

Promoting co-existence of Khoisan primal health care in a western dominated health system

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DECLARATION

I, Maria Pienaar (Student number 24548787), declare that the mini dissertation with the title: ***Promoting co-existence of KhoiSan primal health care in a western dominated health system*** is my own work and that all the sources that are used, have been indicated and acknowledged by means of a complete referencing method.

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Maria Pienaar

.....

December 2019

DEDICATION

I dedicate this work to the following people:

My late parents Ma and Pa Meintjies, Brother Johannes Meintjies, Pa Johannes Fredericks, Ma Rachel Fredericks, Sarie Kriel and my Mother-in-law Miena Pienaar.

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I wish to convey my appreciation to the following people who supported me in achieving this milestone in my life:

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LIST OF ABBREVIATIONS

WHO	World Health Organisation
TCM	Traditional Chinese Medicine
TM	Traditional Medicine

ABSTRACT

Background: Prior to the evolution of modern health medicine, African indigenous persons used their own indigenous health care services. Most have continued to do up to this day. In fact the dependence on indigenous healers and indigenous healing methods is a wide-spread practice in South Africa including urban areas, where Africans prefer indigenous healers as opposed to western health care practitioners. This practice confirms the World Health Organisation's assertions that more than 80% of the African community makes use of the indigenous healers. The Traditional Health Act of South Africa advocates for primal health care to be acknowledged.

Prior to 1994 an oppressive and western dominated health care context existed. This however changed when; the new Constitution, as the master law that is governing the country is upholding the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom. The Constitution is very clear in stating that everyone has the right to have access to health care services. The National Health Insurance's main aim is about universal health coverage. Hence, the researcher is promoting the co-existence of Primal health care alongside a western dominated context.

Purpose: The aim of this research was to explore and describe the co-existence of Primal Health Care practices of a KhoiSan community shoulder to shoulder with a western health dominant system in a rural province of the Northern Cape in South Africa. Furthermore, to propose recommendations for policy makers in health to address this challenge.

Design: The proposed method for conducting this research is qualitative explorative, descriptive and contextual in nature. Subsequently, the non-probability sampling method was employed. Data was collected through focus group discussions. Data was analysed according to thematic analysis in psychology as described by Braun and Clarke (2012: 60-69).

Conclusions: The recommendations are based on the research findings. A major recommendation to address the challenge within the KhoiSan community is policy formulation.

Key words: health promotion, co-existence, primal health care, western health care

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1. CHAPTER ONE: OVERVIEW OF THE RESEARCH

1.1 Introduction

Every community has different health care systems in place. These are to ensure the well-being of its community members (Van Rooyen, *et al.* 2015: 1). It is also in this vein that indigenous health knowledge is an essential component of human culture (Rankoana, 2012: 1). According to Ohajunwa (2019: 70) to ignore the indigenous knowledge and traditions of the community is to almost ensure failure in development. Notwithstanding the use of hospitals and clinics for the provision of primary health care needs, there are communities and individuals that make use of indigenous health care services (Gumede, 1990: 45; Rankoana, 2016: 47). According to White (2015: 1), the use of indigenous medicines is a worldwide phenomenon. The dependence on indigenous healers is a wide-spread practice in all South Africa including urban areas, where Africans prefer indigenous healers as opposed to western health care practitioners (Sorsdahl *et al.* 2010: 284; Ovuga *et al.* 1999: 276). The World Health Organisation (2013:16) revealed that more than 80% of African people make use of Traditional Medicine (TM).

In light of the foregoing, Pienaar (2013: 128) asserts that a primal health care system is a super-health system rooted in the African belief systems and services of more than 70% of the community. This reality is noted that at times indigenous practitioners as well as medicinal plants are the main source and often the only source of health care to many people (WHO 2013: 16). Similarly, (Mphuthi 2015: 1) indicates that approximately 80% of the South African population are still using medical plants due to pharmaceutical drugs being too expensive.

In addition to the above observation, Chance *et al.* (2019: 5) comment on this African reality when they state that people in Cameroon prefer the use of traditional health system. The authors further assert that, preference is influenced by provision of quality health care that is embedded in cultural aspects and values (Chance *et al.* 019:5). In South Africa, Pinkoane *et al.* (2012: 12) state that about 80-90% of African health care users, utilise both the indigenous healers and the biomedical personnel's services.

In the light of the above, looking at the current and dominant western health care practice the concern raised by Mthanti (2015: 14) is alarming. The author points out that under the western health system the cost of health care is increasing and adding on to the cost burden the quality of western health care is deteriorating. While agreeing to some extent to this observation, Johnson (2017: 26) contends that the healthcare system in South Africa is slowly being transformed. He however notes that there is extensive intensifying of cost expenditures associated with this.

Barring from the above, Krah, *et al.* (2018: 157) argues that the integration of the indigenous health system and biomedical health systems is pivotal and can improve the quality of community health care. Hence, Pienaar (2017: 3) also argues that there should be advocacy for the coexistence of African indigenous practice as part of governmental strategies to deal with health issues which unfortunately has extensively failed. This strategy includes the Alma-Ata Declaration, the Millennium Development Goals (MDGs), the Sustainable Development Goals (SDG), and not limited to the World Health Organization Traditional Medicine Strategy 2014 (Pienaar, 2017: 3).

Sadly, in South Africa in the current White paper on National Health Insurance (NHI) that discusses strategy for the improvement of biomedical health systems there is an obvious absence of indigenous health (Ohajunwa, 2019: 69). On the contrary Ghana another African country, in 2004 established the National Health Insurance Scheme (NHIS) to mitigate challenges that continue to be part of the biomedical health system. In fact, the indigenous health system is commonly utilised as biomedicine in Ghana (Krah, *et al.* 2018: 157).

Evidently from all the above mentioned, the western health system cannot always meet the health care needs of all individuals. Hence it is essential for the promotion of the coexistence of indigenous health care along the same lines with western dominated health systems. According to White (2015: 1) despite the introduction of western medicine and health care systems in Africa, many African communities are continuing to rely on indigenous health care.

Adding on to the above, Nare, *et al.* (2018: 2) assert that the shortage of western-trained practitioners is greater than that of indigenous health professionals. Therefore, the burden embedded on the primary health care system will only be alleviated through the co-existence of primal health practice with primary health care (Nare, *et al.* 2018: 2). Taaka, *et al.* (2013:

128) put forward the notion that western practitioners must take cognisance of the dominant status of how the indigenous African community played within the dominant health care system and known as primal healthcare system.

In the light of the above argument, primal health care is based on an African philosophy and around the concept of Ubuntu which is anchored on the importance of humanity and community. According to Tavernaro-Haidarian (2018: 5), *Ubuntu* is widely defined as ‘I am because we are. Primal health care services rendered by indigenous African community have been existing for millenia. It is also noteworthy to mention the primal health care services are cost effective, accessible, and efficient (Nare *et al.* 2018: 2). Therefore the researcher endeavoured to embark on this research to promote the co-existence of primal health care and western health care.

1.2 Problem Statement

Pinkoane *et al* (2012: 13) state that South Africa recognises indigenous health practitioners, but these health care providers are not depended on as official health care givers. The Traditional Health Practitioners Act of (22 of 2007) advocates for Indigenous health practitioners to be autonomous; to self-regulate and control their own practices like the western health practitioner. Adding on to this it is evident that more than 80% of indigenous people (WHO 2011:379) utilize indigenous health care. Despite the glaring evidence of continuous usage and supportive legislation of primal health care in indigenous African communities, this health care system is not formally acknowledged in the western dominated health provision system of South Africa. The latter poses a challenge for indigenous communities who have stuck by their health care systems since time immemorial. It is for this reason that the researcher envisaged carrying out a study focused on promoting the co-existence of KhoiSan Primal health care side by side with the western health system in a rural province in South Africa.

1.3 Research Aim

The aim of this research was to explore and describe the co-existence of Primal Health Care practices of a KhoiSan community shoulder to shoulder with a western health dominant system in a rural province, Northern Cape in South Africa.

