group] *easily. Badimo ba hao* [your ancestors] *they always have confidence in themselves."* (THP 1, Sangoma).

Another THP said:

"It is difficult to learn the language of someone else when you are still alive, now if I say I will teach you, three months you are a doctor… it goes with the language." (THP13, Sangoma, Gobela)

It emerged that within ATHKPs, language is not only important for communication, but also for naming, defining, and explaining the traditional health concepts, anatomical structures, and illness.

"You get ngaka ya setso [a traditional healer], *who cannot elaborate in depth the signs and symptoms tsa* [of] *stroke, but he can diagnose using his concept. Like if I want to explain myself in English, I may lose some of the meaning. But if I express myself on something that I do in my language then I will get it right.* (THP 18, *Sangoma*/herbalist).

"We unpack the body from an environmental perspective, we give a scope wherein meriri [hair] *replaces the grass, madi* [blood] *replaces water, marapo* [bones] *replace matlapa* [rocks] *and the skin replaces the soil. So, we unpack around that."* (THP 1, *Sangoma*)

THP 1, (*Sangoma*) went further and said:

"It's just like when you change the plant or medicine itself, the herb… let's say this is a "licorice" [root extract]. *Surely, I might not be explaining the qualities and the ingredients and the usage, but the moment I say sehlare se* [this herb] *ke maphakoro* [traditional herb]*, you will find that I have a longer list of conditions that may be treated than that of a well-trained doctor from Western medicine."*

Surely the use of language in ATHKPs is important in clarifying diseases and their causes. Participants shared examples to indicate that more must be done to understand traditional health from a perspective of THPs, with more focus put on similarities and differences in expressing and clarifying health related issues.

4.3.3 Theme 3: Challenges encountered by traditional health practitioners

It emerged that as part of practising, THPs encounter several problems in relation to treating presenting problems brought by patients. Some of the challenges include not having the expertise to manage the problem that brought the patient to your practice, expectations of the family and lack of recognition for THPs. To deal with these challenges, sometimes it requires a THP who is prepared to serve patients who may come without money to pay for the service rendered by the THP. It appears that ancestors play an important role in guiding the THP on what to do in helping the patient. Participants had this to say about their work:

"Sometimes as a doctor you look at your medicine in the dispensary and you realise no man, here, there is no plan. You play around and you say did you take him (the patient) *to the doctor, and they say we took him to all doctors. You don't know where you will borrow the medicine. It becomes very difficult, then something says to you…. It is not about yourself. Take the patient in and we* (ancestors) *will tell you what you must do."* (THP1, *Sangoma*)

"So, another challenge is recognition. In most countries we are not recognised. If we are, we are being shunned upon, because you are a traditional healer." (THP 5, Diviner)

"A healer needs to accept that maybe you may not be the specialist of the problem that brought the patient to you." (THP 14, *Sangoma*)

One Participant (THP 17, Diviner/*Gobela*) raised concerns regarding attempts to give THPs categories of practice which do not necessarily reflect how things are done in ATHKPs. This participant commented on the laws that are made available to deal with the classification of THPs, but remained skeptical on how effective they would be. The participant said:

"You see I have a problem with this whole thing of trying to classify us as traditional healers. It is not like the western system, where nurses and doctors have their classification and categories. In Africa traditional health, one can fall within any of the areas of practice and that may happen over time. For example, it would be difficult for me to classify myself as one particular practitioner because I started off as a

Sangoma, but I perform duties outside the known duties of a Sangoma, such as praying for people using water as a diviner, I also do medicinal plant harvesting as an herbalist. Also, I am a Gobela, and I train initiates. Therefore, trying to classify traditional healers has become problematic and is misleading. I have seen that they have come up with laws to do that, but whether it will work or not I do not know."

Another THP indicated the importance of ancestral protection in treating patients.

"So, it is very challenging, we are going against bad spirits, against the wave. But if you have very strong ancestors, you always conquer and you feel grateful about it." (THP 2, Diviner)

Other participants reported the issue of bogus THPs who are often looking for quick money while promising their patients things that may not be possible.

"And you also have bogus healers whom you need to differentiate. And there are a lot of them wanting to make profits. Money fast." (THP 17, Diviner/*Gobela*)

"Sometimes in traditional healing, a person will come without money, and you will still have to treat them, hoping that one day they will remember and pay you. So, it is not for getting a quick rich scheme. But some people turn it around then they rob people." (THP 13, *Sangoma/Gobela*)

It also emerged that internalised values and upbringing of a THP determines how they interact and manage patients who presented to their practice. Sometimes the THP may be seen as the last hope by the patient and family. One participant said the following regarding their experience with a patient and their family.

"It is very painful to see a family that accompanied a patient, but they are also spiritually down and when they look at you is like they are looking at God. They believe that they have brought someone, and you will be able to manage the person. Even the referral system of the people who sent the patient to you believe that you will manage the patient, you do not want to lose that confidence, you have to work hard and if really it is not up to you and you also see, others will tell you we have been to all doctors." (THP 10, Diviner)

*"It also depends on how you were brought up, even yourself. If you are brought up to believe that you have to make a lot of money in traditional healing, then you are having a problem. You will end up charging people a lot of money." (*THP 6, *Sangoma*)

Another participant indicated the importance of being sensitive to the needs of the patients which may be influenced by their gender or origin of the problem.

"Remember, some problems are not here based on physical pain others their pain is caused by violence, gender violence. Now she does not feel comfortable to speak to me as a woman, even a man does not feel comfortable speaking to a woman." (THP 1, *Sangoma*)

It emerged that there are stereotypes and one-sided views about ATHKPs which are fueled by western religion and philosophies. Some participants believe that there are no contradictions between what is practiced in ATHKPs and religions such as Christianity. However, people still do not believe the role of spirits in ATHKPs.

"The very same bible tells you that they are now spiritual. What has died is the body, but they live forever. Why can't you believe that? This is where I seriously don't understand, people just pick up a verse in the bible and then they hang to that verse without reading the whole bible to realise that even Isiah was an herbalist, Isiah was also a holder of information from the spirits. Because Isiah was sent by God to go to Ezekiel when you read your Isiah Chapter 38. Whereby he went and said, God has answered you. Which means Ezekiel when he was praying, God decided to go to Isiah, who was a vessel to take the message from God. To say, what he was asking for is answered. but we are told Ezekiel was already dying as he was having a boil or a wound that was not healing. But no one talk about it." (THP 13, *Sangoma*)

Other participants said:

"I see myself as a Christian because I grew up in a family where we went to church. It is really challenging sometimes because people do not believe that I can be a healer and be Christian at the same time. how do you convince such people when all they see is witchcraft and evil spirits?" (THP 5, diviner)

"Many people do not know that some of us pray the same God as the one they pray. So, it is only stereotyping that people have about us." (THP 11, Sangoma)

Being a THP comes with challenges that must be overcome. However, values play an important role that facilitates the relationship between the THP and their patients. Most challenges that arise during the rendering of care by THPs may influence the outcome and experiences of patients. These include the attitude of the THP towards the patient and their families and stereotypes about ATHKPs.

4.3.3. Theme 4: Competencies of traditional health practitioners

During the interviews, the participants were asked to describe their views on the knowledge and skills that are required for THPs. Participants reported the core skills that a THP must possess to be regarded as competent in the traditional healing process. It emerged clearly that THPs perform various roles in their independent practices and some of these roles, such as patient counselling, may not necessarily be skills they learnt during their training. Notably there are similarities in the approaches that most THPs adopt in the traditional healing process such as when the patient walks in and the process of consultation. Within this theme, to sub-themes that emerged are skills required in the traditional healing process and supplementary roles of THPs.

4.3.3.1. Subtheme 4.1: Skills required in the traditional healing process

To be able to help patients successfully and proficiently, THPs must master several skills which are essential for provision of safe African traditional health practice. The core skills that were reported by participants include assessment and diagnosing of patients, prescribing, and referring the patients where and when necessary. The skills are discussed below as categories.

4.3.3.1.1. Category 1: Assessment and diagnosis of patients

Participants reported that when patients come to their practices, the first skill that must be used is for assessing patients. The assessment of patients is initiated when the patient is still walking into the practice by observing their movement and other body gestures. It was also reported by one participant that spiritual element of the healing process is important to facilitate the spiritual connection with the patient. However, in

most cases, assessment is done simultaneously with diagnosing the problem that brought the patient to the THP. The following was said by THPs regarding assessment and diagnosing of patients:

*"When a person gets here, you immediately connect, and you can see that this person is seating uncomfortably. Have you ever seen a sick person; you may have already diagnosed him? It is not a question of no wait a bit so I can see this person. That thing itself makes the people who brought him very comfortable. By the time this person gets in, the most important aspect is to see your patient through the glass, not the mirror where you look upon yourself. Put yourself in the patient's feet" (*THP 1, *Sangoma*)

*"It starts with a discussion … how do we experience this headache? when it started? the observations of that particular individual who has a headache, you must be able to explain, especially to the traditional doctor who is not divining." (*THP 4, Herbalist)

"That person must be able to diagnose. Remember we have bone diviners, where you will chat and talk about issues and deliberate issues, even if the person is not a diviner, is an herbalist, there should, there will be that discussion." (THP 13, *Sangoma/Gobela*)

"Yes, there is assessment, there is diagnosis… we even go beyond. By checking for the spiritual cause of the problem." (THP 11, *Sangoma*)

Other participants reported on the role of ancestors, who assist in diagnosing the patient. The participant said:

"What I have also noticed is because I don't sit with muthi [Herbs] *that is already mixed. So, I sat with plants. When I go to mix these plants, the ancestors still diagnose for me."* (THP 5, Diviner)

"Traditional medicine is about diagnosing by throwing bones and giving whatever therapy of some sort… ofcourse as guided by the ancestors". (THP 7, Sangoma)

"So, as you go along there is diagnosis even when they come back, you still diagnose. Was the first treatment effective or not. The only problem is that we also take the history about how you feel now, what is happening now?" (THP 17, Diviner)

"We do a lot of observation; we observe them and then we diagnose. Sometimes we diagnose when the patient is away, to say to ancestors there is this patient that I am treating are we on the right track, where am I lacking. What do I need to do?" (THP 18, *Sangoma*)

Participants also reported the importance of using diagnostic procedures such as throwing bones and using a glass of water as part of diagnosing the patient's problem.

"There is a lot of mathematics within bone throwing. The instruments to diagnose are different, others would use shells. There is a lot that one can do to learn those instruments. It cannot be done in one night. It needs discipline, code of ethics, standards and other things and it needs time". (THP 1, *Sangoma*)

"Now a person who divines will always throw his bones and say… in fact, before you can explain to say I have a headache, a bone diviner will always throw the bones and check what could be the cause of this problem. Then the discussion will start from there, he will tell you that your headache is caused by something" (THP 10, Diviner)

"I throw bones, then I also use divination, but I also use spirituality, I can even use a glass of water. Where I just take a glass of water and look at it and before I know it, I am getting the right messages." (THP 13, *Sangoma*)

Another participant who is also practicing as a professional nurse reported that she also uses western principles to come to a diagnosis.

"When it comes to diagnosis, I use both traditional and… because some of the illnesses you think a client will think is only traditionally handled and only to find that, no no no no, these are kidneys." (THP 17, Diviner)

4.3.3.1.2. Category 2: Prescribing of medicines

It was reported by participants that prescribing herbs and plants is an important skill for THPs. In treating their patients, THPs use a variety of animal and plant derived medicines which are used for a variety of illnesses. Ancestors are reported by participants to also play an important role in diagnosing undetected problems that patients have and the prescribing of medicines for the health issue.

"Well traditional health practice is broad but includes diagnosis, prescription and discussions about things that are bothering our patients". (THP 3, Herbalist)

"I will be putting a plant to treat the problem I detected when throwing the bones and they [ancestors] *will say, yes can you also add that other plant because the patient is also having a brain tumor."* (THP 9, Herbalist)

"We give our patients medicines that will help them or heal their pain. These medicines are given to us by ancestors. Sometimes when you are sleeping you are directed to a certain place go epa dihlare [extract herbs] *for a specific disease.* (THP 16, Herbalist)

"Ditaola di tlo bontsha hore [The bones will show that] *which medicine you must give, then you realise that it is not about you. Badimo ba gago* [Your ancestors]*, they cannot give you something and not show you the way to use it."* (THP 6, *Sangoma*)"

Another participant reported that there are different ways in which the THPs measure how much medicine must be given to patients. The participant said:

"Remember, even the medicine that we give, the amount you must put is given by the ancestors... Something will tell you, hore o tshele spoon se one [that you must pour one spoon] *or you may use your nail to measure..."* (THP 1, *Sangoma*)

Participant (THP 17), who is also a nurse reported that she used traditional medicines to assist a child patient who had speech problems. This participant went further and raised issues of parental involvement in giving medicines to patients who are minors.

"There is this young man, who when he came, he was stuttering, you would even think he had autism, and very withdrawn not even smiling. We are now in our third week instituting treatment and giving him herbs. The unfortunate part is that the parents are not supporting him. Instead, they are giving him medications to sleep because he cannot sleep at night and so on. And this has been happening for years. Do you know that now he is beginning to talk much better than when he came? Even now passes jokes and we are all surprised. Even my trainees said hah we didn't know that this guy can pass jokes and laugh and smile and so on. He was so depressed, and he already had visions of killing himself. And I haven't met his parents, I am just helping him. But I want to meet his parents because for us as

traditional healers, it is very important the family is involved. I cannot finish the treatment without meeting the family. The funny part the father is an administrator in a hospital who thinks, they only must pray and sent the child to the priest, not the traditional healing way." (THP 17, Diviner/*Gobela*)

When participants were probed on the names of medicines, they use for treating different patients, some of them said they are unwilling to share that information as it is sacred information that must be protected. The participants said the following:

"There are a lot of herbs that we use to treat different diseases, whereby those medicines are not there in hospitals or the clinic. Unfortunately, I cannot tell you their names because it is my ancestors' knowledge. We have been telling people that our herbs work but they still don't trust us." (THP 15, Herbalist)

"The herbs that I have here, is for treating people with different diseases. I have treated a patient with sefolane [foot ulcer/cancer]*."*

*"I used to work with people from Department of Science and Technology... I shared with them some of the herbs because they said they are writing a book about our herbs. They never came back to me to say this is the book. So, I decided I will not share information about herbs with people from universities or government anymore. Because now you go to the shops you see those medications in bottles." (*THP 1, *Sangoma*)

4.3.3.1.3. Category 3: Referring the patients to other practitioners.

Some participants reported that THPs sometimes must refer patients to other THPs for another consultation or refer to western doctors when they see the problem warranting that. Furthermore, participants reported that their local THP associations assist in referrals when they cannot help the patient.

"I have relationships with other traditional healers in our association. We know who is good ka bolwetsi bjo bo feng [specialist for certain illnesses]. *So, we talk among ourselves, the main aim is to defeat the problem that is bothering this person."* (THP 12, Herbalist)

"I send my patients to my Gobela when I have patients that I cannot treat mo ndumbeng [practice site]*. I know He has a lot of experience in treating malwetsi a ho fapana* [different diseases]." (THP 8, *Sangoma*)

"But they have told you that there is no doctor that we have not seen, so you have to get the second opinion within this practice. I will then write another traditional healer and inform him that I am brining the patient and I need second opinion, I have given the patient 123 and please manage further." (THP 14, *Sangoma*)

Another participant acknowledged that there are certain conditions of patients which warrant their referral to Western medicine. This was said:

You must accept that ha o makgona tsohle [you are not an expert in everything]. *Sometimes you will also see that no man this patient needs to be seen by doctors in hospitals first. In that case I immediately write a referral letter and my son helps me with driving them there.* (THP 1, *Sangoma*)

However, participants reported negative encounters when referring patients to clinics and hospitals. Such challenges are associated with unwillingness to collaborate, negative attitude towards traditional medicine and lack of recognition by nurses and doctors. This was said:

"Nurses do not see us as their colleagues, they still undermine our practice. For example, you can write a referral to the clinic or hospital, but they can never do the same. It is like a one-way traffic." (THP 7, *Sangoma*)

"I sometimes accompany my patients to the clinic. But the nurses never allow me to explain what my diagnosis is. Their attitude is like, sometimes it hurts... can you imagine being undermined in front of the patient and relatives?" (THP 11, *Sangoma*)

"The nurses tell our patients that we are killing people by giving them herbs. So, you see that we still have a long way to go. We need to respect each other." (THP 4, Herbalist)

4.3.3.2. Subtheme 4.2: Supplementary roles of THPs

It was reported that THPs also perform duties that are not core skills that are acquired during their training. Some of the skills, as reported by participants, they learn over

time, whereas others come naturally. Under this subtheme, three categories of skills were reported, namely counselling of patients, exorcism, and plant harvesting. The categories are discussed below.

4.3.3.2.1. Category 4: Counselling of patients

THPs are sometimes required to provide advice and psychological support to patients who came for consultation. The counselling may also be directed at the family. It also became apparent that participants who are also nurses find it easier to counsel patients.

"You find that a patient is afraid because maybe he has been to other healers, who could not help him. So, you have to advise him and make sure he is comfortable." (THP 1, *Sangoma*)

"That is that… then my western, of course my western knowledge helps me a lot when it comes to counselling." (THP 17, Diviner/*Gobela*)

"You discuss the spiritual, including their heart because they may have told him [patient] *that he is going to die, you have Covid, but when he gets here, as you look at him you give him the psychological therapy."* (THP 11, *Sangoma*)

Another participant also highlighted the importance of THPs considering individual needs of patients when doing the consultations.

"The only thing with traditional healing is you don't put people together and give them health education together. You deal with an individual, then after an individual you deal with the family." (THP 15, *Sangoma*)

Seemingly THPs adopt multiple roles which cannot be separated or classified by specialisation in traditional health practice. Therefore, counselling patients becomes a default role that they play.

"As much as people think we only treat patients, at times you find yourself in a situation where the patient start crying…what must you do? You try get to the bottom of the problem."

Participant THP 1(*Sangoma*) further reported the importance of being sensitive to the patient's presenting problem, especially if it is a patient of the opposite gender.

"Another partnership ok is my wife. what I have practiced is not what she practiced, gender perspective you know. I would call her and say this person is a woman and please attend to her in-depth and you must talk because sometimes patients, based on gender, they tend not to be at ease. They would tell you that they have abdominal pains but from the waist downwards because it will embarrass her because of certain reasons. So, my wife will then reassure the patient because they speak the same language." (THP 1, *Sangoma*)

4.3.3.2.2. Category 5: Exorcism (casting out evil spirits)

Some participants reported that as part of their work, they must cast out evil spirits that may be a result of witchcraft. It became clear that in ATHKPs when a person has misfortunes, it is usually associated with witchcraft or possession of evil spirits. THPs are at times compelled to learn different ways of evicting evil spirits. The following was said by participants:

"When you are a traditional healer, you are not a witch. But then you have to overcome what the witches have done, and you have to learn that. If they made somebody to be mad, then you have to use medicines to bring back the person's mind into normal." (THP 13, *Sangoma*, Gobela)

"You throw the bones, and the ancestors immediately tell you that this person o na le senyama [bad luck] *and wena as a ngaka* [you as a healer] *you must cleanse the person and remove the bad luck."* (THP 8, *Sangoma*)

"A patient will come to you and say I cannot sleep at night, I always have bad dreams. Some of them tell you about ditokoloshe [demonic creature] *or maybe mathata a lenyalo* [marriage problems] *… then you have to seek guidance from your ancestor on how to fight the witchcraft."* (THP 5, Diviner)

Participants also reported the interventions they perform when casting out witchcraft or evil spirits from patients. Some THPs reported the following:

"As soon as I realise that a person is having problems with evil spirits. I cleanse them first nge'mpempo [burn incense] *then give them muthi for bathing at home or when they sleep."* (THP 16, Herbalist)

"In my practice many patients come with life challenges. Tse dingwe wa bona hore tse ke dilo tsa batho [other things you can see that it is a result of a spell cast by witches]*. You have to be brave and help the person. Nna ke berekisa letswai sometimes madi a kgogo* [I use salt and chicken blood]." (THP 9, Sangoma)

4.3.3.2.3. Category 6: Plant harvesting

It emerged that one of the important roles of the THP is to identify and collect herbs to be used in their practice. While this skill can be learned during training of the THP, it is a skill that even seasoned THPs need to work effectively. To support this important role of the THPs, participants said:

"I go and identify plants in the bush, so you can see that I am an herbalist." (THP 3, Herbalist)

I have not yet taken you to the forest to learn about plants and herbs. When I take you to the forest, it is another job, because the species of herbs and plants have similarities." (THP 1, *Sangoma*)

"We do many things such as interpreting visions, plant harvesting, performing cleansing ceremonies and others." (THP 17, Diviner/*Gobela*)

Other participants still highlighted the role of ancestors in guiding THPs to specific herbs that they need to harvest.

"You have to trust your ancestors to guide you so that you know which herbs to use. Knowing your medicines is very important for rona mangaka [doctors]" (THP 14, *Sangoma*)

"Even the medicine that you get in the forest, they need to be respected. There are specific times that you must harvest them. O swanetse o hlomphe hlago [you must respect nature] *ka tsela e o hlomphang badimo ba gago* [the same way you respect your ancestors]" (THP 4, Herbalist)

This theme has demonstrated that THPs possess knowledge and skills that are necessary for them to carry out their work competently. Furthermore, it became apparent that training and continuous practice ensures they perform their duties diligently. It also emerged that THPs perform certain roles that may not be seen as typical THP duties such as counselling.

4.3.4. Theme 5: Views of THPs on the training of nurses on ATHKPs

This theme emerged in response to the question that was prompting THPs to share their views on what they think nurses should be taught about regarding ATHKPs. Although not all THPs were able to respond to this question, it was evident that THPs who also practice as nurses were more interested in responding to this question. Participants reported their appreciation of the fact that nurses are not necessarily going to be THPs, rather they should learn what THPs do. It also emerged that teaching nurses on ATHKPs may foster collaboration between nurses and THPs. This is what was said by participants:

I think we have to teach them the basics about what it is [ATHKPs], *and so on. Because they will not become traditional healers, but they have to understand who are traditional healers, what do they do?* (THP 1, *Sangoma*)

"So, I am grateful that you are trying to put up a standard for integrated learning of nurses because they are learning only the western and they believe that they have to live the western way and they have to practice the western way. Whereas as we said, 80% of these patients come from traditional healers. And we do need collaboration and the collaboration can start with the training. They are not going to ask a nurse that was trained in the western, to now start collaborating. It is very difficult because they do not understand anything. So, create understanding as they are being trained. The way you acquire knowledge is the way you are going to impart it; it is the way you are going to internalise knowledge." (THP 11, *Sangoma*)

"In traditional healing we have our own way of doing things, how we communicate and so forth. So, if they become aware of our customs, our beliefs… then our relationship may improve. Because we can do a lot of things that they do. Basically, I am trying to give you a scope so that you can see that we do have similarities. You hear me." (THP 18, *Sangoma*/Herbalist)

"We do have regulations that govern traditional health practitioners if you get your strategies from WHO of 2005. Visit that because the one that is the latest is already taking into consideration that there is collaboration, the one that is ending in 2023, the second strategy and so on. They have a lot. And look into the types of complementary and alternative therapies, so that they do not just deal with traditional

health practitioners but look at all the alternative healthcare practices." (THP 17, Diviner/*Gobela*)

"They must understand their constitutions. What governs traditional health practice in South Africa, what governs African traditional health practice in our country." (THP 7, Sangoma)

One participant who is a nurse commented about how in Western medicine patients are grouped according to their perceived needs, whereas some may not need the intervention. An example of breastfeeding was used as follows:

"But there are times when we seem to group them together like when we do health education, today we are teaching about breastfeeding. Is it all of them who really need breastfeeding? No. why can't we individualise? There are times where we do not individualise. Even in the wards, people would just come in and preach. Do they all come from the same church? Whom do we allow in the west to come and preach. Sometimes we do not allow those that are more spiritual because they make noise. hey! (emphasis) *That's how they worship. Maybe some clients come from those churches. Why do you decide whom to allow and whom not to allow?"* (THP 15, Herbalist)

Another view was raised by participant THP 7 regarding collaboration between THPs and nurses. The participant indicated that THPs should not be incorporated into the nursing profession. This is what the participant said:

"Don't incorporate them [THPs] *into your own nursing profession, don't incorporate them to come and sit in a hospital. But how can you assist them so that they can establish units where people can get treatment for traditional medicine and so on. I don't believe in integration; I believe in collaboration*. "(THP 7, *Sangoma*)

THP 1 commented regarding the visit that should be arranged for nurses to the traditional health practices to observe what is being done by THPs. The participant said:

"Then also practical visits, where they can go and see a traditional healer at work. How to enter a traditional healer's home as well. Visit the homeopathies, visit those

that are using Chinese traditional medicine, because here you are trying to open up their minds as well." (THP 1, *Sangoma*)

Another perspective that was raised is regarding ethics in research, especially within the African context. The participant recommended that nurses be taught about the ethos of Western medicine as compared to traditional healing. This was said:

"If you take for instance, the book of Ndebele et al in 2010, where they developed a very nice book called research ethics in Africa, it does have prescription on when you are going to do research on traditional healers. What aspect of ethics are you going to address. And learn a little bit about what is ethical in traditional healing. Ethos of traditional healing versus Western medicine. Then professional practice, you can also compare what is professional practice in traditional medicine. Do they have to belong to an organisation like nurses belonging to Sigma Theta Tau or honor society? What is there for traditional healers?" (THP 17, *Sangoma/Gobela*)

The findings in this theme demonstrate that there are a lot of possibilities that exist for sharing knowledge and learning from one another. It appeared that THPs do take interest in what nurses do and this was evident when the views expressed were highlighting how things are done in nursing. It is also important to note that ethics of practice taught to nurses should encompass how they should engage with traditional healers.

4.4. Summary

This chapter discussed the different phases used in this study. Phase 1 of the study adopted a qualitative, explorative, and descriptive design. The aim of this phase was to explore and describe the the knowledge, skills, and roles of THPs in the provision of healthcare in South Africa. From the data collected, the themes that emerged are: were reported and quotations from the participants were used to explain each theme and subthemes. The views of THPs on ATHKPs have been explained to provide the reader with a broader understanding of how THPs view their own practice. The next Chapter 5 discusses the findings of this phase.

CHAPTER 5

DISCUSSION OF THE FINDINGS OF THE QUALITATIVE PHASE AND LITERATURE CONTROL

5.1. Introduction

In Chapter 4 the empirical findings of qualitative Phase 1 were presented by the researcher. The findings revealed the views of THPs on the tenets of ATHKPs and roles of THPs in communities. Findings revealed the themes and subthemes which emanated from the interviews with THPs. This chapter will discuss the findings with supporting literature.

5.2. Discussion of findings

The aim of qualitative phase of this study was to explore the views of THPs on ATHKPs as well as their roles in the provision of healthcare in the South African health system. The researcher undertook qualitative content analysis process to analyse the data from the interviews. Five themes and subthemes emerged from the data in this phase of the study. Findings revealed that in ATHKPs, the unique system of health encompasses all elements of life, including the physical, spiritual, and psychological elements of life. As such, THPs clarified their roles and understood the underlying principles in this system of healthcare. Furthermore, participants described ancestral calling as a cornerstone of being a THP, supplemented by spiritual connection with the ancestors.

It emerged that elements of practice in ATHKPs include training which takes different forms, while learning to perform various roles and language used for naming, diagnosing, and communicating ancestral orders. It is without a doubt that THPs experience challenges in their practice emanating from their interactions with patients and other health professionals such as nurses and doctors. Competencies of THPs were identified by the researcher in terms of the knowledge and skills and the supplementary roles they perform, which are not part of their training such as counselling of patients and plant harvesting. The last theme that emanated in Chapter 4 explained the views of THPs on what nurses can be taught on with regards to

ATHKPs.The findings are discussed in terms of the themes that emerged in Chapter 4.

5.2.1. Theme 1: Traditional health practitioners defined the features of African traditional health knowledge and practices

Within this exploratory study, a meaningful understanding and clarity is provided on how the THPs defined ATHKPs as a unique system of health. More insight was provided in this study on what the features of ATHKPs are as defined by the custodians of such practice (THPs). Modern definitions of traditional medicine restricted the practice to the use of herbal medicines for healing, it excluded the spiritual aspect and focused more on the physical and physiological process of healing (Oliver 2013). While the concept of ATHKPs may be used synonymously with African traditional medicine, ATHKPs goes further to include elements of knowledge systems and practices, which are also clearly encompassed in the definition in the WHO Traditional Medicine strategy (WHO 2013). Practices within the context of ATHKPs are all the rituals, social conduct, and rules that a group of people subscribe to, to manage their lives and health challenges. Hence it emerged from the interviews that THPs view ATHKPs as a way of life for Africans. Sifuna (2022) supports the view that traditional medicine in Africa permeates all aspects of life including practices around birth or death, marriage, societal roles, and use of medicinal substances. In most communities, the understanding and practice of ATHKPs has persisted despite advancement of most western values and practices.

5.2.1.1. Subtheme 1.1 African Traditional Health Knowledge and Practices is a way of life for Africans

This study however, demonstrated that ATHKPs is a way of life for Africans in the sense that it cannot be separated from the everyday life and cultural practices of the African people. While the belief in Africa is that health and illness are inseparable and closely linked, they are mostly understood to be spiritual experiences that require African traditional approaches in dealing with them (Sifuna 2022). Yet in this study, THPs reported that most Africans still see their ancestral ways of living as primitive and in extreme cases, perceives the knowledge and practices of ATHKPs as the practise of witchcraft (Mothibe & Sibanda 2019). This may have been fuelled by the western schooling system and indoctrination on a large scale, which vilifies the

practice of ATHKPs (Gqaleni, Mbatha & Mkhize 2010). As an example, the type of food a pregnant woman eats is entrenched in the beliefs and culture of the group. Nonetheless, there are prohibitions that are still in place, preventing pregnant mothers from indulging in them without a scientific base for the restrictions. As a way of life for Africans, ATHKPs is part of a schooling system which dictates how individuals go about their lives despite the contradictions that arise between ATHKPs and western system. The THPs reported a distinguishing feature that defines ATHKPs, is its focus on balancing the physical and spiritual realms. Approaches to life and health problems are aimed at eliminating the cause and restoring parity (Amzat & Razum 2017).

Understanding how ATHKPs is viewed and understood by African communities has implications for the health system generally and health professionals. Health interventions within the modern biomedical system must also consider the comprehensive nature of ATHKPs and its bearing on the acceptability of health interventions (Solera-Deuchar, Mussa, Ali, Haji & McGovern 2020). It was reported by THPs in this study that ATHKPs is not necessarily a separate system of health but rather it is how African societies live their lives and meet their daily health needs.

5.2.1.2. Subtheme 1.2 THPs are called by ancestors

Participants reported that to be eligible to practice as a THP, an individual must meet specific criteria and comply with certain elements in preparation for their role as a THP. According to THPs in this study, the initial criteria for qualifying as a THP is ancestral calling which may present in various ways such as an illness or life difficulties. The initial calling does not necessarily specify the category or nature of specialisation one will embark on. Kubeka and Blokland (2016) reported occurrences that precede a calling such as being led through dreams to the person who must train the healer for their specific calling. Another study also mentions mental illness which can only be lessened by conceding to the call, known as *ukuthwasa* (de Villiers & Ledwaba 2003).

This study affirmed that a person may be chosen by ancestors even before they are born to become a THP. Regardless of the circumstances that led one to be a THP, ceding to ancestral calling is a difficult decision for many as it disrupts many aspects of life including work, school, and family relations (Bakow & Low 2018). This is associated with demands of doing ancestral work which demands a lot of commitment and dedication to helping people in need. Therefore, different people experience their

calling in unique but different ways (Knoetze 2019). However, THPs reported that there is a strong correlation between ancestral calling and history of traditional healing in their family, fulfilling a common Sepedi language proverb says "*rutang bana ditaola le se ye le tsona badimong"* loosely translated as "teach children knowledge and wisdom before you depart". Ceding to ancestral calling is seen as part of an identity formation for an individual who goes through a transformative phase, from a life of ill-health, misery, and life challenges, to being a THP who can now help people in need (Sigida & Sodi 2023). Ancestral calling should therefore be considered as a legitimate step in a THPs journey, like nursing which is referred to as a calling profession premised on selfless service to humankind (Emerson 2017). In this study, it also emerged that THPs must be willing to serve without expectations as it aligns with *ubuntu.*

5.2.1.3. Subtheme 1.3 Ability to connect and maintain the spiritual connection with the ancestors

What emerged from this study was that the unique circumstances and conditions that every individual or group endure determines how ATHKPs is used. THPs emphasised that spirituality is one of the bases for defining ATHKPs. Hence this study has endeavoured to provide clarity on the role of spirituality and connection with ancestors within the practice of ATHKPs. THPs described ATHKPs as a system heavily influenced by the spirituality and customs within the African group. Those customs would then dictate how individuals should behave and conduct themselves in different phases of their life from childhood until old age. In this study, findings indicate that ATHKPs encompasses spiritual, physical, and mental interventions as elements of the healing process. Spiritual alignment is recognised as an essential element of life that contributes to growth, prosperity, and good health (Knoetze 2019).

Additionally, it emerged that spirituality within ATHKPs may manifest as illness which requires an inquiry into the genetic make-up of a person to determine ancestral linkage with the presenting problem. Indeed, spiritualty and connection with the ancestral spirits requires a balance between the body, the mind, and the soul (Lebaka 2018). This is a founding principle for ATHKPs because spirituality and religion in African contexts are inseparable. Having said that, most spiritual practices in Africa are still referred to as cults or myths. Spirituality in ATHKPs is being practiced throughout

Africa in written and unwritten forms as seen in cultural and religious practices such as dancing, singing and rituals. Therefore, connecting with the spiritual realm is an important element of the THP. From this study it is apparent that THPs consider spiritual connection with ancestors essential for good health and healing in ATHKPs.

