PERSPECTIVES OF HEALTH WORKERS ON TRADITIONAL MEDICINE INTEGRATION INTO CONVENTIONAL MEDICINE IN SELECTED HEALTH FACILITIES IN ZIMBA DISTRICT

BY

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DECLARATION

I, **Namuyaba Hamanyanga** hereby declare that this dissertation submitted to the University of Zambia as partial fulfilment of the award of the degree of Master of Public Health (Health Promotion and Education) is my own work and has not been submitted either wholly or in part for another degree to this University or any other or Institute for higher education.

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APPROVAL

This dissertation of **Namuyaba Hamanyanga** has been approved as fulfilling the requirements or partial fulfilment of the requirements for the award of Master of Public Health in Health Promotion and Education by the University of Zambia.

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ABSTRACT

Over the years, many researchers have tried to address how to integrate traditional medicine with conventional biomedical diagnoses. While some countries have well managed to combine both Traditional Medicine (TM) and Conventional Medicine (CM) others have not. In many African, South American and Asian countries, TM is used in parallel with conventional medicine but this often comes with considerable difficulties. This is particularly true for what may be considered indigenous diseases that may not easily relate to a conventional diagnosis and poses issues regarding patient centred communication. With this situation at hand some integration between the two systems needs to be encouraged and further, this is because the practice of traditional medicine in Zambia is probably on the increase in spite of the great advances in orthodox medicine. This study aimed at studying the perspectives of health care providers on the integration of traditional medicine with conventional medicine. This was done by exploring attitudes towards integration of TM and CM, assessing the perceived benefits and risks of TM and by understating the motive behind referring patients to traditional healers.

The study employed a case study design and was conducted in Zimba district in Southern province of Zambia and targeted health workers among them nurses, doctors, clinical officers and community health assistants. The study sample was 20 key informants purposely selected. Purposive sampling was also used to select six health facilities out of 11 found in Zimba. Content analysis was used for data analysis. Firstly, the data was transcribed manually and themes were identified upon which content analysis was based. Further some background data such as age, sex, occupation, beliefs of respondents in witchcraft etc. was entered and analysed using SPSS version 22 and presented in form of descriptive statistics.

In terms of background characteristics, the study found that majority of the respondents were male (60%), and in the age bracket of 25-36 (50%) and majority were community health assistants (45%). The study also found that majority of respondents (75%) believed that some illnesses were caused by supernatural powers such as witchcraft. Further, the study found that majority of respondents believed that TM has power to cure certain illnesses such as epilepsy, STIs etc. Furthermore, the study established that majority of health workers support the integration of TM and CM with those against integration being in the minority. Additionally, the study established that majority of health workers interviewed were comfortable to refer a patient to try TM if CM fails.

The study found that TM use was characterized by uncertainties in terms of its benefits and risks. Health workers support its integration. The study therefore recommends that government must come up with a policy to support the integration of TM with CM.

Keywords: *Integration, Tradition medicine, Convention medicine, Healthcare providers*

DEDICATION

I dedicate this dissertation to my family, who have consistently provided me with the much-needed support to undertake my studies. I am eternally grateful to them for their help during my studies. I further dedicate this dissertation to my husband and children who have always believed in me and encouraged me to work hard. They are the source of inspiration in my life- I love you!

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ABBREVIATIONS AND ACRONYMS

ATM	African Traditional Medicine
CM	Conventional or Contemporary Medicine
EMDRAC	Eastern Mediterranean Drug Regulatory Authorities Conference
MUTHI	Multi-Disciplinary University Traditional Health Initiative
NCCAM	National Centre for Complementary and Alternative Medicine
PE	Primary Education
PHC	Primary Healthcare
SE	Secondary Education
STDs	Sexually Transmitted Disease(s)
TDs	Traditional Doctors(s)
TE	Tertiary Education
THP	Traditional Health Practitioners
TM	Traditional Medicine
WHA	World Health Assembly
WHO	World Health Organization
ZMH	Zimba Mission Hospital
HIV	Human Immunodeficiency Virus
TMPs	Traditional Medical Practitioners
BC	Before Christ
MSD	Musculoskeletal Disorder Management
CAM	Comparative Evaluation of the complementary and Alternative Medicine
CBS	Culture –Bound Syndromes
AMNIH	Alternative Medicine and National Institute of Health
NHIS	National Health Insurance Scheme