1.4 Research objectives

Research objectives of this research were to:

- Explore the current Primal Health practices of a selected KhoiSan community;
- Propose recommendations for the co-existence of Primal health care system alongside the western dominated health care structure in this community.

1.5 Research questions

- What are the current primal health care practices of a selected KhoiSan community in a rural province in Northern Cape in South Africa?
- How can the KhoiSan Primal Health care co-exist with a western dominated health care system?

1.6 Conceptual Definitions

1.6.1 Health promotion

According to the Alma-Ata Declaration (1978: 1) health promotion forms the key component of Primary Health Care. Furthermore, the Declaration states that government has a social obligation to the universal community to ensure health for all (Alma-Ata declaration, 1978: 11). Subsequently, Dennil and Rendall-Makosi (2012: 152) define health promotion as a practice where the health care user is taking charge of his/her own health. Furthermore, the

authors assert that health promotion is essential to reach holistic health but is not just limited to physical and psychosocial wellbeing (Dennil and Rendall-Makosi, 2012: 152). Congruently, Berenuera *et al.* (2017:6) concur with other authors in the sense that health promotion is based on public policy, community factors and institutional elements.

Thus, health promotion in this study forms the cornerstone of Primary Health care and is focused on the prevention of illness and promotion of health, rather than a curative approach. Equally important, health promotion is everyone's business, including the community.

1.6.2 Primal health Care Services

The *Concise Oxford English Dictionary* (2008:1139) defines primal as relating to an early stage in evolutionary development. Interestingly, Taaka, *et al* (2013:128) also perceive primal health care as the original health provision in indigenous communities that has stood the test of time. Consequently, Groz-Ngate *et al* (2014:124) allude that throughout many centuries people have solely depended on natural elements to treat a variety of illnesses in families. In this study, primal health care service is used to refer to a KhoiSan indigenous health service that integrates indigenous use of natural medicine and methods to heal and treat the community in prevention of illness and promotion of health.

1.6.3 Western health care services

According to Groz-Ngate *et al.* (2014: 124), western communities in everyday situations are of the opinion that their western way is the only method to treat illnesses. The mainstream medicine way is looking at evidence based philosophies/doctrine to manage poor health and surgical intervention. The author is of the opinion that the majority of people including health professionals, are still stereotyped and are not open to other ways of how people can maintain their health status. As a result, clients are not receiving culturally competent care because the health fraternity is not culturally sensitive. Awareness needs to be raised among health professionals so that they become culturally sensitive in a way that they will follow a holistic approach dealing with clients.

Mphuthi (2015: 5) states that the western health system is an organism (also known as allopathic medicine, biomedical, conventional medicine, orthodox medicine, mainstream medicine) in which health professionals accept the following as the truth: they know what cause diseases, treating signs and symptoms and it is strongly believed that they have all the answers of curing diseases. The family as collective remains the reliable source for health history. Curing the illness as they believe; requires that they put a measurable yardstick in place for the expected outcome. In this set-up, the physician remains the authoritative figure.

Presenting in a synopsis in this research western health care service was viewed as the only way to treat illness in the country, including provision of primary health care services. Most people are also of the opinion that because it was “scientifically” based it must remain in a supreme position when compared to other health care systems.

1.6.4 Co-existence

Co-existence means to live together, at the same time, or in the same place. It is to live in peace with another as a matter of policy or others despite differences (Merriam Webster Learner’s Dictionary (2014: 108). Therefore, in this study co-existence is important to both western and Indigenous primal health care practices despite their differences.

According to Bock (2015: 19) when two powers meet one will rub off on the other and after the experience neither of the two parties will be the same. Reflecting on this statement it is clear that the two powers refers to the western and indigenous health modes. The ultimate goal of the researcher is, not promoting competition or stating that one system is better than the other; instead both systems can learn and benefit from each other.

In summary, for this research the term co-existence means to exist together at the same time, place, and live in peace despite the differences. It is vital to understand that co-existence does not promote competition with one claiming to be better than the other. It actually argues that both practices can contribute to health benefits and better quality of life to the community.

1.6.5 Indigenous health practitioners/healers

According to Mokgobi (2014: 5), the term indigenous practitioner/healer is umbrella concept that encompasses different types of healers with different types of training and expertise. Subsequently, Maluleka and Ngulube (2018: 113) referred to indigenous practitioner/healer as a person who engages in indigenous medical plants for medicinal purposes. Significantly, indigenous practitioner/healers are responsible for promotion of mental and physical well-being of the community (Maluleka, 2017: 15).

Hence in this research indigenous practitioner/healers is person trusted by community for provision of holistic indigenous health services which includes diagnostic, treatment, and therapeutic interventions and not limited to preventative health services.

1.6.6 Western health practitioners

Groz-Ngate et al. (2014:14) states that western health care workers find themselves in western communities in daily situations are of the view that their western way is the only means to treat illnesses. The conventional medicine way is looking at substantiation on rational /principle to manage health. The author is of the view that majority of the people including health professionals, are still narrow minded and are not open to alternative ways of how people can uphold their health status

1.7 Division of chapters

This study is consisting of four Chapters that are unpacked as follow:

- **Chapter One:** This introduces the research and therefore gives a broad synopsis of the complete study.
- **Chapter Two:** It gives an overview on the research design and methods of data collection and validation for the preferred design.
- **Chapter Three:** In this section the researcher presents the results of the research.

- **Chapter Four:** This is the last one and the focal point of this chapter is on the recommendations, limitations and conclusion of the study.

1.8 Summary

Chapter one unpacked the introduction of the research as well background to this study. It is then followed by the problem statement, aim, objectives and research questions. In addition, this Chapter also illuminates the concepts used in the research. The following chapter provides an outlay of the research methodology.

2. CHAPTER TWO: RESEARCH METHODOLOGY

2.1 Introduction

In the previous chapter, the overview of the research was outlined. This chapter mainly focuses on a detailed description of the research design and methods which the researcher utilized to achieve the aim and objectives of this research. In it a detailed description of trustworthiness and ethical consideration was provided. The aim of this study was to promote the co-existence of primal health care practices of a KhoiSan community in a rural in the Northern Cape Province of South Africa alongside those of a western care framework.

Table 1 (Research Methodology)

Research approach	Qualitative
Research design	Explorative, descriptive and contextual design
Setting (Context)	KhoiSan Community in Northern Cape
Population	All Khoisan Community
Sample	KhoiSan indigenous health care workers
Sampling method	Non-probability sampling method
Sampling technique	Purposive sampling technique
Sample size	Data saturation
Data collection method	Focus groups discussion
Data collection tool	Open-ended questionnaires
Data Analysis	Thematic analysis in psychology as described by Braun and Clarke (2012:60-69)

2.2 Research approach

The qualitative research approach is frequently used to explore meaning and provide understanding of human experiences through interaction. According to Brink *et al.* (2018: 104) the main goal of the qualitative research approach is to understand the experiences of the participants rather than predicting them. Creswell (2014: 4) states that qualitative research is an approach for exploring and understanding the meaning “... individuals or groups ascribe to a social or human problem”. Subsequently, Brink *et al.* (2018: 103) postulate that qualitative research is used to explore, describe and provide in-depth understanding human experiences in their natural settings.

Hence, in this study the qualitative research method was employed with the aim to explore and describe the co-existence of primal health care practices in the western dominated context of a KhoiSan community in a rural of the Northern Cape Province of South Africa. This method includes study context, population, and sampling but not limited to data analyses in order to achieve the research aim and objectives of this research.

The researcher interacted and engaged the indigenous health care workers in their natural setting. Fouche and Delport (2011: 102) argue that the natural language of the participants is used to extensively understand their world. Therefore, this qualitative research was conducted in the natural setting which is at KhoiSan community in a rural of the Northern Cape Province of South Africa. Importantly, extensive data was collected from indigenous health care workers through their own language.

2.3 Research methods

Burns and Grove (2005: 73) describe research design as a “blue print” which guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal. According to Fain (2017: 157), a research design is an overall plan of an investigation that outlines aspects of sample collection and analyses based on a specific research. Therefore, this research follows an explorative, descriptive and contextual qualitative design (Burns and Grove, 2005: 52) with the aim of exploring and describing the co-existence of primal health care practices of a KhoiSan community in a rural of the Northern Cape Province of South Africa alongside western practices.