5.2.2. Theme 2: Elements of practice in ATHKPs

Elements of practice within this theme refers to processes and essentials that needs to be in place or met for one to function optimally and competently as a THP. It's important to note that while traditional healing practices vary among different cultures and communities worldwide, there are fundamental similarities in terms of requirements for practice (Mokgobi 2015). This means that requirements and practices for becoming a traditional healer can differ significantly based on the beliefs, customs, language, and traditions of each group. While recognising that ancestral calling is the cornerstone of traditional health practice, undergoing training remains a fundamental step in becoming a THP (van der Watt, Biederman, Abdulmalik, Mbanga, Das-Brailsford & Seedat 2021). Closely linked to training is the use of language during the training period which was reported as important by THPs.

5.2.2.1. Subtheme 2.1 Training of Traditional Health Practitioners on ATHKPs

Despite the training that THPs undergo, it remains a contentious matter in relation to the credibility of some training and the level at which training is conducted (Louw & Duvenhage 2016). The proposed regulations in THPs Act 22 of 2007 nonetheless prescribes the minimum standards for student THPs and outlines requirements for registration as a THP. This should go a long way in formalising the training of THPs and bringing much needed reassurance to communities that the THPs have met the minimum requirements for registration as practitioners, like mainstream health care system.

THPs are led in different ways to a more experienced THP, known as *Gobela*, for their training. *Gobelas* undergo extensive training and apprenticeship themselves, learning from experienced THPs, and gaining practical knowledge through hands-on experience. They acquire deep understanding and expertise in using natural remedies, conducting rituals, and connecting with the spiritual realm based on their cultural beliefs. Therefore, potential initiates may be directed by ancestors in dreams

or be informed of their gift during a consultation with a THP. However, Most THPs can also learn the craft of practice within their family, where they are taught by their parents. Accordingly, the process of training for THPs involves shadowing where they learn to perform various skills and roles of the THP. As part of their training, THPs learn to identify and harvest plants, analyse, and interpret dreams and perform cleansing ceremonies (van der Watt et al. 2021). However, it was reported in this study that there are also challenges related to the time it takes to train THPs, which has been reduced drastically by bogus trainers. Although the training of THPs differ from region to region, there are similarities in terms of the process such as staying with the trainer during the period of training (Mokgobi 2014), learning to conduct consultations, diagnosis, and prescribing treatment (Nompumelelo et al. 2019). This takes place in the form of an apprenticeship and shadowing. Eventually the trainee must graduate, where a big ceremony is held in the presence of family and the community at large, to confirm that the initiate has been found competent. Some THPs reported that there are times wherein a THP can fail their training and may need further training. This finding is also reported by Mokgobi (2014). Nevertheless, the THP, even after initiation (*ho thwasa)*, remains answerable to their trainer, who must ensure their competence prior to their independent practice.

5.2.2.2. Subtheme 2.2 Language as a medium in African Traditional Health Knowledge and Practices

One of the profound elements of ATHKPs is the language within health is defined and interpreted among Africans. The unique language used in ATHKPs to clarify names, illness and processes provides a good basis for communication and knowledge exchange among African people. More insight was provided by THPs on the value of language in naming plants or herbs, labelling anatomic structures and making correlations between the body and the environment. THPs indicated that their inability to elaborate on medical terms does not mean that they are not knowledgeable about illness such as stroke and diabetes. The extent to which researchers translated the language used in ATHKPs as understood and described by THPs must be further explored, especially in relation to the categories used such as herbalist, diviner and *Sangoma*. Effort must be made to determine if these concepts represent the views of THPs on the ground. Hence, language is an important medium in communicating with ancestors and for purposes of training for THPs (Sundas 2023). Cultural and spiritual

meaning of certain practices within ATHKPs must be interpreted literally as they are to provide contextual and meaningful explanations (Sobiecki 2014). Within ATHKPs, language provides a sense of belonging and pride in ancestors, which can therefore facilitate a gravitation towards ATHKPs among people who uses such a service (Dowling & Grier 2023). Using an indigenous language that people understand is essential in the development and maintenance of the language. In this study, THPs demonstrated that language is essential for many elements of ATHKPs and should not be directly translated to other languages.

Language plays a significant role in traditional medicine across various cultures and societies (Sundas 2023). Within ATHKPs, language is used for various activities including chants, prayers, incantations, and specific phrases, holds a significant role in traditional healing rituals. These spoken words are believed to carry spiritual power and are used to invoke blessings, call upon ancestral spirits, or conduct ceremonies aimed at healing (Ozioma & Chinwe 2019). Notably the rhythm, tone, and specific words used in the rituals are considered powerful tools for channelling healing energy (Chelangat 2021). In summary, language in ATHKPs serves as a vessel for preserving knowledge, communicating with patients, conducting healing rituals, identifying medicinal plants, transmitting cultural values, and empowering individuals to participate actively in their own healing processes. The specific language used is deeply intertwined with the cultural context and beliefs associated with traditional healing practices.

5.2.3. Theme 3 Challenges encountered by THPs

This study reported that THPs, like other health practitioners experienced challenges in rendering services in the communities they serve. It is evident that THPs often face various challenges in practicing their craft, many of which stem from societal, cultural, and systemic factors (Zimba & Nomngcoyiya 2022). One of the dominant challenges raised by THPs in this study is regarding stigmatisation and lack of recognition. Traditional healing practices are from time-to-time stigmatised or not given recognition in formal healthcare systems. This lack of acknowledgement often leads to THPs being marginalised or not integrated into broader healthcare structures, hindering their ability to contribute effectively to healthcare (Masoga & Shokane 2022). Compounding to the marginalisation of THPs, are legal and regulatory issues. In South Africa, there

are currently legal and regulatory challenges for THPs. Most of the time THPs face restrictions or lack legal recognition, impacting their ability to practice freely or access resources and opportunities available to other healthcare professionals (Tshehla 2015; van Ellewee & Rautenbach 2020). The Traditional Health Practitioners' Act 22 of 2007 was enacted to formalise the practice of THPs, yet there have been barriers to its implementation because of unclear terms of reference for the THP Council which is yet to be established. In the current study THPs reported that classification of THPs in terms of the categories in the THP Act 22 of 2007, is problematic and misleading as one can practice in more than one category. This demonstrates that there are still grey areas on the matter of recognition and regulation of THPs.

Findings in this study indicate that THPs face challenges in accessing essential resources needed to enhance their practice. This limitation tends to affect the quality and efficacy of their healing services. Especially because ATHKPs often operate separately from mainstream or modern healthcare systems. This lack of collaboration or integration can lead to missed opportunities for combined or complementary treatments, hindering comprehensive patient care (Innocent 2016). Often, particularly in rural areas, THPs might face challenges when serving poor communities who are often unable to pay for the services. This may lead to financial instability or difficulties in sustaining their practice due to limited resources such as medicinal herbs or other healing substances (Magoro 2008). Nonetheless, it was reported in this study that THPs still have a moral duty to help all patients, even those who are unable to pay, demonstrating that values and norms play an important role in ATHKPs.

Due to the lack of scientific validation or understanding of ATHKPs, there are misconceptions or misinformation about their efficacy and safety, leading to scepticism or reluctance in seeking health services from THPs (Mngqundaniso & Peltzer, 2008). The stereotypes are fuelled by religions such as Christianity, wherein the practice of ATHKPs is associated with witchcraft (Mnguni & Sakuba 2021). Addressing these challenges often requires a collaborative approach involving governments, healthcare authorities, communities, and traditional healers themselves (Mokgobi 2015) to foster mutual respect, recognition, and integration of ATHKPs within broader healthcare systems while also preserving cultural heritage and traditional knowledge.

5.2.4. Theme 4: Competencies of Traditional Health Practitioners

Traditional health practitioners possess a unique set of competencies, skills, and knowledge that are specific to their cultural context and healing practices (Nompumelelo et al. 2019). According to THPs in the current study, these competencies vary widely depending on the traditions, customs, and healing methods within different communities. It is evident that THPs have deep knowledge of traditional healing systems, including herbal medicine, spiritual healing practices, ritualistic methods, and traditional diagnostic techniques. They have learned this knowledge through apprenticeships, oral traditions, and practical experience during initiation (Hewson 2015).

5.2.4.1. Subtheme 4.1: Skills required in the traditional healing process

In the traditional healing process, THPs must possess a set of core skills which are essential for provision of safe and effective traditional health services. The core skills that were reported by THPs in this study include assessment and diagnosing of patients, prescribing of medicines, and referring the patients.

5.2.4.1.1. Category 1: Assessment and diagnosis of patients

According to THPs in this study, the first step in the traditional healing process is assessment of patients as they walk into the practice. Often THPs employ various methods to assess patients, combining observation, questioning, intuition, and sometimes spiritual insights (Nompumelelo et al. 2019). The assessment process in traditional healing practices can differ widely based on cultural beliefs, the healer's expertise, and the nature of the illness or ailment (Adu-Gyamfi & Anderson 2019). Traditional health practitioners keenly observe the patient's physical appearance, body language, facial expressions, skin colour, posture, and overall demeanour. During the initial phase of a consultation, THPs look for signs of illness, imbalance, or abnormalities that might indicate underlying health issues (Nene 2014). It was reported by THPs that the role of ancestors during consultations is central to the direction of the healing process.

During the assessment of patients, THPs engage in dialogue with the patient to gather information about their symptoms, medical history, lifestyle, emotional state, and any other relevant factors (van der Watt et al. 2021). The THP would further ask questions

to understand the nature of the ailment and its potential causes. It was reported by THPs in this study that to conducting consultations with patients requires one to possess a deep understanding of cultural beliefs, spiritual practices, and the connection between physical, mental, and spiritual well-being. This understanding will the guide their approach to healing and the methods they employ.

Traditional Health Practitioners use different methods for diagnosis which may include observation, questioning, and sometimes spiritual or intuitive insights to determine the cause of an illness or imbalance in a patient (Shange & Ross 2022, Sodi 2009). Some THPs may use specific tools or instruments for divination like bones, cards, or objects might be used for diagnosis or to gain insights into the patient's condition (Nortje, Oladeji, Gureje & Seedat 2016). Diagnostic practices such as bone throwing and using glass of water were reported by THPs in this study. Ogana (2009) also report disgnostic methods such as *Ukubona* (diagnosing illness before client outlines), *Ukuvumisa* (asking the client to agree with the diagnosis) and prayer. While there seems to be more than one way of diagnosing patients, some THPs indicated that they use both traditional and western methods to diagnose patients. While THPs often rely on intuition, spiritual guidance, or visions to understand the root cause of an illness or imbalance, they must tap into spiritual energies or communicate with ancestral spirits to gain insights into the patient's condition (Masango & Nyasse 2015). It is therefore important to note that the assessment methods used by THPs vary widely across diverse cultures and traditions. For example, in Ethiopia THPs diagnose mental illness using interviews, or reading religious books to get to a diagnose (Gutema & Mengstie 2023). Therefore, the approach to assessment and diagnosis is often deeply rooted in cultural beliefs, spiritual practices, and the healer's inherited knowledge and experience.

5.2.4.1.2. Category 2: Prescribing of medicines

Often THPs prescribe medicines based on their extensive knowledge of herbal remedies, natural substances, and traditional healing practices. These prescriptions typically involve the use of medicinal plants, herbs, roots, minerals, and sometimes animal products, which are believed to possess healing properties (Zuma et al. 2016). The role of ancestors in guiding the THP on what medicinal substance to give, was also emphasised by THPs. When prescribing medicines, THPs often tailor their

prescriptions to the individual patient's needs, which is one unique feature of ATHKPs. It was reported by THPs that they consider the patient's specific symptoms, health condition, medical history, and even personal characteristics before prescribing a remedy. However, the remedies in traditional health practices are marred in secrecy as they are believed to be sacred information which belongs to their ancestors (Masango 2019). In some cases, THPs use combinations of multiple ingredients to create a remedy. They might blend various herbs or natural substances to enhance the healing effects or address multiple aspects of an ailment (Mothibe & Sibanda 2019).

It is important for THPs to have knowledge of dosage, frequency, and methods of administration for their prescribed remedies. When prescribing the remedies, THPs must provide instructions on how to prepare the remedy, the proper dosage, and the duration of treatment (Ozioma et al. 2019). Remedies prescribed by THPs might also include spiritual components such as prayers, chants, or rituals believed to augment the healing process (Bojuwoye 2005). These spiritual elements are essential for promoting overall well-being. It becomes important to note that while traditional healing practices have been existing for generations and are valued in many communities, the efficacy and safety of some traditional remedies have not always been scientifically validated (Mothibe & Sibanda 2019). As such, caution should be exercised, especially when considering interactions with conventional medication or in cases where there might be potential adverse effects.

5.2.4.1.3. Category 3: Referring the patients to other practitioners

Referral of patients by traditional healers can occur in several ways, depending on the THP's practices, beliefs, and the specific situation of the patient. While THPs primarily focus on traditional healing methods, there are instances where they might refer patients to seek additional or alternative care (Sorsdahl, Stein & Flisher 2013). In this study THPs reported that sometimes they recognise certain cases that fall outside the scope of their expertise or healing methods. If they encounter conditions, they feel unable to effectively treat or diagnose, they might refer the patient to seek care from other THPs that they work with or from healthcare providers such as nurses and doctors in clinics or hospitals. In other words, there are situations where THPs must acknowledge the need for complementary or additional care, they might then refer

patients to modern medical practitioners (Mutale, Matenga, Wagner, Clemens & Audet 2021). This collaboration between traditional and modern healthcare systems allows for a more comprehensive approach to patient care.

THPs reported negative encounters with nurses and doctors in the health facilities when they refer or accompany patients. It was reported that nurses do not recognise THPs as colleagues and are often unwilling to collaborate with THPs. Moshabela and Zuma (2016) also reported negative encounters and attitude by biomedical practitioners towards THPs. It is vital to highlight that the referral practices of THPs can vary significantly based on individual beliefs, cultural context, and the THP's level of interaction or acceptance within the broader healthcare system (Mutale et al. 2021). Collaboration and communication between THPs and modern healthcare providers can contribute to better healthcare outcomes for patients by ensuring they receive comprehensive and appropriate care.

5.2.4.2. Subtheme 4.2: Supplementary roles of THPs

Traditional health practitioners often play supplementary roles in the communities, offering additional support and services that also complement modern medicine (Gietaneh et al. 2023). These supplementary roles vary based on cultural contexts, community needs, and the specific expertise of the THPs. Supplementary roles refer to all the skills that THPs learn over a period of practice, but not necessarily learnt during their training. Such skills include counselling of patients, exorcism as well as plant harvesting.

5.2.4.2.1. Category 4: Counselling of patients

During times of crisis, THPs offer emotional support and counselling to individuals, families, and communities. They provide comfort, guidance, and rituals that aid in coping with grief, trauma, or challenging life events (Nortje et al. 2016). As reported by THPs in this study, THPs offer cultural and spiritual guidance to individuals seeking support beyond physical healing. They may provide counselling, spiritual advice, and guidance related to life events, mental well-being, or spiritual matters (Bomoyi & Mkhize 2017). In remote or underserved areas where modern healthcare may be limited, THPs often serve as primary healthcare providers, offering accessible and affordable healthcare options to communities with limited access to formal medical

facilities. In addition to performing rituals, THPs may offer counselling, guidance, and emotional support to individuals affected by spiritual afflictions. They may help individuals understand the nature of their experiences and provide reassurance or advice on avoiding future spiritual disturbances (Edwards 2014). The supplementary role of counselling highlights the value of THPs in addressing various aspects of health and well-being within their communities. The contribution of THPs in this regard demonstrate that they can contribute significantly to holistic and culturally sensitive healthcare provision.

5.2.4.2.2. Category 5: Exorcism (casting out evil spirits)

Findings in this study indicate that THPs are faced with situations where they deal with patients who are spiritually afflicted. It is important to note that beliefs and practices related to exorcism or spiritual cleansing vary widely across cultures and religions (Ozioma & Okaka 2019). According to THPs in this study, spiritual affliction, being possessed by evil spirits and witchcraft are examples of health problems that requires them to exercise the practice of exorcism. Traditional health practitioners who engage in these practices operate within the frameworks of their cultural and spiritual beliefs (Shoko 2007). However, these practices are not universally accepted or recognised in all societies, and their effectiveness may vary based on individual beliefs and perspectives (Chanda 2021). Nevertheless, the role of ancestors in guiding the THP and casting out the spells was emphasised in this study. However, competent THP must be proficient in performing healing rituals, ceremonies, and spiritual practices specific to their cultural traditions. These rituals are believed to have healing properties and are used to restore balance and harmony (Ozioma & Okaka 2019).

To perform the role of exorcism, THPs must often possess the knowledge and skills to identify signs of spiritual afflictions or possessions. Sometimes they use their intuitive abilities, rituals, divination methods, or consultations with spirits or ancestors to diagnose the presence of evil spirits or negative energies affecting an individual (Chaitanya, Baye, Ali & Usamo 2021). These rituals can involve chanting, prayers, the use of sacred objects, herbs, or symbolic gestures to cleanse the individual or their environment (Harries 2019). In this study, THPs reported that they use herbs *(muthi),* salt and others slaughter animals to cast out the malevolent spirits. Often THPs offer spiritual healing and protection methods believed to shield individuals from further

spiritual harm or possession. They may provide amulets, talismans, or prescribe specific rituals for ongoing protection against negative energies (Rashed 2020). These demonstrates that THPs perform various roles simultaneously, confirming the holistic nature of healthcare they provide.

5.2.4.2.3. Category 6: Plant harvesting

Plant harvesting is one the supplementary roles that THPs play, which they may or may not have learnt during their initiation. Traditional health practitioners possess extensive knowledge about medicinal plants, including their identification, properties, uses, and preparation methods (Semenya & Potgieter 2014). This knowledge is often passed down through generations or learned through apprenticeships and firsthand experience. Traditional health practitioners often engage in plant harvesting as part of their practice, as medicinal plants play a crucial role in traditional healing process. They collect various parts of plants, such as leaves, roots, barks, flowers, or fruits, which are believed to possess medicinal properties. It was reported by THPs in this study that extensive skill is required to identify and harvest various parts of plants because of their similarities. Additionally, the practice of plant harvesting by THPs is deeply rooted in cultural traditions, knowledge, and respect for nature (Mbongwa, Twine & Williams 2021). It appears that some THPs believe in the sacredness of specific locations or sites where medicinal plants grow. They approach plant harvesting with respect, performing rituals or ceremonies to honour the plants and the spirits associated with them (Magoro 2008). The role of ancestors in this regard is also valuable as reported by THPs in this study.

In summary, these competencies demonstrate the diverse skill set and deep knowledge that THPs possess, allowing them to provide care and support within their communities using traditional healing methods. The competencies of THPs are vital as they form the foundation of their practice and contribute significantly to the health and well-being of their communities. Overall, the competencies of THPs are valuable assets that contribute to the holistic well-being of communities, preserving cultural heritage, and providing accessible and culturally relevant healthcare options. When recognised, respected, and integrated appropriately, these competencies can complement and enhance modern healthcare systems.

5.2.5. Theme 5: Views of Traditional Health Practitioners on the training of nurses on ATHKPs

In relation to this theme, some THPs were enthusiastic about the prospect of nurses learning about ATHKPs. Findings indicate that THPs believe that when nurses are taught about ATHKPs it will foster collaboration and broaden their understanding on the roles played by THPs in the communities. Training nurses on ATHKPs involves providing them with knowledge, skills, and understanding of traditional healing practices, herbal remedies, cultural beliefs, and alternative healthcare methods that are part of the traditional medicine systems in the specific communities (Lawrence, Bollinger, Stewart & Moshabela 2021).

According to THPs in this study, nurses need training to understand and respect diverse cultural beliefs, practices, and healing systems. This includes learning about the cultural contexts in which ATHKPs operates and the significance of traditional healing practices within those communities. In turn, nurses will be culturally competent and sensitive to the needs of their patients. Furthermore, training of nurses on ATHKPs must include education on various traditional healing methods, such as herbal medicine, spiritual healing, rituals, and alternative therapies used in diverse cultures (Günaydin & Özpulat 2018). This knowledge may help nurses appreciate the value of these practices and their potential role in patient care.

As reported by THPs, nurses can also receive training on the identification, properties, preparation, and administration of medicinal plants and herbal remedies used in traditional medicine (Gyasi et al. 2018). This training may involve learning about the efficacy, dosage, and potential interactions of these remedies. As part of learning about ATHKPs, nurses will learn about ways to integrate traditional healing practices into patient care plans, promoting a more comprehensive approach to healthcare delivery. Nurses will recognise situations where collaboration or referral to THPs might benefit patients, ensuring a more comprehensive approach to healthcare (Lawrence et al. 2021). Therefore, training nurses on ATHKPs enables them to provide more culturally competent and inclusive care, respecting patients' cultural beliefs and preferences while integrating traditional healing methods sensibly into modern healthcare practices.

5.3. Summary

This chapter discussed the findings concerning the views of THPs on ATHKPs as well as their roles in the provision of healthcare in the South African health system. It is evident that THPs play important roles in the communities. Although it appears ATHKPs is not well understood by communities and other health care providers. In-depth information and knowledge were gained in this phase of the study regarding the features of ATHKPs and its elements of practice. The results of this phase of the study were used to develop a self-administered questionnaire in Phase 2, which was completed by nurse educators in the NEIs. In Phase 2, Chapter 6 will present findings from the quantitative non-experimental design.

CHAPTER 6

PRESENTATION OF QUANTITATIVE PHASE 2 RESULTS

6.1. Introduction

In Chapter 5, the findings from Phase 1 of the study, including themes and subthemes that emanated from the semi-structured interviews, were presented, and discussed in detail. This chapter will present the results from the quantitative Phase 2, including the research design and methods.

6.2. Summary of research design

Quantitative, cross sectional, non-experimental descriptive design was used in this phase of the study to identify the level of teaching ATHKPs and determine the content of ATHKPs that is being taught in nursing curricular for the R425, R171 and R174 nursing programme at public NEIs.

6.2.1. Data collection and analysis

Data in this phase were collected through self-administered questionnaires which were distributed to nurse educators who teach undergraduate nursing programmes in the NEIs. The NEIs included nursing colleges, Universities, and universities of technology.

The objectives of this phase of the study were:

- Identify the level of teaching for ATHKPs in nursing programmes in public NEIs.
- Determine the contents of ATHKPs taught in the nursing curriculum in public NEIs.
- Assess methods of teaching and assessment of ATHKPs in public NEIs.

6.2.2. Brief description of the data collection methods

The questionnaires were distributed to all the NEIs as hard copies, via email and Qualtrics software for nurse educators to complete. A total of 408 questionnaires/responses were returned and captured in Table 6.1 below. The distribution occurred from February 2022–June 2022 to obtain the responses of the respondents on the questionnaire.

Table 6.1: Total number of questionnaires completed

Method of response	Number completed	Frequency%
Hard copies	316	77,46%
Email	24	5,88%
Qualtrics	68	16,66
Total	408	100%

6.2.3. The research questionnaire/data collection tool

The structure of the questionnaire ensured that the objectives of the study are achieved, and this will be presented in terms of the four sections below. The questionnaire was developed by the researcher from the findings of Phase 1, with the assistance of the statistician and research supervisors as described in Chapter 3.

6.2.3.1. Section A: Demographic data of respondents

Demographic profile of the respondents included six items (1–6), namely, institution type, age, gender, discipline of nursing taught, programme offered at the NEI and years of experience as nurse educators.

6.2.3.2. Section B: Structure of the module/s for teaching ATHKPs

This section includes five items (7–11), to assess the level of teaching for ATHKPs in the respective nursing college, university, or University of technology nursing department.

6.2.3.3. Section C: Content of ATHKPs taught in the module/s

This section had a total of eight sub-sections (12–19), to evaluate the content of ATHKPs taught in the modules the educators teach.

6.2.3.4. Section D: Methods of teaching and assessment of ATHKPs in the module.

This section consisted of five items (20–24), with both closed and open-ended questions to assess the method of teaching and assessment of ATHKPs in the module/s.

6.3. Realibity of the data collection tool

The Cronbach's alpha coefficient was used to determine the internal consistency of the questionnaire. The tool yielded overall internal consistency and reliability of 0,9589 which was graded as a marvellous level. Additionally, scale of reliability for the sections were determined and confirmed further reliability of the data collection tool. The interpretation of the Cronbach's alpha (marvellous) is based on Kaiser's classification (1974). The interpretation of each section in terms of reliability is summarised in Table 6.2 below.

Table 6.2: Summary table showing the adequacy of the tool by the level of reliability for each section

Items	Description	No of Items	Reliability Coefficient	Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy (Kaiser 1974)
A1 - A7	Demographics	6	0,8138	Meritorious
B7 - B11	Assess the structure of the module/s for teaching ATHKPs	5	0,7082	Middling
C12a - C13e	Evaluating content of ATHKPs taught in the module/s	12	0,9207	Marvellous
C14a - C14g	Training and regulation of THPs	7	0,8136	Meritorious
C15a - C15j	Roles of THPs	10	0,9412	Marvellous
C16a - C185	Categories OF THPs and Teaching of CAM	13	0,9179	Marvellous
Overall	All Items		0,9589	Marvellous

6.4. Presentation of findings

The presentation of findings will be in line with the structure of the questionnaire as follows; demographic profile of the respondents (Section A), the structure of modules for teaching ATHKPs (Section B), content of ATHKPs taught in ATHKPs (Section C), methods of teaching and assessing ATHKPs (Section D).

6.4.1. Section A: Demographic data

The demographic data of respondents will be discussed in terms of the institution type, age, gender, discipline of nursing, program offered and years of experience.

6.4.1.1. Institution type

In this study the respondents were from nursing colleges, universities, and universities of technology. Of the 408 responses that were received, 86% (n=353) were from the nursing colleges. Respondents from the universities constituted 11% (n=43), whereas respondents from the universities of technology added to 3% (n=12). **Error! Reference source not found.** below illustrate the distribution of respondents.

Figure 6.1: Pie Chart showing respondents' institution type

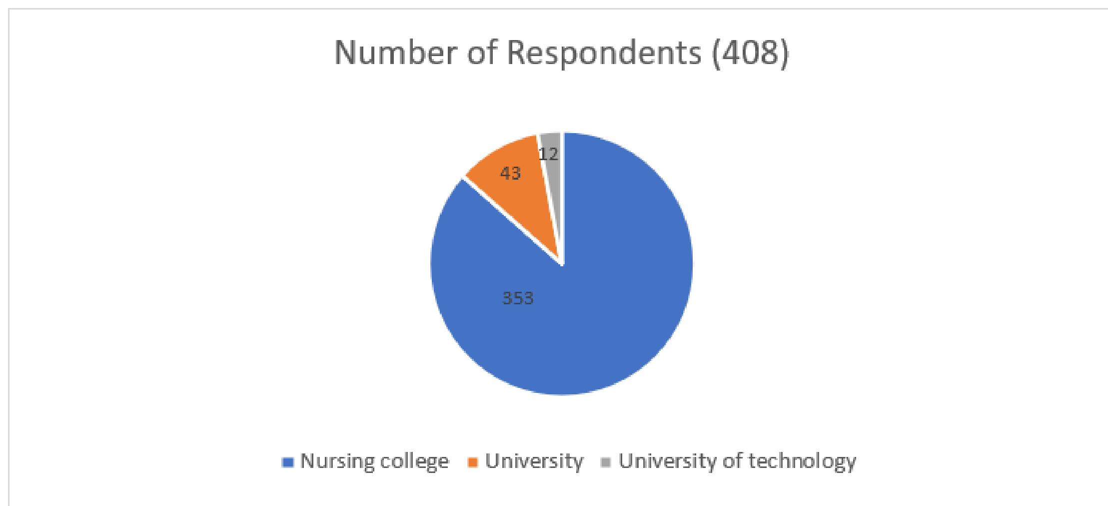


Figure 6.1

6.4.1.2. Age and gender distribution of respondents

The ages were grouped into five categories: 18–24, 25–34, 35–44, 45–54, and >55. Results are presented in **Error! Reference source not found.** below.

Figure 6.2: The number of participants in each age category

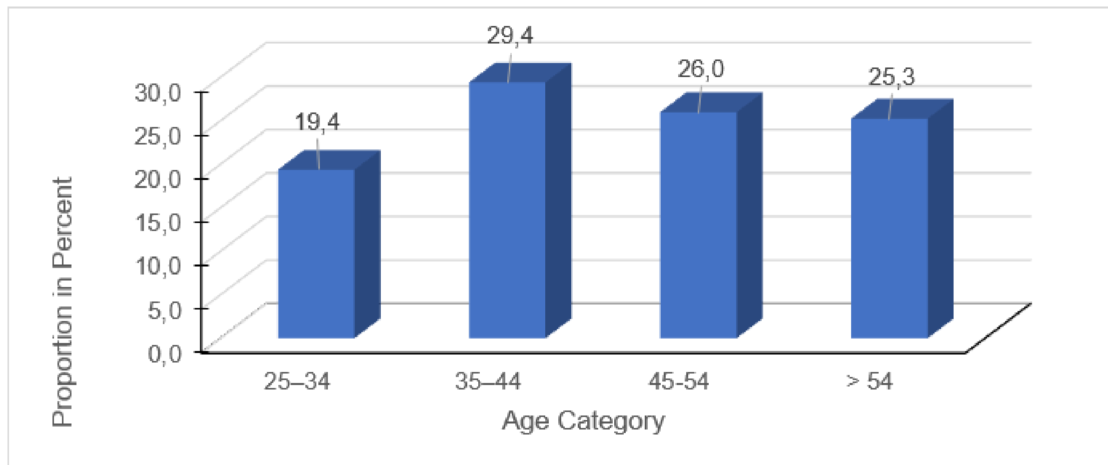


Figure 6.2

In this study, most nurse educators 93,87% (n=382.98) were females, while the males constituted a minority of 6,13%, (n=25).

6.4.1.3. Discipline of nursing and programme offered

Most of the respondents are teaching general nursing (n=170, 41,67%), followed by mental health (n=96 23,04%). Midwifery had the least number of respondents (n=61 14,95%). General Nursing Science as a discipline, forms the core of all nursing programmes and constitutes the majority credits of most nursing programmes. The General Nursing Science discipline is offered throughout training from the first year of study until students exit the programme. Therefore, it would be expected that this discipline constitutes majority of staff members and ultimately respondents in any NEI. Figure 6.3 below shows the distribution of respondents per discipline of nursing taught.

Figure 6.3: Pie Chart showing number of respondents by discipline

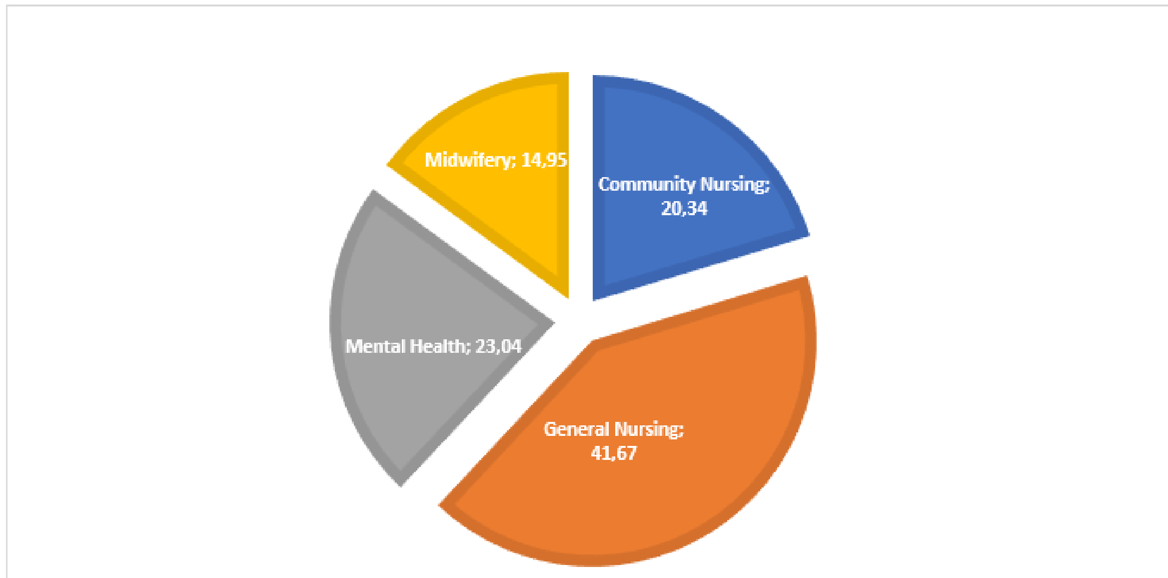


Figure 6.3

Further, the disciplines were regrouped into two namely, General Nursing versus Others, where some assessment of association in their responses was done. The difference between the two groups was not statistically significant ($p<0.05$). This therefore implies that level of study of ATHKPs is effectively non-affected.

6.4.1.3.1. Nursing programmes offered at the NEI

On the other hand, respondents were required to indicate the nursing programmes that are offered in their NEIs. Five options were given to participants and results indicated a repetitive pattern, where respondents from the nursing college selected Option 1 (Diploma in Nursing (general, community & Psychiatry) and Midwifery – R425) and option 5 (Diploma in General Nursing- R171). Similarly, respondents from the Universities selected Option 2 and 3 respectively (Bachelor's Degree in Nursing Science - R425 & Bachelor of Nursing (R174) leading to registration as a Professional Nurse and Midwife). Respondents from the universities of technology selected Option 3 (Bachelor of Nursing (R174) leading to registration as a Professional Nurse and Midwife) and Option 4 Bachelor of Technology - R425).

6.4.1.4. Years of experience

Most participants (47,30%, n=197) were in the 6–10 years, followed by the 2–5 years, with 25,98% (n=106). Few respondents (11,76%, n=48) had experience of more than 15 years. A summary of the results is presented in Figure 6.4 below.