WORKING DEFINITIONS

Traditional Medicine: In this study, TM refers to health practices, knowledge, and beliefs incorporating plant, animal-based medicines, spiritual therapies and manual techniques and exercises applied to treat, diagnose and prevent illnesses or maintain well-being, (Luedke & West, 2006:4). Thus, TM is used to explain the traditional medical practice that has been in existence even before the advent of modern medicine.

Integration: In this study, it refers to the complementary use of both traditional medicine and modern medicine in the diagnosis, treatment and prevention of illnesses in health facilities.

Orthodox / Modern medicine: It is any medical systems that is based on sound biomedical research and are considered western or foreign in Zambian.

Traditional Medical Practitioners TMPs: Medical practitioners whose healings are based on beliefs, ideas, herbs, or naturally occurring substances those that are local to the people.

Health Workers: Is an individual who provides preventive, curative, promotional or rehabilitative health care services in a systematic way to people, families or communities.

CHAPTER ONE: INTRODUCTION

1.1 Introduction

The Tonga people of Zambia and Zimbabwe (also called 'Batonga') are a Bantu ethnic group of southern Zambia and neighbouring northern Zimbabwe, and to a lesser extent, in Mozambique. They are related to the Batoka who are part of the Tokaleya people in the same area. In southern Zambia they are patrons of the Kafue Twa. Zimba district accommodates one of the Tonga's of the plateau (Colson, 1971; Gordon, 2005).). Knowledge about traditional medicine among the Tonga is passed on orally from father to son or mother to daughter. Healing knowledge is jealously guarded in most of the families. In the Tonga land, the popularity of traditional healers is attributed to the fact that they take full account of the socio-cultural background of the people.

In the Tonga environment, the therapeutic potential of traditional medicine is great and requires further in-depth study to improve methods and training and to form a more effective organization within the ranks of traditional healers. In the physical medicine, vegetable, animal, and mineral substances are used. In the metaphysical division of traditional medicine, prayers, invocations, or incantations are offered to some mysterious and powerful forces (Gordon, 2005).

1.2 Background of the Study

Traditional Medicine (TM) "refers to health practices, knowledge, and beliefs incorporating plant, animal-based medicines, spiritual therapies, and manual techniques and exercises, applied to treat, diagnose, and prevent illnesses or maintain well-being'' (Luedke and West, 2006:4). The term is used to explain the traditional medical practice that has been in existence even before the advent of modern medicine. Traditional medicine is widely used around the world and valued for a number of reasons. At the International Conference on Traditional Medicine for South-East Asian Countries in February 2013, the WHO Director-General, Dr Margaret Chan stated that "traditional medicines of proven quality, safety, and efficacy, contribute to the goal of ensuring that all people have access to care".

For many millions of people, herbal medicines, traditional treatments and traditional practitioners are the main source of health care and sometimes the only source of care. This is care that is close to homes and is accessible and affordable. It is also culturally acceptable and trusted by large numbers of people. The affordability of most traditional medicines makes them all the more attractive at a time of soaring health-care costs and near universal austerity. Traditional medicine also stands out as a way of coping with the relentless rise of chronic non-communicable diseases. Regardless of reasons for seeking out TM, there is little doubt that interest has grown and will almost certainly continue to grow around the world.