2.3.1 Study context

The research was carried out among the KhoiSan community in the rural of the Northern Cape Province of South Africa. Northern Cape Province is the largest province in South Africa with desert landscapes, wildlife and gemstones.

2.3.2 Population

Brink *et al* (2012: 131), states that population is a particular group of people that a researcher has interest in studying. Therefore, the population in this study was the indigenous health practitioners in the Northern Cape Province in South Africa.

2.3.3 Sampling

Brink *et al* (2012: 132), define sampling as a process of selecting a sample or representation from a population of interest. In this study, purposive sampling was employed to select participants who are knowledgeable with the phenomena under study. More importantly, indigenous health care workers were able to provide the researcher with extensive data regarding the research questions of this study.

2.3.4 Sample size

The sample size of this study was determined by data saturation. The researcher conducted two focus group discussions with seven (7) participants and nine (9) per group (16 participants in total). According to Hancock *et al* (2016: 2126), data saturation in qualitative research is achieved when there are no new emerging ideas during data collection.

2.4 Data collection Methods

Data collection is described by Cresswell and Poth (2017:148) as a series of interrelated activities aimed at gathering extensive information to answer emerging research questions. In equal measure, Brink, *et al.* (2018: 133) asserts that data collection is an essential approach

employed by the researcher in answering research questions. Significantly, qualitative data collection methods are flexible (Kumar, 2019: 238).

The focus group discussion as a data collection method was used in this research to gather and collect extensive data from indigenous health care workers regarding the co-existence of primal health care practices of a KhoiSan community in the same praxis area with western ones. The focus group discussion qualitative data collection method is described by Brink, *et al.* (2018: 144) as about five to 12 participants sharing their experiences regarding phenomena under study simultaneously with the researcher. Subsequently, Kumar (2019: 197) refers to a focus group discussion as a qualitative data collection strategy used to explore attitudes and opinions regarding the research question. According to Finch *et al* (2013: 233-234) a focus group includes about six to eight people. However, the number might also be influenced by sensitivity or complexity to the research question. Equally, the first conducted focus group interview was having seven indigenous health care workers, the second facilitated focus group interview was having nine indigenous health care workers and the third focus group discussion session comprised of five indigenous health care workers. It is equally important to point out that, 16 indigenous health care workers in total participated in this research.

2.5 Data analysis

Data analysis in qualitative research is a systematic process of searching, interpretation and classification of the collected data in the form of linguistic or visual material (Wong, 2008: 14; Flick, 2013: 5; Flick, 2018: 420). According to Dilshad and Latif, (2013:196) in focus group interviews, the process of data analysis begins shortly after the group sessions end. The recorded interviews and field notes were analysed using the thematic method of data analysis (Creswell & Poth 2018:123). A protocol with guidelines was given to an independent coder, who is an experienced qualitative researcher, to carry out the thematic analysis. The interviewing researcher and the independent coder met for a consensus discussion to agree on the identified themes. In this study, thematic analysis in psychology as described by Braun and Clarke, (2012:60-69) to analyse collected data was used. Braun and Clarke (2012:60-69) describe six phases of thematic analysis and they are delineated as follows:

- **Phase one:** Familiarizing yourself with your data,

- **Phase two:** Generating the initial code,
- **Phase three:** Searching for themes,
- **Phase four:** Reviewing themes
- **Phase five:** Definition and naming themes and
- **Phase six:** Producing the report.

2.6 Ethical Consideration

This researcher observed the five general principles by the APA (2010: 3-4). Ethical clearance was granted from the North West University (NWU) Ethical Committee and permission was sought from the royal house of the KhoiSan. Subsequently, three fundamental ethical principles as described by Brink *et al.* (2018: 29-30) were ensured from the beginning until the end of the research. The following process of transparency was followed: Data collection process, the aim and objectives of the study clearly explained to participants and informed consent. Notably, these five ethical principles were the principle of beneficence and malfeasance, principle of fidelity and responsibility, principle of integrity, principle of justice and lastly principle of respect of people's rights and dignity.

Table 2 (Ethical Consideration)

ETHICAL PRINCIPLE	APPLIED IN THE COMMUNITY
1.Beneficence and Non Malfeasance Promote advancement of a safe and a harmless environment during research. Conflicts that occur should be managed effectively and efficiently. The researcher guards against the interference of external	The researcher promoted the advancement of safety during the involvement of the community and their leader the chief where the intension of the study was presented and the benefit to the community was highlighted. A collective consent was granted by the chief of this community.

factors resulting in a potentially destructive outcome.	A harmless environment during the research was created by a two-way communication and mutual understanding and where participants could feel free to communicate. This community is mainly Afrikaans speaking but translation was done and validated to ensure authenticity. Participants could feel free to withdraw from the study and were not compelled to participate. The researcher guarded against the interference of external factors that could have resulted in a disastrous outcome. As soon as misunderstandings were identified issues were clarified by the researcher and validated by the community. It was important to clear the air between participants and the researcher to create a safe environment
2, Fidelity and Responsibility This is to ensure excellent rapport where participants are the cornerstone of any project. Researcher should accept responsibility and accountability for their code of conduct and acts and omissions and expects no compensation.	It is a pre-requisite of the researcher to adhere to fidelity and responsibility within each specific community she will be working with. She ensured excellent rapport where participants were the cornerstone of the project. The researcher took responsibility for her acts and omissions while conducting this study without compensation gain.
3. Integrity Transparency is a very important aspect when conducting any study. Presenting the truth is imperative. The aspect of integrity is linked to the code of conduct and ethical codes. All this is to be within the legal framework.	During the research process it was vital for the researcher to be open and share the truth with the community. The researcher had to start the process by consulting with the chief of this community who is the most respected and senior person within this community. It was made clear that the

	intellectual tools of this community would be utilised to make an impact in global health issues. It was vital to acknowledge the intellectual tools of the community. The researcher adhered to the code of conduct and ethical codes of research in this regard.
4. Justice To be fair and importantly, access to benefit should be ethically and morally fair. Equity is an important element when applying fairness, and not violating the rights of individuals and groups.	The purpose for this research was to the benefit of the very community. The results were presented to the community as well. The researcher owed it to the community. Fairness was applied by presenting the intention of this study to the chief who is the leader of this community. Consent was obtained and signed. The fact that this community is mainly Afrikaans speaking meant that translation was done and validated to ensure authenticity.
5. Respect of people's rights and dignity Respect is a very broad concept but important and should be adhered to throughout the research process. Respect means accepting people for who they are and not being judgemental. The participants are from a very rural community but their intellectual tools are of immense value to the health sector.	Respecting the community for who they are as well as their practices and culture. The community that participated in this study is from a rural community and is mainly Afrikaans speaking. They were treated with respect in interactions with the researcher. The researcher realized that lack of respect could jeopardise the entire research process.

2.7 Trustworthiness

Lincon and Guba as cited in Brink *et al.* (2018: 158-159) and Brink *et al.* (2012: 126-128) describe four criteria of trustworthiness as credibility, dependability, confirmability and transferability. These were strictly followed to ensure the trustworthiness of this research.

2.7.1 Credibility

Anney (2014: 276) refers to credibility as the confidence that can be placed in the truthiness of the research findings. Credibility is whether the research process is consistent and information obtained represents the participants' original views. In this research credibility was achieved through the use of focus group discussions as a method of data collection which ensured prolonged engagement.

Furthermore, credibility in this research was met by adhering to crystallization. Crystallization refers to the use of multiple methods in qualitative research to develop in depth understanding of social issues (Carter *et al.*, 2014: 545). In this research, data were collected from three separate groups comprising of six to nine members utilizing the focus group discussion approach. Prolonged engagement was also adhered to in this research in which researcher facilitated three focus group discussions over a period of three months and data was saturated.