Figure 6.4: Funnel chart of respondents by years of experience

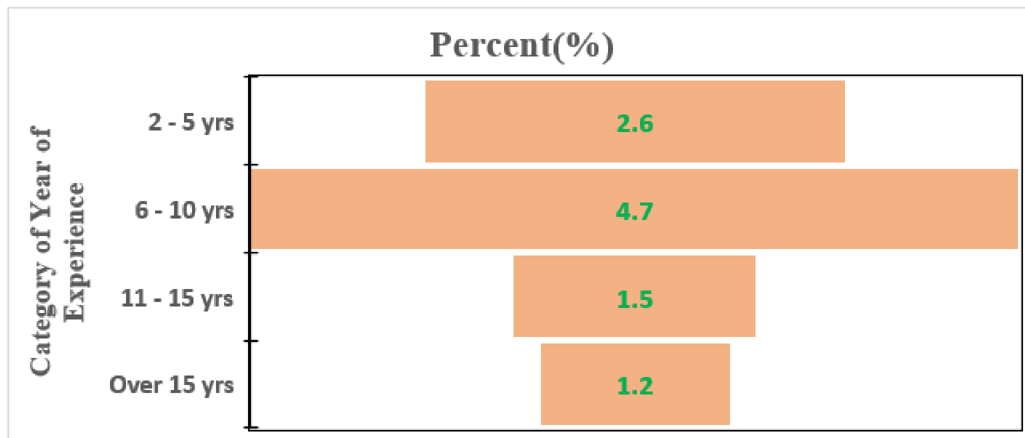


Figure 6.4

Having said that, it is important to note that most senior nurse educators may not have qualified for inclusion in the study as they teach mostly postgraduate programmes. Therefore, younger less experienced nurse educators would have been the predominant age group and subsequently this may have influenced the results. The experience of nurse educators is significant as it may be a determinant of whether they are receptive to inclusion of ATHKPs in their teaching practices or not.

6.4.2. Section B: Structure of modules for teaching ATHKPs

The purpose of this section was to assess the level at which ATHKPs is being taught by respondents at the NEIs in the disciplines they teach. The results showed that 288 (70,59%) participants indicated that the discipline in which the module is taught does not cover ATHKPs. However, 62,8% (n=256) confirmed that there are clear objectives outlining how the module is taught. Furthermore, 64,7% (n=264) confirmed that there are clear objectives on how the module is assessed. This may mean that teaching ATHKPs remains unstructured, or nurse educators do not necessarily know what

needs to be taught and how it should be taught. Table 6.3 below highlights the responses on the structure of modules being taught on ATHKPs.

Table 6.3: Responses on structure of module being taught

The following content is included in the module/s:			
Item	**Yes**	**No**	**Not Sure**
Does the discipline in which you teach have a module that covers ATHKPs?	80(19,6)	288(70,6)	40(9,8)
There are clear objectives outlining how the module is taught	256(62,8)	49(12,0)	103(25,3)
There are clear objectives on how the module is assessed	264(64,7)	49(12,0)	95(23,3)

6.4.2.1. Level of teaching for ATHKPs in NEIs

About 56,6% (n=231), which is most of the respondents, indicated that ATHKPs is not taught at any level of the nursing programme in their disciplines. However, about 20,1% (n=82) indicated that ATHKPs is taught at Level 3 of their programme, 10,7% (n=44) at Level 4, 8,8% (n=36) at level. Cumulatively, 43,38% of respondents indicated that ATHKPs is taught. See Figure 6.5 below.

Figure 6.5: Level of teaching for ATHKPs

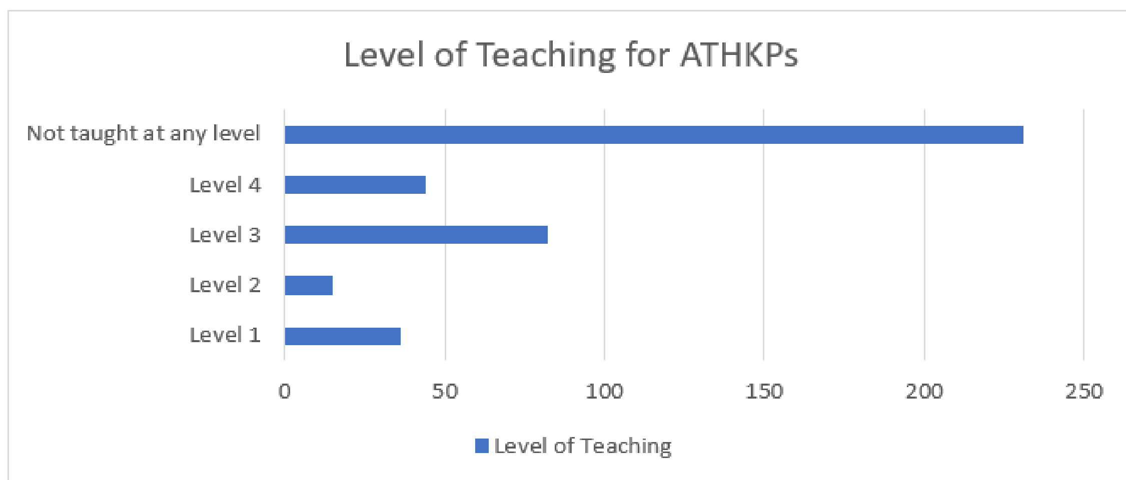


Figure 6.5

6.4.3. Section C: Content of ATHKPs taught in the module/s

The purpose of this section is to evaluate the content of ATHKPs taught in the module in your institution. The items in this section where developed and organised, based on the themes and ideas that emanated in Phase 1 of the study. Respondents were required to choose the response that best describes the content included in module/s for teaching ATHKPs in the discipline they teach. The items were classified under the categories of overview of ATHKPs, values and beliefs about ATHKPs, training and regulation of THPs, roles of THPs, categories of THPs as well as teaching of CAM.

6.4.3.1. Overview of ATHKPs

Respondents were required to indicate which items was included as content in their teaching ATHKPs on overview of ATHKPs. Overview in this context, refers to general knowledge underpinning ATHKPs such as its history, philosophies, and principles. See Table 6.4 below.

Table 6.4: Responses on teaching ATHKPs

The following content is included in the module/s:					
NO	**Item**	**Disagree n (%)**	**Agree n (%)**	**Not sure n (%)**	**No Response n (%)**
12.a	The origin and history of ATHKPs	271(66,4)	85(20,8)	51(12,5)	1(0,3)
12.b	African philosophies such as Ubuntu	257(63,0)	102(25,0)	49(12,0)	0(0,0)
12.c	The evolution of traditional medicine	222(56,1)	152(37,3)	27(6,2)	0(0,0)
12.d	Definition of health from a traditional healing perspective	314(77,0)	67(16,4)	27(6,6)	0(0,0)
12.e	Approaches to illness in traditional healing (physical, psychological, and spiritual)	300(73,5)	82(20,1)	26(6,4)	0(0,0)
12.f	The use of language in identifying and naming things, objects, or people in ATHKPs	293(71,8)	98(24,0)	17(4,2)	0(0,0)

12.g	Diagnostic methods used in traditional healing	201(49,3)	110(27,0)	97(23,7)	0(0,0)

With respect to the general overview, it is clear from the responses above that the participants disagree that most of the content is included in the modules. From above, the percentage of those who agreed was highest for the question 12.c, the evolution of traditional medicine (37,3%, n=152) and lowest for the question (12.d) definition of health from a traditional healing perspective (16,4%, n=67). In other words, the general response is poor. Overall agreement score on this scale is 35%. This means that there is minimal teaching ATHKPs regarding overview as depicted in the table above.

6.4.3.2. Teaching of values and beliefs about ATHKPS

On the scale for values, the responses also show high level of disagreement. It is to be noted that the level of uncertainty (Not Sure) is high in questions 13.a and 13.d, scoring 22,6% (n =92) and 32,4% (n=132) respectively. Interestingly, question 13.c on signs of ancestral calling scored highest in terms of disagreement with its teaching. The cumulative score on this scale with respect to agreement is 16,4%. See Table 6.5 below.

Table 6.5: Responses on teaching about values and belief on ATHKPs

The following contents are included in the module/s:					
NO	**Item**	**Disagree n (%)**	**Agree n (%)**	**Not sure n (%)**	**No Response n (%)**
13.a	The values, beliefs and principles underlying ATHKPs	264(6,7)	52(12,8)	92(22,6)	0(0,0)
13.b	The role of spirituality in traditional healing	279(6,4)	92(22,6)	37(9,0)	0(0,0)
13.c	Signs of ancestral calling	379(92,9)	3(0,7)	26(6,4)	0(0,0)
13.d	Various types of African foods	235(57,6)	41(10,0)	132(32,4)	0(0,0)
13.e	Stereotypes about ATHKPs	305(74,8)	42(10,3)	61(15,0)	0(0,0)

6.4.3.3. Training and regulation of THPs

With respect to training and regulation of THPs, the results indicate that there is still a high disagreement with all the statements, with most respondents indicating that not much is taught regarding the training and regulation of THPs. However there seems to be some level of agreement regarding item 14.g, Similarities between ATHKPs and other health systems such as Western medicine, where an improved 27% (n=110) responses agreeing with the statement was captured. On the item 14.a. on laws, regulations and policies governing traditional medicine, 23% (n=94) of the respondents recorded that they are not sure. This may be indicative of the unstructured nature of teaching ATHKPs, where the outcomes are not possibly aligned to ATHKPs. The cumulative score on this scale with respect to agreement is 11,8%. See Table 6.6 below.

Table 6.6: Responses on training and regulation of THPs

The following contents are included in the module/s:					
NO	**Item**	**Disagree n (%)**	**Agree n (%)**	**Not sure n (%)**	**No Response n (%)**
14.a	Laws, regulations, and policies governing traditional medicine	290(71,1)	24(5,9)	94(23,0)	0(0,0)
14.b	Training of THPs to become competent practitioners	378(92,7)	3(0,7)	27(6,6)	0(0,0)
14.c	Accountability of THPs in traditional healing	358(87,8)	34(8,3)	16(3,9)	0(0,0)
14.d	Regulation and governance of THPs	325(79,7)	15(3,7)	68(16,7)	0(0,0)
14.e	Implementation of Traditional Health Practitioner's Act 22 of 2007	316(77,5)	31(7,6)	61(15,0)	0(0,0)
14.f:	Recognition of THPs	333(81,6)	14(3,4)	61(15,0)	0(0,0)
14.g	Similarities between ATHKPs and other health	201(49,3)	110(27,0)	97(23,7)	0(0,0)

	systems such as Western medicine				

6.4.3.4. Roles of THPs

The results in this section still indicate a high-level disagreement with the all the statements. For example, most of the participants, 91,9% (n=375) disagreed with item 15.j on exorcism (casting out evil spirits in possessed patients), indicating that it is possibly regarded as an irrelevant issue to be taught to nurses. Further, 24,3% (n=99) of the respondents agreed with item 15.a physical assessment of patients. The cumulative score on the scale of assessment regarding agreement is 14,1%. See Table 6.7 below.

Table 6.7: Responses on roles of THPs

The following contents are included in the module/s:					
NO	**Item**	**Disagree n (%)**	**Agree n (%)**	**Not sure n (%)**	**No Response n (%)**
15.a	Physical assessment of patients	269(65,9)	99(24,3)	40(9,8)	0(0,0)
15.b	Spiritual assessment and alignment	316(77,5)	65(15,9)	27(6,6)	0(0,0)
15.c	History taking and discussions	293(71,8)	88(21,6)	27(6,6)	0(0,0)
15.d	Diagnosis of patients	347(85,0)	19(4,7)	42(10,3)	0(0,0)
15.e	Harvesting herbs and medicinal plants	365(89,5)	1(0,3)	42(10,3)	0(0,0)
15.f	Technique of measuring quantity of medicines	348(85,3)	18(4,4)	42(10,3)	0(0,0)
15.g	Writing of referral letters by THPs	359(88,0)	18(4,4)	31(7,6)	0(0,0)
15.h	Collaboration between nurses and THPs	365(89,5)	12(2,9)	31(7,6)	0(0,0)
15.i	Counselling of patients	319(78,2)	73(17,9)	16(3,9)	0(0,0)

15.j	Exorcism (casting out evil spirits in possessed patient)	375(91,9)	2(0,5)	31(7,6)	0(0,0)

6.4.3.5. Categories of THPs

Considering the assertion on the categories included in teaching, it is clear from the responses that the greater proportion of the participants disagree with teaching about categories of THPs. Respondents (24,8%, n=101) agreed that they teach about the THP category of *Sangoma,* 20,8%(n=85) on Herbalist, 20,3% (83) on Diviner, 9,1% (n=37) on category of traditional surgeon, and 4,9% (n=20) on Traditional birth attendant. Therefore, the cumulative score on this scale is 23% of agreement. See Table 6.8 below.

Table 6.8: Responses on categories of THPs

The following categories of THPs are included in the teaching:					
NO	**Item**	**Disagree** **n (%)**	**Agree** **n (%)**	**Not sure** **n (%)**	**No Response** **n (%)**
16.a	Diviner	293(71,8)	83(20,3)	32(7,8)	0(0,0)
16.b	Herbalist	293(71,8)	85(20,8)	30(7,4)	0(0,0)
16.c	*Sangoma*	276(67,7)	101(24,8)	31(7,6)	0(0,0)
16.d	Traditional surgeon	297(72,8)	37(9,1)	74(18,1)	0(0,0)
16.e	Traditional Birth Attendant	299(73,3)	20(4,9)	89(21,8)	0(0,0)

6.4.3.6. Practical teaching ATHKPs

With respect to the practical teaching ATHKPs, the level of disagreement is also high as can be seen in the responses on each of the statements. About 15,7% of respondents indicated that they were not sure if content on ethics for conducting research and collaborating with THPs was included in the nursing curriculum. The cumulative score on the scale is very poor regarding agreement, scoring (6,9)%. See Table 6.9 below.

Table 6.9: Responses on the practical teaching ATHKPs

The following methods are used to teach practical for ATHKPs:					
NO	Item	Disagree n (%)	Agree n (%)	Not sure n (%)	No Response n (%)
17.a	Physical visits by THPs to the institution to teach nursing students	361(88,5)	22(5,4)	25(6,1)	0(0,0)
17.b	Practical visits by students to traditional health practices	391(95,8)	0(0,0)	17(17)	0(0,0)
17.c	Ethics for conducting research and collaborating with THPs	338(82,8)	6(1,5)	64(15,7)	0(0,0)

6.4.3.7. Teaching of CAM

It is also observed that there is still some high level of disagreement on this category, however the degree of not being sure was high. While the level of disagreement was above 58% for all the items, 32,8% (n=134) of the respondents agreed with item 18.b herbal medicine, natural products, and others. The notable increase in the “not sure” may indicate that some level of teaching on CAM may be taking place as seen in the responses below. The cumulative score on the scale regarding agreement is 19% for including content on teaching CAM. See Table 6.10 below.

Table 6.10: Responses on the teaching of CAM

The following CAM content are taught in the curriculum:					
NO	Item	Disagree n (%)	Agree n (%)	Not sure n (%)	No Response n (%)
18.a	Mind-body medicine (Acupuncture, Meditation, Yoga, Hypnotherapy)	273(66,9)	35(8,6)	100(24,5)	0(0,0)

18.b	Herbal medicine, natural products, others (nutritional supplements or not specified)	243(59,6)	134(32,8)	31(7,6)	0(0,0)
18.c	Manipulative and body-based practices (massage, spinal manipulation, other)	239(58,6)	74(18,1)	95(23,3)	0(0,0)
18.d	Homeopathy and naturopathy, energy field, art therapy, aroma therapy	281(68,9)	22(5,4)	105(25,7)	0(0,0)
18.e	Equilibrium therapy	308(75,5)	1(0,399)	99(24,3)	0(0,0)

6.4.4. Overall scores on each scale of agreement

The overall assessment is that this aspect of curriculum is still at the formative stage. The high level of disagreement demonstrates that there is minimal, if not limited, teaching or integration of content on ATHKPs as depicted in the low level of agreement in Figure 6.6 below.

Figure 6.6: Average agreement for Section C items

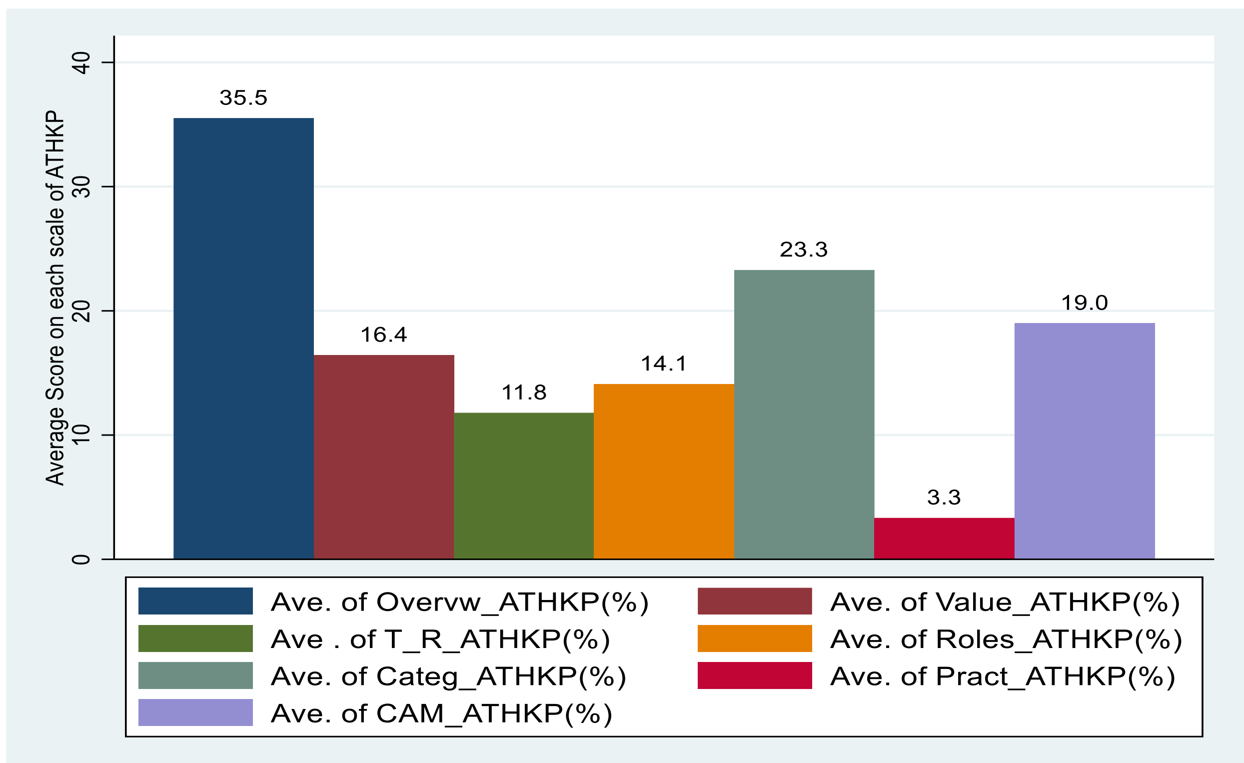


Figure 6.6

6.4.5. Section D: Methods of teaching and assessment of ATHKPs in the module

The purpose of this section was to assess the methods of teaching and assessment for ATHKPs in the nursing module/s. This was done to achieve the third objective of this phase of the study.

6.4.5.1. Short description of course content taught on ATHKPs

Respondents were requested to provide a short description of the course or module content included in their modules with examples of how the approach is used. The responses were categorised according to their similarities and themes. About 54,17% (n=221) of the respondents did not respond to this item. An additional 23,28% (n=95) indicated that there is no course content available for teaching ATHKPs. Of those that responded, beliefs about ATHKPs and the use of herbal medicine seems to be the most prevalent content being taught, scoring 5,00%(n=19) and 3,72% (n=15) respectively. Table 6.11 below illustrates the responses on content being taught on ATHKPs.

Table 6.11: Responses on the description of course content being taught

Course Content on ATHKPS	Frequency	Percent (%)
Ethical issues	5	1,22
Collaboration	12	2,94
Complementary and alternative medicine	8	1,96
None (no content)	95	23,28
Mental health	8	1,96
Roles of THPs	7	1,71
Healing methods	4	0,98
Traditional Midwifery	6	1,47
Use of herbal medicines	15	3,72
Multidisciplinary approaches	2	0,49
Beliefs about ATHKPs	19	5,00
Cultural practices	6	1,47

No response	221	54,17
	408	**100**

6.4.5.2. Approach to teaching ATHKPs in module

The responses to the question "*Which of the following best describes the approach to teaching ATHKPs in your discipline*" showed that respondents may have had little knowledge or understanding of what was required of them. It appears that the theoretical approach to teaching ATHKPs is the predominant approach (17,64%, n=72), followed by projects with a score of 7,4% (n=30). Regarding practical teaching ATHKPs, 99,8% (n=400) responded negatively to this statement, indicating the monolithic and seemingly superficial approach to the module where it is being taught. Table 6.12 below answers Question 20: Which of the following best describes the approach to teaching ATHKPs in your discipline?

Table 6.12: Responses on the description of course content being taught

Item		**Yes n (%)**	**No n (%)**	**Non-Response n (%)**
20.a	Theory only	72(17,64)	335(82,10)	1(0,24)
20.b	Practical only	1(0,24)	407(99,75)	0(0,0)
20.c	Problem based learning	4(0,98)	404(99,01)	0(0,0)
20.d	Projects	30(7,35)	378(92,64)	0(0,0)
20.e	Others	8(1,96)	400(98,03)	0(0,0)

6.4.5.3. Examples of how the approach to teaching ATHKPs is used

Respondents were required to provide examples of the approach used to teach ATHKPs in their disciplines. About 44,36% (n=181) of the respondents did not respond to the item. On the other hand, like the previous item, 34,31% (n=140) of respondents reported that there is no approach to teaching ATHKPs (none). However, for those teaching ATHKPs, the lecture method seems to be the most used approach to teaching ATHKPs (8,03%), followed by projects (5,32%, n=24). See Table 6.13 below for responses.

Table 6.13: Responses on examples of how ATHKPs is taught

Examples of how ATHKPs is taught	Frequency	Percent (%)
Assignments	3	0,73
Classroom group discussions	19	4,65
Lecture presentation	32	8,03
None	140	34,31
Projects	24	5,32
Visits to THPs or CAM	4	0,98
Debates	5	1,22
No response	181	44,36
	408	**100**

6.4.5.4. Assessment tasks used in the course for ATHKPs

The response to the question "21. *Do you have assessment tasks used in your course for ATHKPs?"* showed that there are minimal assessment tasks for assessing ATHKPs. The majority have no assessment task used in their course for ATHKPs. Only 68 (16,66%) answered "Yes" as presented in Figure 6.7 below.

Figure 6.7: Number of respondents on assessment tasks used in course

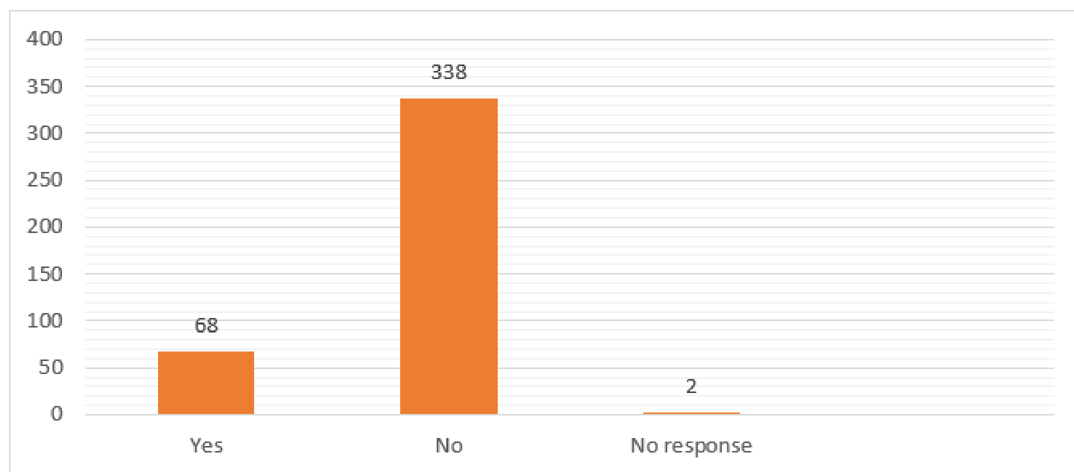


Figure 6.7

6.4.5.5. Examples of assessment tasks used in module/course for ATHKPs

Respondents were further required to respond to the Question 21.1 *"Please indicate, if applicable, the examples of assessment tasks used in your module/course for ATHKPs".* There is a high level of no response, where 35,76% (n=146) of the respondents did not complete the item. On the other hand, 46,8% responded by indicating that there are no assessment tasks used in the module. Tests and examinations seem to be the most used assessment tasks as shown by 11,74% (n=47) of the respondents. In relation to Question 21. above, there seems to be congruency in the scores in relation to the "no response" and "none" responses. See Table 6.14 below.

Table 6.14: Assessment tasks used in the module for teaching ATHKPs

Examples of assessment tasks	Frequency	Percent
Assignment portfolios	14	3,43
Test and examinations	47	11,74
Research Projects	10	2,45
None	191	46,81
No response	146	35,76

6.4.5.6. Importance of teaching nursing students about ATHKPs

The responses to the question 22 *"How important do you think it is to teach nursing students about ATHKPs?"* show that nurse educators are positive about the teaching ATHKPs in nursing curricula. The majority of 249 (61,03%) indicated that it is important to teach ATHKPs while 125 (30,64%) were not sure whether it is important or not. This finding which is summarised in Table 6.15, shows that there is great potential for teaching ATHKPs as reported by nurse educators.

Table 6.15: Responses on importance of teaching ATHKPs in nursing curriculum

Importance of teaching nursing students about ATHKPs	Frequency	Percent
Not important	35	8,53
Not sure	125	30,64
Important	249	61,03
	408	**100**

6.4.5.7. Suggestions on content to be included in curriculum for nurses

The response to the question 23 *"What content do you think should be included in the curriculum for nurses on ATHKPs?"*, showed a similar pattern of poor response to the question. About 69,12% (n=282) of respondents did not respond to this item. However, as a majority response, 9,58% (n=39) respondents indicated that "approaches to disease management in ATHKPs" should be included in the nursing. On the other hand, 8,58% (n=36) of the respondents suggested that content on regulation and training of THPs should be included. Interestingly, 2,74%(n=12) indicated that it is not possible to include content in the nursing curriculum. See Table 6.16 below for details.

Table 6.16: Suggestions on content to be included in nursing curriculum

Suggestions on content to be included in nursing curriculum	Frequency	Percent
Regulation and training of THPs	36	8,58
Collaboration strategies	17	4,16
Referral system	3	0,73
Approaches to disease management in ATHKPs	39	9,58
Effectiveness of medicines and interventions	19	4,65
Not possible to include	12	2,74
No response	282	69,12
	408	**100**

6.4.5.8. Suggestions to assist in development of module on ATHKPs

Respondents were required to provide suggestions that could assist in the development of ATHKPs module. Results on this item indicate a poor response rate where cumulatively, 37,00% (n=151) responded to this item. Training of THPs and nurses scored most of the suggestions, with a score of 13,25% (n=53), followed by defining scope of practice and regulation of THPs with a score of 6,21% (n=25). See Table 6.17 below for other suggestions on development of modules for teaching ATHKPs.

Table 6.17: Suggestions to assist in development of ATHKPs module

Suggestions on the development of module on ATHKPs	Frequency	Percent
Training of THPs and nurse educators	53	13,25
Creation of collaboration platforms	15	3,67
Open communication with THPs	17	4,16
Define scope of practice and regulation of ATHKPs	25	6,12
Support from stakeholders	10	2,45
Database of herbal medicines	17	4,16
Develop guidelines for engagement	14	3,43
No response	257	62,99
	408	**100**

6.5. Summary

This chapter presented results from the quantitative Phase 2 data collected from nurse educators from universities, universities of technology and nursing colleges. The results in this phase of the study paints a bleak picture regarding the current teaching ATHKPs. There seems to be high levels of disagreement or uncertainty among nurse educators in terms of the teaching ATHKPs. The findings also support the assertions by THPs in Phase 1, where it was reported that nurses seem to have negative attitude and lack knowledge on ATHKPs. Some of the comments on content being taught in NEIs included beliefs about ATHKPs. Other comments from respondents included the unscientific ways of doing things in ATHKPs as reasons why it will not work.

Furthermore, it became evident that teaching ATHKPs is mostly limited to theoretical content, which nurse educators may have limited knowledge about. It is not surprising that most of the participants disagreed about their teaching ATHKPs. A promising finding, nevertheless, is that the nurse educators seem to agree that teaching ATHKPs is important, demonstrating the potential for implementation in curriculum. Suggestions were made by respondents regarding the integration of ATHKPs into nursing curricular. The next chapter will discuss the results of Phase 2.

CHAPTER 7

DISCUSSION OF RESULTS FOR QUANTITATIVE PHASE 2

7.1. Introduction

The previous chapter presented results of the quantitative phase which included data from the self-administered questionnaires from nurse educators. This chapter presents the discussions of the results presented in Phase 2 of the study. The results will be discussed in terms of the sections of the questionnaire as presented in Chapter 6.

7.2. Objectives of the phase of the study

This phase of the study aimed to achieve the following objectives:

- Identify the level of teaching for ATHKPs in nursing programmes in the public NEIs.
- To determine the contents of ATHKPs taught in the NEIs.
- To assess methods of teaching and assessment of ATHKPs in public NEIs.

7.3. Discussion of results

The discussions will be presented chronologically according to the findings and the structured questionnaire. The discussion is also guided by the objectives and hypotheses of the research study. In this study the respondents were from nursing colleges, universities, and universities of technology, ensuring that views of nurse educators in different contexts are represented.

7.3.1. Section A: Demographic data

Of the 408 responses that were received, 86% (353) were from the nursing colleges. Respondents from the universities constituted 11% (43), whereas respondents from the universities of technology added to 3% (12). In South Africa, nursing education and training is offered in accredited nursing colleges, universities, and universities of technology. This study has highlighted that most nurse educators are employed in the nursing colleges, which is a public sector-based institution and can be expected. This was also supported by an audit by the National Department of Health (2012) in the

Strategic Plan for Nurse Education, Training and Practice 2012/13 – 2016/17, where it was confirmed that most nurse training in South Africa takes place within the public college sphere (National Department of Health 2012). Evidently, most of the nurse education and training is offered at nursing colleges. According to Zwane & Mtshali (2019), an estimated 80% of the nurses in training in South Africa are from the colleges. Therefore, this study supports evidence in existing literature about the number of nurse educators working in the public colleges exceeding that of universities and universities of technology. This means that the results of the study may be representative of the general population of nurse educators.

7.3.1.1. Age and gender of respondents

The results indicate that most of the respondents fall within the age group of 35–44 (29,4%), followed closely by age group 45–54 (26,2%). There were about 103 (25,9%) responses from the >54 age group. The SANC reported as at 2020/12/31, that there were about 27% registered nurses on the database (SANC Age Statistics 2020). The 25–34 age group constitutes the lowest number of respondents (19,3%). Statistics on the nursing workforce in South Africa demonstrate an ageing workforce, with experienced nurses retiring from the service, thereby leaving a gap in the number of nurses currently on the SANC database as reported in the current National Strategic Plan for Nursing Education and Practice 2020/21-2025/26 (National Department of Health 2020).

This demographic variable of age in the nursing profession can be transferred to nursing education, where a reported number of educators are of advanced age and are steadily leaving the profession for various reasons, including advanced age. Similar findings are reported in a scoping review of the nursing faculty shortage in Canada. According to the results of an audit done in nursing education institutions, the average age of nurse educators is high, where 77% of the nurse educator population is over the age of 40 (National Department of Health 2020). The result of this study in terms of age distribution of nurse educators, is like the age distribution of the professional nurses on the SANC database (SANC Age Statistics 2020). Conversely, when assessing the years of experience for respondents, most participants (47,3%), had years of experience ranging between the 6–10, followed by the 2–5 (25,9%). This comes as a notable finding, because it would be expected, in

line with SANC statistics on age of professional nurses, that majority respondents should be having above 15 years of experience. Having said that, this current study did not undertake to make relationships between years of experience and responses of nurse educators.

In terms of gender, the results indicate that females dominated the responses. Most nurse educators who responded were females (93,8%), while the males constituted a minority of 6,1%. It is common course that the nursing profession is a female dominated profession as witnessed by the SANC register database (SANC 2022) and therefore confirms the results of this study on gender distribution. Accordingly, most nurse educators are females, despite reported increase in males joining the nursing profession and nursing education fraternity. Globally, men are underrepresented in the nursing profession and faculty (Palmer 2019) notwithstanding their contribution to nursing as a profession (Barrett-Landau & Henle 2014). Therefore, the gender picture depicted in this current study confirms a global phenomenon of nursing being a female dominated profession. Yet there is paucity of literature regarding gender and affinity to ATHKPs.

7.3.1.2. Nursing disciplines and programmes offered in the public NEIs

The nursing disciplines which are offered in NEIs, in line with SANC regulations include community nursing, general nursing, mental health and midwifery. The findings indicate that most of the respondents are teaching general nursing (41,67%), followed by mental health (23,4%). Midwifery had the least number of respondents (14,95%). In South Africa, the nursing profession is undergoing major transformation with the phasing out of legacy qualifications and phasing in of new Higher Education Qualifications Sub framework (HEQSF) Aligned qualifications (SANC Circular 5/2019). The legacy qualifications in the context of this study are the Diploma in Nursing (General, Community & Psychiatry) and Midwifery, Bachelor's Degree in Nursing Science, and the Bachelor of Technology. The above qualifications are offered in terms of the SANC regulation, R425, which qualifies the candidates as a nurse and midwife.

On the other hand, the new qualifications being offered are aligned to regulations R171 and R174, leading to registration as a general nurse and professional nurse &

Midwife offered both at nursing colleges and universities respectively. The results therefore represent the content of ATHKPs for both the legacy (R425) and the new qualifications (R171 & R174). The above result on the offering of the new programmes requires further probing, especially in line with the programme outcomes of the new programmes, as they were designed to be community and primary care focused where THPs are subtly involved in provision of health services and ATHKPs is widely practiced. It must therefore be determined separately if there is any relationship between programme offered and teaching ATHKPs. The offering of the new nursing programmes was triggered by recommendations to locate nursing programmes within higher education fraternity in The National Strategic Plan for Nursing Education and Training- 2012/13-16/17(National Department of Health 2012). Therefore, the curricula offered in these NEIs, and programmes must prepare the nurse and or midwife to offer comprehensive nursing services that consider the physical, psychological, and spiritual needs of patients. As such, it would be uncommon to find the inclusion of alternative medicine, such as ATHKPs, in the curricula for both legacy and new qualifications.