Across the world, TM is either the mainstay of health care delivery or serves as a complement to it. According to National Centre for Complementary (NCC) and Alternative Medicine and National Institute of Health (AMNIH) traditional medicine in some countries is termed as non-conventional medicine or complementary medicine (NCC, 2010). The World Health Assembly (WHA) resolution on Traditional Medicine (WHA62.13) adopted in 2009 requested the then WHO Director-General to update the *WHO Traditional medicine strategy 2002-2005* concerning the aims of supporting Member States in developing proactive policies and implementing action plans to strengthen the role traditional medicine plays in keeping populations healthy based on countries' progress and current new challenges in the field of traditional medicine. The *WHO Traditional Medicine Strategy 2014-2023* devotes more attention on prioritizing health services and systems including traditional and complementary medicine products, practices and practitioners reappraises and builds on the *WHO Traditional Medicine Strategy 2002–2005*, setting out the course for TM and CM in the next decade (WHO, 2015).

Traditional medicine is one of the most common methods used in the treatment of ailments in most developing countries. Due to its intrinsic qualities, unique and holistic approaches as well as its accessibility and affordability, it continues to be the best alternative care available for the majority of the global population particularly for those in the rural areas of developing countries. In Africa, Asia, Latin America and the Middle East, 70-95% of the population still use traditional medicine for their primary health care and about 100 million people are believed to use traditional medicine in the European Union alone (Wang *et al*.,

2011). Over 25% of the pharmaceutical preparations in the world and more than 50% in the USA contain plant derived active ingredients.

The TM industry is worth big money. In 2012 for example, global sales of Chinese herbal medicine reached US$83 billion, up more than 20% from the previous year. The global market for all herbal supplements and remedies could reach US$115 billion by 2020 with Europe being the largest and the Asia-Pacific the fastest growing markets. The demand is steered by the growing emphasis on healthy living and concerns over the side effects of mainstream drugs (Rinaldi & Shetty, 2015).

TM practices, particularly whole medical systems such as Traditional Chinese Medicine share many of the same core values. These practices tend to be characterized by a holistic and highly individualized approach to treatment, an emphasis on maximizing the body's' inherent leading ability involving patients as active participants in their own care. Additionally, these practices are known for addressing physical, mental and spiritual attributes of a disease with strong emphasis placed on prevention and wellness (Meijin, et al., 2016). Also, TM practices employ considerable diverse methods and vary significantly between regions. As opposed to relatively modern practices, traditional medicines have the benefit of substantial use prior to clinical use as well as stronger cultural associations which in turn provide evidence of safety and efficacy and results in traditional medicine being more readily acceptable by some populations (Edwards, et al., 2012).

It has been acknowledged by the WHO that "traditional or alternative medicine has many positive features and that traditional medicine and its practitioners play an important role in treating chronic illnesses and improving the quality of those suffering from minor illnesses and certain incurable diseases" (WHO, 2002). Traditional medicine is not only a vital source of health care, but also an important source of income for many communities where it can form an integral part of a community where it does not just regard human health as a purely physical entity but takes into consideration patients' social and cultural environment (David, 2013).

In addition, knowledge that is posed by indigenous people and local communities in harvesting and preparing herbs is invaluable not only to the indigenous people and local communities who have historically used medicines, but also for any attempt to export and

use medicine outside of its traditional environment. TM knowledge also contributes to a community's' way of life and spiritual beliefs. For example, Traditional African Medicine is characterised by a holistic world-view that embraces people, animals, plants and inanimate objects as an inseparable whole from which all beings derive their life force (Firenzuoli & Gori, 2007).

The most common reasons for using traditional medicine are that it is more affordable and more closely corresponds to the patients. The major use of herbal medicines is for health promotion and therapy for chronic as opposed to life threatening conditions. However, usage of traditional medicine increases when conventional medicine is ineffective in the treatment of the disease such as in advanced cancer and in the face of new infectious diseases. Furthermore, traditional medicines are widely perceived as natural and safe that is, not toxic. This is not necessarily true, especially when herbs are taken with prescription drugs, over –the-counter medication or other herbs as is very common (Canter Ernst, 2004: Oato et al 2008: Cohen & Ernst, 2010).