2.7.2 Transferability

According to Anney (2014: 277) transferability refers to the degree in which the research results can be transferred to other contexts with different participants'. Consequently, research should provide a thick description of research methodology for those who seek to transfer the research findings to their own context (Nowell *et al.*, 2017: 3). The findings of this research cannot be generalised but only speak to the defined context of this research. Transferability of the research instruments and findings was also achieved through the sampling technique in which the sample was selected based on the indigenous health care workers'. It is equally important to state that with a detailed description of the research methodology and discussion of the results' transferability was achieved.

2.7.3 Dependability

Nowell *et al* (2017: 3) asserted that for the research to achieve dependability, the logic, as well as a traceable and clearly documented research process should be ensured. Brink *et al* (2012: 127) state that enquiry audit is essential for the research to achieve dependability. Inquiry audit refers to the degree in which research procedures, data and relevant supporting documents can be scrutinised by someone outside the research and s/he can critique the research process (Creswell, 2014: 202).

The co-coder and researcher analysed the research findings independently. Consensus discussions were held on the coding themes. Furthermore, the dependability aspect in this research was ensured through members checking in which was done simultaneously during data collection. This was by means of focus group discussions. Brink *et al.* (2018: 159) refers to member checking as taking the findings of the research back to the participants for correction of possible errors and additional information.

2.7.4 Conformability

Brink *et al.* (2018: 159) define conformability as potential for congruency of data in terms of accuracy or relevance. Congruently, Novell *et al.* (2017: 3) refer to confirmability as ensuring that the interpretation and the findings of this research are clearly driven from data. More crucially, conformability obliges the researcher to demonstrate how the conclusion and recommendations of the research have been arrived at (Novell *et al.*, 2017: 3). In this research, the conclusion and recommendation were achieved through collection of data using focus group discussions. A focus group discussion is a qualitative data collection method with which the researcher probes questions and controls the dynamics of the discussion (Nyumba *et al.*, 2018: 21).

2.8 Summary

This chapter interrogated the research methodology. The focus was on the research design, data collection methods and measures to ensure the trustworthiness of this research. These measures are highlighted as key issues that helped in guiding the study. The enormity and importance of ethical considerations was outlined. The next chapter (three) gives an overview of realization of the research findings, data analysis as well as discussion of the research findings.

3. CHAPTER THREE: REALIZATION OF THE RESEARCH FINDINGS

3.1 Introduction

The previous chapter (two) outlined the research methodology employed to achieve the research aim and objectives. Therefore, in this chapter (three) focus is on the detailed discussion of the data collection process and methods that were employed in this research. Focus group discussions were employed to collect research data from indigenous health care workers. Importantly, the research findings were discussed through engagement with the themes that emerged.

3.2 Data collection

As previously discussed Brink *et al.* (2018:133) assert that data collection is an essential approach employed by the researcher in answering research questions. Consequently, qualitative data collection methods are flexible (Kumar, 2019: 238). The focus group discussion qualitative data collection method was used in this research to gather and collect extensive data from indigenous health care workers regarding the co-existence of primal health care practices of a KhoiSan community on an equal basis with western informed ones.

According to Nyumba *et al.* (2018: 21) a focus group discussion is a commonly used tool in qualitative research in which the researcher assembles a group of participants to discuss a specific topic. Similarly, Kumar (2019: 197) refers to a focus group as a qualitative data collection strategy used to explore attitudes and experiences of a given sample regarding research questions. Hence, the researcher employed this qualitative method of data collection (focus group discussion) to generate discussion and answer the research questions about the current primal health care practices of a selected KhoiSan community in the rural province, Northern Cape in South Africa and how the KhoiSan primal health care can co-exist with a western dominated health care system.

Barring from the above, the researcher with the assistance of an Indigenous Health Knowledge System scholar (supervisor) who has signed a memorandum of understanding with the Griqua Royal House established rapport with the chief of the community. The researcher's intention to conduct research was communicated to the chief. The chief of the community arranged a special meeting between researcher and indigenous health gatekeeper of this defined KhoiSan community and permission was granted to interact with indigenous health care workers.

As a follow up to the above, the researcher was invited to a meeting with indigenous health care workers at the local community hall. A time slot of 15 to 20 minutes was granted to the researcher to explain the purpose of her study and to recruit participants to subsequent focus group discussions. The indigenous health care workers provided the researcher with dates and time on which focus group discussions could be facilitated.

The researcher followed a prescribed process for data collection and this process entailed the use of the focus group discussion as a qualitative method for collecting data (Nyumba *et al.*, 2018: 21; Kumar, 2019: 197). Silverman (2011: 207) describes principles of focus group discussions and includes: recruiting a small group of participants consisting of six and eight, encouragement of informal discussion, a focus group discussion is based on schedule questions and stimulus material, researcher does not ask questions but encourages interaction of participants, and there is also audio recording of discussion for transcribing and analysing.

According to Silverman, (2019: 223) the focus group discussion as a qualitative data collection method is effective and user-friendly to facilitate rather than an individual interview. A focus group discussion was facilitated on the defined context of the KhoiSan community and indigenous health care workers interacted among themselves and created the essential process of generating data. The moderator or group facilitator (researcher) commenced the focus group discussions by asking broad questions about the topic of interest. This practice is based on the notion that the focus group discussion encourages participants to explore and clarify individual and shared experiences (Tong *et al.*, 2007: 251). It is worth noting that indigenous health care workers answered the group facilitator's questions and they were encouraged to talk and interact with each other.

Noting the above, indigenous health care workers listened to other participants' views, reflected on what was said and in the light of this considered their own standpoint (Finch *et*

al., 2013: 220). Furthermore, the responses they gave confirm what Finch *et al.* (2013: 220) assert in that as the focus group discussion continued the indigenous health care workers' responses became sharpened, refined and most importantly moved to a deeper and more considered level.

The guideline for data collection comprised of two main questions that were coupled with probe questions, namely:

1. What are the current primal health care practices of a selected KhoiSan community in the rural province, Northern Cape in South Africa?
2. How can the KhoiSan Primal Health care co-exist with a western dominated health care system?

Equally important is the fact that the researcher facilitated three focus group discussion sessions separately in a conducive environment that was arranged by indigenous health gatekeeper. The first group comprised seven indigenous health care workers from this selected KhoiSan community. Subsequent focus group discussion sessions included nine indigenous health care workers and the last one comprised of five indigenous health care workers.

3.3 Data analysis

In qualitative research data analysis is a systematic process of searching, interpretation and classification of the collected data in the form of linguistic or visual material (Wong, 2008: 14; Flick, 2013: 5; Flick, 2018: 420). According to Dilshad and Latif, (2013: 196) in focus group discussions, the process of data analysis begins shortly after the group sessions end. The recorded audio recorded discussions and field notes were analysed using the thematic method of data analysis (Creswell & Poth 2018: 123). A protocol with guidelines was given to an independent coder, who is an experienced qualitative researcher, to carry out the thematic analysis. The moderator or group facilitator (researcher) and the independent coder met for a consensus discussion to agree on the identified themes. Braun and Clarke (2012: 60-69) describe six phases of thematic analysis in psychology and are delineated as follows:

- **Phase one:** Familiarizing yourself with your data,

- **Phase two:** Generating initial code,
- **Phase three:** Searching for the themes,
- **Phase four:** Reviewing the themes
- **Phase five:** Definition and naming the themes
- **Phase six:** Producing report.

In this research three (3) themes were constructed, eight (8) sub-themes were also generated and thirteen (13) categories emerged during data analysis. It is also noteworthy to mention that the researcher discussed constructed themes, sub-themes and categories separately and this is supported by direct quotations from indigenous health care workers' responses.

Table 3: (Themes, Sub-Themes and Categories)

<i>THEMES</i>	<i>SUB-THEME</i>	<i>CATEGORIES</i>
1. INDIGENOUS HEALING PRACTICES	1.1. Healing Rituals e.g. Cleansing	1.1.1. Treating health care users of different ages, from infants to elders. 1.1.2. Indigenous antenatal care
	1.2. Indigenous counselling as health promotion.	1.2.1. Counsellors are elders and healers
	1.3. Indigenous massage as a healing method	1.3.1. Pain relief
2. INDIGENOUS PLANT MEDICINE UTILISATION	2.2. Indigenous plant medicine as preventative method	2.2.1. Medicinal plants used to prevent illnesses such as cancer. 2.2.2. Medicinal plants used as recreational beverages.
	2.3. Indigenous Plant Medicine for curative purposes.	2.3.1. The use of medicinal plants for the treatment of various illnesses in the community including treatment of infertility.