7.3.2. Section B: The structure of modules for teaching ATHKPs

In line with the objectives of the study, this section assessed the structure of modules wherein ATHKPs is being taught. Results pointed to a high level of disagreement, where most of the respondents (70,5%) indicated that there is no module in their area of specialisation (discipline) within the curriculum. However, 62,8% and 64,7% of the respondents indicated that there are objectives outlining the teaching and assessment of the module respectively. Similar findings were reported by the Dar Al Uloom University in Saudi Arabia, where a survey was conducted to assess any teaching of traditional and complimentary medicine. The results were that there is no teaching of any alternative medicine in the curriculum (El Olemy 2012).

Subsequently, a study was undertaken to develop an undergraduate module for complimentary medicine and integrative health at the Dar Al Uloom university (El Olemy, 2021). This module was taught in the fourth year of study. Lawrence, Bollinger, Stewart and Moshabela (2021) reported that the teaching of traditional medicine remains largely part of a hidden curriculum, where students learn by observing interactions between practitioners and patients without any form of outcomes or

assessment related to the experiences. Clearly, teaching any content requires a structural approach with clear outcomes and methods of delivery. Without the outcomes or modular structure, the teaching becomes haphazard and does not meet the requirements in terms of knowledge and skills that must be acquired.

Any formal teaching requires structure in terms of outcomes to ensure that the intended knowledge, skills, and attitude are achieved. Having said that, in South Africa, there is limited information on the structure or module for teaching ATHKPs. Additionally, there are no clear guidelines from the SANC regarding the elements of traditional medicine that should be integrated into the curriculum for nurses at undergraduate programmes. During accreditation of programmes, NEIs are given the prerogative to develop curricula in line with the competencies provided by SANC. Based on the graduate attributes envisaged by the NEI, the inclusion of ATHKPs may receive priority or not. For example, most universities in the rural landscape of the country, based on population demographics, may prefer a structured approach to teaching ATHKPs as their students are likely to serve in areas where the use of traditional medicine is rife (Kpelao, Teclessou, Ntimon, Pegbessou, Salifou, Adjita & Moumouni 2018). A report by Chitindingu et al. (2014), on their study exploring the integration of traditional, complimentary, and alternative medicine (TCAM) into medical curriculum, stated that there is limited structure for integrating TCAM in curriculum. Therefore, results of this study reflect the current situation in nursing education institutions regarding the teaching ATHKPs, that it remains unstructured and minimally taught where it is included in curriculum.

7.3.2.1. Level of teaching for ATHKPs

Regarding the level of teaching in the nursing curriculum, results in this study indicate that indeed ATHKPs is taught to some extent, although about 56,6% indicated that it is not taught at any level. Conversely, about 43,3% indicated that ATHKPs is taught at some level of study in their discipline of nursing. From the responses above on whether there is a module for teaching ATHKPs, results indicated that 70,5% of respondents disagreed. However, in responding to the item on level of study for teaching ATHKPs, there is an increment of around 14%. This increase may mean that maybe there is no module for teaching, but content is included in the discipline, or that the respondents are aware of the teaching ATHKPs in other disciplines or level of

study in their institution. A study by Chitindingu et al. (2014) reported that there is teaching of TCAM in medical schools at undergraduate level, although the study did not mention the levels of teaching. In China though, traditional medicine is taught in the second year of study to students enrolled for conventional medicine (Qu, Zhang, Dai, He, Wu, Zhang, Zhu, Gu, Wang & Xu 2021). The level of study in this instance is important as it determines the level of teaching, complexity of content and teaching approaches for ATHKPs.

7.3.3. Section C: Content of ATHKPs taught in the module/s

Furthermore, in the questionnaire, respondents were required to choose the response that best describes the content included in module/s for teaching ATHKPs in the discipline they teach. The items for content of modules taught was derived from the themes that emanated in Phase 1, where THPs were interviewed to explore the knowledge, skills and values underpinning ATHKPs. The ideas were then clustered according to similarity. As such, this section will be discussed in terms of the categories and not as individual items.

7.3.3.1. Overview of ATHKPs

Overview of ATHKPs included content covering history, philosophies, principles, and practices for healing and managing diseases from an African perspective. The category of overview of ATHKPs scored an average of 35,5% on agreement with teaching of Overview. This demonstrates that there is some level of teaching on the items included in the category. However, results still indicate a high level of disagreement regarding the teaching of items under this category. Formal teaching in any science discipline includes the teaching on history and origin of the science, its underlying principles, philosophies, and methodologies for validating the science (Wright & Wolinski 2017).

In a study by El Olemy (2012), where a module was designed to teach TCAM, overview of their module included history of TCAM, and principles used in TCAM. Similarly, the nursing curriculum is structured in a way that the basic medical sciences are taught at entry level to lay a foundation for subsequent learning. Within the basic medical sciences, students are taught principles, philosophies and theories underpinning provision of healthcare services (SANC 2013). Evidently the high level

of disagreement regarding the teaching of basic principles and philosophies of ATHKPs result in the unstructured approaches to teaching the content.

In Taiwan, the curriculum for teaching health sciences students about traditional medicine, including nurses, involve content on philosophies (humanism), professional ethics and interpersonal relationships (Chou, Chiu, Lai, Tsai & Tzeng 2012). Similar to an African philosophy of Ubuntu, humanism aims at respecting and acknowledging the value of sharing common goals and helping those in need (Taghinezhad, Mohammadi, Khademi & Kazemnejad 2022). In this study, 25% of respondents agreed that African philosophies including Ubuntu are included in the curriculum in the discipline they teach. Manganyi (2017) recommended the inclusion of Ubuntu as a philosophy that should underpin the training of undergraduate nurses in a study undertaken in Limpopo Province South Africa.

Philosophies are central to teaching as they help students in analysing concepts, definitions and facilitate contextualised problem solving (Barrow & Woods 2006). Additionally, Ngunyulu, Sepeng, Moeta, Gambu, Mulaudzi and Peu (2020), reported the views of nursing students, who supported the application of Ubuntu in designing a decolonised nursing curriculum. Ubuntu philosophy should henceforth, be taught to facilitate and support patient's right to access respectful healthcare as nurses will be sensitised and strive to meet the needs of the patients (Himonga 2013). Therefore, the importance of including African philosophies in contextualising concepts such as health, caring, healing, illness in ATHKPs should form the basis for curriculum design and development.

7.3.3.2. Definition of health and use of language in ATHKPs

Notably, the item of defining health from a traditional healing perspective (12.d) scored the lowest (16,4%) of all the items on overview of health category. This result is concerning equally because common understanding of concepts is important for facilitating collaboration, referrals, and communication between the different systems of healthcare. There should be a common way of using language and defining concepts between Western medicine and as used in ATHKPs (Igboin 2014). The unique language used in ATM to clarify names, illness and processes provides a good basis for communication and knowledge exchange among African people. The value

of language in naming plants or herbs, labelling anatomic structures and making correlations between the body and the environment (Sobiecki 2014). Language also provides a sense of belonging and pride in those using it thereby facilitating access to culturally sensitive care. Using an indigenous language that nurses and patients understand therefore creates a common understanding and is essential in the development and maintenance of the language (Mphasha & Lebese 2017). NEIs should therefore take into consideration the various meanings and connotations attached to concepts, diagnosis, and practices so that nurses are taught to be aware of this as well.

7.3.3.3. Values and beliefs about ATHKPs

Regarding the teaching of values and beliefs about ATHKPs, a high level of disagreement is noted on all items. Although the results indicate the general increment on the scoring for "not sure". A score of 22,6% was recorded for "not sure" on an item of values, beliefs and principles underlying ATHKPs. The results prove that teaching ATHKPs, in most cases, disregards the importance of values and beliefs that underlies the practice of ATHKPs. In ATHKPs, values and beliefs form the basis for practice and influences many aspects of life in this system of health (Idang 2015). The value belief system dictates how a people interprets health problems, the sources of diseases and the health interventions that are required to remedy the challenges (White 2015).

For example, in African culture and religion there is a close relationship between spirituality and illness where it is believed that there are supernatural powers creating diseases and suffering (Siler, Arora, Doyon, & Fischer 2021). For a patient who believes in such supernatural causes of illness, spiritual interventions may take precedence over medical interventions (Kesler, Hopkins, Torres & Arti 2015). Similarly, a patient who believes that their suffering or illness is a result of punishment from the spiritual realm, may refuse treatment for symptoms or illness. If there is a mismatch between the nurses' value belief system and that of the patient in terms of causes, naming and management of diseases, there will likely be conflict resulting in misdiagnosis, mismanagement, and poor compliance from patients. Therefore, teaching nurses on values and beliefs in ATHKPs eliminates possible barriers to nurse-patient relationship thereby facilitating openness and trust. Nurses must be

sensitive to patient's way of life and advocate for its protection as required, which the nursing curriculum should address.

7.3.3.4. Teaching and content on Spirituality

Results indicate that 22,6% of respondents agreed that there is content in their discipline teaching about the role of spirituality in traditional healing. Although there is still a high level of disagreement (68,4%) with this item, it seems to be the highest scoring item under the category of values and beliefs about ATHKPs. Seemingly there is some level of teaching on spirituality in the nursing disciplines. Spirituality forms an important element of healthcare as it contributes directly to wellbeing of individuals and influence how care is provided (Harrad, Cosentino, Keasley & Sulla 2019). This supported by the WHO (2012), where an emphasis on spiritual element to the definition of health was alluded to.

Results of this study regarding the disagreement with teaching of spirituality supports findings by Chandranohan and Bhagwan (2016), who reported that there is poor progress in integrating spirituality in nursing education. However, there seems to be poor clarity between spirituality and religion, which influences how nurses provide nursing care (Linda, Phetlhu & Klopper 2019). Whilst spirituality is all encompassing, different people may belong to different religions. A need to have educational programmes for nurses on spirituality and its role in provision of holistic care has been reported (Wu, Tseng & Liao 2016). Having such a programme will improve the competence of nurses on spirituality and facilitate their learning from traditional health perspective.

7.3.3.5. African food and nutrition

Further the findings indicate that 32,4% of the nurse educators agreed that they teach students in their discipline about types of traditional African foods. Although there is still high disagreement with the item, there seems to be some level of inclusion of African foods in the disciplines. The high level of micronutrient deficiency in South Africa among children and adults can be overcome when nurses have knowledge on types of African food in South Africa that are available in communities such as dark green leafy vegetables (Schonfeldt & Pretorious 2011). Nurses are the primary carers and should possess knowledge about traditional regional foods and their nutritional

values (Dantas et al. 2020). Content about such traditional foods should be included in the curriculum, so that the nurses are able to render applicable nutritional health education to patients, who undoubtedly eat traditional food as part of their stable meals.

Nurses must be aware of various types of food that may be prohibited based on religious, health and cultural preferences (Jeong, Park, Lee, Ko & Shin 2017). Further, restrictions on certain food are necessary to prevent health problems such as allergies, poisoning and pregnancy-related health problems (Jeong et al. 2017). Traditional foods are reported to have high nutritional value, affordable and provide a sense of joy as they provoke happy feeling among patients (Hanssen & Kuven 2016). Changing health patterns have contributed to the erosion of knowledge on traditional foods among populations, including nurses. The value of traditional food on health of populations and food security seems to be undermined. The European Herbal & Traditional Medicine Practitioners Association (2007) recommend the inclusion of various types of food in curriculum for herbal and traditional medicine.

Therefore, nurse educators must include the content on African food in the disciplines so that nurses become aware of the contribution of the traditional food system in building healthy societies (Al-daihan & Bhat 2012). Food such as leafy vegetables *(morogo)* and edible insects are accessible in abundance in the African landscape. For example, *Lerotho* (Spider plant), pumpkin leaves, *Thepe* (Amaranthus) and many others grow naturally, have high nutritional value and are easy to cook (Cernansky 2015). On the other hand, insects such as locusts, Mopane worms are rich in proteins and other micronutrients such as iron, phosphorus, and Vitamins (Kwiri, Mujuru & Gwala 2020). The extent to which the content on African dietary food can be integrated, will determine the extent to which nurses will include the content in their health education.

7.3.3.6. Training, regulation, and roles of THPs

Results further indicated a high disagreement regarding content on the training and regulation of THPs. A score of 11,8% agreement was recorded, indicating that there is no structured way the content is taught. The similarities between ATHKPs and Western medicine item (14.g) scored the highest (27%) for all the items in the category

of training and regulation of THPs. Almost a similar score was recorded for not sure on the same item. Training and regulation of THPs are important in legitimising ATHKPs. Like many other professions, THPs must open their system to scrutiny so that their practice can be recognised and respected. Nurses must know and trust that the THPs who refer patients to them are regulated, properly trained and possess the required recognition status according to their regulating body (Louw & Duvenhage 2016).

There is paucity of literature on the teaching of training and regulation of THPs in nursing curricula in South Africa. Notably in South Africa there is no notable formal education and training infrastructure for the THPs. Louw and Duvenhage (2016) reports that the strength of traditional healing lies in its well-established informal system of training. The training of THPs remains a bone of contention in terms of the recognition of the "qualifications", level of training and types of exams to be taken (Nompumelelo et al. 2019). Similarly, a high level of disagreement (77,5%) was reported regarding the implementation of the Traditional health practitioner's Act 22 of 2007. The THPs' Act serves as a framework for training and regulation of THPs. Therefore, with regards to training and regulation of THPs, more still needs to be done to ensure that there is a structured and formalised education system which will ensure that ATHKPs are scrutinised fairly and recognised as required.

Regarding the content on the category of roles of THPs in provision of health services, a high level of disagreement is also reported. The data shows a low level of agreement, scoring a marginal 14,1%. About 24,3% of respondents agreed that they teach content on physical assessment of patients. Although the score on agreement for this item (15.a) is averagely low (24,3%), it is the highest score for agreement on this category of roles of THPs. Knowledge and skills possessed by THPs is necessary in assisting the prevention and treatment of patients within the health system (George, Chitindingu & Gouw 2013). According to Nompumelelo et al. (2019) spiritual assessment and diagnosing patients using various methods is the cornerstone of consultations with THPs. Knowledge on such methods among nurses is important to determine the extent to which the data presented by patients should be accepted. There also seems to be limited literature on the content for teaching addressing roles of THPs.

This may mean that educators who do teach about the roles, may teach out of context, or provide a skewed view about roles of THPs. The competency-based framework will provide a standard for nurses to understand various roles of THPs. Of particular interest is that most respondents (85,3%) disagreed that there is teaching about collaboration between nurses and THPs. This is significant because there is so much emphasis on collaboration between nurses and THPs at various levels (Campbell-Hall, Vicky, Petersen, Bhana, Arvin, Mjadu, Hosegood & Flisher 2010). In Burkina Faso nurses received training on collaborating with THPs and they reported on the challenges associated with collaborating with THPs, including poor documentation, delayed referrals, and licencing issues (Boly, Compaore, Ouedraogo, Zeba, Magnini, Bance, Yoda, Nitiema, Belemlilga, Ouedraogo, Ilboudo, Belemnaba, Ouedraogo, Lompo, Kini & Ouedraogo 2021).

In South Africa there are reports of collaboration between nurses and THPs, however such collaborations take place in the community based on needs of patients such as on HIV/AIDS management, Tuberculosis, and other chronic health problems (van Rooyen et al. 2015). There is paucity in terms of teaching nurses to collaborate and where this is done, in the context of the multidisciplinary team, THPs are seldom included as members of the multidisciplinary team even though they are the first point of care for most patients in rural communities (Ennion & Rhoda 2016). Nursing curricular should consider the roles played by THPs and possible areas of collaboration must be identified to facilitate exchange of knowledge and skills.

A greater proportion of the respondents disagreed that there is teaching about categories of THPs in their discipline. On a scale of agreement, 23% of respondents agreed that there is some level of teaching on various categories of THPs. A high level of disagreement on this category demonstrates lack of clarity or knowledge on such categories among nurse educators. The category of *Sangoma* is rated highest (24,8%) in terms of agreement with its teaching. The THPs Act 22 0f 2007 makes provision for different categories of THPs. Like nurses knowing categories and specialisations of the multidisciplinary team, they should as well be knowledgeable of various categories of THPs. However, delays in implementing a register and formalising the profession of THPs may be leading to poor recognition of the various categories (Mothibe & Sibanda 2018). Accordingly, patients have high regards for their THPs and their

specialisations, and nurses must be wary of prejudicially labelling THPs to avoid conflict between traditional and Western medicine (Gunaydin & Ozpulat 2017). Nevertheless, the teaching of nurses about categories of THPs remains in its infancy and unstructured.

7.3.3.7. Practical teaching of ATHKPs and CAM

The practical teaching ATHKPs appears to be minimal with a high level of disagreement recorded. Only about 5% of the respondents agreed that their practical teaching involves practical visits by THPs to the nursing institution. On the other hand, 15,7% reported that they are not sure if ethics for conducting research and collaborating with THPs is taught in their discipline. According to the WHO Traditional Medicine Strategy 2014-2023, a cohesive and integrative approach to health must consider the roles played by THPs in providing safe, respectful, and cost-efficient services. Mutual respect is necessary, where nurses are willing to work with THPs and be willing to allow students to learn the art and craft of ATHKPs.

According to Krah et al. (2018), nurses must be acquainted to the traditional and religious practices, language, and cultural beliefs of the local people. The use of herbal medicine for treating various ailments can only be understood if explained by THPs. This will be possible if there are opportunities to visit and interact with THPs to learn more about the principles, procedures and language used in ATHKPs. In China, nurses are trained on Traditional Chinese Medicine, by visiting the practice site where practitioners offer training to nurses (Zhao et al. 2021). Therefore, there is an opportunity for NEIs in South Africa to integrate the approach in their curriculum or modules. In fact, 0,98% of participants have confirmed that they do visits to the THPs in item 20.1 (examples of how ATHKPs is taught in disciplines). It shows that the opportunities do exist for the practical integration of ATHKPs.

On the teaching of Complementary and Alternative Medicine (CAM), a high level of disagreement was noted (58%). Although as compared to teaching ATHKPs, there is slight improvement on the agree and not sure items in terms of teaching CAM. Herbal medicine and natural products are closely linked to ATHKPs and forms the core of the practice. It would be interesting to note the actual content taught and the approach from which it is taught. It is important to note that herbal medicine within Western

medicine is mostly discussed from a toxicity point of view as opposed to efficacy point of view.

7.3.3.8. Implication of results for content included in curriculum

Although there is some high level of disagreement with almost all the items under the content for teaching ATHKPs, there is some positive signs that the teaching does happen albeit minimally. Furthermore, it appears that the teaching remains unstructured and not aligned to any outcomes, which then classifies the content as informal or extracurricular activity for students. It becomes necessary to reflect on the necessity of the content, as proven in this study that and in literature that most Africans in the communities still prefer and use ATHKPs as a first line of health service before they consult allopathic practitioners in modern medicine (Mngqundaniso & Peltzer 2008). As a results nurses will most likely provide health services to these patients and must possess the necessary knowledge, skills, and attitudes to be able to assess, diagnose and interpret signs of traditional medicine use, and provide appropriate nursing interventions and referral in line with the patients' rights and fulfilling their advocacy role. This should not be taught haphazardly and requires a structured approach through the development of competencies, which entail the knowledge, skills, and attitudes to facilitate their understanding of this unique system of health care. Hence the need identified in this current study.

7.3.4. Section D: Methods of teaching and assessment of ATHKPs in the module

This section aimed at assessing how ATHKPs is taught and assessed at the NEIs within the modules or disciplines in line with third objective of the study. When required to indicate on the description of module content that is included in their curriculum, there was a high level of no responses (54,1%), which matched the findings in Section A where 70,6% of respondents also indicated that there is no module for teaching ATHKPs.

7.3.4.1. Approaches to teaching ATHKPs

When respondents were required to indicate the approach that best describes how they teach ATHKPs in their discipline, 17,7% indicated that they teach theory only, while 7,4% indicated that they use projects. There was a high level of disagreement

with the approaches that were provided in the questionnaire. There is no practical teaching ATHKPs, where 99,8% indicated that they do not teach practically at all. Integration of theory and practice remains a challenging task for many education institutions, where theory teaching tends to dominate practical teaching (Ott 2021). As seen in this current study, there is more teaching of theory as opposed to practical, which means student nurses knowledge on ATHKPs is limited to the classroom and no application whatsoever takes place in clinical practice, where they interact with patients who uses the system of health taught in the classroom. Chitindingu et al. (2014) reported that of the seven medical schools that participated in their study on approach to teaching TCAM, four (4) taught theory only, two (2) used problem-based learning and one did not teach TCAM at all. Saifan et al. (2021) in Jordan, reported the challenges of integration, where student nurses in their study raised concerns regarding the absence of learning opportunities taught in the classroom in the clinical setting. The finding from the above study is not different from this current study where theory is predominantly taught without practical follow up or outcomes linked to the theory content in clinical.

A high level of no response was also noted when participants were required to provide examples of how the approach to teaching ATHKPs is used. While there is still high level of no response and none, cumulatively scoring 78,6%, lecture presentations scored 8%, while projects followed with a score of 5,32%. The findings are like category 20 (Which of the following best describes the approach to teaching ATHKPs in your discipline), where both lecture method and projects both scored 17,7% and 7,4% respectively. It is of interest to note that 0,9% reported that they take their students to visit THPs or CAM as an example of how ATHKPs is taught. Based on the numbers, it looks like taking students to visit THPs can be classified as a project. Although there is paucity of literature, The University of Kwa-Zulu Natal in South Africa has started with the project of sensitising nurses and facilitating collaboration between nursing students and THPs. This is done by arranging visits to THPs and inviting THPs into the university and share the worldview informing their practice (Dlamini 2020). According to Bertrand (2012) nurses who have been trained in Traditional Chinese Medicine, have demonstrated significant competence, and can easily integrate traditional medicine into their practice. The same can be said about ATHKPs if nurses are practically taught about the system of health care. Regarding the assessment

tasks, most respondents (82,8%) indicated that there are no assessment tasks used in the module for ATHKPs, 16,7% agreed with the statement. Results indicate that test and examinations are the most used assessment tasks (11,4%), followed by assignment portfolios (3,2%). Determining how the assessment is done and what the activities are is necessary to confirm the nature of learning that takes place.

7.3.4.2. Importance of teaching students about ATHKPs

One of the most important results in this study is that 61% of the respondents reported that it is important to teach nursing students about ATHKPs. While 30,6% were not sure if it is important or not, a low of 8,3% indicated that it is not important. This is significant as it opens platforms for engagement and discussions in efforts to integrate and standardise teaching in the curriculum. Lawrence et al. (2021) reported that medical students associated their knowledge and skills deficit about traditional medicine on lack of teaching as opposed to their lack of desire to learn about traditional medicine. Other studies support the results of this study, where nurses in clinical practice have reported the value of traditional medicine and their willingness to learn, but also cited curricular restrictions and poor knowledge about traditional medicine as barriers to integration and teaching (Asare, Aziato & Boamah 2021; Gyasi et al. 2018). It is an indictment on the education institutions to restructure and re-evaluate the effectiveness and responsiveness of their programmes, as evidenced by students' and nurses' pleas to want to know more about traditional medicine.

The data collected from this phase of the study required respondents to provide suggestions regarding the content and development of a module on ATHKPs. Although there was a low response rate (37,1%), important suggestions were noted in terms of content and activities that can be done. Some of the respondents (2,7%) indicated that it is not possible to include ATHKPs in nursing curriculum, while 13,25% suggested that nurses and THPs should both be trained on each system of health care. Accordingly, THPs to be trained on Western medicine and nurse educators to be trained on ATHKPs. The training of THPs has been happening across the African continent over the past decade. Most of the training was tailored to foster collaboration, cross-referral, and management of communicable such as Tuberculosis (Sima, Bjune et al. 2019) , HIV AIDS (Audet, Ngobeni & Wagner 2017) Malaria (Jombo et al. 2010) and other pandemics such as Ebola in Congo (Wang & Liu 2020). This demonstrates

that THPs have for some time, been open to be capacitated with the knowledge and skills from Western medicine. Although the general response from nurses has been negative towards ATHKPs, there are reports of nurses who are keen on collaborating and learning from THPs (van Rooyen et al. 2015:05; Solera-Deuchar et al. 2020). This has been a thorny issue which has been demonstrated throughout this study that the licencing and registration of THPs hinders seamless collaboration due to the mistrust between the two systems regarding legitimacy of ATHKPs (Abrams, Falkenberg, Rautenbach et al. 2020). Training of THPs and nurses is an important milestone in overcoming some barriers, as it will result in mutual respect and open platforms for knowledge exchange. Closely linked to training, is defining the scope of practice and regulation of THPs, which respondents (6,2%) suggested could help in the development of the module on ATHKPs.

The level of mistrust in ATHKPs among health professional is exacerbated by the undefined scope of practice (Mokgobi 2014) and delays in the registration of THPs in South Africa (Beyers 2020). The process of registering and licencing THPs has not progressed as expected and such remains a stumbling block for collaboration as also reported in the current study. Additionally, respondents suggested the development of guidelines for engagement between nurses and THPs. Guidelines are necessary for ensuring that the terms and conditions of engagement are known to all parties and to eliminate confusion and conflict regarding the roles of each stakeholder (Green & Colucci 2020); especially because it has been reported that THPs and nurses are willing to collaborate and work hand in glove.

Respondents (4,2%) also reported that having a database of herbal medicine may contribute to developing a module on ATHKPs. Like teaching pharmacology to nurses, THPs have a list of medicines used to treat various ailments which can be taught to nurses. It does not mean that the nurses will prescribe or use the medicines, but their knowledge on such medicine will assist in understanding possible contraindications or possible toxicity when the patient has been prescribed medicine in a western medical setting. In Beijing, a database for natural medicines or herbs known as TarNet, was developed to provide information on medicinal plant compounds so that THPs and health practitioners can be able to verify compounds in herbs given to patients (Hu, Ren, Sun & Sun 2016). Similarly in Indonesia, a plant metabolite database was

developed to promote standardisation and modernisation of herbal-derived products with present pharmacological criteria (Nguyen-Vo, Nguyen, Do, Nguyen, Trinh, Cao & Le 2019). In South Africa, the South African Medical Research established an Herbal Drugs Unit which provide knowledge to increase the development of herbal traditional medicine by using modern scientific methods to understand the compounds in indigenous medicines. Additionally, there is the South African natural compound database which contains about 600 natural medicines and products (Hatherley et al. 2015). Based on the suggestions of the respondents, having a database might not be the biggest impediment to developing a pharmacology-oriented unit within the module.

It is well-known that ATHKPs is marred in secrecy and sacred information is sometimes only shared verbally within the circle of THPs (Kanu 2018). Therefore, getting THPs to share such information may be challenging because THPs have raised concerns regarding issues of intellectual property (Mokgobi 2013) and exploitation by scientists with whom they have shared information about certain medicinal herbs. Although issues of secrecy are a barrier to development and advancement of traditional medicine, measures must be put in place, especially by government to prevent the abuse of secrecy declarations by pharmacological companies and private businesses (Masango 2020). The Covid-19 pandemic has demonstrated how attractive the black market is to the general population and businesses in terms of herbal medicines (Mphekgwana, Makgahlela & Mothiba 2021).

A variety of medicines were used, which even nurses were aware of, but their efficacy was not known. Therefore, including a database of herbal medicine for teaching will go a long way in reducing death and prolonged illnesses associated with toxicity and poor compliance by patients. Although the no response rate was as high as 69%, there are positive contributions and suggestions demonstrating that the inclusion of ATHKPs in nursing curriculum is possible.

7.4. Summary

In this chapter the results of Chapter 6, quantitative Phase 2, was discussed in detail and supported with literature. In the discussion, it was confirmed that teaching ATHKPs remains fragmented, unstructured and focuses on theoretical, classroom-based teaching. Furthermore, it was reported that successful development of the module will require training of both nurse educators and THPs on both systems of healthcare.

Suggestions made by respondents on the development and content of ATHKPs were supported by literature. It can be concluded that opportunities for teaching exist but requires a structured approach. The next chapter discusses the integration and merging of data that emanated from Phases 1 and 2.

CHAPTER 8

INTEGRATION AND INTERPRETATION OF THE CONVERGED RESULTS

8.1. Introduction

The purpose of this study was to develop a competency-based framework for standardising ATHKPs in undergraduate nursing curriculum. The study followed an exploratory sequential mixed method design, where qualitative data collected in Phase 1, informed the development of the survey instrument in quantitative Phase 2. In this chapter, the researcher will integrate and relate the findings of the qualitative and quantitative phases. A summary of the findings from the two phases will be highlighted, then a discussion to integrate the findings will ensue. This chapter will be embedded on the integration and interpretation of the converged findings of the study. Creswell and Clark (2018) identify convergence or divergence as a method of interpreting the results gathered from both designs. Lastly this chapter will also provide the discussions on the integration of Phase 1 qualitative findings and Phase 2 quantitative results informing the development of the proposed competency-based framework for standardising ATHKPs in nursing curriculum.

8.2. Process followed to integrate the findings

Data was first collected from the THPs in Phase 1 through qualitative interviews which were semi-structured. The questions posed to THPs were the following: what are the roles of THPs in rendering health services in South Africa? The findings were presented and discussed in Chapter 4 and 5 respectively.

In the second quantitative phase, the researcher collected data from nurse educators through a self-administered questionnaire focusing on the content of ATHKPs taught in nursing curriculum, methods of teaching and assessment as well as the recommendations of nurse educators regarding how ATHKPs can be taught in nursing curriculum in South Africa. The results and discussion from this Phase 2 were presented in Chapter 6 and 7 of this study respectively. In terms of weighting, it can be concluded that the intended audience for the study is nurse educators at NEIs and regulatory bodies such as the SANC. Therefore, the weighting of the data in the study

aligns more towards the quantitative than the qualitative phase of the study based on the aim and research questions. However, this does not mean that information collected from THPs is less important, in fact it is the very information that informed the study direction. The qualitative phase was used as a database for providing structure for the questionnaire which required the custodians (THPs) of the information to be included.

Lastly, the integrated and converged data was then used to develop the competency-based framework, which was the last objective of this study. The integration assisted the researcher to interpret and better understand the qualitative responses and the numerical results regarding the extent to which ATHKPs is taught and assessed in nursing education institutions. The following objectives were met in Phases 1 and 2 of the study.

8.2.1. Qualitative objectives (Phase 1: THPs)

- To explore and describe roles of THPs in rendering health services in South Africa.

8.2.2. Quantitative objectives (Phase 2: Nurse educators)

- Identify the level of teaching for ATHKPs in nursing programmes.
- To determine the contents of ATHKPs taught in the nursing curriculum in public nursing education institutions (NEIs).
- To assess methods of teaching and assessment of ATHKPs in public NEIs.

8.3. Integration of the qualitative and quantitative results

The exploratory sequential method allowed the researcher to collect the data sequentially and then merge the data at the end. However data from Phase 1 informed Phase 2, where both designs were integrated. The reseracher will compare the findings side-by-side before merger as recommended by Creswell and Clark (2018). This means that qualitative findings will be presented first and then, statistical results presented to confirm if the content provided by THPs regarding ATHKPs, is what is being taught in nursing curriculum. It is noted that there may be challenges associated with mixing, including data converging or diverging (Creswell & Clark 2018).

Table 8.1 below illustrates the comparison made between Phase 1 and Phase 2 of the study. Qualitative Phase 1 findings guided the development of the questionnaire,

in particular Section C, which focused on the content of ATHKPs taught in nursing curriculm across the different disciplines of nursing. The researcher then added another column where the converged data is intepreted. The comparison was based on whether what THPs regard as knowledge, skills or behaviours required in ATHKPs, is being included in the nursing curriculum. It should be noted that some sections of the questionnaire will not be compared with themes, such as Section A and B, D and E, which focused on the demographic data, the level of teaching for ATHKPs, methods of teaching and assessment, as they were not relevant to the questionnaire.

However, the information is used in the development of the competencies in the next chapter. The development of the questionnaire was also discussed in detail in Chapter 3, to indicate how themes were converted into questionnaire items. Hence themes will be compared with associated questionnaire items, for example, in Section C, the item of overview of ATHKPs emerged from the theme features of ATHKPs, whereas item on values and beliefs about ATHKPs emanated from Theme 2 on elements of practice in ATHKPs.

Table 8.1: Comparison between the qualitative results and the quantitative findings

Theme 1	**Qualitative Findings (THPs)**	**Quantitative Results (Nurse educators)**
Features of African Traditional Health Knowledge and Practices	• THPs defined the features of ATHKPs citing its history, underlying principles and therapies. • It was reported that ATHKPs was integrated into everyday life for Africans and informs healthcare seeking behaviour. • ATHKPs is closely linked to ancestral calling but not everyone with a calling has to go for initiation as a THP. • ATHKPs provides framework for guiding individuals on their societal roles and behaviours expected for men, women and teenaagers. • Spiritual alignment determines how individuals respond to health and life challenges.	• Overview of ATHKPs included content covering history, philosophies, principles, and practices for healing and managing diseases from an African perspective. • There is high level of disagreement for teaching content associated with this theme. • The category of teaching about overview of ATHKPs scored an average of 35,5%, indicating some level of teaching, albeit low. • Definition of health from an African perspective scored the lowest for content taught under overview (16,4%).
Interpretation of the converged data on features of African traditional health knowledge and practices		
Based on the data provided by THPs regarding what ATHKPs is and its features, the results from Phase 2 questionnaires revealed that there is minimal teaching ATHKPs on features of ATHKPs. It is also apparent that nurse educators lack knowledge and		

understanding of what ATHKPs is, and what its underlying principles are. This is evidenced by the high level of disagreement with the teaching of most items in the questionnaire. Notably, some educators indicated that they do teach about topics such as ubuntu philosophy, diagnostic methods and certain diagnostic concepts used in ATHKPs. It is necessary to conduct more qualitative studies to explore and identify the types of diseases and diagnostic methods taught in nursing curriculum as this was not specifically determined in this current study. The study aimed to determine whether some of the features described by THPs were considered when teaching nursing students.