At least 70% of Zambians use traditional medicine. Traditional and complementary/alternative medicine is used and accepted by a great majority of the population, regardless of ethnic, religious, or social background. There are more than 35 000 members of the Traditional Health Practitioners' Association of Zambia, founded in 1978, and thousands of non-members. Currently, herbal medicine, naturopathy, traditional Chinese medicine, reflexology, spiritualism and other forms of medicine are practised in Zambia. Both Zambians and foreign nationals practise traditional and complementary/alternative medicine (WHO, 2017).

1.3 Problem Statement

For many years, many researchers have tried to study how to integrate traditional medicine with conventional biomedical diagnoses. In many African, South American and Asian countries, TM is used in parallel with conventional medicine but this often comes with considerable difficulties (Rivera, et al., 2013). This is particularly true for what may be considered indigenous diseases that may not easily relate to a conventional diagnosis and poses issues regarding patient centred communication (Saifur, 2017). With this situation,

there ought to be some integration between the two systems and further, this is because the practice of traditional medicine in Zambia is probably on the increase in spite of the great advances in orthodox medicine. This is evident by more advertisements in the press, on the streets and in our townships of advertising.

People worldwide when faced with a medical problem have the potential to seek healthcare from different providers (Sato, 2012) generally from Traditional medical practitioners and orthodox healthcare professionals, where TM and CM are used as complements while in some cases they are used to substitute each other (Van Andale, al., 2012).

After independence in 1964, the Zambian Government did not enact legislation to regulate traditional medicine, nor was a clear policy on the practice of traditional medicine postulated. Nevertheless, traditional medicine continued to be practiced and was tolerated by the authorities (WHO, 2017). Despite the wide use of TM and the long history of complaints of malpractices in the use of TM, there has been no legal framework to control the Traditional Health Practices. Based on this premise, it can be said that there is no regulation that stops health workers from referring patients to traditional healers.

1.4 Justification of the Study

The knowledge from this study may help understand how contemporary health workers conceptualize disease and how they make choices of treatment. The findings will also enhance the bank of knowledge and the judicious use of alternative medicine. Secondly, the knowledge may help bridge the gap and conflict between the use of African traditional healing methods and contemporary medicine (Osuji, 2014). There is also an increasing realization that diseases including HIV/AIDS, chronic illnesses such as chronic fatigue syndrome, migraine headaches and chronic pain, certain seizures, mental illness and many others may be better treated combining the best from alternative African healing and conventional medicine (PBS, 1993).

Traditional medicine and complementary/alternative medicine are neither integrated with allopathic medicine nor into the national health system in Zambia. However, Traditional Birth Attendants and Community Health Care Workers practice at the level of primary health care. The Zambian Government recognizes traditional and

complementary/alternative medicine and there are national policies on traditional and complementary/alternative medicine. The Traditional Health Practitioners' Association reviews and registers traditional practitioners for licensing. Although there are no official regulatory measures for recognizing the qualifications of practitioners, plans are under way to develop such regulations (WHO, 2017).

There is need for further research to be done on the integration of TM in an effort to convince the government to take responsibility of the health of their people and formulate national policies, regulations and standards as part of comprehensive national health programs to ensure appropriate safety and effective use of traditional medicine (Moreira, 2014).

1.5 General Objective

The study aims to describe based on lived experiences, the perceived benefits and risks of traditional medicine in regards to its use and integration with conventional medicine.

1.5.1 Specific Objectives

1. To explore from the health care providers, their lived experiences towards the integration of traditional medicine with conventional medicine.
2. To assess the health workers 'perceived benefits and risks associated with traditional medicine.
3. To understand the motives among health workers for referral of patients to traditional health practitioners.

1.6. Research Question

What are the perspectives of health workers on the use of traditional medicine and its integration with conventional medicine in Zimba district?

1.6.1 Specific Research Questions

1. What has been the experience and attitudes of health workers towards the integration of traditional medicines with conventional medicines in Zimba district?
2. What are the perceived benefits and risks associated with traditional medicines by health workers?