3. INDIGENOUS COUNSELLING AS HEALTH PROMOTION	3.3. Healthy lifestyle practices	3.3.1. Cultural rituals e.g., introduction of the baby and indigenous marriage; 3.3.2. Rites of passage;
	3.4. The link between medicinal use and spirituality	3.4.1. The use of medicinal plants for spiritual purposes (to remove force;
	3.5. Benefits of indigenous health practices in the community	3.5.1. Longevity; 3.5.2. Active communal participation irrespective of age; 3.5.3. Ownership of communal health practice.

3.4 Discussion of the research results

The discussion takes an unusual process where description, observations and statements are integrated to form a storyline under the three themes mentioned. Only principles are discussed, some information that is sacred to the KhoiSan community is not divulged.

THEME ONE: INDIGENOUS HEALING PRACTICES

Like all other indigenous people in the rural areas, this community in the Northern Cape has its own indigenous health practices that are transferred from generation to generation. These practices have sustained them to date because they *only have a basic clinic in the village and most of the time this clinic is without western medication. Therefore, the community learned to survive on the indigenous health practices and the communal healers, a practice that has been part of their life since time immemorial.*

Sub-Theme 1.1

Healing Rituals e.g. Cleansing

Participants in this research opine that healing rituals in this selected KhoiSan community are performed to treat health care users of different ages, from infants to elders. This includes the provision of indigenous antenatal care to pregnant women. It is equally important to highlight that most rituals require secrecy; therefore, participants in this research could not reveal much of the important information. Two categories emerged within this sub-theme of *healing rituals e.g. medicinal baths, and treating health care users of different ages, from infants to elders and Indigenous antenatal care.*

Category 1.1.1

Treating health care users of different ages, from infants to elders.

There was the realization that indigenous health care workers or healers provide holistic indigenous health care and treat community members of all ages. It also came out that in this selected community of the KhoiSan, the most popular practice is the healing ritual of spiritual cleansing. This is normally done after a family member has passed on.

“The whole family is bathed with medicinal plants.”

“Healers treat you from a young age and throughout life.”

In the light of the above, Nare *et al.* (2018: 7) indicate that indigenous health care workers use various indigenous methods to heal their clients. Equally worth noting was that the practice of indigenous healing rituals is common among African cultures and they include cleansing (Setsiba, 2012: 2-3). According to Seretlo-Rangata (2017: 15), cleansing is an indigenous ritual that is performed a few months after the passing on of the deceased. Furthermore, the author asserts that medicinal plants are also given to the widow of the late to take away bad luck (Seretlo-Rangata., 2017: 15).

Category 1.1.2

Indigenous antenatal care

Participants highlighted that pregnant women are treated by indigenous midwives and mostly in the antenatal phase very few give birth in the community. *“We still have indigenous midwives that assist us before birth”* However, they mostly give birth at the community hospital, which is 40 kilometres away from the village, because of western health policy enforcement.

Sub-Theme 1.2

Indigenous counselling as health promotion

“The adults call you then they sit you down and talk to you about your challenge and give you guidance and resolutions”

This sub-theme emerged after participants emphasised that various methods such as indigenous counselling are used for health promotion. Participants asserted that, indigenous counselling is therapeutic in nature and is embedded in the principles of Ubuntu. It also was highlighted by participants that, elders and indigenous healers facilitate indigenous counselling.

Category 1.2.1

Counsellors (Elders and healers)

In this category it was observed that elders in this KhoiSan community are responsible for facilitation of indigenous counselling. Similarly, in another study conducted in Nigeria on indigenous healing and counselling Okocha, (2016: 41-42) noted that indigenous counselling is a service that is provided by indigenous health care practitioners to facilitate the ability among indigenous health care users to attain optimal psychosocial wellbeing. To affirm the importance of these practitioners, Mwendwa, (2014: 11) referred to elders or indigenous healers facilitating counselling as counselling leaders.

Sub-Theme 1.3

Indigenous massage as a healing method

“The grannies massage us when we are pregnant.”

Through the practice of indigenous massaging the researcher realized that this is another indigenous method used by indigenous health care workers or healers to heal members of this selected KhoiSan community. Significantly, indigenous healing practices in African cultural communities incorporate massaging as a pain relief strategy. Baakeleng, (2019: 32), asserts that indigenous health care practitioners during indigenous massaging are capable of analysing the body using their hands especially on diagnostic abnormalities.

Category 1.3.1

Pain relief

Another realization that came to the researcher’s awareness as new knowledge was that indigenous health care workers or healers mostly use massage for body pain relief. *“Elders massage us when we are in pain.”* Participants further alluded that a massage has the effect of bringing about *positive change in the individual’s body, such as lesser tension*. Of particular importance is the fact that indigenous massaging in this selected KhoiSan community is considered an effective indigenous health method of healing pain (Harris *at al.* 2014: 3). In support of this, a study conducted by Keeratitanont *et al.* (2015: 31) has findings that also highlight the effectiveness of the Traditional Thai Massage as a method for reducing pain’s severity.

THEME TWO: INDIGENOUS MEDICINAL PLANTS UTILISATION

This theme came about when participants repeatedly talked about the utilisation of indigenous medicinal plants to heal and prevent illness in the KhoiSan community. It became clear that these *medicinal plants are used to prevent illnesses such as cancer*. It was equally highlighted that, *medicinal plants are used as recreational beverages* in this community. It in addition came out that, indigenous health care workers use *indigenous medicinal plants for the community's health but on a curative basis*. It was also noted that, there is *widespread use of medicinal plants for the treatment of various ailments in the community that include the treatment of infertility*. To confirm the importance of medicinal plants to the KhoiSan community the Chief declared the following famous words: "*The veldt is our chemist.*"

Sub-Theme 2.2

Indigenous plant medicine as a preventative method

It came to realization of the researcher that this selected KhoiSan "*The community mostly relies on indigenous plant medicines as a preventative method*, as they stated, "*We regularly indulge in certain plant medicines to avoid illness or bad spirits.*" According to Jaradat and Zaid, (2019: 2) indigenous communities have been using indigenous plant medicines from time immemorial for treatment, protection, and prevention of various illnesses. This community of the KhoiSan uses medicinal plants for different reasons, including that of recreation, healing and for preventative of chronic conditions such as cancer (Tsobou *et al.*, 2016: 152).

Category 2.2.1

Medicinal plants used to prevent illnesses such as cancer

The use of indigenous plant medicines in this KhoiSan community is quite wide and they are used for various *illnesses and as preventative measures for cancer, for example the cancer bush*. This confirms what Street and Prinsloo (2012: 5) observe when they assert that different cultures have been using indigenous medicinal plants such as African potato to for many ailments including cancer. Interestingly, this is unique only to this community for Jaradat *et al.* (2016: 2)

state that, indigenous health care practitioners in Palestine also use medicinal plants for treating various types of cancer. Hence, Iqbal *et al.* (2017: 1130) states that indigenous medicinal plants with their phyto-chemicals inhibit the progression and development of cancer.

Category 2.2.2

Medicinal plants used as recreational beverages

Participants in this research further asserted that medicinal plants are used in the brewing of recreational beverages. Notably, rooibos is one of the indigenous beverages that was identified as being used in this KhoiSan community. It was observed that it is as well used for various purposes including preventative measures against heartburn and also for increasing amounts of breast milk for breast-feeding mothers (Street & Prinsloo, 2012: 4). This is consistent with Maroyi (2014: 776) who points out that plant species are rich in nature and are widely used in TM and are not limited to flavouring beverages.

“We drink bush tea cold with lemon and honey”

Sub-Theme 2.3

Indigenous Plant Medicine usage

It also came out in the study that indigenous medicinal plants’ usage can further be used for the treatment of various illnesses in this selected KhoiSan community and just to name one ailment: infertility. It was said to be treated by the use of a plant called *Beautiful girl*.