The context within which this content on features of ATHKPs are taught has also not been established in this phase 1 of the study. Yet, within ATHKPs context is important in determining health interventions as well as unique ways of giving meaning to situations or occurrences in terms of the spoken language, diagnostic procedures and how people relate with one another and the environment (Okaiyeto & Oguntibeju 2021). It is therefore essential to contextualise the teaching of such content and focus on the interpretation of health concepts, names given to diseases (diagnosis), and determinants of health from an African perspective. When planning the teaching of students on such content, nurse educators should consider the philosophical underpinning influencing health seeking behaviour and disease management among Africans.

Despite poor responses to these items on features of ATHKPs, other respondents indicated that some level of teaching does take place in the NEIs. An overall 35% level of agreement is however a promising sign that nurse educators are aware of some features of ATHKPs and attempt to integrate it into their teaching, albeit minimal and unstructured. Although there is abundant literature regarding ATHKPs and traditional healing in general, most researchers and academics use different concepts to define ATHKPs, creating inconsistencies in understanding and interpretation. While some define it as African traditional medicine, others use the concept traditional healing to define ATHKPs. This has been problematic because the context within which it is practiced may influence the interpretation. This affects nurse educators' understanding of the concepts as well. Similarly, there is paucity of

literature regarding what informs the content of ATHKPs that is included in the curriculum. Further, no studies were conducted in nursing in South Africa on the inclusion of ATHKPs in the nursing curriculum.

Regarding ancestral calling, almost all participants (99,3%) indicated that they do not teach about ancestral calling in their discipline. Whether or not it is necessary for nurses to be taught about ancestral calling processes for THPs is a contentious issue. This is more so because there has been a rise in number of individuals who accede to ancestral calling, which is often diagnosed as mental illness in Western medicine. Further there are reports of more and more nurses who are practicing as THPs. Nurse educators cannot ignore the fact that nurses are likely to meet patients or fellow nurses who present with history of ancestral calling and require their intervention. Potential misdiagnosis exists when nurses are not aware of the differences between mental health manifestations and signs of ancestral calling. This is especially important in instances, as reported by Washington (2010), where it may be difficult for healthcare workers to diagnose mental health symptoms in persons with ancestral calling.

Additionally, nurses play an important role in managing such potential conflict of belief systems, where patients being served are utilising both systems of healthcare (Ozpulat & Gunaydin 2018). Therefore, their socialisation into the nursing profession by NEIs must consider that. This can only happen if nurses are taught and sensitised about the values, beliefs, and traditions of Africans from an African perspective. However, respondents in this study highlighted that there is minimal teaching of nurses on such features of ATHKPs. While the level of agreement is low, it provides a promising prospect that some level of teaching on the content is taking place.

Nurses are often faced with the challenge of explaining to the patients the disease processes in their languages and may end up directly translating African names to medical (western) terminologies (Cunningham 2017). Similarly, in any education system, understanding the fundamental concepts and their meaning is crucial for clarifying and ensuring common understanding of a phenomena. Interestingly, there are healthcare providers who are also THPs who may contribute to the development and translation

of terminologies. Although, not openly practiced, there are instances where nurses who are also THPs, are caught up in a conflict of belief systems, where they may consult patients who are also open to second opinion from THPs about their problem (Tessendorf & Cunningham 1997). The education system for nurses has not made provision on how such circumstances should be dealt with and leaves it at the hands of the practitioner. This is precisely why a competency framework is essential; to standardise the training of nurses. However, this is contrary to results of Phase 2 in this study, where it was revealed that there is minimal or limited teaching on ancestral calling, African spirituality, and principles of healing from an African perspective.

One of the profound revelations of Phase 2 of the study was that most nurse educators (71,8%) indicated that they do not teach about African perspectives on health or interpretation of health concepts from an African perspective. The monolithic perspective in the nursing curriculum in a diverse country like South Africa is likely perpetuating the burden of disease as it has an implication on the health advice nurses render to patients. Eventually this determines whether patients comply with treatment and health interventions or not and influences health seeking behaviours (Ngunyulu et al. 2020). Only 24% of nurse educators include this content in their teaching programmes based on the macro curriculum. There is a need to reflect on the factors that influence the unstructured inclusion of ATHKPs in NEIs among nurse educators and whether this translates to clinical practice.

Theme 2	Qualitative Results (THPs)	Quantitative Findings (Nurse educators)
Elements of practice in African Traditional Health Knowledge and practices.	• To be a THP requires a person to be chosen by their ancestors for a particular calling. • Training of THPs depends on the nature of their calling.	• High level of disagreement with the teaching on ancestral calling, meaning of African health concepts and training of THPs.

	• It may be in a form of internship or mentorship within the family • THPs reported that Indigenous languages serve as a medium for communicating with the ancestors and a tool used in the training of initiates. • Language is also important in naming, defining, and explaining the traditional health concepts, anatomical structures, and illness.	• However, 27% reported that they teach about similarities between ATHKPs and Western medicine • Not much is taught about the regulation of THPs or laws that govern conduct of THPs. • THPs are still not recognised as members of the health team, as evidenced by 81,6% disagreement on this item. • About 24% reported to be teaching about indigenous languages • Minimal or unstructured teaching on elements of practice in ATHKPs.
Interpretation of the converged data on elements of practice in African traditional health knowledge and practices		
It was noted that there is some level of teaching in the NEIs regarding this theme on elements of practice in ATHKPs. Interestingly the nurse educators agreed that they teach about similarities between ATHKPs and Western medicine. The extent to which the comparison between the two systems is done and the context of comparison has not been determined in this current study, but due to the high level of disagreement with the item on recognition of THPs as members of the health team; it confirms that the content and teaching elements of practice in ATHKPs remains unstructured. Furthermore, results indicated that the laws and regulations governing the practice of THPs are not included or considered in the curriculum, demonstrating the possible further shunning of the practice.		

Consensus and clarity should be sought among healthcare workers on important elements of ATHKPs that can be considered and integrated in the curriculum for nurses. The repeal of the Witchcraft Suppression Act of 1957 and the enacting of the Traditional Health Practitioners Act 22 of 2007, was based on the premise that perception towards ATHKPs may shift and a possible change of mindset among Africans as well as other populations may change (Nemutandani et al. 2016). Little progress has been made as evidenced by the limited knowledge demonstrated by nurse educators in this current study. According to Nemutandani et al. (2016), such repressive laws have dictated ways of thinking among Africans about ATHKPs, and have perpetuated further stereotypes, which have been transmitted structurally through curriculum designs in higher education.

This may be closely linked to why South Africa recently experienced a disruption in higher education with students leading the petition for a decolonised, Afrocentric, and contextually responsive curriculum. Such a movement was triggered by lens through which most curricula were viewed (Du Plessis 2021). There was however acknowledgement from government regarding the urgency of the issues raised in relation to teaching methodologies, research approaches, disregard for African pedagogies as well as language policies that perpetuated inequality among different ethnic groups and western hegemony (Senekal & Lenz 2020). This is important as it relates to the nature and structure of nursing curriculum, where not much has changed despite efforts to decolonise teaching and learning and ensure the recognition of African pedagogies as legitimate educational approaches understood by Africans.

When asked about the importance of language, THPs reported that language forms the basis for understanding concepts, names, and objects in ATHKPs. Yet the results in Phase 2 indicated that nurse educators do not teach about the concepts the indigenous names or diagnosis for a variety of health conditions. The naming of diseases in particular influences how the patients or communities perceive the seriousness or source of the health problem. While western societies believe that illness is from a natural cause which should be scientifically explained, African societies and most probably other indigenous societies, focus on the

supernatural, with importance on spiritual interventions and pleasing of the spiritually powerful. Indeed, such disparities may affect the patient's attitude to healthcare interventions and coping mechanisms. Differences in terms of diagnoses such as *Makgoma*, which is a disease caused by having sexual intercourse with a widow (Mathibela, Potgieter & Tshikalange 2019), *Thema* and *Sejeso* which refers to neck retraction & gastroenteritis respectively (de Villiers & Ledwaba 2018), to name but a few, demonstrate the potential misdiagnosis by patients themselves or healthcare workers. Patient's health seeking behaviours are influenced by how they interpret the source of the health problem. Hence this is an area of great importance, to ensure that the teaching focus on contextual meaning of concepts and disease processes.

While THPs shared that training forms an important element of practice in ATHKPs, doubt has been cast regarding the validity of the training methods for THPs by some allopathic practitioners. Although the duration and intensity of training vary from one THP to the other, common practices during training include observations, mentoring and shadowing of the *uGobela*(trainer). Louw and Duvenhage (2016) also concurs and added that training of THPs involves mentoring and shadowing to ensure the mentee gains experience and develops expertise. This unwritten curriculum for training of THPs creates doubt among allopathic practitioners, who are accustomed to the modern scientific way of disseminating information and teaching of a predetermined curriculum, with outcomes and associated assessment criteria. While in ATHKPs, the ancestors will determine when a person can now graduate to be an independent THP, allopathic practitioners have a predictable programme of training, hence there is a high level of disagreement among nurse educators on the teaching about training of THPs, which may be associated with the perception about "informal" curriculum for THPs. Having said that, the credibility and reputation of any practice relies on the quality of training received by practitioners as well as their ability to meet the demands for the service they provide. Similar sentiments were shared by THPs in the current study, where issues of training, category of practice and challenges were raised as important components of ATHKPs.

The survey questionnaire in Phase 2 assessed the elements of training, regulation, and categories of THPs, that are included as part of the nursing curriculum. This study does not imply that nurses must be taught about how THPs are trained, rather focuses on the credibility of the knowledge and skills the THPs possess. It is further envisaged that by acquiring such knowledge nurses will be able to identify specialisation areas for THPs, to foster collaboration. Yet in this study, results indicated that there is limited content highlighting the teaching of nurses on the types of training THPs undergo. It is evident from the results that, nurse educators are not aware of the Traditional Health Practitioners' Act 22 of 2007, which makes provision for practice and regulation of THPs. Interestingly, nurse educators highlighted the presence of bogus THPs as a challenge that enhances the mistrust between the different systems of healthcare. This was also highlighted by Zuma et al. (2016), who reported that lack of regulation places ATHKPs at loggerheads with modern health system and requirements for practice. Hence the exclusion of ATHKPs is not irrational, based on the even more growing trend of bogus THPs who do not go through the proper processes of training and competence development.

In Phase 1, THPs voiced their concerns regarding the stereotypes that exist and persist about ATHKPs. It was reported that ATHKPs is still associated with witchcraft, thereby fuelling the negative image and willingness of people to openly consult with THPs. As such, according to THPs, most Africans do not believe that a person can be a THP and still be a Christian. The study findings in Phase 1 revealed that there are no contradictions between what is practiced in religions such as Christianity and ATHKPs. Examples of biblical figures who were herbalists were given by THPs to illustrate that one can be a healer and still be aligned to religions such as Christianity. The above point is relevant because it is a known fact that the nursing profession has an inseparable link to Christian religion which was spread by colonisation. The history of nursing in South Africa details the role played by missionaries in spreading Christianity in Africa and beyond. Florence Nightingale, regarded the mother of the nursing profession, was a firm believer in Christianity and that influenced how she practiced nursing, as well as how she taught nurses (Murphy & Walker 2013). Obviously, the training of nurses by missionaries or Catholic nuns meant that one way of doing things was emphasised, disregarding the

African belief system. The emphasis on Christianity persisted throughout the era of colonisation to date, as seen by Christian practices integrated into nursing routine such as morning prayers. It is therefore not surprising that the nursing curriculum is well aligned with the values, beliefs, and principles of Christianity.

On the other hand, ATHKPs has been associated with ancestral worship, which is incompatible with the Christian doctrine (Harrington 2015). A critical analysis of the training of nurses reveals that socialisation of nurses focuses on and promotes Christianity than any other belief system. Hence, stereotypes that exist about ATHKPs are challenging to overcome. Indeed, practicing traditional medicine was criminalised in South Africa through the Witchcraft suppression Act 3 of 1957, making it even more challenging to adopt ATHKPs freely. Yet, the nurse educator's belief system influences how they portray the message about ATHKPs to students. Hence 74,8% of respondents indicated that they do not teach students on stereotypes surrounding ATHKPs. To the contrary, the stereotypes are probably emphasised.

Theme 4	**Qualitative Results (THPs)**	**Quantitative Findings (Nurse educators)**
Competencies and categories of Traditional Health Practitioners	• THPs must master several skills essential in the traditional healing process including: ➢ Assessing and diagnosing of patients ➢ Prescribing interventions medicinal therapies ➢ Arranging for referral and follow up for patients. • THPs also perform supplementary roles including the following:	• A low agreement was reported regarding the inclusion of content on roles/competencies of THPs (14,1%). • A high level of disagreement was reported in terms of teaching about diagnosis of patients (85%), measuring medicines (85,3%) and writing referral letters (88%).

	➢ Counselling of patients on variety of issues ➢ Conducting of exorcism or dispossession ➢ Perform plant harvesting and processing herbs. • THPs reported that Categories of THPs are not restrictive in terms of the roles they play.	• Most respondents (85,3%) indicated that there is no teaching about collaboration or referral between nurses and THPs. • Results indicate minimal teaching of content and lack of knowledge on the categories of THPs.

Interpretation of the converged data on competencies and categories of THPs

THPs identified the competencies required in Traditional Heath Practice, which are the knowledge and skills required in the traditional healing process as well as supplementary roles for THPs. Supplementary roles are duties that the THPs perform, which were not part of their initiation training such as counselling, exorcism, and plant harvesting. However, results in Phase 2 indicate that nurse educators lack knowledge and awareness regarding the competencies or roles played by the THPs as evidenced by the poor response and low level of agreement with the teaching about the items under this section of the questionnaire. Because competencies outline the knowledge and skills of practitioners, society can be assured that THPs are properly trained and that the areas of competence are identified. This will contribute to establish a common ground between THPs and other health professionals.

Yet results in Phase 2 paint demonstrate that most nurse educators are not aware, nor teach about the roles played by THPs in the provision of health services. This is despite the support for integration of THPs into the health system as pronounced by the WHO traditional medicine strategy: 2014-2023 and the National Department of Health in South Africa. Furthermore, there is abundant research in South Africa, conducted by nurses and other allopathic practitioners on the roles played by THPs in communities and collaboration possibilities (Zuma et al. 2016; Mokgobi 2014; Nompumelelo et al. 2019). However, such information has not

translated to knowledge that can be integrated into curriculum. This brings out the important question of who decides what should be in a curriculum and what influences those decisions.

The high level of disagreement with all items regarding roles and categories of THPs supports the assertion that there is lack of knowledge and awareness among nurse educators on what ATHKPs is about. Attention must be paid to latest developments in South Africa regarding recognition, registration, and accreditation of traditional health practice and THPs (Nompumelelo et al. 2019). The THPs' Act makes provision for categories such as diviner, *Inyanga* and traditional surgeon among others, further affirming the roles played by THPs in their different categories. Collaboration between THPs and allopathic practitioners is noted in literature, although it is not formalised (Mokgobi 2013). One of the problem areas is that nurses to be specific, have not been trained on how to engage with THPs and there is no formal government policy document on how this should be managed. Despite the challenges nurses face in the communities, THPs continue to be consulted and are referring patients to clinics and hospital (Mothibe & Sibanda 2019). The high level of disagreement with teaching about collaboration between THPs and nurses, should be a concern which nursing education institutions should address. Especially because there are reports of nurses have conformed their willingness and eagerness to collaborate with the THPs (van Rooyen et al. 2015). Nursing education institutions have not responded, through curricula revision and inclusion of ATHKPs, outlining the role of THPs, areas of possible collaboration and referral pathways.

One area of contention regarding ATHKPs is on accountability and lack of proper legislation for collaboration, referrals, and knowledge sharing (Abrams et al. 2020). Without policy document regarding the role of THPs in society, and without clarification of how THPs fit into the system, nurses do not have a leg to stand on should they embrace and integrate ATHKPs in their curricula. Government and professional regulators must be clear regarding this, so that guidelines are put in place to facilitate the formalisation of ATHKPs. The community and health professions must be assured that THPs are properly trained and can be trusted by ensuring that the channels of accountability are known. In the nursing profession, the NEI and nurse educators assure the community that

nurses trained in their institutions are qualified. The same assurance from THPs is required to eliminate the mistrust and negative image associated with ATHKPs. Interestingly the proposed regulation for training of THPs in South Africa outlines the requirement for training of THPs, including minimum number of years per category and accreditation of training schools (Street 2016). This can be used as a good starting point for inclusion of ATHKPs in curricula as the aspect that was casting doubt on ATHKPs is being addressed. Unfortunately, the process of implementation has been slow, hence little to no knowledge is demonstrated by nurse educators on the regulation, training, and registration of THPs.

Theme 5	**Qualitative Results (THPs)**	**Quantitative Findings (Nurse educators)**
Views of Traditional Health Practitioners and THPs on the training of nurses on ATHKPs	• THPs reported that teaching nurses on ATHKPs may foster collaboration between nurses and THPs. • Nurses to be taught on the healing processes and triaging of patients. • Teaching must also focus on ethics, laws and regulations that govern traditional health practice. • African customs and beliefs to align similarities or differences.	• High level of disagreement regarding the teaching of nurses on ATHKPs (96,7%). • Yet, 61% of the respondents reported that it is important to teach nursing students about ATHKPs. • Only 5,4% of nurse educators agreed that THP visits to NEIs is arranged in their NEIs. • Further 95,8% disagreed with practical visits to THPs' practices

	• Other THPs indicated that nurses should be taught about how to collaborate with THPs. • Practical visits to see traditional healers at work was also suggested. • Further THPs suggested physical visits to the nursing education institutions to teach nurses about ATHKPs.	• A high of 82,6% disagreed with teaching on ethics for conducting research and collaborating with THPs. • Most used approach for teaching ATHKPs is theoretical lectures. • Low response rate on assessment approaches for ATHKPs. • Suggestions made by educators on content to be included in curriculum were: ➢ Regulation and training of THPs ➢ Collaboration strategies ➢ Referral system ➢ Approaches to disease management in ATHKPs ➢ Effectiveness of medicines and interventions ➢ Not possible to include • Regarding nurse educators inputs on suggestions to assist in development, the responses were: ➢ Training of THPs and nurse educators

		➢ Creation of collaboration platforms ➢ Open communication with THPs ➢ Define scope of practice and regulation of ATHKPs ➢ Support from stakeholders ➢ Database of herbal medicines ➢ Develop guidelines for engagement
Interpretation of the converged data on views of traditional health practitionersand nurse educators on the training of nurses on ATHKPs		
In this theme the views of both THPs and nurse educators are compared and integrated. From the views of THPs, training of nurses on ATHKPs may facilitate collaboration between THPs and nurses. Collaboration appeared to be an important element emphasised by both THPs and nurse educators, which may facilitate mutual respect and trust. On the other hand, nurse educators strongly supported the training of nurses on ATHKPs and viewed it as important. While THPs are receptive to participating in the teaching of nurses on knowledge and practices in ATHKPs, results from Phase 2 reveal that most nurse educators are still sceptical about THPs visiting the NEIs to teach nurses. Although the focus of the study was on whether they teach or not, it may be important to determine in future studies, whether nurse educators are receptive or positive about the involvement of THPs in the teaching of nursing students (Lawrence et al. 2021). Generally, the results pointed out that nurse educators may still be lacking interest in knowing more about ATHKPs, as demonstrated by the low level of agreement and being unsure with aspects pertaining to training of nurses on ATHKPs. Although it appears the approach to teach about ATHKPs, as reported by both THPs and nurse educators, remains unstructured and is different from what is currently happening in the curriculum, there are promising signs based on commonalities.		

Interestingly, of the nurse educators who teach about ATHKPs, the commonly used method for teaching the content is classroom theoretical lectures. Results demonstrate a high likelihood of such theoretical content not being formally assessed and being converted to mostly “nice to know” information. Additionally, such content is likely to be part of the extracurricular activities which do not form part of the core syllabus. Theoretical teaching ATHKPs alone is not enough as it only amounts to poor integration and comprehension of the subject matter (Lawrence et al. 2021). This therefore justifies the disregard many nurses have regarding ATHKPs, as the teaching does not provide platforms for internalisation and correlation of theory and practice. For example, when nurses are taught about a certain herb, and they visit the THP or learn about its processing, indications, and dangers, they are better positioned to diagnose patients with and overdose or possible disease the THP was treating. Therefore, the subjective data, is converted to objective real-life data when nurses have been practically exposed and assessed on such information.

Nurse educators made suggestions on content that can be included in the curriculum on ATHKPs. This was an essential element of Phase 2 as it demonstrated issues nurse educators identify as important regarding ATHKPs. While there was a high level of no response, those that responded to the open-ended question about suggestions, included teaching about regulation of THPs. Regulation of THPs has been identified as a prominent concern among allopathic practitioners to determine who is duly qualified and certified to practice as a THP (Abrams et al. 2020). It is through regulation that many other concerns will be addressed regarding the scope, level of practice and specialisation among THPs. Yet, THPs raised concerns about regulation which may disregard the cornerstone of ATHKPs which is ancestral calling and guidance throughout THPs lifespan. In fact, in Phase 1, one THPs condemned the western way of categorising and classifying the THPs. Therefore, when comparisons are made between THPs and allopathic practitioners, consideration should be given to categorisation as interpreted by THPs.

Regarding the suggestion that may assist in the development of a module for teaching ATHKPs in the nursing curriculum, nurse educators suggested that firstly there should be training for both nurses and THPs on each system. This means there must be

knowledge sharing and a mutual respect for knowledge in each system of health care. Literature has indeed reported that nurses and THPs are willing to learn from each other (Abrams et al. 2020; Oseni & Shannon 2020). The ground is therefore fertile for nurse educators to collaborate with THPs, to learn from them and share their knowledge as well. Based on regulatory prescripts, nurse educators should endeavour to seek clarity from the regulatory body where there is potential conflict of interest in terms of what content is permissible or not in the curriculum. Nurse educators further suggested that collaborative platforms can be created where THPs and nurses can freely share their views, fears and wishes relating to how both systems can work hand in glove. Collaborative platforms are necessary to facilitate knowledge exchange and to give recognition to the contribution made by each health system (Nemutandani et al. 2015). This was also supported by suggestions regarding having an open communication. That would mean that in a collaboration partnership, all stakeholders must be open about their concerns about the other, be transparent about processes they use to manage health problems. This may not be easy as it is known that ATHKPs is marred with secrecy, where sacred information is often withheld from the public. It then means that certain information in the content for curriculum may be discussed in general terms, defeating the very purpose of open communication and collaboration.

Notably, nurse educators suggested that regulation of THPs and their defined scope of practice may assist in the development of module/s for teaching ATHKPs. Although the Traditional Health Practitioners' Act 22 of 2007 was enacted for this purpose, little progress can be reported on. Yet it seems like educators are not aware of the existence of such an Act. More still needs to be done to share information about such developments so that some of the concerns raised by allopathic practitioners regarding regulation of THPs, can be addressed. In countries such as China, India and some parts of Africa the practice of traditional healers is formalised and regulated, hence the teaching in those countries is structured and well aligned with the education system requirements (Liang et al. 2021; Awodele, Amagon, Wannang & Aguiyi 2014). Nurse educators are therefore well positioned to conduct research and provide the profession with evidence provided by THPs during collaborative engagements and to ensure that the curriculum reflects the reality of Africans, based on information shared by custodians of ATHKPs. One important suggestion made by respondents was

regarding the development of guidelines that would regulate how nurses should engage with THPs. Such guideline or policy from government is currently non-existent, creating challenges for nurse educators to teach about collaboration or referral pathways. Further, it means that nurse educators use their discretion on what is wrong or right pertaining to ATHKPs. Presumably the uninformed and unstructured information may be detrimental to learning of students or may conflict with what is known by students as some of the students may also be THPs. When there is conflict of beliefs, learning seldom take place or is resisted.

Another important suggestion was made regarding the development of a database for herbal medicines to facilitate knowledge among nurses on different herbs used by THPs. Results in Phase 1 indicated that there are different herbs for different health problems. Further there are ways to harvest, preserve and process different herbs used by THPs. Such information may not be necessary for nurses in detail; however, nurses may have to know the indigenous names of medicines, their indications and method of administration. When patients present to health facilities, there is a likelihood that they may have taken certain medicinal substances for whatever health problem that brought them to the health facility (Hughes, Aboyade, Clark & Puoane 2013). Knowledge of such medicine and their potential toxicity or contraindications can help nurses to avoid complications, delayed recovery and manage non-adherence to Western medicine. It is a well-known fact that most patients are on dual treatment modalities, including herbal and pharmaceutical substances (Azizah, Halimah, Puspitasari & Hasanah 2021). A database which may serve as a reference book will go a long way in assisting nurses to manage patients who have been treated by THPs prior to presenting to health facilities. Therefore, the support of all stakeholders, including government, regulatory bodies, NEIs, THP organisations and communities is necessary.

8.4. Summary

In this chapter, the integration and convergence of the data was done to identify areas of similarities and differences compared side-by side. Results indicate that what THPs describe as tenets of ATHKPs, are either taught in an unstructured way or minimally taught. The themes that were discussed revealed that some element of teaching does take place, which was noted as a step in the process of standardising ATHKPs. Yet the context and approach to teaching remains theoretical, with minimal involvement of knowledge holders such as THPs. Further nurse educators identified the rigid and often packed curriculum which may hinder integration of more outcomes in the modules. The interpretation of results also revealed that standardising ATHKPs in nursing curriculum is a multi-stakeholder approach, requiring consideration of multiple factors such as regulatory framework, collaborative guidelines, development of databases for herbal medicine and support from government. Chapter 9 presents the development of the envisaged framework for standardising ATHKPs in nursing curriculum.

CHAPTER 9

DEVELOPMENT OF A FRAMEWORK FOR STANDARDISING AFRICAN TRADITIONAL HEALTH KNOWLEDGE AND PRACTICES IN NURSING CURRICULUM

9.1. Introduction

In Chapter 8, findings of Phase 1 and results of Phase 2 and themes were converged as well as interpreted in terms of similarities or common occurence. The themes discussed in the previous Chapter 8 laid foundation for the competencies which will form part of the competency-based framework which nurse educators can use to design curriculum and teach nursing students. Chapter 9 represents Phase 3 of the study, whose aim was to develop a competency-based framework. The development of the competencies in this phase is based on the converged results from the empirical findings obtained in Phase 1 and Phase 2 as well as literature reviewed on competencies for nurses on traditional medicine. In this chapter, a detailed explanation of how the framework was developed is also provided. The guiding principles for development of the framework will be outlined as well as as the theoretical framework which guided the development.

9.2. Integration results from Phase 1 and Phase 2 to inform competencies for the competency framework

The development of competencies in the competency-based framework for standardising ATHKPs in nursing curriculum was based on literature, the themes from Phase 1 provided by THPs on their roles (knowledge, skills and attitudes) in provision of healthcare as well as recommendations in Phase 2, from nurse educators regarding what should be included in the nursing curriculum on ATHKPs. Nurse educators in Phase 2 reported that there is minimal teaching and an unstructured approach to teaching ATHKPs in the NEIs, further confirming the need for developing competencies to standardise teaching ATHKPs. The researcher converted the integrated statements from Phases 1 and 2 to outcomes which made up the competency list as indicated in Table 9.1 below.

Table 9.1: Summarised themes and draft list of competencies

Phase 1 summary of themes	Phase 2 summary of themes	Converged list of competencies from integrated themes
• Knowledge on history, underlying principles (philosophies) and therapies in ATHKPs • Understanding ancestral calling and its manifestations • Appreciates the role of sprituality and spiritual alignment • Demonstrate knowledge on the regulation and categories of THPs • Understands the value of language for communicating in ATHKPs • Understand leadership and management approaches in indegenous settings • Assessment of patients including history taking	• Understand values and beliefs about ATHKPs • Understanding ethical issues related to ATHKPs • Collaboration with THPs • Understanding of mental health and related management • Appreciates roles of THPs • Knowledge on healing methods • Understand the use of herbal medicines and side effects • Demonstrate knowledge on cultural practices	1. Possess knowledge on the history,values, principles, and philosophies underlying practice in ATHKPs 2. Assumes Accountability and responsibility in relation to use of ATHKPs 3. Collaborating and appreciating roles of other health professionals 4. Understanding of ethical and legal issues in practice 5. Possess communication and language skills 6. Referral to other health professionals 7. History taking from patients 8. Assessment of patients 9. Diagnosing various ailments

• Identify diagnostic procedures and terminology • Prescribe health interventions and medicinal therapies • Referral of patients and follow up • Conduct counselling services • Conducting of exorcism or dispossession • Perform plant harvesting and processing		10. Demonstrate knowledge on pharmacological interventions 11. Leadership and management perspectives in ATHKPs

The competency list was drafted based on similarities, in terms of the themes that emanated from the both Phases 1 and 2. The researcher noted that the richest data emanated from the THPs, who are the custodians of ATHKPs. However nurse educators contributed vitally, in identifying knowledge gap areas for teaching ATHKPs and by suggesting competency areas for teaching ATHKPs in nursing curriculum such as appropriate use of concepts or language, regulatory issues and diagnostic processes to name a few. Based on the domains from the SANC's (2004) generic competencies, which will be explained below, the following core competencies were identified:

- Demonstrate professional accountability for the delivery of nursing care as per SANC standards that is consistent with moral, altruistic, legal, ethical, regulatory and Ubuntu principles in relation to ATHKPs.
- Communicate effectively with patients, families and professional colleagues fostering mutual respect and shared decision making to enhance health outcomes.
- Apply basic sciences in the assessment, diagnosis and treatment of the physiological, physical, psychological, social & spiritual problems of patients and their families with various disorders in relation to ATHKPs.
- Demonstrate understanding of required leadership and strategies to manage resources enhancing the use of ATHKPs and to promote collaboration.
- Identify, evaluate and use the best practices in relation to ATHKPs, considering patient's preferences, experience and values to inform clinical decisions.
- Demonstrate an understanding of indigenous research methods and processes.
- Apply nursing process in caring for patients with various disorders.
- Promotes appropriate use of the concepts, principles, theories, and standards of practice in ATHKPs.
- Describe the principles of various therapies and treatment modalities in used ATHKPs.
- Identify and manage risks associated with simultaneous use of ATHKPs and conventional medicine.
- Develop understanding of the methods of drug storage, administration and maintenance and risks in the ATHKPs context.

- Collaborate with THPs and other health providers and efficiently utilise resources in caring patients.

9.3. Guiding principles used for the development of competency-based framework

Principles are a set of laws or ideas that set out how something happens or how it works (Cambrige Online dictionary 2023). Principles are beliefs or rules that govern behaviour (Denman & Al-Mahrooqi 2018). Accordingly, principles provide a framework that stipulates approaches that are correct and that which guides development of character. Therefore it is also necessary to establish a set of principles when developing the competency-based framework to use as a point of reference when evaluating the developed competencies. The principles are essential for ensuring that the developed competencies and framework are acceptable and recognised and to also guide development of other competency frameworks. In developing the competency-based framework, the researcher utilised a variety of sources in order to identify relevant and suitable principles to guide the development of the competency-based framework for standardising ATHKPs in nursing curriculum. Principles that guided the development of the competency-based framework in this study stem from decolonisation of the nursing curriculum through the African indegenous lens (indegeinity) and Ubuntu principles as well as as well as principles for developing competencies for health professions as recommended by Batt, Williams, Rich and Tavares (2019). The development of competencies stems from the consultations conducted with THPs and nurse educators to get their perspectives on ATHKPs. Further the consultations were done to identify the scope, areas of competence as well as limitations.

9.3.1. Decolonisation and African indegeneity

Recent protests by students in South African universities have sparked much debates about the nature and structure of curriculum at most univesities(Council on Higher Education 2017). At the core of the protests was a call for more responsive curricula which are contextually relevant to the indegenous populations (Mheta, Lungu & Govender 2018). In Africa, indegenous approaches are aimed at providing equal recognition and respect for the knowledge, beliefs and practices of African people

through meaningful consultations and appreciation of their worldview (Werner 2023). In this study extensive consultations were conducted with THPs, who are also knowledge holders and keepers for ATHKPs. As knowledge holders, THPs appreciated the approach of consulting them when collecting data about ATHKPs. This gave the THPs, who are mostly marginalisedd and based in poor communities, feelings of self-worth and confidence in their knowledge and contribution to health of societies they serve. At the same time, the research challenged nurse educators on their views about what ATHKPs is as well as its principles. The African indegeinity lens ensured that nurse educators reflect about their own prejudices and perceptions about THPs and ATHKPs.

9.3.2. Guiding principles for developing competency frameworks for health professions according to Batt et al (2019)

The guiding principles for developing competency frameworks for health professions are shown in Table 9.2 below.

Table 9.2: Guiding principles

Principle	Description	Application to study
Stakeholder engagement	The principle highligth the importance of broad stakeholder engagement within and close to the profession (e.g. educators and other healthcare professionals) informed by intended uses, purposes and comprehensiveness of the developmental process and outputs	In this study, various stakeholders from different backgrounds were consulted. Key stakeholders include THPs and nurse educators who are the intended end users of the competency framework.
Process oriented	The principle states that developers must consider not just outputs, but also processes (both inputs and activities). These processes should be evaluated throughout the development, and the insights	Input of nurse educators, academics and THPs who are also practising as health workers was sought.

	used to improve processes for ongoing competency development and revision.	
Theoretically informed	Theoretical approaches are required to explain how processes lead to outputs, how practice was explored and described, and how the competency framework was (or will be) evaluated.	The competency framework was designed in line with the SANC competency framework for professional nurses. Adopting the SANC competency framework as a guiding theoretical framework will facilitate acceptance and application in various nursing contexts.
Alignment	While the choice of methods remains at the discretion of developers, such choices need to be aligned with a) the intended uses, purpose, and scope of the framework, and b) acceptable to the community of users (i.e., the profession)	The framework was developed from inputs of nurse educators, who are also end-users of the framework. The language used in the SANC competency framework was adopted and aligned in the development process.
Need for guidance	The development process needs broadly applicable guidelines, rather than prescriptive steps to follow, to allow for transfer across contexts and necessary adaptations for use.	The domains in the competency framework are aligned to the generic SANC competencies, meaning they are applicable in a variety of nursing contexts and can be adapted by other health professionals as well.
Changing contexts	Competency frameworks are developed within dynamic health and social contexts that are subject to continuous change—specifying the competencies needed for professional practice includes	Developments in South African health system necessitates adjustment among nurses regarding the role of ATHKPs in communities. Nurse educators and nurse practitioners have an obligation to understand ATHKPs as they practice in communities

	accounting for this continuous change.	where ATHKPs is widely used and accepeted.