3. What motives encourage health workers to refer patients to traditional health practitioners?

1.7 Organisation of Dissertation

The study is structured into six chapters. Chapter one of this dissertation provides a brief overview of the issues surrounded traditional and conventional medicine in public health. It also provides the problem statement, rational of the study and provides an overview of the objectives of the study. Chapter two gives an in-depth literature analysis of issues surrounding traditional and conventional medicines. This chapter is followed by the Methodology section which outlines among others the study design, sampling techniques, data collection and analysis techniques. Chapter four presents the study findings while Chapter five presents the discussion of the findings. The conclusions and recommendations of the study are presented in Chapter six.

CHAPTER TWO: LITERATURE REVIEW

2.1 Integration of TM with CM

This part of the thesis reviews various literatures related to traditional medicine and its integration into conventional medicines. The literature was reviewed from global, regional and national perspectives and covered various themes such as emergence of traditional medicine, adaptability and integration of TM to name a few.

2.2 Emergence of Traditional Medicine

Since the beginning of human civilization, medicinal plants have been used by mankind for their therapeutic value. Nature has been a source of medicinal agents for thousands of years and an impressive number of modern drugs have been isolated from natural sources. Many of these isolations were based on the uses of the agents in traditional medicines. The plant based, traditional medicine systems continue to play an essential role in health care, with about 80% of the world's inhabitants relying mainly on traditional medicines for their primary health care (WHO, 2013). The use of traditional health care remains widespread, both in rural and urban areas and has important implications for the provision of public health care. The traditional knowledge embedded in traditional medicine has the potential to contribute to the improvement of public health, but is currently under-researched and underutilized.

A scientific study that was carried out in Western India on Comparative Evaluation of the complementary and Alternative Medicine Therapy and Conventional Therapy use for Musculoskeletal Disorder Management (MSD) and its association with job satisfaction among dentists revealed that dentists using CAM therapies had greater overall health and more life satisfaction compared to Conventional Therapy users. Further, it was recommended that CAM education should be incorporated in the dental curriculum to train the budding dentists about better management of MSD and says education and additional research are needed to promote an understanding of the complexity of the problem and to address the problems' multifactorial nature. It went on to say dentists should adopt a holistic way of treating their musculoskeletal complaints in that knowledge and training of alternative therapies is very much required (Gupta *et, al*, 2014).

According to the WHO (2005), a "medicinal plant" is any plant, which in one or more of its organs contains substances that can be used for therapeutic purposes or which are precursors for the synthesis of useful drugs. This definition distinguishes those plants whose therapeutic properties and constituents have been established scientifically and plants that are regarded as medicinal but which have not yet been subjected to thorough investigations. The term "herbal drug" determines the parts of a plant (leaves, flowers, seeds, roots, barks, stems etc.) used for preparing medicines. Furthermore, WHO defines medicinal plant as herbal preparations produced by subjecting plant materials to extraction, fractionation, purification, concentration or other physical or biological processes which may be produced for immediate consumption or as a basis for herbal products. Medicinal plants are plants containing inherent active ingredients used to cure disease or relieve pain. The use of traditional medicine and medicinal plants in most developing countries as therapeutic agents for the maintenance of good health has been widely observed.

In integration, another scientific study was done in Brazil on Culture –Bound Syndromes (CBS) of a Brazilian Amazon River population. Tentative correspondence between traditional and conventional medicine terms and possible ethno pharmacological implications where the goal was to identify drugs that alleviate human illness via analysis of plants alleged to be useful in human cultures throughout the world (Giulitti *et al*., 2005). Culture- Bound Syndromes being wide spread among Latin American populations is recognised and treated by traditional cure experts with the local resources available. It was possible to establish the hypothetical correlation between CBSs as described by the riverine population studied and some etic terms. The importance was to help the proportion of target –oriented pharmacological studies of the natural resources used by communities and also that some of the clinical manifestations could be recognised and be used by the doctors of conventional medicine (Pagani *et al*, 2017).