Still in relation with the above deliberated sub-theme, Baakeleng (2019: 32) affirms that indigenous healers prepare different herbs with animal fat and skin to cleanse women’s womb of infertility, thus enabling the woman to conceive. In a study conducted by Jaradat and Zaid (2019: 11) in the West Bank area of Palestine, it is shown that infertility in males and females can be treated with the help of indigenous medicinal plants.

Category 2.3.1

The use of medicinal plants for the treatment of various illnesses in the community including treatment of infertility

Participants alluded that *indigenous medicinal plants are also used to treat infertility among women* in the KhoiSan community. The researcher learnt and confirmed that women in this selected community consult with indigenous health care workers for infertility treatment. This is one of the most popular practices, because the western medicine does not offer competent solutions.

In the light of the above, Semenya *et al.*, (2013: 336) assert that fertility among South African black women is a central theme as it is accepted that women ensure the preservation and propagation of the tribe. Furthermore, the authors submit that there are certain medicinal plant species that are used to treat female infertility (Semenya *et al.* 2013: 336).

THEME THREE: INDIGENOUS HEALTH PROMOTION

This theme came about when the participants in this research repeatedly talked of how this selected community of the KhoiSan observes and undertakes various indigenous health practices for a healthy lifestyle. Furthermore, in this theme participants explored the linkages between medicinal use and spirituality in the defined context of this research. Notably, indigenous health care workers in this research further explored the benefits of indigenous health practices in the identified KhoiSan community. Significantly, three sub-themes were constructed including six categories within this theme (*Indigenous medicinal plant utilisation*).

Sub-Theme 3.1

Healthy Lifestyle Practices

This is where the realization came that healthy life style is essential for the psychosocial wellbeing of the KhoiSan community and this is upheld through practices of cultural rituals and other rites of passage. Mahlatsi (2018: 50) asserts that indigenous rituals are performed at different stages of an individual's communal life. The findings in a study by van den Ende (2015: 29) point out that the indigenous rituals are not only important symbolic practices but they are practiced to construct meaning and reality. The indigenous community indicated that they take, "*Appropriate indigenous plants before the onset of a season, e.g. "lengana combination before winter"*". This is in line with the flu vaccine in the western dominated medical practice where common vitamins to strengthen the immune system are dispensed.

Category 3.1.1

Cultural rituals e.g., introduction of the baby to the family and indigenous marriage

This is where rituals are performed for welcoming and introducing the new born baby into the family and more importantly to the ancestors. Furthermore, this selected KhoiSan community in the rural of Northern Cape performs different indigenous rituals for various purposes such as recovering from an illness and for peace and unity in the family (Soe, 2018: 131). The participants in this research also asserted that indigenous marriages are as a practice significant because they spiritually and culturally connect both families, that of the bride and the groom.

The community mentioned *the “introduction of the newborn after three months when they name it then they drink the ‘urine’ of the infant.”* The mother also come officially out of the house of delivery.” This ritual is dominated by fellow birth-giving mothers and elders.

Category 3.1.2

Rites of passage

One of the lifestyle practices mentioned that cultivate psychosocial and spiritual health through belonging is the *“rite of passage”*. According to Mahlatsi (2018: 50), the rite of passage is an indigenous ritual performed to emphasize the transition of the individual from one stage of life to another. In this research, participants alluded that the rite of passage is an indigenous ritual that is executed to mark significant event taking place in individual’s life stages including birth and transition from childhood to adulthood. Furthermore, the rite of passage involves indigenous affirmation and provides a strong space of growth among communal individuals in the selected KhoiSan community. This is also echoes with Salo’s (2018: 181) observation when he asserts that the rite of passage is an indigenous practice that symbolises the start of the journey into the wider world of adulthood.

Sub-Theme 3.2

The link between medicinal use and spirituality

The study showed that there is connection between medicinal use and spirituality in this KhoiSan community. During indigenous functions *“certain indigenous plants are burnt that have a calming effect”*. This assists the healers to get into a spiritual trance and enter the spiritual realm. In agreement with this observation, Nare *et al.* (2018: 5) states that the indigenous healing process includes the use of medicinal plants and the process is highly spiritual and sacred. Baakeleng (2019: 28) further states that indigenous health care workers consult with the spirit world to be guided with respect to medicinal plants and how they are to be used.

Category 3.2.1

The use of medicinal plants for spiritual purposes (against forces of darkness and healing);

According to Ozioma and Chinwe (2019: 199), indigenous healing also known as spiritual cleansing is performed to bath an ill person with water or animal blood. Furthermore, the authors aver that the indigenous healing process is a holistic health care system for the community and is categorised into three levels of speciality, namely: divination, spiritualism and herbalism (Ozioma & Chinwe., 2019: 199). In support of this reality, Mphuthi (2015: 67) states the notion that the concept of health in indigenous communities has always been viewed as a collective perspective which incorporates four dimensions of life namely: the spiritual, the intellectual, the physical and the emotional wellbeing. What is of significance that also came out of this study, is that the participants articulated that community indigenous health practitioners or healers are gifted with spiritual and divination connections in respect of knowledge and access medicinal plants to be used for the purpose of healing practices or ceremonies. This is evident below when participants articulated that: *“We as a community are used to doing the trance dance during the full moon to edify ourselves”*

Sub-Theme 3.3

Benefits of indigenous health practices in the community

According to World Health Organisation (WHO), (2013: 28) TM is integral in meeting the primal health care needs of communities. Participants in this research indicated that there are *great benefits of utilisation, preservation* and importantly they are evident in their selected KhoiSan community. According to participants, these benefits include longevity, active communal participation irrespective of age and ownership of communal health practice. The benefits of indigenous health practices in the community were further delineated by Dunn (2017: 46) in a study investigating the challenges and benefits of TM in a case study done in Tanzania. The author articulates that the benefits of the utilisation of indigenous health services is that indigenous health practitioners or healers provide holistic health services and attempt to connect community members to social and emotional equilibria based on the community’s cultural aspects (Dunn., 2017: 46).

Category 3.3.1

Longevity

Some participants in this research stated that among other *benefits of indigenous health practices in the community* is longevity in the sense that the lifespan of elders in this community ranges from *eighty (80) years to hundred and five (105) years*. According to Mahlatsi (2018: 7), longevity has been experienced in some African indigenous communities by sustaining their indigenous health systems and practices.

Category 3.3.2

Active communal participation irrespective of age;

According to the participants, the *indigenous health practices in the community* are for the whole commune of the KhoiSan irrespective of age.

Category 3.3.3

Ownership of communal health practices

As the chief mentioned that the veldt is their chemist, this community implements its indigenous health practices and medicine since time immemorial. Most of the community members have substantial knowledge of medicinal plants. On observation I noted that the community owns and uses their indigenous health practices and medicine. They have annual festivities called the “*Griqua festival*” where health practices are show-cased in a workshop format

3.5 Chapter Summary

This chapter highlighted the three themes found during this research. It became clear that the community believes and celebrates its health practices. It is further illuminated in this chapter that the community's main focus is on preventive medicine than on curative. The positioning of primal health care becomes easier in such a situation because it is a lifestyle practice in this community where the uplifting of spirituality is held in high regard. Hence the future positioning is seen at three levels namely: primal health care; primary health care and curative health care. The following chapter will conclude this research with insights and recommendations.

4. CHAPTER FOUR: CONCLUSIVE INSIGHTS FROM THE RESEARCH, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION OF THIS RESEARCH

4.1 Introduction

This chapter focuses on the final introduction, conclusive insights, limitations and recommendations in addition to the conclusion of the research. Notwithstanding the findings and literature integration in the previous chapter, a relevant question is asked: Why does the researcher advocate for the co-existence of KhoiSan primal care side by side with the western health care system? The following discourse illuminates the rationale for the promotion and advocacy for the co-existence of KhoiSan primal health care alongside the western health care system.