9.4. Theoretical model and development of the competency-based framework

The development of the competency-based framework was guided by the South African Nursing Council competency framework for professional nurses. Using the SANC competency framework ensured the applicabilty, usability and acceptability of the competency-based framework by NEIs (Jones, Fawns & Aitken 2020). Batt el al. (2019) recommends that developers of competency frameworks consider the role of important stakeholders such as professional regulators as they are important custodians of what may be included in the curriculum for the professionals they regulate. Further, competency frameworks should consider the context within which nurses operate as regulated by the SANC, as it impacts how nurses provide health services in relation to ATHKPs. Hence the rationale to adopt of a widely known and used competency framework of the SANC to guide the structure of the competency-based framework.

The SANC competency framework consists of five domains, namely professional, ethical, and legal practice, care provision and management, personal development and quality care, management, and leadership as well as research (SANC 2014). Therefore the competencies are clustered within each of the domain based on the relevance and similarity of themes to each subdomain. Further, the competencies are divided into core competencies (generic) and specific competencies within the subdomains of the SANC framework.

9.4.1. Domain 1: Professional, ethical and legal practice

This domain highlights the moral and ethical principles and standards that describe how nurses should conduct themselves, considering the laws and scope of practice. The domain covers issues related to professional accountability, practicing within the ethical code of conduct, and recognising laws and legislation governing the profession. The SANC and the public expect nursing professionals to conduct themselves professionally in a manner that upholds their values and beliefs by acting ethically. The conduct of nurses should be such that they protect the autonomy of patients to

exercise their freedom to choose health services they deem culturally appropriate and sensitive to their needs. Most patients presenting to health facilities are often vulnerable and nurses must be aware of the ethical responsibilities to ensure no harm to patients, and that patients are treated justly within the legal framework of nursing and health-related laws. Core competencies in this domain are (SANC 2014):

- Professional practice
- Ethical practice
- Legal practice

In this study, competencies for this domain focus on professional and ethical conduct of nurses in relation to ATHKPs, where nurses are expected to practice their advocacy roles with integrity within the limits of their profession. See Table 9.3 below.

Table 9.3: SANC Domain 1 - For professional, ethical, and legal practice

DOMAIN 1: PROFESSIONAL, ETHICAL AND LEGAL PRACTICE **Core competency** Demonstrate professional accountability for the delivery of nursing care as per SANC standards that is consistent with moral, altruistic, legal, ethical, regulatory and Ubuntu principles in relation to ATHKPs.		
Subdomain	**Specific SANC competency**	**Integration of competencies (findings) with SANC specific competencies**
Professional Practice	• Accepts accountability for increased responsibility for own professional judgment, actions, outcomes of care and continued competence in accordance with legislation and competency frameworks. • Recognises and practises within the professional, ethical, and legal parameters. • Recognises own level of competence and limitations to take actions. • Consults with or refers to appropriate others when encountering situations beyond own competence. • Recognises and respects different levels of accountability for the range of available health care professionals.	• Recognises own accountability and responsibility in relation to practice of ATHKPs. • Recognises roles of THPs within the interprofessional healthcare team • Demonstrate respect and appreciates the legitimacy of training for THPs as competent practitioners. • Practice reflectively through use of evidence-based nursing in relation to ATHKPs • Participate in activities related to improving access of patients to alternative health services. • Refer patients to appropriate others including THPs, on request.
Ethical practice	Practises in a manner that conforms to the Code of Ethics for Nurses and employer's code of conduct.	• Considers the scope of practice in relation to ATHKPs.

	Engages in effective ethical decision-making with respect to own professional practice areas. Acts in an advocacy role to protect Human Rights and questions violations of a health care user. Respects the health care user's rights to privacy and dignity. • Challenges behaviour and health care practices that could compromise health care user's privacy, safety, and dignity.	• Advocates for patients' and their families' rights and choices • Challenges stereotypes and behaviours that discriminates patients utilising ATHKPs. • Demonstrates sensitivity to language, cultural, and religious practices of patients
Legal practice	• Practises in accordance with Professional and other relevant Legislation and including those specific to Advanced Practice Nurse in a special practice area. • Practises in accordance with relevant policies, procedural guidelines, and protocols • Recognises and acts upon laws relating to the professional role and/or professional code of conduct.	• Recognises laws, regulations and policies governing traditional medicine such as Traditional Health Practitioner's Act 22 of 2007 • Demonstrates understanding of regulation and governance of traditional health practice. • Practises in accordance with relevant policies, procedural guidelines, and protocols governing ATHKPs.

9.4.2. Domain 2: Care provision and care management

In this domain, the SANC expects professional nurses to provide care to patients by evaluating and analysing data and applying their knowledge and skills to respond to patients' health needs and demands as may be required. Professional nurses are expected to provide appropriate, safe, and timely nursing interventions as required by their scope of practice and highlighted in the code of conduct (SANC 2014). Core competencies that are identified in this domain focus on health promotion, assessment, diagnosis, planning, and implementation of nursing care by nurses. The SANC expects professional nurses to be able to provide nursing care, which in the context of ATHKPs, may include advising patients on the safe use of ATHKPs and encouraging disclosures for those using traditional medicines and practices. Further, health promotion may require nurses to have knowledge on nutritional aspects such as edible insects, fruits, and herbs in the community. In terms of assessing patients, professional nurses are expected to collect history on the use of ATHKPs, identify signs of use of ATHKPs such as incisions, topical ointments and any worn charms (Ramaube 2018). Nurses understanding of these practices may help prevent stigma, promote disclosure and trust between patients and health providers.

Further, professional nurses must have the knowledge and skills on the diagnostic language used in ATHKPs. This is important for common understanding and cooperation from the patients. Many patients who visit the THPs, are mostly given traditional diagnosis, which may not be the same as the diagnosis in the biomedical system. The use of diagnostic tools and language, therefore, becomes an important part of diagnosis and management of illness, based on the aetiology and manifestation. In terms of planning for care and implementation, professional nurses must be aware of barriers that may influence the patients' ability to accept the interventions or even delay their willingness to give consent. For example, some patients may need to consult their THPs before consenting to any surgical interventions, whereas others may need to be reassured that they will be allowed to possess the byproducts of the interventions such as placentas and other human tissues. While considering the regulations and laws informing practice, professional nurses must also be aware of the implications some of the interventions may have on the patient accepting their diagnosis and future compliance with health prescriptions.

Nurses must be able to record such information as part of the nursing care plan to ensure continuity of care and to improve communication with the multidisciplinary team and facilitate the implementation of patient-centred, family-oriented and culturally responsive care.

Core competencies in this domain are (SANC 2014) as shown in Table 9.4:

- Health promotion.
- Assessment, diagnosis, planning and implementation.
- Evaluation, recording and information management.
- Therapeutic communication and relationships.

Table 9.4: SANC Domain 2 - Care provision and care management

DOMAIN 2: CARE PROVISION AND CARE MANAGEMENT

Core competencies

- Apply basic sciences in the assessment, diagnosis, and treatment of the physiological, physical, psychological, social, and spiritual problems of patients and their families with various disorders in relation to ATHKPs.
- Apply nursing process in caring for patients with various disorders.
- Describe the principles of various therapies and treatment modalities used in ATHKPs.
- Identify, evaluate, and use the best practices in relation to ATHKPs, considering patient's preferences, experience, and values to inform clinical decisions.
- Communicate effectively with patients, families and professional colleagues fostering mutual respect and shared decision making to enhance health outcomes.

Subdomain	Specific SANC competency	Integration of competencies(findings) with SANC specific competencies
Health promotion	• Assesses health education needs specific to the area of speciality. • Plans, develops, and implements needs-based programmes to promote health and wellbeing. • Develops and uses follow-up systems to ensure that health care users receive appropriate services.	• Assess the health education needs of patients in relation to ATHKPs. • Develops programmes to promote health needs of patients and families. • Utilises appropriate referral and follow up systems to ensure continuity of care. • Promotes disclosure and safe use of ATHKPs

Assessment, diagnosis, planning, and implementation	• Gathers accurate and relevant objective and subjective data required for practice in speciality practice area through systematic Health and Nursing Assessment • Orders diagnostic tests and procedures in line with Scope of Practice for advanced practice nursing standards/ competence • Organises, synthesises, analyses, and interprets data from different sources to derive nursing diagnoses and determine a care plan. • Shares and documents findings accurately, complete, and in a timely manner complying with Nursing. • Practice Standards and institutional policies. • Reviews and revises the care plan regularly, where possible in collaboration with other members of the health care team • Implements a range of advanced procedures, treatments, and interventions in accordance with the developed care plan and best practice standards.	• Collects systematic subjective and objective data from patients related to ATHKPs. • Demonstrate knowledge on diagnostic methods and procedures used in ATHKPs. • Diagnoses signs on patients utilising ATHKPs. • Plans for care considering views of other health care providers and patients. • Establishes priorities based on patient's needs and request. • Collaborate with health care team members including THPs to meet patient's care needs. • Responds appropriately to patient's cultural, spiritual, and psychological needs.

Evaluation, recording and information management	• Documents interventions and health care user responses accurately and in a timely manner • Monitors and documents progress towards expected outcomes accurately and completely. • Evaluates progress towards planned outcomes, in consultation with health care users, families and/or carers and health care team	• Documents accurately observed data and views of patients on ATHKPs. • Provides support to patients and health care team based on patient's needs. • Evaluates collected data and planned outcomes in collaboration with patients.
Therapeutic communication and relationships	• Initiates, develops, and discontinues therapeutic relationships using a range of advanced communication and interpersonal skills. • Maintains a relationship that respects the boundary between health care user and self. • Listens to others in an unbiased manner, respects points of view of others, and promotes the expression of diverse opinions and perspectives. • Communicates and shares information including views of health care users, families with other health care team.	• Develops therapeutic relationships between self, families, and patients. • Respects boundaries between self and patient's choices in relation to ATHKPs. • Promotes the expression of diverse views and cultures. • Communicates information regarding the patients' health choices o ATHKPs with healthcare team members.

9.4.3. Domain 3: Personal development and quality of care

Within this domain, professional nurses must posses the knowledge and skills to identify risks in the health care setting and take the necessary precautions to facilitate provision of quality nursing care (SANC 2014). Professional nurses must strive for life-long learning so that they continuously improve their competency and application of best practice guidelines. As such, patients must be nursed in health care environment that is psychologically and physically conducive for their speedy recovery. Attending to shortcomings in knowledge about ATHKPs and creating a health care environment that facilitates a balance between the value belief systems of patients and nurses is a core competency to be acquired by nurses in this domain,

Core competencies in this domain are (SANC 2014) as shown in Table 9.5:

- Quality improvement
- Continuing personal development

Table 9.5: Domain 3 - Personal development and quality of care

DOMAIN 3: PERSONAL DEVELOPMENT AND QUALITY OF CARE

Core competencies

- Promotes appropriate use of the concepts, principles, therapies, and standards of practice in ATHKPs.
- Identify and manage risks associated with simultaneous use of ATHKPs and conventional medicine.

Subdomain	Specific SANC competency	Integration of competencies(findings) with SANC specific competencies
3.1 Quality Improvement	• Promotes dissemination, use, monitoring and review of Nursing Practice Standards and best practice guidelines. • Leads/Participates in developing and adapting Nursing Practice Standards to the health care environment. • Ensures safe and proper storage, administration and recording of therapeutic substances. • Complies with infection prevention procedures and challenges breaches in other practitioner's practice.	• Promote integration of ATHKPs into nursing standards and best practice guidelines • Develops nursing care standards appropriate to patients' health needs. • Identify infection prevention strategies in relation to use of ATHKPs by patients. • Ensures proper storage, administration and recording of therapeutic substances. • Identify potential risks to patient safety and acts accordingly. • Responds appropriately to suggestions and concerns of patients about ATHKPs.

3.2 Continuing Personal Development	• Undertakes regular review of own practice by engaging in reflection, critical examination and evaluation and seeking peer review. • Assumes responsibility for lifelong learning, own professional development, and maintenance of competence. • Participates in Unilateral and Multidisciplinary Teaching and Learning	• Reflect on own practices and views about ATHKPs. • Takes responsibility for own learning regarding ATHKPs trends and developments. • Participates in teaching and learning from heath care team members, including THPs. • Maintains competence in practice through critical examination of own practice and peer review

9.4.4. Domain 4: Management and leadership

In this domain, the SANC prescribes that professional nurses undertake managerial and leadership responsibilities in creating a positive work environment (SANC 2014). The professional nurse is expected to adopt and adapt leadership styles to variety of situations by demonstrating respect for others and being sensitive to the multi-cultural, multigenerational and multireligious perspectives of others. Awareness of how the multiple perspectives influence the work environment may inspire respect, trust and confidence in the professional nurse as a team leader. As a manager and leader, the professional nurse must contribute to policies on integration of ATHKPs in health care setting and ensure that subordinates are aware of such policies and implications of such to practice. Emerging trends in health care such as the rise in use of traditional medicine and issues such as recognition and registration of THPs must be part of the competencies a nurse leader possess, so that the services provided are responsive and considers the needs of patients. Within ATHKPs, there are leadership approaches and traits which may differ in implementation and application as opposed to western culture, where democratic principles are informing decision making. In ethical decision making, the principles utilised in biomedical system seems to follow the African perspective of *Ubuntu*, where the greater good of the community takes priority over individual benefits. See Table 9.6 below.

Table 9.6: Domain 4 - Management and leadership

DOMAIN 4: MANAGEMENT AND LEADERSHIP **Core competencies** • Demonstrate understanding of required management and leadership strategies to manage resources for enhancing the use of ATHKPs and to promote collaboration. • Collaborate with THPs and other health providers and efficiently utilise resources in caring patients.		
	Specific SANC competency	**Integration of competencies(findings) with SANC specific competencies**
	• Adapts leadership style and approaches to situations specific to the advanced practice nurse. • Leads in a manner to inspire respect and confidence from others. • Clearly defines contributions and expectations required of team members as team leader or as a team member. • Prioritises workload, manages time effectively and allocates resources to optimise outcomes. • Provides leadership in the development and implementation of Advanced Practice Education and professional development of learners and colleagues in the workplace. • Leads in the development, review, and modification of institutional.	• Identifies emerging trends in health care environment regarding ATHKPs. • Role model good behaviour and attitude towards patients favouring ATHKPs. • Adapts and adopt leadership styles to emerging situations. • Provide appropriate leadership in the development of inclusive policies and standards of care. • Contributes to national policy discourse on ATHKPs. • Uses indigenous management strategies such as *lekgotla*, *mutingati* and others to enhance teamwork. • Appreciates the impact of ATHKPs on resource allocation and utilisation.

	• Uses the change process to influence the introduction of innovations and adaptations to Advanced Practice Field. • Acts as an effective role model for students and within the care team. • Acts as a resource in Advanced Practice Field for students, members of the health team, policy makers and the Public. • Scans practice environment and literature to identify emerging trends and issues. • Uses a range of supportive strategies such as precepting and mentoring when supervising and/or monitoring delegated care.	

9.4.5. Domain 5: Research

Research is an important contributor to the development of any profession or organisation. As such, the SANC expects the professional nurse to conduct research that informs everyday practice. When analysing research findings, rigorous, scientific methods and approaches should be followed so that implementation of any research findings is informed by scientific process. Furthermore, the professional nurse should possess knowledge and skills to implement research outcomes. This is important for the integration of ATHKPs in curriculum as there is abundant research studies and position papers from organisations such as WHO, that recommend the inclusion of ATHKPs (traditional medicine) in the biomedical health system and in health sciences curriculum (Ngunyulu et al. 2020; Kpelao et al. 2018; Lawrence et al. 2021; Chitindingu et al. 2014). Further, research competency is vital for professional nurses who work in indigenous communities where there are processes and ways of doing things in relation to gaining access, implementing community outreach programmes, holding of meetings and protocols for getting approval (Herman 2015; Peu 2021). Such information becomes important in the everchanging role of nurses in the South African context. See Table 9.7 below.

Table 9.7: Domain 5 - Research

<table>
<tr><td colspan="3">DOMAIN 5: RESEARCH

Core competency

• Demonstrate an understanding of indigenous research methods and processes.</td></tr>
<tr><td></td><td>Specific SANC competency</td><td>Integration of competencies(findings) with SANC specific competencies</td></tr>
<tr><td></td><td>• Initiates and conducts research to inform practice in speciality.
• Analyses and critically interpret research findings.
• Reviews and evaluates research reports.
• Implement research outcomes.</td><td>• Initiates research on ATHKPs to inform practice.
• Applies principles and ethics for conducting research in indigenous settings.
• Demonstrate knowledge indigenous methods and designs for conducting research.
• Implements research outcomes regarding ATHKPs.
• Correctly interprets research findings</td></tr>
</table>

9.5. Components of the competency based framework

The competency-based framework was developed to assist nurse educators and NEIs to standardise their teaching ATHKPs in nursing curriculum. According to Batt et al. (2019), competency frameworks for health professionals must outline the nature and purpose of the framework as well as the scope of the framework to facilitate its applicability and acceptance. The following components are discussed to provide clarity on the competency-based framework, in line with recommendations of Batt et al. (2019):

1. Nature and Purpose of Competency-based Framework for Nurses

2. Scope and context of the framework

3. Philosophical underpinning for the framework

4. Benefits of the competency-based framework

9.5.1. Nature and purpose of competency-based framework for nurses

The competency-based framework is developed in response to the changing landscape in African healthcare systems where more and more people are opting for African Traditional Health Knowledge and Practices to meet their health needs or as a supplementary health service. The role of ATHKPs in African communities cannot be overlooked (Harik 2021) and therefore nurses must possess the knowledge, skills, and behaviours to manage health problems brought by patients to the biomedical health system. Hence, this framework has been developed for use by the nurses to assist them to carry out their nursing duties and obligations to patients. It is envisaged that this framework will improve nurse's knowledge and skills, while changing attitudes towards ATHKPs and patients utilising such services. The framework can be used together with other frameworks focusing on improving patients experiences with using the mainstream health system, while maintaining the autonomy to make decisions about their health.

9.5.2. Scope and context of the framework

The framework is designed to assist nurses and NEIs to assess their knowledge and skills on ATHKPs and to ensure that there is a standardised way of teaching and integrating ATHKPs into curriculum or nursing practice. The extensive adoption of the

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framework by nurses, nurse educators, NEIs, and professional bodies will ensure that training programs are aligned with the African healthcare context. The competency-based framework aligns well with the SANC competency framework for professional nurses as well as promoting the achievement of the rights of patients as enshrined in the South African Constitution, Act 107 of 1996, the Patient's Rights Charter and the WHO Traditional Medicine strategy (2013).

The framework is developed for use in NEIs for teaching nurses about ATHKPs, yet it is most applicable in clinical settings where nurses interact with patients from various backgrounds, especially those who support the use of ATHKPs. The framework covers processes and elements of healthcare within ATHKPs, and the knowledge and skills required to diagnose and interpret data emanating from engagements with patients or possible referrals from THPs. The framework does not aim to impose ATHKPs on nurses, but rather provides clarity on pertinent issues that require nurses to have some understanding when dealing with patients from African communities where ATHKPs is commonly practiced. The competencies in the framework can be scaled down to different categories of nursing as required.

9.5.3. Philosophical underpinning for competency-based framework

This framework is premised on the belief that the construction of knowledge must be based on the contextual needs of the communities. This will enable African communities to participate and develop their own education underpinned by an African indigenous knowledge system lens (Higgs 2009). In the earlier chapters, THPs identified Ubuntu as a philosophy underpinning ATHKPs. Hence in this framework, Ubuntu, which forms part of indigeneity lens, is applicable. An African indigenous lens can be regarded as a framework within which Africans perceive, process, and interprets the world and informs their perspectives about how individuals look at themselves and have a common understanding of the world (Almeida & Kumalo 2018). Indigeneity is also relevant as it forms part of the decolonial project which challenges ways of thinking and being. At the core of Ubuntu philosophy is a view that all person's health choices are respected and that the health users trust that health providers have their interests at heart. The values that inform Ubuntu are mutual respect, reciprocity, communism, a sense of belonging, empathy, and caring (Muhammad-Lawal, Anokwuru, Bhana-Pema & Mulaudzi 2022). It is through these

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values that nurses will better understand the holistic nature of patients and what influences them from the point they come to the health establishment until they leave.

9.6. Benefits of the competency-based framework for standardising ATHKPs in nursing curriculum

The main benefits of the competency-based framework is that nurses will have a better understanding of ATHKPs, its features and elements as well as change their attitude regarding the processes of health care provided by THPs. Ultimately the improved knowledge and skills by nurses and nurse educators will benefit the patients as they will receive unprejudiced care that respects their rights to consult for second opinion (Nompumelelo et al. 2019). Benefits for nurses, NEIs and patients are as follows:

9.6.1. Nurses

- Improved understanding of patients' health-seeking behaviours (Mngqundaniso & Peltzer 2008).
- Appreciation of the role THPs and ATHKPs play in communities.
- Improved communication and prospects of collaboration (Solera-Deuchar et al. 2020).
- Nurses understand their responsibilities towards their patients.

9.6.2. NEIs

- Provides a structured approach to integration in curriculum.
- Communicates the message of being responsive to community needs.
- Provide learning opportunities for nurse educators on the stereotypes surrounding ATHKPs.
- Serves as a baseline platform for discussions about values and beliefs and their influence on teaching about ATHKPs.

9.6.3. Patients

- Disclose the use of ATHKPs without fear of prejudice or being shun (Makoa 2000) and improved nursing care which is sensitive to their needs
- Reduced misdiagnosis and misinterpretation of signs means less time in nursing care (Shewamene, Dune & Smith 2017).

9.7. Presentation of competency-based framework for standardising African traditional health knowledge and practices in nursing curriculum

Table 9.8: Competency-Based Framework for Professional Nurses on ATHKPs

COMPETENCY-BASED FRAMEWORK FOR PROFESSIONAL NURSES ON ATHKPs		
DOMAIN 1: PROFESSIONAL, ETHICAL AND LEGAL PRACTICE		
Core competency	**Competency**	**Specific competency**
1.1 Professional	Demonstrate professional accountability for the delivery of nursing care as per SANC standards that is consistent with moral, altruistic, legal, ethical, regulatory and Ubuntu principles in relation to ATHKPs.	• Recognises own accountability and responsibility to practice ATHKPs within scope of practice. • Recognises roles of THPs and functions within the interprofessional healthcare team • Demonstrate respect and appreciates the legitimacy of training for THPs as competent practitioners. • Practice reflectively through use of evidence-based nursing in relation to ATHKPs • Participate in activities related to improving access of patients to alternative health services. • Refer patients to appropriate others (THPs) on request.
1.2 Ethical Practice		• Advocates for patients' and their families' rights and choices. • Challenges stereotypes and behaviours that discriminates patients utilising ATHKPs.

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		• Demonstrates sensitivity to language, cultural, and religious practices of patients.
1.3 Legal Practice		• Recognises laws, regulations and policies governing traditional medicine such as Traditional Health Practitioner's Act 22 of 2007. • Demonstrates understanding of regulation and governance of traditional health practice. • Practises in accordance with relevant policies, procedural guidelines, and protocols.
DOMAIN 2: CARE PROVISION AND CARE MANAGEMENT		
Core competency	**Competency**	**Specific competency**
2.1 Health promotion	Apply basic sciences in the assessment, diagnosis, and treatment of the physiological, physical, psychological, social & spiritual problems of patients and their families with various disorders in relation to ATHKPs.	• Assess the health education needs of patients in relation to ATHKPs. • Develops programmes to promote health needs of patients and families. • Utilises appropriate referral and follow up systems to ensure continuity of care. • Promotes disclosure and safe use of ATHKPs.
2.2 Assessment, diagnosis, planning, and implementation.	Apply nursing process in caring for patients with various disorders.	• Collects systematic subjective and objective data from patients related to ATHKPs. • Demonstrate knowledge on diagnostic methods and procedures used in ATHKPs.

	Describe the principles of various therapies and treatment modalities in used ATHKPs.	• Diagnoses signs on patients utilising ATHKPs. • Plans for care considering views of other health care providers and patients. • Establishes priorities based on patient's needs and request. • Collaborate with health care team members including THPs to meet patient's care needs. • Responds appropriately to patient's cultural, spiritual, and psychological needs.
2.3 Evaluation, recording and information management.	Identify, evaluate, and use the best practices in relation to ATHKPs, considering patient's preferences, experience, and values to inform clinical decisions.	• Practises in accordance with relevant policies, procedural guidelines, and protocols. • Documents accurately observed data and views of patients on ATHKPs. • Provides support to patients and health care team based on patient's needs. • Evaluates collected data and planned outcomes in collaboration with patients.
2.4 Therapeutic communication and relationships	Communicate effectively with patients, families and professional colleagues fostering mutual respect and shared decision making to enhance health outcomes	• Develops therapeutic relationships between self, families, and patients. • Respects boundaries between self and patient's choices in relation to ATHKPs. • Promotes the expression of diverse views and cultures.

		• Communicates information regarding the patients' health choices of ATHKPs with healthcare team members.
DOMAIN 3: PERSONAL DEVELOPMENT AND QUALITY OF CARE		
Core competency	**Competency**	**Specific competency**
3.1 Quality Improvement	Promotes appropriate use of the concepts, principles, therapies, and standards of practice in ATHKPs. Identify and manage risks associated with simultaneous use of ATHKPs and conventional medicine	• Promote integration of ATHKPs into nursing standards and best practice guidelines. • Develops nursing care standards appropriate to patients' health needs. • Identify infection prevention strategies in relation to use of ATHKPs by patients. • Ensures proper storage, administration and recording of therapeutic substances. • Identify potential risks to patient safety and acts accordingly. • Responds appropriately to suggestions and concerns of patients about ATHKPs.
3.2 Continuing Personal Development		• Reflect on own practices and views about ATHKPs. • Takes responsibility for own learning regarding ATHKPs trends and developments.

		• Participates in teaching and learning from heath care team members, including THPs. • Maintains competence in practice through critical examination of own practice and peer review.
DOMAIN 4: MANAGEMENT AND LEADERSHIP		
Core competency	**Competency**	**Specific competency**
	Demonstrate understanding of required management and leadership strategies to manage resources for enhancing the use of ATHKPs and to promote collaboration. Collaborate with THPs and other health providers and efficiently utilise resources in caring patients.	• Identifies emerging trends in health care environment regarding ATHKPs. • Role models good behaviour and attitude towards patients favouring ATHKPs. • Adapts and adopt leadership styles to emerging situations. • Provide appropriate leadership in the development of inclusive policies and standards of care. • Contributes to national policy discourse on ATHKPs. • Uses indigenous management strategies such as lekgotla, mutingati and others to enhance teamwork. • Appreciates the impact of ATHKPs on resource allocation and utilisation.
DOMAIN 5: RESEARCH		
Core competency	**Competency**	**SPECIFIC COMPETENCY**

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	Demonstrate an understanding of indigenous research methods and processes.	• Initiates research on ATHKPs to inform practice. • Applies principles and ethics for conducting research in indigenous settings. • Demonstrate knowledge indigenous methods and designs for conducting research. • Implements research outcomes regarding ATHKPs. • Correctly interprets research findings.

The competency framework will be validated as part of the postdoc project, where various experts and stakeholders who have vested interest in ATHKPs will participate.

9.8. Summary

This chapter discussed the development of the competency framework. This third phase of the study was the last and final phase of the study which included findings from interviews with THPs, quantitative data from nurse educators and validation from literature. The development of the competency framework was informed by the South African Nursing Council competency framework for nurses. The SANC framework was used to cluster competencies into 5 domains. The competency-based framework to standardise teaching ATHKPs in nursing curriculum in South Africa was lastly presented in table format. In Chapter 10, the findings will be summarised, strengths and limitations of the study described, and recommendations made.

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CHAPTER 10

SUMMARY OF THE FINDINGS, RECOMMENDATIONS, IMPLICATIONS, LIMITATIONS, AND CONCLUSIONS

10.1. Introduction

In Chapter 9, the development of the competency-based framework for standardising ATHKPs in nursing curriculum in South Africa was presented. Chapter 10 outlines the summary of the study findings and implications. The recommendations will be made for utilising, applying, and adopting the framework. Lastly the study limitations are described to highlight areas of application, transferability, and credibility of the study findings.

10.2. Overview of the study and summary of the findings

The aim of the study was to develop a competency-based framework for standardising ATHKPs in nursing curriculum. The study had four objectives which were achieved in three phases as follows:

PHASE 1

This phase utilised a qualitative method in which data were gathered through semi-structured interviews with THPs.

Objectives:

- Explore and describe the views of THPs on African Traditional Health Knowledge and Practices.
- To explore and describe Knowledge and skills of THPs in the provision of healthcare in South Africa.

PHASE 2

This phase adopted a quantitative, cross-sectional descriptive design. Data were collected from nurse educators.

Objectives:

- To determine the knowledge of nurse educators on ATHKPs

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- To identify the level of teaching for ATHKPs in nursing education institutions in South Africa.
- To determine the contents of ATHKPs taught in the nursing curriculum in public nursing education institutions (NEIs).
- To assess how ATHKPs is being taught in public NEIs.

PHASE 3

The results from Phases 1 and 2 were integrated to develop the competency-based framework in this phase of the study.

Objective:

- To develop the competency-based framework to standardise the African traditional health knowledge and practices in nursing curriculum.

Figure 10.1 below outlines the various phases of the study.

Figure 10.1: Framework of the research process

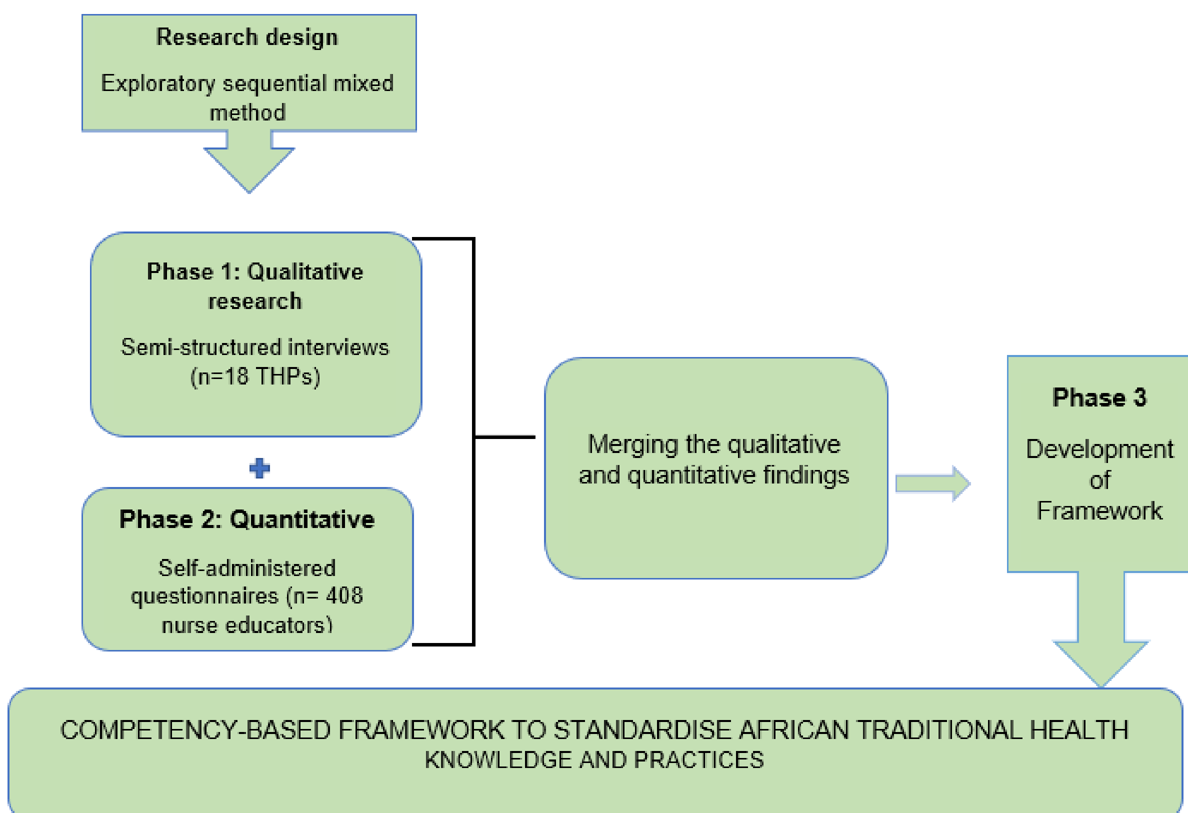

Figure 10.1

10.2.1. Phase 1 - Qualitative, explorative, and descriptive design

The five themes that emerged were: The features of African traditional health knowledge and practices, elements of practice in African traditional health knowledge and practices, challenges encountered by traditional health practitioners in practice, competencies of traditional health practitioners and views of THPs on the training of nurses on ATHKPs. The themes were discussed in relation to literature. A summary of the five themes is presented and discussed below.

10.2.1.1. Summary of Theme 1: The features of African traditional health knowledge and practices

The study revealed that ATHKPs is a unique system of health care with its founding principles. THPs described ATHKPs as a way of life for Africans, describing how Africans live their lives from birth to adulthood. It emerged that ATHKPs is not only about using herbs, but encompasses other elements of life including gender roles, dietary prescripts, and maintenance of relationships. Furthermore, ATHKPs encompasses not only the physical, but also the spiritual realms, making its approach to health care a comprehensive one. Ancestral calling was reported by THPs as the cornerstone of ATHKPs, which is often preceded by life challenges such as becoming ill or having dreams. A trained THP should be able to maintain spiritual connection with the ancestors and be spiritually aligned in line with their calling. Traditional health Practice encompasses many aspects of life and should be recognised and legitimised. Spirituality is strongly entrenched in ATHKPs and forms part of the connection with the ancestors. Interestingly, participants who are diviners focused more on the spiritual nature of traditional health.