2.3 Global Perspective

The World Health Organisation (WHO) estimates that one-third of the world's population has no regular access to essential modern medicines; in some of Asia, and Latin America, as much as half of the population face these persistence shortages. However, in these situations, the rich resources of traditional remedies and practitioners are available and

accessible. The WHO, Global Atlas of Traditional, Complementary and Alternative Medicine relate well to one of WHOs' overall strategic directions in traditional medicine for 2002-2005; that of tackling excess mortality and morbidity especially among the poor and the marginalised populations. There has been a global resurgence of interest in the use of traditional medicine over the last decade. The Fifty –Sixth World Health Assembly formally acknowledged this in May 2003 where member states discussed the WHO Traditional Medicine Strategy 2002-2005 and adopted resolution WHA 56.31. These documents set out squarely the major challenges; the lack of organised networks of traditional practitioners, the lack of sound evidence of the safety, efficacy and quality of traditional medicine, the need for measure of proper use of traditional medicine and to protect and to preserve traditional and natural resources necessary for the sustainable application and measures for training and licencing of traditional practitioners (WHO 2002).

India for example has several traditional medical systems such as Ayurveda and Unani which have survived more than 3000 years mainly using plant based drugs. The "*materia medica"* of these systems contains a rich heritage of indigenous herbal practices that have helped to sustain the health of most rural people of India. The ancient texts like Rig Veda (4500 – 1600 BC) and Atharva Veda mentions the use of several plants as medicine. These texts refer to more than 700 herbs as medicinal (Kleinman & Sung, 1979). As a result of systematic developments and improvements, these systems are now being used more widely by the public at national and international levels. Through these developments, some Indian systems of medicine like the Ayurveda and Yoga mentioned above are emerging in the international arena due to global demand and the popularity of holistic approaches.

The government of China has paid significant attention to the development of Traditional Chinese Medicine (TCM) since the foundation of the People's Republic of China in 1949, where the division of the ministry of Public Health was established in 1951 and was made the Department of TCM in 1954. The Chinese constitution stipulates that "both modern medicine and traditional Chinese medicine must be developed" thereby giving both emphasis and taking into account a principal area of work for health in China

2.4 Regional Perspectives

The use of traditional medicine in Africa is said to be the oldest in that it used to be the dominant medical system available to millions of people in Africa in both rural and urban area communities. There are still strong indications that traditional health care systems are still in use by the majority of people in Africa (Romero-Daza, 2002). The use of traditional medicine has been encouraged by WHO mostly in developing countries just to promote the incorporation of its useful elements into national care systems (Akerele, 1987). Part of the reason for using traditional medicine is that the biomedical system which is popularized by governments cannot cope with current morbidity and mortality rates in Africa where it is very difficult to make generalizations about health conditions because they vary from one region to another and even within individual countries.

A study carried out in Ghana to explore the integration of TM found that health care users, providers 'experiences and attitudes towards the implementation of intercultural health care policy revealed that there is a wider positive attitude to and support for integrative medical care in the country, though inter-provider communication in a form of cross-referrals and collaborative mechanisms between healers and health professionals seldom occur and remains unofficially sanctioned. It goes on to say that the traditional healers and health care professionals are sceptical about intercultural health care policy mainly due to inadequate political commitment to provide education. Furthermore, mistrust was found to be serious between the practitioners due to the diversity of healing approaches and techniques and weak institutional support, lack of training to meet standards of practice, poor registration and regulatory measures as well negative perception of integrative medical policy (Mohammed Gyasi *et, al*, 2017).

Traditional medicine plays an important and underestimated role in public health, often being the primary source of health care and possibly the only accessible, affordable and culturally acceptable source of care (WHO 2013). Africa for instance counts roughly one traditional health practitioner per 500 individuals and one biomedical doctor per 40 000 individuals and an estimated 70 to 80% of the population uses traditional health care (Mills *et, al*. 2006; WHO 2002a; WHO 2013). Similar numbers are found for Asian countries. In the Lao People's Democratic Republic, traditional health practitioners are major suppliers

of health care for 80% of the population living in rural areas with each village counting one or two traditional health practitioners (WHO 2013).