Since the existence of humanity the concern was always to search for good health or health in its wholeness. During the search to find the best medicine on the market to treat incurable illnesses one vital aspect remains void - the human component (Ndung'u 2009: 87). Begun and Malcolm (2014: 3) further recommend that the community members should take care of their own health on a daily basis. This approach should be preventative and redress the imbalances of authority and resources. Hence it is viewed that KhoiSan primal health care is more cost-effective and accessible to address the mentioned challenges.

Begun and Malcolm (2014: 3) further state that community members should identify the extent of their needs and implement a plan of action. This can be done through the empowerment of the workforce e.g. training in terms of social determinants of health. The common goal is to have a health system to cater for everyone and the resources should be significant. The researcher made the conclusion that although health systems differ, therefore the KhoiSan primal health care as a supreme health system in the community can be used alongside the western one in providing holistic care across the community to reduce disjointed services and across the globe in the provision of public health.

Awodele (2012: 1) further suggests that these communities might have a broader picture in mind implementing the co-existence approach as they are already covering the primary health care aspect which they can benefit from.

On the other hand, Begun and Malcolm (2014: 3) asserts that public health has not been used to its maximum capacity, and has in some instances been devalued in the area of legislation and practice. It is known that the public health system contributes enormously providing excellent health care to the community at large. Mbelekani *et al.* (2017: 210) strongly remind policymakers that the South African Constitution binds the state to work towards the progressive realisation of the right to health. According to Mbelekani *et al.* (2017: 210) it is very clear that people within the current dispensation are still experiencing challenges in accessing health care services. A large number of Africans still suffer the after-taste of the colonial system. In addition, Coovadia *et al.* (2009: 824) state that despite the redress of wealth disparities being identified as a key goal of the post 1994, government wealth disparities grew in the first decade of democracy, including in health care. However, Thomson (2009: 2) asserts that the inception of the new dispensation in South Africa, from a health perspective, traditional healing remains on the agenda.

Adding on to the previous discussion, Mahlatsi (2018: 11) acknowledges that the African community on matters concerning their health practices has a system which has stood the test of time. The author makes a valuable statement saying that two thirds of the world's 6.1 billion people prefer indigenous health practices. Regardless of the sophisticated western health system, it is clear that indigenous healing methods still stood the test of time and remain the preferred the health system in even in the African American community. Gowon and Goon (2010: 386) state that it is estimated that 80-90% of the population in Africa make use of TM to help meet their primary health care needs. WHO (2014: 8) also states that collectively TM is either the foundation of health care delivery or serves as a matching to it. In other countries TM or non-conventional medicine is named complementary medicine (Gowon & Goon, 2010: 386). The two terms non-conventional and complementary are racist in nature in that they give primacy to western medicine, yet the reality is that more people in emerging economies depend on them. They can therefore not be non-conventional, neither can they be complementary. It is in fact western medicine that is complementary in their situation. TM is known for its evidence based excellence, safety and worth adding to the goal of ensuring that all people have a right of entry to care which is vital.

King (2005: 1) also states that for many decades' prior the development of western orthodox medicine, the Europeans used dance as primordial healing ceremonies. These practices remained in existence in greater parts of the world.

The authors Broom and Tovey (2007: 608) state that it is important if policy makers could hear the plea for intervention made by global health organisations on the important role that TM is playing. TM as one of the most primordial methods of healing has seen accolade keep on surfacing in its support in terms of the vital role it has in indigenous communities. It is evident that TM reduces health related challenges. This call was made to focus on the part of the community, the underprivileged who have been forgotten especially in the rural poor areas. Government who are the forerunners regarding legislation must take cognisance of the marginalised communities. Awodele (2012: 90) states that this is not a new enterprise in that many developing countries made a paradigm shift towards using TM. In support of the previous author Wang *et al.* (2017: 2) explore the development tendency of Traditional Chinese Medicine (TCM) hospitals in China and investigate their improvement with regards to medical service with special reference to the changing co-existence with western medicine at TCM based hospitals. TCM is known as a sector made up of TCM service (TCM doctors) and TCM products (including Chinese patent medicine, Chinese herbal pieces, and Chinese herbs).

On the contrary, Hartmann and Gone (2012: 1) discovered four vital components that are threatening incorporating traditional healing into this urban situation. These threats potentially could stir the fire: traditional healing protocols compared to the struggle to make a living which is a fact and reality, the community has been represented by different tribes in traditional healing services compared to what is expected to be aligned according to their cultural beliefs, norms and standards. It is also true to take cognisance of the fact that some areas are very rural and thus deprived. Bignate (2015: 6) sadly raises the concern that traditional health practices are taking place and the rights of the healers and users are not legally defined. In this community “Modern medication” as it is known is also referred to as ‘western’ or ‘official’ and that is the only approach familiar to them.

On the other hand Harley (2006:4) raises an important area on the co-existence of health systems which forms the key aspect of the study. The author states that co-existence between indigenous and western health systems is imperative. These two systems should support each other, and should be culture sensitive, by compromising. The researcher is of the opinion that it is a matter of urgency to all public sectors to integrate TM into western modelled public health systems. It is clear that communities can benefit by having a holistic approach to manage and sustain their health status. Moreover, integration of traditional and Western medicine has a great potential for the treatment of many diseases in China (Wang *et al.* 2017: 2).

Awodele (2012: 93) raises an important aspect in terms of co-existence in the mind gap that has to be identified. He notes that there is lack of knowledge and it can only be acquired through learning from one another. Training has to be conducted to address the identified gaps since practitioners need to be empowered. The co-existence approach which will be unfolding will ensure that the community can benefit immensely. The two health care systems should be premised on reverence for one another (Struthers *et al.* 2004: 3). The authors also make clear that despite the choices made in terms of these healing systems, the common goal is to promote the co-existence and health care users should be encouraged to use both health care systems. Furthermore, Owusu-Ansah and Mji (2013: 1) support the idea that research conducted needs to seek and emphasize responsiveness about the need to include indigenous knowledge in the plan and operation of research, particularly disability research, in Africa. It affirms the appropriateness of the Afrocentric concept in African research and argues for the necessity for an emancipator and participatory type of research which values and includes indigenous knowledge and peoples.

Knowledge or science, and its ways of investigation, cannot be detached from a people's history, cultural context and worldview. The worldview shapes consciousness and forms the abstract structure within which knowledge is required, critiqued and or understood. Knowledge has cultural significance and should be scientifically proven for its particular focus, from its point of view. It is therefore unsafe, if not unfair, to call to any one method of investigation as collective. According to the sacred concepts and methods of indigenous communities such as the KhoiSan, Western thoughts are insufficient to explain all of the ways of knowing because globally one can only dream about when we have the truth based on specific cultural experiences' (Asante 1987: 168). Therefore, Asante argues that all cultures and the indigenous ways of knowing arising from them are to be respected and valued in their uniqueness.

Although still indistinct, it is worthwhile to see that some African scholars (for example, Tanyanyiwa & Chikwanha 2011; Ntumngia 2009; Pence and Nsamenang 2008; Nsamenang 2006; Mkabela 2005; Mpofu 2002; Mpofu 1994) have taken on the significant yet menacing task of making important contributions to the African reality. Western theories from and constructs believe and assert that African knowledge has much to supplement existing western knowledge and methodologies. Western knowledge fails to acknowledge that African knowledge and methods of knowing have produced results and contributions to the universal community (Owusu-Ansah and Mji 2013: 5).