10.2.1.2. Summary of Theme 2: Elements of practice in African traditional health knowledge and practices

Like other systems of health care, ATHKPs involves training in a variety of disciplines, which are not exclusively permanent areas of specialisation or practice for THPs because they can transit from being in one of the specialisations to another. Training was reported as a significant step towards being a THP, a process known as *ukuthwasa/ho thwasa.* The training of THPs depends on the nature of their calling. Most of the training may even happen in the family, where parents who are THPs may teach their children. The training includes mentoring and shadowing of the trainer by

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the trainee. Yet, some participants raised their concerns regarding the nature of training and the increasing number of false THPs who are not properly trained. The challenges raised are related to the duration of training and incompetence after completing the training. Accountability of the THPs lies with the individual, but the trainer *(uGobela*), must ensure thorough training so that the THP is competent. Lack of standards and regulation for training of THPs are identified in this study as key determinants to emergence of bogus practices.

Yet, some participants described the influence and importance of language in ATHKPs. According to the participants, language serves as a medium for communicating with the ancestors and a tool used in the training of initiates. The use of different languages may create interferences when the THP is communicating with the ancestors. Notably, language is not only important for communication, but also for naming, defining, and explaining the traditional health concepts, anatomical structures, and diagnosis/illness.

10.2.1.3. Summary of Theme 3: Challenges encountered by traditional health practitioners

THPs encounter several problems in relation to treating presenting problems brought by patients. Some of the challenges include not having the expertise to manage the problem that brought the patient to your practice, expectations of the family and lack of recognition for THPs. To deal with these challenges, sometimes it requires a THP who is prepared to serve patients who may come without money to pay for the service rendered by the THP. It appears that ancestors play an important role in guiding the THP on what to do in helping the patient. Further challenges and concerns were raised regarding attempts to give THPs categories of practice which do not necessarily reflect how things are done in ATHKPs. Stereotypes and one-sided views about ATHKPs still hold back the recognition and trust for ATHKPs. Some participants reported that there are no contradictions between what is practiced in ATHKPs and religions such as Christianity, yet ATHKPs is still marginalised and ostracised.

10.2.1.4. Summary of Theme 4: Competencies of traditional health practitioners

Traditional health practitioners perform various roles in their independent practices and some of these roles, such as patient counselling, may not necessarily be skills they

learnt during their training. Notably, there are similarities in the approaches that most THPs adopt in the traditional healing process such as when the patient walks in and the process of consultation. To be able to help patients successfully and proficiently, THPs must master several skills which are essential for provision of safe ATHKPs. The core skills that were reported by participants include assessment and diagnosing of patients, prescribing, and referring the patients where and when necessary. Diagnostic procedures such as throwing bones and using a glass of water are among methods used as part of diagnosing the patient's problem. THPs also perform duties that are not core skills that are acquired during their training. Some of the skills, as reported by participants, they learn over time, whereas others come naturally such as counselling, exorcism, and plant harvesting.

10.2.1.5. Summary of Theme 5: Views of traditional health practitioners on the training of nurses on ATHKPs

Although not all THPs were able to respond to this question, it was evident that THPs who also practice as nurses were more interested in responding to this question. Participants reported their appreciation of the fact that nurses are not necessarily going to be THPs, rather they should learn what THPs do. It also emerged that teaching nurses on ATHKPs may foster collaboration between nurses and THPs. Another perspective that was raised is regarding ethics in research, especially within the African context. The participant recommended that nurses be taught about the ethos of Western medicine as compared to traditional healing. The findings in this theme demonstrate that there are a lot of possibilities that exist for sharing knowledge and learning from one another. It appeared that THPs do take interest in what nurses do and this was evident when the views expressed were highlighting how things are done in nursing. It is also important to note that ethics of practice taught to nurses should encompass how they should engage with traditional healers.

10.3. Phase 2 : Quantitative, cross sectional, non-experimental descriptive design

The self-developed questionnaire used to collect data was based on findings from Phase 1 and literature. The questionnaires were distributed to the NEIs as hard copies, via email and Qualtrics software for nurse educators to complete. 408

questionnaires/responses were returned and captured. The questionnaire had four sections as follows:

- Section A: Demographic data of respondents
- Section B: Assess the structure of the module/s for teaching ATHKPs.
- Section C: Evaluating the content of ATHKPs taught in the module/s.
- Section D: Methods of teaching and assessment of ATHKPs in the module

10.3.1. Section A: Demographic data

Of the 408 responses that were received, 86% were from the nursing colleges. Respondents from the universities constituted 11%, whereas respondents from the universities of technology added to 3%. Most of the respondents were teaching general nursing (41,67%), followed by mental health (23,4%). Midwifery had the least number of respondents (14,95%). Most participants (47,30%), had 6–10 years of experience, followed by 25,98% with 2–5 years' experience.

10.3.2. Section B: the Structure of Modules for Teaching ATHKPs

The purpose of this section was to assess the level at which ATHKPs is being taught by respondents at the NEIs in the disciplines they teach. With the objectives of the research clearly stated, assessing the structure of the modules for teaching showed that 70,59% of the participants indicated that the discipline in which the module is taught does not cover ATHKPs. Respondents (62,8%) however confirmed that there are clear objectives outlining how the module is taught. Furthermore, it was also confirmed by 64,7% of respondents that there are no clear objectives on how the module is assessed. This may mean that teaching ATHKPs remains unstructured, or nurse educators do not necessarily know what needs to be taught and how. Regarding the level of teaching in the programme, respondents were required to choose from Level 1, Level 2, Level 3, Level 4 and not taught at any level. About 56,6%, which is most of the respondents, indicated that ATHKPs is not taught at any level of the nursing programme in their NEIs. However, 20,1% indicated that ATHKPs is taught at Level 3 of their programme 10,7% at Level 4, 8,8% at Level 1 and 3,6%. Cumulatively, 43,38% of respondents indicated that some element of ATHKPs is taught.

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10.3.3. Section C: Content of ATHKPs taught in the module/s

The purpose of this section was to evaluate the content of ATHKPs that is taught at the institution. The items in this section were developed and organised, based on the themes and ideas that emanated in Phase 1 of the study. Respondents were required to choose the response that best describes the content included in module/s for teaching ATHKPs in the discipline they teach. The items were classified under the categories of overview of ATHKPs, values and beliefs about ATHKPs, training and regulation of THPs, roles of THPs, categories of THPs as well as teaching of CAM. There is a high level of disagreement (>60%) with teaching on all the items under this section, yet there was significant improvement regarding the teaching of CAM. The overall conclusion regarding content taught on ATHKPs, is that this aspect of curriculum is still at the formative stage. The high level of disagreement demonstrates that there is minimal, if not limited, teaching or integration of content on ATHKPs.

10.3.4. Section D: Methods of teaching and assessment of ATHKPs in the module

The purpose of this section was to assess the methods of teaching and assessment for ATHKPs in the nursing modules. This was done to achieve the third objective of this phase of the study. Overall, there was poor response for this section of the questionnaire, with only 23,87%of respondents indicating that there is content for teaching ATHKPs. About 54,17%of the respondents did not respond to this item. Of those that responded, beliefs about ATHKPs and the use of herbal medicine seems to be the most prevalent content being taught in the modules, scoring 5,00% and 3,72% respectively. Most nurse educators reported that they teach ATHKPs only theoretically, without any practical activities. The teaching and assessment of ATHKPs remains the monolithic and seemingly superficial approach to the module where it is being taught. Importantly, most nurse educators (61,03%) indicated that it is important to teach ATHKPs while 30,64% were not sure whether it is important or not. Evidently, there is great potential for teaching ATHKPs as supported by nurse educators. Suggestions were made by nurse educators regarding what could assist in the development of ATHKPs module. Results on this item indicated a poor response rate where only 37,1% responded to this item. Training of THPs and nurses scored most of the suggestions, with a score of 13,25%, followed by defining scope of practice and regulation of THPs with a score of 6,21%.

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In summary, the teaching ATHKPs remains fragmented, unstructured and focuses on theoretical, classroom-based teaching. Successful development of the module on ATHKPs will require training of both nurse educators and THPs on both systems of healthcare. most participants disagreed about their teaching ATHKPs. A promising finding, nevertheless, is that the nurse educators seem to agree that teaching ATHKPs is important, demonstrating the potential for implementation in curriculum.

10.4. Phase 3 : Development of framework for standardising ATHKPs in nursing curriculum

The objective of phase 3 was to develop a competency-based framework for standardising ATHKPs in nursing curriculum in South Africa. The findings and process of development was outlined in Chapter 9. Development of the competency-based framework was based on the integrated results from Phases 1 and 2. Themes that emanated from the integration were used to draft the list of competencies. The guiding principles that informed the development of the competency-based framework, include decolonisation of curriculum, stakeholder engagement, as well as the ability of the competency framework to respond to changing healthcare contexts.

10.4.1. Description and summary of the final developed competency-based framework

The SANC competency framework for professional nurses was adopted as a theoretical framework to guide the structure and domains of the competency-based framework. Adopting the SANC competency framework ensured that the competency-based framework developed in this study, are aligned to expectations of the SANC from professional nurses. The integrated results from Phases 1 and 2 were categorised into the five domains of the SANC competency framework, in line with the themes from the results of the integration. The domains that informed the structure of the competency-based framework include:

1. Professional, ethical, and legal practice
2. Care provision and management
3. Personal development and quality care
4. Management and leadership
5. Research

10.4.1.1. Professional, ethical, and legal practice

This domain in the SANC competency framework includes the ethical-legal elements of nursing practice, including the code of conduct, and accountability of practitioners. The specific SANC competencies in this domain were integrated with the competency findings from Phases 1 and 2, to draft competencies that reflect ATHKPs. The competencies in this domain were categorised thematically into three subdomains, namely professional practice, ethical practice, and legal practice. The subdomains clarify important elements to be considered by nurses regarding their responsibilities and limitations in relation to ATHKPs. Findings in Phase 2 had revealed that nurse educators were sceptical and lacked knowledge on regulations and laws that govern ATHKPs. The domain outlines competencies to address gaps and concerns raised by nurse educators.

The following core competency were developed in this domain:

- Demonstrate professional accountability for the delivery of nursing care as per SANC standards that is consistent with moral, altruistic, legal, ethical, regulatory and Ubuntu principles in relation to ATHKPs.

10.4.1.2. Care provision and management

The core competencies that were identified in this domain were categorised in terms of the subdomains which included health promotion, assessment, diagnosis, planning, and implementation of nursing care by nurses in relation to ATHKPs. The SANC expects professional nurses to be able to provide nursing care, which in the context of ATHKPs, may include promoting health by advising patients on the safe use of ATHKPs and encouraging disclosures for those using traditional medicines and practices. Additionally, this domain includes a list of competencies aimed to equip nurses with knowledge and skills on assessment, diagnostic practices and language used in ATHKPs, as well as requirements for evaluating and recording information pertaining to ATHKPs use by patients. Maintaining therapeutic communications and relationships between nurses, THPs and patients requires nurses to be equipped with knowledge, skills, and positive attitude to promote cooperation and provide patients with information that assist them to make informed decisions about their health. It is envisaged that competencies in this domain will facilitate understanding and appreciation among nurse practitioners.

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The following core competencies were developed in this domain:

- Apply basic sciences in the assessment, diagnosis, and treatment of the physiological, physical, psychological, social, and spiritual problems of patients and their families with various disorders in relation to ATHKPs.
- Apply nursing process in caring for patients with various disorders.
- Describe the principles of various therapies and treatment modalities used in ATHKPs.
- Identify, evaluate, and use the best practices in relation to ATHKPs, considering patient's preferences, experience, and values to inform clinical decisions.
- Communicate effectively with patients, families and professional colleagues fostering mutual respect and shared decision making to enhance health outcomes.

10.4.1.3. Personal development and quality care

The SANC competency framework in this domain highlights the need for nurses to possess knowledge and skills that will enable them to identify and manage risks in the health care setting to facilitate provision of quality safe nursing care. In this domain, competencies that were developed focused on how integration of ATHKPs in nursing practice by professional nurses may improve quality of services offered to patients. Further, the domain highlights the need for nurses to continually develop themselves to have knowledge on the latest trends and practices in ATHKPs. The use of herbal medicine and traditional health interventions in the wake of Covid-19 in 2020 is an example of knowledge areas that impacts health care services. Professional nurses therefore had to be aware of how such herbs and interventions impacted health, which is one area that can be addressed through continuous professional development.

The following core competencies were developed in this domain:

- Promotes appropriate use of the concepts, principles, therapies, and standards of practice in ATHKPs.
- Identify and manage risks associated with simultaneous use of ATHKPs and conventional medicine.

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10.4.1.4. Management and leadership

The SANC competency framework highlights the importance of having managerial and leadership abilities to facilitate utilisation of resources and creation of a positive work environment. Nurses operate in an environment with diverse views, beliefs and values about authority and leadership approaches. Within ATHKPs, there are leadership approaches and traits which may differ in implementation and application as opposed to western culture, where democratic principles are at the centre of decision making. This domain highlighted competencies that may assist nurses in understanding management and leadership strategies from an African perspective, including integration of Ubuntu into leadership approaches. The list of competencies in this domain is aimed at conscientising nurses about context of leadership in African communities, including how that will facilitate collaboration between nurses and THPs.

Core competencies in this domain include:

- Demonstrate understanding of required management and leadership strategies to manage resources for enhancing the use of ATHKPs and to promote collaboration.
- Collaborate with THPs and other health providers and efficiently utilise resources in caring patients.

10.4.1.5. Research

Professional nurses are expected to participate in and conduct research and contribute to the development of the scientific body of knowledge in nursing. Such research requires that nurses understand the principles of conducting research in a variety of settings, including the indigenous setting where contextual ethical issues tend to create challenges for nurses to gain access. This domain provides competencies that identifies knowledge and skills nurses should possess when conducting research in indigenous setting such as procedures for gaining access and consent, various indigenous methods of collecting data in a research set-up.

Core competency for this domain is:

- Demonstrate an understanding of indigenous research methods and processes.

10.4.2. Components of the competency-based framework

The developed competency-based framework has the following components:

1. Domains and competencies.
2. Nature and Purpose of the Competency-based Framework for Nurses on ATHKPs.
3. Scope and context of the competency-based framework.
4. Philosophical underpinning for the competency-based framework.
5. Benefits of the competency-based framework.

10.5. Recommendations

The study presented the competency-based framework for standardising ATHKPs in nursing curriculum in South Africa. The following recommendations are made regarding the adoption, implementation, and application of the competency-based framework.

10.5.1. National Department of Health

- The roles played by THPs in rendering health services must be acknowledged and recognised, supported, and endorsed, so that communities can trust THPs.
- The registration of THPs must be formalised and finalised to create avenues for THPs to freely practice, collaborate and to be held accountable for their actions. The slow progress in this regard is affecting the implementation of policies, regulations, and strategic plans.
- The NDoH, as the custodian of health in South Africa, must liaise with all stakeholders in nursing education institutions regarding the adoption of the competency-based framework. This means that NDoH must champion the integration of ATHKPs into the health systems by funding programmes and organising awareness campaigns.

10.5.2. South African Nursing Council (SANC)

- The South African Nursing Council is the custodian of nursing education and training in South Africa. Any framework developed for nurses must consider the position of the SANC regarding the relevance of the framework for nurses. In this regard, the study recommends that the SANC publish a position statement

or guidelines regarding the integration of ATHKPs into nursing education and practice. This will go a long way in validating the role played by THPs and put nurses at ease when they must collaborate with THPs.

- Endorse the competency-based framework as a standard for teaching ATHKPs in nursing education institution and for practicing in health establishments. This is in line with the laws and regulations of South Africa such as the Constitution, Act 108 of 1996, which permits citizens to practice their cultures and religions without prejudice. Further, the SANC code of conduct directs nurse practitioners to conduct themselves within the scope of their profession, including advocating for patients. Endorsement of this framework will ensure that nurses practice safely and in a consistent manner in relation to ATHKPs.
- The SANC can consider collaborating with THPs Council, to understand better the concerns that most nurse educators raised as potential challenges to integration and collaboration with THPs.

10.5.3. Traditional Health Practitioners (THPs) council

- The THPs council is the custodian of traditional health practice in South Africa. As such, they are required by law, in terms of the Traditional Health Practitioners Act, 22 of 2007, to promote, protect and monitor the use of ATHKPs in defence of communities. The THP Council must endorse the framework and validate the content as representative of what ATHKPs is about.
- The THP council should collaborate with the SANC and Higher education institutions to develop training programs or capacity-building programs to be utilised during the training of THPs and nurses.

10.5.4. Department of Higher Education and Training (DHET)

- In line with calls for decolonisation of curriculum, the DHET must consider implementing the framework as part of its social responsiveness. Higher education institutions must be supported in revising their curriculum, which encompasses ATHKPs in all its facets.
- Further, develop guidelines for developing training programmes that respond to international trends such as SDGs, WHO traditional medicine strategy and emigration.

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- Nursing education institutions must consider the implementation of the framework for teaching nurses about ATHKPs. A starting point could be the development of collaborative partnerships with THPs and organisations, to learn from them. Regular training and workshop on the framework and what it aims to achieve is recommended.
- Within the current curriculum, content on ATHKPs must be included to prepare nurses for challenges in the communities when they must collaborate with THPs or provide services to patients who utilise both systems of health care.

10.5.5. Civil society

- Health needs of a society are best known by those who stay in those communities. Civil society organisations must advocate for the recognition of THPs and the services they offer. This in turn will sensitise nurses and institutions to want to know more about ATHKPs.
- The shortage of resources should trigger civil society organisation that advocates for rights of communities, to discuss with the NDoH on sourcing the services of registered THPs to help alleviate the burden on the health system. Yet this will not be possible if nurses are not knowledgeable about ATHKPs.

10.6. Recommendations for future research

The study revealed that most educators still lack knowledge and understanding regarding ATHKPs. In addition, there is paucity of literature regarding curriculum reforms, focusing on ATHKPs in nursing. The study therefore recommends that a study must be conducted with nurses regarding their knowledge about ATHKPs and their views about being taught about the topic. Further studies can be conducted to determine potential challenges associated with THPs teaching about ATHKPs to nurses.

10.7. Implications of the study

The study has revealed that there is a lack of structure for teaching ATHKPs by nurse educators. Further there are no guidelines or policies outlining how the approach to teaching ATHKPs or collaboration with THPs should be. The results of this study may be used to guide policy formulation by the National Department of Health wherein the different roles that THPs play are acknowledged and the extent to which nurses may

collaborate are outlined. The framework lays a good foundation for NEIs to revise their curricula and to be more inclusive of alternative health services such as ATHKPs. The SANC must champion, regulate and promote safe use of ATHKPs by nurse practitioners to safeguard the nursing profession. This is a grey area in nursing education and practice and must be clarified.

10.8. Unique contribution of the study

The competency-based framework for standardising ATHKPs in nursing curriculum is the first to be developed, not only in nursing, but generally in health professions in South Africa. The framework is unique as it integrates competencies on ATHKPs and the SANC domains into a field of research that is rarely studied. The competency framework is developed to ensure that theoretical content is identified separately from the knowledge, skills, and behaviors of nurse practitioners. The competencies are developed from information provided by THPs, who are the custodians of ATHKPs. Converging ATHKPs into nursing content provides a unique contribution as the competencies and content focuses on contemporary, community-based, culturally relevant information as reported by THPs. Further this study responds to the call to decolonise curriculum in South Africa, where nurses are taught to contextually apply knowledge and skills within their African context and understanding. Therefore, this study has taken a significant step in proving that ATHKPs is a science and can be taught at the highest level.

10.9. Strengths and limitations of the study

Scientific research strives to provide a balanced view on how a certain finding or outcome was achieved. It is therefore necessary for researchers to provide an in-depth description on the strengths and limitations of their studies to facilitate interpretation, transferability, and application of the study outcomes.

10.9.1. Strengths of this study

This study brings together different worldviews that have been perceived to be contradictory. The views of THPs about ATHKPs bring to light the existing similarities between traditional health practice and biomedicine. As such the competency-based framework is a unique and first for nursing framework, which considered views of indigenous knowledge holders to inform its development. The study included respondents from all the different types of NEIs in South Africa; Universities,

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universities of technology and nursing colleges, making it a comprehensive study with a high response rate. The results also demonstrate a broader view regarding the teaching ATHKPs.

10.9.2. Limitations of the study

10.9.2.1. Limitation concerning the methodology

Phase 1 data collection was limited to a specific geographical location, making generalisability challenging. When Phase 2 of the study commenced, there was not existing questionnaire which had been used to collect data on teaching of specific content on traditional medicine in nursing curricula in South Africa or globally. Hence, the tool used was specifically developed and validated for the current study and context. Yet the questionnaire was piloted and assessed by a team of experts before being used.

10.9.2.2. Limitations of exploratory sequential mixed methods

In this study, the participants were heterogenous, making data merging and interpretation challenging as the participants come from different contexts of work. More time was required for managing the data set, as they were of different populations. Creswell's side-by-side comparison was used to converge the data and integrate the findings.

10.9.2.3. Limitations regarding access to participants

Accessing THPs was challenging as they are currently not fully registered with the THP Council. Accessing participants and getting approval to participants in Phase 1 was delayed because of the covid 19 pandemic, however the traditional health practitioners' organisations assisted with connecting the researcher and THPs. The nature of the study was such that the researcher had to build trust with the THPs first before data collection due to the mistrust that seemed to persist between THPs and researchers.

10.9.2.4. Limitations of the competency-based framework

The framework was developed from the data that emanated in the study and literature review. However, the framework has not been validated, and will be done as part of the post-doctoral project, to refine and conduct stakeholder consultations.

10.10. Conclusion

The final chapter oulined the conclusion of the study project. The main aim of the study was to develop a competency-based framework to standardise ATHKPs in nursing curriculum in South Africa. It was necessary that that framework developed, reflects the core knowledge which represents the views of THPs, who are the custodians of ATHKPs. Hence the study consulted the THPs as a starting point to lay foundation of what constitutes knowledge, skills and behaviours within this system of healthcare. It is from this information, that a more contextualised approach to subsequent phases and data collection. The developed competency-based framework will help facilitate understanding and tolerance between nurses and THPs as they will have a broader view and appreciation of the similarities and differences between ATHKPs and biomedical health system.The findings of the study confirmed that ATHKPs is a uniques system of health care and nurses who are aware of the principles and ways of doing things within this system are better equiped to manage patients problems. Yet it was proven that not structure existed on how nurses can be taught about ATHKPs as evidenced by the high level of disagreement and uncertainty among nurse educators on the content of ATHKPs being taught in curriculum.

Furthermore, the approach to teaching ATHKPs has been proven to be superficial, theory-focused without associated learning outcomes or assessment activities. This demonstrates that ATHKPs is considered generally, as an add-on content without any curricula relevancy. Yet, nurses in South Africa, on a daily basis manage patients who are using ATHKPs extensively. This has been proven in literature and in this study. In line with the WHO Traditional Medicine Strategy 2014-2023, the competency-based framework streghthens and supports plans to implement and develop policies on integration of traditional medicine into the biomedical health system. Moreover, the framework will ensure that nurses practice safely, thereby supporting SDG 3, which aims to improve health services and save lives. Nurses who are equiped with knowledge on ATHKPs, are better positioned to identify, diagnose and manage patient health problems without delay and making patients feel vulnerable. The developed competency-based framework serves can serve as a guide for NDoH and NEIs in recognising the importance of nurses having knowledge and skills on ATHKPs. Curricula reformations should consider how this framework can be integrated into teaching of nurses at various levels of their training.

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ANNEXURES

Annexures A to B: Participant's Information and Informed Consent Document

Annexure A: Phase 1 Participant's Information and Informed Consent Document

PARTICIPANT'S INFORMATION & INFORME D CONSENT DOCUMENT

STUDY TITLE: DEVELOPMENT OF A COMPETENCY-BASED FRAMEWORK TO STANDARDISE AFRICAN TRADITIONAL HEALTH KNOWLEDGE AND PRACTICES IN NURSING CURRICULUM IN SOUTH AFRICA.

Sponsor: National Research Fund (Prof FM Mulaudzi)

Principal Investigators: Mr ME Moeta

Prof FM Mulaudzi

Prof M Rasweswe

Institution: University of Pretoria

DAYTIME AND AFTER-HOURS TELEPHONE NUMBER(S):

Daytime number/s: 012 350 3150

Afterhours number: 073 824 3332

DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:

				:
date	month	year		Time

1) INTRODUCTION

You are invited to volunteer for a research study. I am doing this research for Doctoral degree purposes at the University of Pretoria. This document gives information about the study to help you decide if you would like to participate. Before you agree to take part in this study, you should fully understand what is involved. If you have any questions, which are not fully explained in this document, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about what we will be discussing during the interview.

2) THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to develop a competency-based framework to standardise the African traditional health knowledge and practices in nursing curriculum in South Africa. By doing so we wish to learn more about African traditional health knowledge and practices and how this can be taught to nurses in line with patient-centered care. This information will enable nurses to develop a curriculum that considers the role of Traditional health practitioners and how this should be taught.
You will be interviewed by the researcher in a place that is private and easy for you to reach.

3) EXPLANATION OF PROCEDURES AND WHAT WILL BE EXPECTED FROM THE PARTICIPANTS

If you agree to participate, you will be asked to participate in an individual interview which will take about 45 minutes. The individual interview will be a one-on-one meeting between the two of us. I will ask you several questions about the research topic. This study involves answering some questions such as how would you define African traditional health knowledge and practice? What are the unique features of ATHKPs? What are the values and beliefs informing African traditional health practice? What knowledge, skills and attitudes are required for competent traditional health practice? With your permission, the interview will be recorded on a recording device to ensure that no information is missed.

4) RISKS AND DISCOMFORTS INVOLVED?

We do not think that taking part in the study will cause any physical or emotional discomfort or risk. The only possible risk and discomfort involved is sharing information that you may deem sacred in terms of your practice norms. However, you are not compelled to share any information that you deem sacred.

5) POSSIBLE BENEFITS OF THE STUDY

You will not benefit directly by being part of this study. But your participation is important for us to better understand Traditional Health Practitioners roles. The information you give may help the

researcher improve how nurses are trained and their understanding of traditional health practitioners roles so that they can collaborate in the interest of the well-being of patients.

6) COMPENSATION

You will not be paid to take part in the study. However, any cost you have because of taking part in the study, for example transport costs will be paid back to you should you use your own transport to meet the researcher (reimbursed).

7) VOLUNTARY PARTICIPATION

The decision to take part in the study is yours and yours alone. You do not have to take part if you do not want to. You can also stop at any time during the interview without giving a reason. If you refuse to take part in the study, this will not affect you in any way. You will still receive standard care and treatment for your illness.

8) ETHICAL APPROVAL

This study was submitted to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, Medical Campus, Tswelopele Building, Level 4-59, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been given by that committee. The study will follow the Declaration of Helsinki (last update: October 2013), which guides doctors on how to do research in people. The researcher can give you a copy of the Declaration if you wish to read it.

9) INFORMATION ON WHO TO CONTACT

If you have any questions about this study, you should contact:

Professor FM Mulaudzi 012 350 3178

10) CONFIDENTIALITY

We will not record your name anywhere and no one will be able to connect you to the answers you give. Your answers will be linked to a fictitious code number, or a pseudonym (another name) and we will refer to you in this way in the data, any publication, report, or other research output.
All records from this study will be regarded as confidential. Results will be published in medical journals or presented at conferences in such a way that it will not be possible for people to know that you were part of the study.

The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Research Ethics Committee. All these people are required to keep your identity confidential. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

All hard copy information will be kept in a locked facility at HW Snyman Building North, at the University of Pretoria, for a minimum of 15 years and only the research team will have access to this information.

11) CONSENT TO PARTICIPATE IN THIS STUDY

- I confirm that the person requesting my consent to take part in this study has told me about the nature and process, any risks or discomforts, and the benefits of the study.
- I have also received, read, and understood the above written information about the study.
- I have had adequate time to ask questions and I have no objections to participate in this study.
- I am aware that the information obtained in the study, including personal details, will be anonymously processed, and presented in the reporting of results.
- I understand that I will not be penalised in any way should I wish to stop taking part in the study and my withdrawal will not affect my treatment and care.
- I am participating willingly.
- I have received a signed copy of this informed consent agreement.

____________________________ ______________________
Participant's name (Please print)
Date

____________________________ ______________________
Participant's signature Date

____________________________ ______________________
Researcher's name (Please print) Date

____________________________ ______________________
Researcher's signature Date

I understand that the interview will be audio-taped. I give consent that it may be audio-taped.

YES / NO

I hereby certify that the person has agreed to participate in this study.

Participant's name (Please print)	Date
Participant's signature or thumbprint	Date
Investigator's name (Please print)	Date
Investigator's signature	Date
Name of the person who witnessed. the informed consent (Please print)	Date
Signature of the witness	Date

Annexure B: Phase 2 Participant's Information and Informed Consent Document

PARTICIPANT'S INFORMATION & INFORME D CONSENT DOCUMENT

STUDY TITLE: DEVELOPMENT OF A COMPETENCY-BASED FRAMEWORK TO STANDARDISE AFRICAN TRADITIONAL HEALTH KNOWLEDGE AND PRACTICES IN NURSING CURRICULUM IN SOUTH AFRICA.

Sponsor: National Research Fund (Prof FM Mulaudzi)

Principal Investigators: Mr ME Moeta

Prof FM Mulaudzi

Prof M Rasweswe

Institution: University of Pretoria

DAYTIME AND AFTER-HOURS TELEPHONE NUMBER(S):

Daytime number/s: 012 350 3150

Afterhours number: 073 824 3332

DATE AND TIME OF INFORMED CONSENT DISCUSSION:

				:
dd	**month**	**year**		**Time**

Dear Prospective Research Participant

Dear Mr / Ms / Mrs …………………………………………………………………..

1) INTRODUCTION

You are invited to volunteer for a research study. I am doing this research for Doctoral degree purposes at the University of Pretoria. The information in this document is provided to help you to decide if you would like to participate. Before you agree to take part in this study, you should fully understand what is involved. If you have any questions, which are not fully explained in this document, do not hesitate to ask the researcher. You should not agree to take part unless you are completely happy with the kind of questions that will be asked.

2) THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to develop a competency-based framework to standardise the African traditional health knowledge and practices in nursing curriculum in South Africa. By doing so we wish to learn more about African traditional health knowledge and practices and how this can be taught to nurses in line with patient-centered care. This information will enable nurses to develop a curriculum that considers the role of Traditional health practitioners and how this should be taught.

You will be interviewed by the researcher in a place that is private and easy for you to reach.

3) EXPLANATION OF PROCEDURES AND WHAT WILL BE EXPEXTED FROM PARTICIPANTS

This study involves answering some questions regarding the content of African traditional health knowledge and practices that is included in the nursing curriculum in your nursing education institution.

We would like you to complete a questionnaire. It will take approximately (will depend on questionnaire developed from Phase 1 data, I cannot preempt at this point) ____ minutes/hour/s. We will collect the questionnaire from you before you leave the ward/ study site. We will / will not be available to help you with the questionnaire. The researcher will keep the completed questionnaires in a safe place to make sure that only people working on the study will have access to it. Please do not write your name on the questionnaire. This will ensure that your answers are kept confidential (so nobody will know what you have answered).

The questionnaire consists of these sections:

6.2.3.1 Section A: Demographic data of respondents

Demographic profile of the respondents includes 6 items (1-6), namely, institution type, age, gender, discipline of nursing taught, programme offered at the NEI and years of experience as nurse educators.

6.2.3.2 Section B: Structure of the module/s for teaching ATHKPs

This section includes 5 items (7-11), to assess the level of teaching for ATHKPs in the respective nursing college, university, or University of technology nursing department.

6.2.2.4 Section C: Content of ATHKPs taught in the module/s

This section has a total of 8 sub-sections (12 -19), to evaluate the content of ATHKPs taught in the modules the educators teach.

6.2.2.5 Section D: Methods of teaching and assessment of ATHKPs in the module.

This section consists of 5 items (20-24), with both closed and open-ended questions to assess the method of teaching and assessment of ATHKPs in the module/s.

4) RISK AND DISCOMFORT INVOLVED

There is no foreseeable physical discomfort or risk involved. If there are questions that are too sensitive for you to answer, you do not need to answer them.

5) POSSIBLE BENEFITS OF THIS STUDY

You will not benefit directly by being part of this study. But your participation is important for us to better understand Traditional Health Practitioners roles. The information you give may help the researcher improve how nurses are trained and their understanding of traditional health practitioners roles so that they can collaborate in the interest of the well-being of patients.

6) ETHICS APPROVAL

This Protocol was submitted to the Faculty of Health Sciences Research Ethics Committee, University of Pretoria, Medical Campus, Tswelopele Building, Level 4-59, Telephone numbers 012 356 3084 / 012 356 3085 and written approval has been granted by that committee. The study has been structured in accordance with the Declaration of Helsinki (last update: October 2013), which deals with the recommendations guiding doctors in biomedical research involving humans. A copy of the Declaration may be obtained from the investigator should you wish to review it.

7) INFORMATION

If you have any questions concerning this study, you may contact:

Professor FM Mulaudzi 012 350 3178

8) CONFIDENTIALITY

All records from this study will be regarded as confidential. All results will be published or presented in such a way that it is not possible to identify the participants.

9) COMPENSATION

You will not be paid to take part in the study. There are no costs involved for you to be part of the study.

10) CONSENT TO PARTICIPATE IN THIS STUDY

- I confirm that the person requesting my consent to take part in this study has told me about the nature and process, any risks or discomforts, and the benefits of the study.
- I have also received, read, and understood the above written information about the study.
- I have had adequate time to ask questions and I have no objections to participate in this study.
- I am aware that the information obtained in the study, including personal details, will be anonymously processed, and presented in the reporting of results.
- I understand that I will not be penalised in any way should I wish to discontinue with the study and my withdrawal will not affect my employment or student status.
- I am participating willingly.
- I have received a signed copy of this informed consent agreement.