4.2 Conclusive Insights from the research

1. Primal health care is based in the family (elders) as well as the community and is grounded in the Ubuntu principles and philosophies (Paul and Pienaar, 2013), therefore promoting shared confidentiality and communal cohesion;
2. The Primal health system care has stood the test of time in Africa, despite the colonial oppression against the support of this health care system. Therefore, we have the Traditional health practitioners Act 22 of 2007 in South Africa (Witchcraft Act 3 of 1957 and Traditional health practitioners Act 22 of 2007)
3. Denial, including prohibiting legislation to refuse indigenous communities not to utilize their primal health care system did not change the health seeking behaviour of indigenous persons, due to the fact that this health care system is still in use. It is evident that indigenous communities still prefer their own health care systems (Witchcraft Act 3 of 1957);
4. Alienating and demonizing indigenous healers in a western health system has not caused their extinction, hence the more than 80% in communities that still utilize healers in the primal health care system;
5. The misperceptions (viewed as witchcraft) against the African primal health care system led to its under-development in Africa, notwithstanding the fact that health was managed in Africa before colonial rule and later oppression of the indigenous communities (Witchcraft Act 3 of 1957);
6. The witlessness against primal health care has led to unqualified judgements against the utilization of this health care system;
7. African primal health care is from the people to the people. It is therefore more cost effective and accessible than western health care, because it is positioned in the community for the community;

8. Despite the legal emancipation of primal health care through legislation, there is no equal health budget that exists to support this health care system for Africans by Africans in South Africa;
9. Primal health care is holistic whereas western health care remains fragmented in the country;
10. Primal health care is mostly focused on the prevention of illness and promotion of holistic health, whereas western health care focuses predominantly on curative (sickness) health delivery.

4.3 Limitations of the research

This research was done in one indigenous community setting. Although saturation was reached, the researcher is of the opinion that more data could have been collected and thus rich if more indigenous communities were included. The mentioned limitation was caused by the financial constraints to include more communities.

4.4 Recommendations of this research

Recommendations for policy makers

- The time is ripe to establish a strategic policy task team to support with regulations, policies and guidelines to advocate for the co-existence of KhoiSan primal and western health care systems;
- There is need for policies that redress the position of primal health care in South Africa, so that they are aligned with the WHO requirements as well as the Traditional health practitioners Act 22 of 2007;
- Budgetary policies to redress the inequality of primal health care to set up sustainable primal health establishments;

Recommendation for the practice

- The facilitation of authentic recognition for primal health care within all departments of health through inclusive practice in all health programmes;
- Facilitate a process of mutual, respectful referrals of health care users between primal health care practitioners and western health care practitioners;

- Support indigenous health care practitioners by addressing their needs to practice as equals of western health care practitioners;
- Enhance the choice of health care users to choose freely between the indigenous health practitioners and western health care practitioners or both;
- Create platforms for indigenous healers for peer-group evaluation, regulation and continuous professional development for them to practice competently.

Recommendations for education

- Recognize the indigenous educational system for indigenous health practitioners and promote certification for safe practice (Rampho, 2019, Baakeleng 2019 & Phokane, 2018);
- Promote indigenous health education among western health care students to stimulate recognition for referrals;
- Facilitate educational drives to market the indigenous primal health care system e.g. that of the KhoiSan;
- Illuminate the preferences of indigenous communities during political rallies and voting to re-educate politicians and the masses about the importance of this health care system.

4.4.3 Recommendation for further research

Further research on the development of a framework for the co-existence of the primal health care system alongside the western health care system has to be undertaken.

4.5 Conclusion

It is understood that the co-existence journey of these two health care systems will not be easy, however it is proposed in this research. Subsequently, it further known that different health care models have been followed by different governments globally and South Africa is no exception especially due to the legacies of the western care system that is largely a product of colonialism and Apartheid. It is also important to note that the conflicts that transpired amongst different health care providers and systems is vital to understand that co-existence is a process which is multifaceted in terms of having the understanding, mutual respect and unity of the different systems and practices.

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ANNEXURE A: NWU – ETHICAL CLEARANCE



NORTH-WEST UNIVERSITY
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Institutional Research Ethics Regulatory Committee

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ETHICS APPROVAL CERTIFICATE OF PROJECT

Based on approval by the **Health Science Ethics Committee (FAST-HSEC)** on **07/09/2017** after being reviewed at the meeting held on **07/09/2017**, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby **approves** your project as indicated below. This implies that the NWU-IRERC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Promoting the co-existence of Khoisan primal health care in a western dominated health system															
Project Leader/Supervisor: Prof AJ Pienaar															
Student: Pienaar M															
Ethics number:	N	W	U	-	0	0	6	6	6	-	1	7	-	A	9
	Institution			Project Number						Year		Status			
Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation															
Application Type: Single Study															
Commencement date: 2017-09-07				Expiry date: 2020-09-07				Risk:		Minimal					

Special conditions of the approval (if applicable):

- Translation of the informed consent document to the languages applicable to the study participants should be submitted to the HSEC (if applicable).
- Any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the HSEC. Ethics approval is required BEFORE approval can be obtained from these authorities.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principle investigator) must report in the prescribed format to the NWU-IRERC via HSEC:
 - annually (or as otherwise requested) on the progress of the project, and upon completion of the project
 - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
 - Annually a number of projects may be randomly selected for an external audit.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the HSEC. Would there be deviation from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-IRERC via HSEC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-IRERC and HSEC retains the right to:
 - request access to any information or data at any time during the course or after completion of the project;
 - to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.
 - withdraw or postpone approval if:
 - any unethical principles or practices of the project are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the HSEC or that information has been false or misrepresented,
 - the required annual report and reporting of adverse events was not done timely and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.
- HSEC can be contacted for further information via Lesetja.Motadi@nwu.ac.za or 018 289 2598.

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the IRERC or HSEC for any further enquiries or requests for assistance.

Yours sincerely

Prof LA
Du Plessis

Digitally signed by
Prof LA Du Plessis
Date: 2017.10.12
08:56:45 +02'00'

Prof Linda du Plessis

Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)

ANNEXURE B: THE GRIQUA ROYAL HOUSE – MEMORANDUM OF UNDERSTANDING

THE GRIQUA ROYAL HOUSE DIE GRIEKWA KONINGLIKE-HUIS



Administration Office: c/o 26th & Beardman Str. Faith Mission Centre Leensdale Elsie's River 7490 PO Box 516 Elsie's River 7480
Tel: 021 932 9901 Fax: 021 931 9400 Email: adamkoku@polka.co.za

MEMORANDUM OF UNDERSTANDING

This memorandum serves as an agreement reached between the Seboka Team under the leadership of Prof. Abel J. Pienaar and the Griqua Royal House. An appointed Seboka member will be expected to abide and respect the values and norms of the community while conducting research.

The following are the terms and conditions of agreement.

- The Seboka team is given the permission to conduct the research within the Griqua community, on a mutual capacity principle;
- The conducted research will be based on the Indigenous Knowledge Systems, of which the community will lead and guide the proceedings;
- The team (Seboka) will conduct the research using multiple research methodologies but the primary approach will be conducting "makgotla" with the assistance of a nominated member of the Griqua Royal House;
- The Seboka team will always respect the community and make sure that all the information is treated confidential;
- The research will be conducted by the appointed Seboka researcher, who will in turn sign the consent;
- Both parties also agree that the shared information remains the property of the Griqua Royal House unless otherwise stated;

This memorandum will be used as a global consent for conducting the research in the community. The participants' rights will also be taken into consideration and be respected while conducting the research. These rights are but not limited to the following:

ANNEXURE C: TRANSCRIPTIONS

Title: Promoting Co-existence of Khoisan Primal Health Care in a Western Dominated Health System;

TRANSCRIPTION FROM FOCUS GROUP DISCUSSION

R: Researcher

IHCP1, ICHP 2, IHCP 3 etc.: Participants names

R: Good morning

IHCP 3: Morning Mam

R: How are you today?

IHCP 3: I am well (smiling), and how are you doing?

R: I'm well thank you. My name Maria, a masters' student from the North-West University Mafikeng Campus. Thank you for agreeing to participate in this research. As per our agreement last week, when I was here. I only have one questions for you, how can primal health (indigenous health become part of western health? The information that you give me will remain between us and I will not use your real name during this discussion; will name you as IHCP 4. The discussion will take 45 minute to 60 minutes. I have a consent form for you to confirm our agreement. Lastly you have the right to withdraw from the study at any given time. I hope you understand me.

IHCP3: For me, they founrd us there, your question should be, how do we accommodate them (laughter from goup members, nodding).....They must know what we are doing, dealing with medicine and cleansing....

ANNEXURE D: TURNIT REPORT

16670264: Maria_Pienaar.doc

by LEEPILE SEHULARO

Submission date: 12-Dec-2019 08:30AM (UTC+0200)

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