______________________________ ______________________

Participant's name (Please print) Date

______________________________ ______________________

Participant's signature Date

______________________________ ______________________

Researcher's name (Please print) Date

______________________________ ______________________

Researcher's signature Date

I hereby certify that the participant has agreed to participate in this study.

Participant's name (Please print)	Date
Participant's Signature or Mark	Date
Investigator's Name (Please print)	Date
Investigator's Signature	Date
Name of the person who witnessed the informed consent(Please print)	Date
Signature of the Witness	Date

Annexure C: Semi-structured Interview Guide

Draft of semi structured interview guide

Main Questions

- How would you define African traditional health knowledge and practice?
- What are the unique features of ATHKPs?
- What are the values and beliefs informing African traditional health practice?
- What knowledge is required for competent traditional health practice?
- What skills are required for competent traditional health practice?
- How do you suggest nurses be taught about ATHKPs?

Annexure D: Questionnaire

Topic: Development of a Competency-Based Framework to Standardise African Traditional Health Knowledge and Practices in Nursing Curriculum in South Africa.

Date……………………………………………

Respondent Identification code……………………… (for office use only)

Dear respondent

Thank you for agreeing to take part in this research project as titled above. Completing this questionnaire will take about 25 minutes of your time. Please remember that your participation is entirely voluntary, and your privacy and confidentiality is assured. This questionnaire is divided into 4 sections. The sections are described in the instructions below. Please fill all the information and pay attention to all instructions. Also feel free to ask questions where you need clarity.

INSTRUCTIONS:

1. Answer all questions.
2. Fill each provided space according to your best knowledge.
3. This questionnaire consists of 4 sections:

- **Section A Demographic data**
- **Section B The structure of the module/s for teaching ATHKPs**
- **Section C Content of ATHKPs taught in the module/s.**
- **Section D Methods of teaching and assessment of ATHKPS in the module**

KEY ** African Traditional Health Knowledge and Practices (ATHKPs)
Traditional Health Practitioners (THPs)

SECTION A: DEMOGRAPHIC DATA

Purpose of this section is to get to know you and your involvement in teaching at your institution.

1. **Type of institution**
   - ☐ Nursing college
   - ☐ University
   - ☐ University of Technology
2. **Age**
   - ☐18-24
   - ☐25-34
   - ☐35-44
   - ☐45-54
   - ☐> 54
3. **Gender**
   - ☐ Female
   - ☐ Male
   - ☐other
4. **Discipline of Nursing in which you teach.**

☐ Community Nursing	☐ Yes	☐ No
☐ General Nursing	☐ Yes	☐ No
☐ Mental Health	☐ Yes	☐ No
☐ Midwifery	☐ Yes	☐ No

5. **Nursing programme offered in your institution**
   (You may choose more than 1 option)
   - ☐ Diploma in Nursing (general, community & Psychiatry) and Midwifery – R425
   - ☐Bachelor's Degree in Nursing Science- R425
   - ☐ Bachelor of Nursing (R174) leading to registration as a Professional Nurse and Midwife
   - ☐Bachelor of Technology- R425
   - ☐ Diploma in General Nursing- R171
6. **Years of experience as a nurse educator**
   - ☐2- 5
   - ☐ 6-10
   - ☐ 11-15
   - ☐ above 15

SECTION B: ASSESS THE STRUCTURE OF THE MODULE/S FOR TEACHING ATHKPs

The purpose of this section is to assess the level at which ATHKPs is being taught at the NEIs. (Please tick the option that best describes the level of teaching for ATHKPs).

7. Does the discipline in which you teach have a module that covers ATHKPs?

☐ Yes

☐No

☐ Not sure

8. The module that covers ATHKPs is credit-bearing (allocated credits)

☐ Yes

☐ No

☐ Not sure

9. There are clear objectives outlining how the module is taught.

☐ Disagree

☐ Not sure

☐ Agree

10. There are clear objectives on how the module is assessed.

☐ Disagree

☐ Not sure

☐ Agree

11. At what level of study is ATHKPs taught in your institution?

☐ Level 1

☐ Level 2

☐ Level 3

☐ Level 4

☐ Postgraduate level

☐ Not sure

☐ Not taught at any level.

SECTION C: EVALUATING CONTENT OF ATHKPs TAUGHT IN THE MODULE/S

The purpose of this section is to evaluate the content of ATHKPs taught in the module in your institution.

Please choose the response that best describes the content included in module/s for teaching ATHKPs in your discipline.

Features of African Traditional Health Knowledge and Practices (ATHKPs) The following contents are included in the module/s:						
No	**Item**	**Disagree**	**Agree**	**Not sure**		
12.	The origin and history of ATHKPs					
13.	African philosophies such as Ubuntu					
14.	The values, beliefs and principles underlying ATHKPs					
15.	The evolution of traditional medicine					
16.	Definition of health from a traditional healing perspective					
17.	Approaches to illness in traditional healing (physical, psychological, and spiritual)					
18.	The role of spirituality in traditional healing					
19.	Signs of ancestral calling					
20.	Various types of African foods					
21.	Laws, regulations, and policies governing traditional medicine					
22.	Training of THPs to become competent practitioners					

Elements of practice in African Traditional Health Knowledge and practices The module/s include the following content:						
No	**Item**	**Disagree**	**Agree**	**Not sure**		
23.	The following categories of THPs are included in the module:					
	• Diviner					
	• Herbalist					
	• *Sangoma*					
	• Traditional surgeon					
	• Traditional Birth Attendant					
24.	The use of language in identifying and naming things, objects, or people in ATHKPs					
25.	Accountability of THPs in traditional healing					
26.	Similarities between ATHKPs and other health systems such as Western medicine					
27.	Diagnostic methods used in traditional healing					

Challenges encountered by Traditional Health Practitioners The following challenges are included in the module:						
No	**Item**	**Disagree**	**Agree**	**Not sure**		
28.	Regulation and governance of THPs					
29.	Implementation of Traditional Health Practitioner's Act 22 of 2007					
30.	Stereotypes about ATHKPs					
31.	Recognition of THPs					

Competencies of Traditional Health Practitioners The following competencies are taught in the module:						
No	**Item**	**Disagree**	**Agree**	**Not sure**		
32.	Physical assessment of patients					
33.	Spiritual assessment and alignment					
34.	History taking and discussions					
35.	Diagnosis of patients					
36.	Diagnostic methods such as bone throwing and using glass of water					
37.	Indigenous names for diseases					
38.	Harvesting herbs and medicinal plants					
39.	Prescribing of medicine by THPs					
40.	Technique of measuring quantity of medicines					
41.	Writing of referral letters by THPs					
42.	Collaboration between nurses and THPs					
43.	Counselling of patients					
44.	Exorcism (casting out evil spirits in possessed patient)					

Practical teaching on ATHKPs The following are included in the module:						
No	**Item**	**Disagree**	**Agree**	**Not sure**		
45.	Physical visits by THPs to the institution to teach nursing students					
46.	Practical visits by students to traditional health practices					
47.	Ethics for conducting research and collaborating with THPs					

Inclusion of Complementary and Alternative Medicine (CAM) The following are included in the module:						
	Item	**Disagree**	**Agree**	**Not sure**		
48.	**The following CAM content are taught in the curriculum:** ● Mind-body medicine (Acupuncture, Meditation, Yoga, Hypnotherapy)					
	● Herbal medicine, natural products, others (nutritional supplements or not specified)					
	● Manipulative and body-based practices (massage, spinal manipulation, other)					
	● Homeopathy and naturopathy, energy field, art therapy, aroma therapy					
	● Equilibrium therapy					

49. Please provide a short description of the course content on ATHKPs if not include above.

SECTION D: METHODS OF TEACHING AND ASSESSMENT OF ATHKPs IN THE MODULE.

The purpose of this section is to determine the methods of teaching and approaches to assessment for ATHKPs in your NEI.

50. Which of the following best describes the approach to teaching ATHKPs in your discipline:

☐ Theory only	☐ Yes	☐ No
☐ Practical only	☐ Yes	☐ No
☐Problem based learning	☐ Yes	☐ No
☐Projects	☐ Yes	☐ No
☐ Other	☐ Yes	☐ No

50.1 Please provide examples of how the approach is used.

51. Do you have assessment tasks used in your course for ATHKPs?

☐ Yes

☐No

51.1. Please indicate, if applicable, the examples of assessment tasks used in your module/course for ATHKPs

52. How important do you think it is to teach nursing students about ATHKPs?

☐ Not important

☐ Not sure

☐ Important

53. What content do you think should be included in the curriculum for nurses on ATHKPs?

54a. List 4 suggestions that you consider will assist in the development of curriculum on ATHKPS.

1…………………………………………………………………………………………………

2………………………………………………………………………………………………..

3………………………………………………………………………………………………..

4………………………………………………………………………………………………..

End of questionnaire

Thank you for responding to the questions.

Annexure E: Ethics Approval Form - University of Pretoria

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 18 March 2022 and Expires 18 March 2027.
- IORG #: IORG0001762 OMB No. 0990-0278 Approved for use through August 31, 2023.

Faculty of Health Sciences **Research Ethics Committee**

20 June 2023

Approval Certificate
Annual Renewal

Dear Mr ME Moeta,

Ethics Reference No.: 812/2019 – Line 3
Title: Development of a Competency-Based Framework to Standardise African Traditional Health Knowledge and Practices in Nursing Curriculum in South Africa.

The **Annual Renewal** as supported by documents received between 2023-06-01 and 2023-06-14 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2023-06-14 as resolved by its quorate meeting.

Please note the following about your ethics approval:

- Renewal of ethics approval is valid for 1 year, subsequent annual renewal will become due on 2024-06-20.
- Please remember to use your protocol number (812/2019) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

On behalf of the FHS REC, Professor C Kotzé
MBChB, DMH, MMed(Psych), FCPsych, Phd
Acting Chairperson: *Faculty of Health Sciences Research Ethics Committee*

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

Research Ethics Committee
Room 4-60, Level 4, Tswelopele Building
University of Pretoria, Private Bag x323
Gezina 0031, South Africa
Tel +27 (0)12 356 3084
Email: deepeka.behari@up.ac.za
www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

Annexure F: Approval Letters from Provincial Health Departments

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

OUTCOME OF PROVINCIAL PROTOCOL REVIEW COMMITTEE (PPRC)

Researcher's Name (PI)	Mr ME Moeta
Organization / Institution	University of Pretoria
Research Title	Development of a Competency-Based Framework to Standardise African Traditional Health Knowledge and Practices in Nursing Curriculum in South Africa.
Contact number	073 824 3332
Protocol number	GP202203 032
Sites	Ann Latsky, Bonalesedi, Chris Hani Baragwanath, Rahima Moosa and SG Lourens Nursing Campuses

Your application to conduct the abovementioned research has been reviewed by the Province and permission has been granted.

We request that you submit a report after completion of your study and present your findings to the Gauteng Health Department.

[X] Permission granted

[ ] Permission denied

Recommended by

MR LR SERONGWA
ACTING DIRECTOR: NURSING COMPLIANCE AND RESEARCH
DATE: 06-05-2022

DEPARTMENT OF HEALTH
LEFAPHA LA BOPHELO BO BOTLE
DEPARTEMENT VAN GESONDHEID
ISEBE LEZEMPILO

OFFICE OF THE HOD
Executive Offices
Northern Cape Department of Health
Private Bag X5049
KIMBERLEY, 8300
Tel: 053 830 2134
Email: BMashute@ncpg.gov.za

Enquiries: / Dipatlisiso: / Imibuzo: / Navrae: Mr. B Mashute

Date: / Leshupelo: / Umhla: / Datum: 04 May 2022

References: / Tshupelo: / Isalathiso: / Verwysing: NC_202203_002

Mr. Mabitja Moeta
HW Snymanan Building
Bophelo Street
Gezina, Pretoria
0183

Project Title: Development of a Competency-Based Framework to Standardise African Traditional Health Knowledge and Practices in Nursing Curriculum in South Africa.

Dear Mr. Moeta

The application for permission to conduct the above-mentioned research study was received and reviewed by the Northern Cape Department of Health.

Decision: Approval is granted to conduct this research project at the Henrietta Stockdale Nursing College in the Northern Cape Province.

The reference number for this research project is NC_202203 02, and please use this reference with all your communication with the Research Coordinator.

Please note the following:

1. This approval is valid for a period of one year from the date of approval.
2. The researcher is requested to make all the necessary arrangement with the college principal, so that the provision of healthcare services is not affected by this research project.

We are committed to achieving our vision through a decentralised, accountable, accessible and constantly improving health care system within available resources. Our caring, multi-skilled, effective personnel will use evidence based, innovative health care and maturing partnerships for the benefit of our clients and patients.

Enquiries: Yvonne Gixela Tel no: 079 074 0659

Email: Yvonne.Gixela@echealth.gov.za / vgixela@gmail.com

Date: 17 March 2022

Development of a Competency-Based Framework to Standardise African Traditional Health Knowledge and Practices in Nursing Curriculum in South Africa. (EC_202203_007)

Dear Mr. M.E. Moeta

The department would like to inform you that your application for the abovementioned research topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.

2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.

3. The Department of Health expects you to provide a progress update on your study every 3 months (from date you received this letter) in writing.

4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Eastern Cape Health Research Committee secretariat. You may also be invited to the department to come and present your research findings with your implementable recommendations.

5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTE

TOGETHER, MOVING THE HEALTH SYSTEM FORWARD

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Department of Health

Ref : LP_2022-02-020
Enquires : Ms PF Mahlokwane
Tel : 015293 6028
Email : Phoebe.Mahlokwane@dhsd.limpopo.gov.za

Mr Mabitja Moeta

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below

DEVELOPMENT OF A COMPETENCY-BASED FRAMEWORK TO STANDARDISE AFRICAN TRADITIONAL HEALTH KNOWLEDGE AND PRACTICES IN UNDERGRADUATE NURSING CURRICULUM IN SOUTH AFRICA.

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
   a. Present this letter of permission to the institution supervisor/s a week before thestudy is conducted.
   b. This permission is ONLY for Giyani Campus, Sovenga Campus and Thohoyandou Campus as requested.
   c. In the course of your study, there should be no action that disrupts the routineservices or incur any cost on the Department.
   d. After completion of study, it is mandatory that the findings should be submitted to theDepartment to serve as a resource.
   e. The researcher should be prepared to assist in the interpretation and implementationof the study recommendation where possible.
   f. The approval is only valid for a 1-year period.
   g. If the proposal has been amended, a new approval should be sought from theDepartment of Health
   h. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.

pp **Head of Department** 14/03/2022
Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street. Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.
Website: http/www.limpopo.gov.za

The heartland of Southern Africa – Development is about people!

Annexure G: Editor Letter

2023/12/18

To whom it may concern.

This is to certify that I have edited this Thesis for the following candidate:

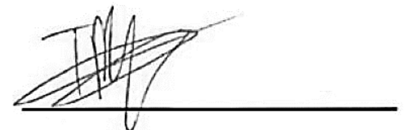
Name: Mabitja Elias Moeta

Student number: 04970480

Title: Development of a Competency-Based Framework to Standardise African Traditional Health Knowledge and Practices in Nursing Curriculum in South Africa.

I used the accepted language in South Africa, which is UK English (not US). While editing, I paid attention to detail and ensured that grammar, sentence structure, punctuation, capitalisation, spelling, word choice, organisation, and paragraphing is correct. Additionally, I have checked it for relevant aspects of consistency in terms of style, format, redundancy, and most importantly, clarity. This is a well-written document that meets all the requirements on the editors' checklist and is suitable for publishing.

Editor: Praise Magidi



Praise Magidi

Qualification: BA Languages Degree

Obtained from: University of Pretoria (in 2012)

Annexure H: Individual Interview Transcript

TRANSCRIPTION

The interview started with explaining the purpose of study and consent was signed.

INTERVIEWER: As explained in the previous meeting, the title of the study is, A competency-based framework to standardise African Traditional Health practice in Nursing Curriculum. We want nurses to be able to understand what traditional healing all is about so that we don't see the behavior we see where nurses scold patients, insults patients and in other cases they male them sign, you know, refusal of hospital treatment because patients have asked for second opinion. This is a big problem that we thought we need to address from an African perspective. So, there are a few questions that we thought we would like to get answers from the African traditional health perspective. Because we are not the experts (in ATHKPs).

INTERVIEWER: Our aim is actually not to say THPs must come work in hospitals, but is to say they must be given respect as specialists in their own right and they must also be given opportunities to operate when patients need them to come in. we saw that the best way to do this is through curriculum, you can tell people in the wards but it is not helping us in any way. So, I am not sure if so, far there are any questions?

Now my first question is, from your perspective, how would you define traditional health practice within your area of specialisation?

Participant: Put it in simple terms please.

INTERVIEWER: What does it include?

Participant:

Well traditional health practice is broad but includes diagnosis, prescription and discussions. It Is a holistic approach in terms of therapy. What type of therapy, maybe spiritual therapy of some sort, giving advice. These three things they work hand in glove. Eh Diagnosing, prescribing, and giving whatever therapy of some sort.

INTERVIEWER: so, it is not limited to giving medications to people when they come?

Participant:

No, it is not about giving, even if you look at different types of traditional practitioners. Whether this person is a herbalist, definitely is not a question of *ke tshwere ke hlogo* (headache), boom boom 1 2 3. That person must diagnose. Remember we have bone diviners, where you will chat and you know torture issues and deliberate issues, even if the person is not a diviner, is

an herbalist, there should, there will be that discussion of saying...he knows *dihlare tsa gae* (his herbs). Definitely, a discussion will start… how do we experience this headache, when did it started, the observations of that individual, who has a headache, you must be able to explain, especially to the traditional doctor who is not divining. So just to give because this person (herbalist) knows different herbs. So *tsa* headache, what causes it, eh what is it, ke side headache or front headache or back headache, *o sa ntsane a itsi* (he/she knows already). The intervention from that doctor will depend on your explanation I am talking about an herbalist. Now a person who divines will always throw his bones and say ah ah, according to your... in fact, before you can explain to say I have a headache, a bone diviner will always throw the bones and check what could be the cause of this problem. Then… the discussion will start from there; he will tell you that your headache is caused by something. but tell me, I still need your input, differ with me if I say your headache is caused by something, maybe you did not sleep well, so differ with me. Because a patient *a ka betha a* u-turn are no *ke robala pila* (I sleep well). Those discussions and deliberations *dia a needega* (they are needed). That's what will lead to what the doctor should prescribe at the end of diagnosing and consultation.

INTERVIEWER: So, it means the solutions for the traditional health practitioners will come from the divination form connecting with the spiritual world?

Participant: Yes, from connecting with the ancestors.

INTERVIEWER: But overtime, can you diagnose certain things without throwing the bones?

Participant: No, as I said, it depends on the type of traditional healer you are. There are specialists within. Now it is not a question of saying, you just think, or I suspect. You know if you are a traditional healer you don't talk of suspicions. You talk based on what you have learnt. If you are not a bone diviner, you are *ngaka-tshupya* (herbalist), I have learnt from my father. Tse ke *dihlare tsa go alafa hlogo* (headache), *tse ke dihlare tsa go alafa maoto* (treat feet). I will definitely rely on the teachings of the elder, but listening… you know the most art, best art in this practice is to listen to your patient, is to not just finally conclude. My bones can, it is not true that your bones cannot go a little bit astray; they always 100%, it is like a stethoscope. They might not be 100%, but the deliberations and discussions and guided by your ancestors. Listen to your connection with your ancestors goes hand in glove with listening thoroughly. That is why in traditional healing you don't spend a short time with your patient, then next, next, next as if you are counting time, that you are running late (*o shiiwa ke nako*).

INTERVIEWER: So there is no such thing as service standards that says after this time I must be done with the patient?

Participant: Exactly and I close the curtains and count the money. it does not work like that. So, this are some of the things.

INTERVIEWER: So how is traditional health practice different from Western medicine? What are the unique features that are there that are different from what is done on the western side?

Participant: Well, there are differences, there are similarities because all of us our focus is on the health of the patient. But the way they diagnose and the way we diagnose, we might not come to the same… the terminology that are used by traditional healers defining the cause of the problem, defining the name and nature of that disease and the instruments that we are using in terms of the diagnostic system. Our diagnostic system, for example, thermometer and all that, you will go to a person and observe them to determine if a person if having fever. It is completely studying the facial expression and other part of the organs of the body tells you that indeed this person *wa lwala* (is sick). By the time you use your diagnostic expertise, already you know that this person is really sick. So, It differs a lot but as I say, most of the Western medicine, they can rather speak a lot based or if they are giving therapy to patient, they rather use the theology Christian methods and say *o rapele* (pray). They rather talk about spirituality but demonising at the same time and discouraging our people not to go to traditional medicine and so on.

So, this are some of the worrying and the question is, are we ready for a situation where each one teaches each one in terms of let's say my final diagnosis, *ngwana o tshwere ke lehlakore* using my African terminology. Can I define it from the African perspective that this is *Lehlakore*. That does not mean when I say ke *lehlakore*, we are arriving and say ke Stroke. If you come to me and say you have studied your what we call (medicine) and these are the signs of stroke, but let us unpack what is the stroke.

We tend to sometimes, if you get a traditional healer (ngaka ya setso), who cannot elaborate in depth the signs and symptoms tsa stroke, but he can diagnose using his concept. like if I want to explain myself in English, I may lose some of the meaning. But if I express myself on something that I do in my language then I will get it right. It's just like when you change the plant or medicine itself, the herb. let's say this is a "licorice". Surely, I might not be explaining the qualities and the ingredients and the usage, but the moment I say sehlare se (this herb) ke *maphakoro*, you will find that I have a longer list than that of a well-trained doctor from Western medicine. I have mentioned quite a lot of differences and similarities.

We differ a lot. like the way of welcoming patients. The journey to a medical doctor will differ from that of going to a traditional healer.

INTERVIEWER: Ok thank you. Now for us to say this person is a qualified traditional health practitioner, what are the minimum standards that should be met?

Participant: We always keep saying traditional healing is a calling. It is a calling in a way that not everyone can become a traditional healer. When we say it is a calling we mean, you are a chosen one. You are a chosen member within your family, prior and before *o belegwa* (before birth). Because prior to your birth the ancestors already know, before your mother goes to the gynecologist or doctors for scan to confirm your gender, the ancestors already know that they will give you a boy because the family is short of boys or to awaken one of the grandparents, they know already. They already have a house for you, a job for you. When you struggle with getting the name, somebody will come and give you the name and you will agree with it.

Maybe let's say you will say the child will be joseph because you want to replace. There are similarities between religion and spiritual practices. So, like when a person dies, where does the spirit go. So, we believe that when someone dies, we bury the body, but their spirit will enter one of the grandchildren down the line.

That's why in our diagnosing, unpacking anatomy and physiology, we can define the body differently. In Christianity they would say the body is the temple of God. And they go deeper when they explain that it is a blessed and sacred place it's a holy place.

We unpack the body from an environmental perspective, we give a scope where in meriri(hair) replaces the grass, madi (blood) replaces water, marapo (bones) replace matlapa (Rocks) and the skin replace the soil. So, we unpack around that.

You go further and say ok if we don't eat there are members of the royal family who are big parts of the body. Some of the body parts depend on these vital organs, the heart the brain etc. there are many ways of defining and unpacking the body (anatomy and physiology). Basically, I am trying to give you a scope so that you can see that we do have similarities. You hear me.

INTERVIEWER: Definitely, even in Western medicine, we say the body depends on what we call vital organs

Participant: Exactly. Like the arm is not from royalty, you can lose it and the other takes over, but you cannot lose the heart. Even if the transplant the heart, the other organs will suffer because this is not the original king. There might be an internal war. that's why we wish for the upcoming generation so that there can be each one teaches the other. The African renal institute must begin to talk the language on how can we unpack it so that our fellow brothers and sisters can understand why the grandparents played such a vital role in rural areas and

so many people survived when the traditional healers managed the villages single-handedly. Maybe with another old-woman and they would say that granny was so good. Unfortunately, their methods and way of doing things were not written down, it was scribed in their blood or brain that's why *ba tsamaya le ditaola tsa bona badimong*. And you will understand that during those years, you have to take children to school with monies earned from treating patients, on the other hand you are teaching your kid's school. Not knowing that at school they are going to talk rubbish about your practice, you get what I mean. So, the contradiction is there. when a child comes back from school and you want them to help you, to be your hand man, he refuses. Now you can see today that most of the traditional healers *(mangaka a setso),* their grandchildren, you find that the grandmother is dealing heavily with the community as primary health care, but their children are Christians *(bazalwane),* where they make them drink petrol. Now there ia a lot of contradictions and the scourge continues under our nose. So when the grandmother passes on, *o tsamaya le ditaola tsa hae badimomg*. It is very difficult because people will say. Was a well-known traditional healer, but he didn't teach even a single of their children. So, it was not a question of he didn't want to, when he says to children, take this patient and go with them to a certain place and use a certain plant… practically. *Ho thwasa* (initiation) is not about the dancing, automatically you start learning by showing them gradually how to mix medications and how to perform certain interventions such as ho *phalaza* (induced vomiting), it is the practical at home, so when I die, the child knows almost everything, so the handover of the practice. Now so it is very difficult when *ke boela badimong* that, *ka mo hae ngwana* will be the chosen one, when they would rather choose those who do not want to participate. The difficulty is, who will teach him?

The hand over. That's why in most cases when a person goes for initiation *(a thwasa),* they say someone went for initiation but is not successful. It is because the quality type of the people who were in charge of the genuine way of doing things, they have passed on. I tend to question people who would say, no I can train you and *ka o thwasisa* within 3 months to be a doctor. So, the lifespan of being a traditional healer is decreasing.

INTERVIEWER: Does that affect their ability to perform their duties?

Participant: It does, it does, I mean there is a reason why we are saying we are the chosen ones. And there is a reason why not everyone can be taught by any tom dick and harry.

The language issues. Remember when we talk about the ancestors, the composition of the language of the person who will participate in initiation, *Nka se thwasise ke morafi o mongwe* easily. *Badimo ba hao* they always have confidence in themselves and while you are still alive it is difficult to learn the language of someone else. Now if I say I will teach you, three months you are a doctor… it goes with the language.

If you are a pure *tebele* and they say you must go to *shangaan* land, you have not yet understood the language but in 2 weeks already know everything. You haven't mastered anything, even you don't understand yourself, the language, you haven't practiced *go bala ditaola* because ditaola is not about throwing them then bomb om bom next…. It is a big mathematics, there is a lot of art. There is a lot of mathematics within bone throwing. The instruments to diagnose are different, others would use shells, others use *mankgwana.* There is a lot that one can do to learn those instruments. It cannot be done in one night. It needs discipline, code of ethics, standards and other things and it needs time.

I have not yet taken you to the forest to learn plants and herbs. When I take you to the forest, it is another job, because the species of herbs and plants have similarities.

INTERVIEWER: Oh, so there are stages

Participant: Yes, it follows stages.

INTERVIEWER: So there is theory that you start with before you go to practice

Participant: Aha. Remember when we said there are differences in training between western and African. When you are going to be a doctor, what leads you to be a doctor, maybe because you like being one as a child. But as you grow you make that decision based on how you have made your research. But to be a traditional healer, as a child you want *go bina malopo* I want to be a traditional healer, when you grow up, you are a different person. At home you attend and apostolic church where they channel you to say we need to go to church. And they make you wear church attire, and it is the rearing at home. But when you grow up then you want to be something else. But as I said you grow there are this spirits that have already decided on you to say you must follow the calling. When you go for initiation, as any traditional healer, why they became a traditional healer, define... for a person to be a traditional healer, they can tell you a very difficult story. Maybe they started by being sick, went for operations, doctors suspected this. Their history is very painful for them to be a traditional healer. Because at times there is denial, especially if you can look these days, the trend of people becoming traditional healers, you find that this person has a PhD degree, this person is defined learned, and being told that you need to go for initiation. Ata the hospital they amputate his finger, saying he is diabetic, *o na le swikiri* and if not, careful they will cut this hand. So, whilst he is still in denial, they keep amputating him slowly but surely. This are warning shots. Then when they start saying they need to now take out one of the members of the royal family meaning (heart) to insert screws, it is the time he realises that he has to go for initiation. He goes for initiation when he is now sick, but the particular person becomes better and powerful traditional healer. The Ph degrees and DA degrees are there. The ancestors will say, yes you have read

the books, but here is the calling, you will use them together. You may have met a person who is a traditional healer but who is a doctor in a university.

INTERVIEWER: Is attitude important though as a traditional health practitioner?

Participant: I think I have a lot of support from the people because of my attitude. The attitude of people when they go to the traditional healer, they only want to listen to what they came for and others will impose on you. A patient will come and say I have pain here and the pain struck me after I walked in and seeing that there was water scattered in my yard. They come to you already having diagnosed themselves, so now you have to listen, that's why I say others come to you from hearsay or from another traditional healer. Others come to you based on what they suspect while others come to you based on their dreams. Someone may say I was eating in my dreams then when I woke up my stomach was sore. So, it is very important to listen to your client and begin to compare what your diagnosis is when you are using your divining bones to make sure that you explain deeper what traditional healing is about. Rather than quickly referring a patient or playing a jack of all trades or portray yourself to your patient. You may not be the specialist of the problem that brought the patient to you. Let's say they bring someone who is mentally ill, and you know yourself that you are not a specialist in that field, but you do have specific medicine to control that current situation of the particular patient. Based on your diagnosis, I mean you can't turn a person away and say no this is not my specialty without giving any alternative or support or take this person to another traditional healer who stays nearby. But let me administer something so they can get to the other traditional healer. Because you know yourself you are not a jack of all trades. It is very vital to talk, so that when people come to you as a traditional healer, sometimes you make them happy. When you diagnose them and elaborate issues in front of your client, even if they come to you crying after you tell them something they start smiling. Then you start believing that this person is getting better. You unpack the spiritual, including their heart because they may have told him that he is going to die, you have Covid, but when he gets here, as you look at him you give him the psychological therapy so that they feel comfortable. When a person gets here, you immediately connect, and you can see that this person seating uncomfortably. Have you ever seen a sick person; you may have already diagnosed him? It is not a question of no wait a bit so I can see this person. That thing itself makes the people who brought him very comfortable. By the time this person gets in, the most important aspect is to see your patient through the glass, not the mirror where you look upon yourself. Put yourself in the patient's feet. sometimes it is very painful to see a family that accompanied a patient, but they are also spiritually down and when they look at you is like they are looking at God. They believe that they have brought someone. Will be able to manage the person. Even the referral system of the people who sent the patient to you believe that you will manage the patient, you do not

want to lose that confidence, you have to work hard and if really it is not up to you and you also see, others will tell you we have been to all doctors. Sometimes as a doctor you look at your medicine in the dispensary and you realise no man, here, there is no plan. You play around and you say did you take him to the doctor, and they say we took him to all doctors. You don't know where you will borrow the medicine. It becomes very difficult, then something says to you…. it is not about yourself. Take the patient in and we(ancestors) will tell you what you must do. Then you go into the consultation room then realise that in fact the problem is not a big deal. Then you do all that you can but for second opinion, you say ok this is within another traditional healer I work with, so let's do this… if the problem persists, phone me. Even if he is asleep, let me know. If the patient is sleeping but still not ok, then we refer for second opinion. But they have told you that there is no doctor that we have not seen, so you have to get the second opinion within this practice. I will then write another traditional healer and inform him that I am brining the patient and I need second opinion, I have given the patient 123 and please manage further. So, we talk among ourselves, the main aim is to defeat the problem that is bothering this person.

INTERVIEWER: So how do you form these relationships with your colleagues within the practice?

Participant: It's a very difficult, it's not an easy thing to do. you hand pick. Sometimes there are those people who paly big. There are people who would say, this is not a big deal, it's a doctor. Then you transfer the patient, then the patient would say, the person you sent me to is not good, it is like you were chasing me away into a lion's den. Then you ask why? Then the patient says That person I could not hear wat they were saying and even the medications he gave to me have not helped. Now you begin to say yhooo I am lonely here. I am an orphan in this practice. i am saying it is a little bit difficult in terms of how you can choose your partners for your practice. Hence, I was trying to say we must have a way to… I can say we are limited if I don't do my referral to my *Gobela* who is in Venda, and for serious issues, then I have this other old man, one day you will meet him. You will see the setup of our practice; it goes with the discipline. I will always write a letter and say … 123... then get my son would accompany them to that person and drop them there. Another partnership ok is my wife. what I have practiced is not what she practiced, gender perspective you know. I would call her and say this person is a woman and 123... please attend to her in-depth and you must talk because sometimes patients, based on gender, they tend not to be at ease. They would tell you that they have abdominal pains but from the waist downwards because it will embarrass her because of certain reasons. Yes, that referral system among us, that discussion about who and how to choose my partners, it is still a little bit difficult you know. And the way we unpack, and deliberate issues is not the same. As I say, patients come to you with an expectation.

Remember, holistically, some are not here based on physical pain others their pain is caused by violence, gender violence. Now she does not feel comfortable to speak to me as a woman, even a man does not feel comfortable speaking to a woman.

INTERVIEWER: So, does gender influence the type of training you get as a traditional healer?

Participant: not often, not really influence it as such, but it is a question of one have to make the patient feel comfortable to talk so it is sometimes difficult. But is there is someone of the opposite gender then, they become comfortable to say we want 123...

INTERVIEWER: I think I am left with one important question: if I were to ask you to tell me as a nurse how do I teach these nurses about traditional health?

Participant: I think you are bound by your laws of your profession. As young generation, based on your research, the way you tell me that, it is matter of researching, how far do they know? How far do they know about our medicines, how far do they know about traditional health system. That's what will guide you and throwing back this ball to them, based on the number that you get about how many that know about this, that will give them an opportunity to learn. For them to know, they must be taught. But to unpack the nursing law. My best advice is department of health does not have the relevant people. You have ministers who subscribe to one belief system, but they want to lead cattle of different breeds. That's where the problem comes. the department of health was controlled by too much religious people and too much science who wanted people to swallow drugs. We had a very good support from one of the scientists who also was called to be a traditional healer.

INTERVIEWER: I have reached the end of the interview. Are there any questions? Do you know any person that I can also contact for an interview?

Participant: Yes, I will send you to *mangaka a mangwe* who I know they are doers.