In Far West Nepal there is at least one traditional health practitioner per 100 people compared to one health worker per 600 people (Kunwar *et, al*. 2012). In countries where the supply of formal biomedical health services is relatively extensive, people may still frequently rely on traditional medicine, as is the case for 76 % of the population of Singapore and 86 % of the population in South Korea (WHO 2013). Finally, in countries where the formal biomedical health sector is well developed there is a steadily growing demand for TM techniques as complementary or alternative therapy (WHO 2002a; WHO 2013). Hence, traditional medicinal techniques that have been proven safe and effective can contribute significantly to public health (WHO 2013).

Traditional health practitioners (traditional healers, midwives, birth attendants) are often highly respected, trusted community members and opinion leaders who play a pivotal role in the provision of primary health care and health-related information and advice (King 2000; Stoop, Verpoorten, and Deconinck Mimeo; WHO 2002a). Aside from medical treatments, traditional health practitioners are often found to provide social and psychological support as well (e.g. Goldman, Pebley, and Gragnolati 2002; Kale 1995).

Although the importance of traditional health care is largest in rural areas where access to biomedical health services is lower, it is not the case that traditional medicine loses its importance for health care provision in urban areas. Obuekwe & Obuekwe (2004) for instance report on how in an urban community in Nigeria (Benin City), women continue to rely on traditional medicine to treat diarrhoea. The authors explain the persistence of traditional health care in urban centres where biomedical health care is readily available by the fact that the beliefs underlying traditional medicine are fundamentally entwined with the community's cultural belief system and world view, and strongly integrated in daily life. Various other studies show that urban communities continue to rely on traditional health care (e.g. Comoro et al. 2003; Liamputtong et al. 2005; Peltzer and Magqundaniso 2008; Sein 2013).

2.5 Adaptability and Integration of Traditional Medicine

Cultural or religious beliefs and TM practices may be consistent or inconsistent with biomedical recommendations. Maslove et al. (2009) for instance document beliefs in Sub-Saharan Africa about malaria being caused by excessive heat, wind or cold, eating certain foods and drinking dirty water. Incorrect information about the causes of malaria will likely result in ineffective prevention measures (Maslove et al., 2009). An incorrect view of the human body may lead to ineffective or even counterproductive action. In rural Dominica for instance, it is believed that the human body contains an organ called the 'worm bag' which houses worms; if not controlled properly, worms may grow in size and number, spread into other organs and cause disease (Quinlan, Quinlan, and Nolan 2002). Nevertheless, the five commonly used plants to treat intestinal worms showed biochemical properties that suggest them to be effective treatments.

Cross-cultural postpartum practices that aim to prevent postpartum haemorrhage – an important cause of maternal morbidity and mortality appear to be consistent with biomedical health practices (Abrams and Rutherford 2011 cited in Radoff et al. 2013). Similarly, many cultures share the belief that the placenta should leave the body of the women, which also corresponds to biomedical knowledge. However, practices used to expulse the placenta vary, with some practices being possibly effective in expulsing the placenta and others ineffective or harmful to the mother (e.g. Berry 2006: O'zsoy and Katabi 2008). Obermeyer (2000) found that the general ethno physiology of pregnancy and childbirth among Moroccan women is not inconsistent with biomedical recommendations. For instance, blood is believed to be poisonous when it remains inside the body of the mother, but there is also a great fear of excessive bleeding during pregnancy. This local knowledge is supported by biomedical knowledge regarding the dangers of childbirth (Obermeyer 2000). Cultural beliefs and practices do not in themselves prevent safe home deliveries or prevent women from using biomedical health care service and as a result women seek both informal traditional care and formal biomedical care. However, the author also reports that women believe that some illnesses or complications have supernatural causes and cannot be cured by biomedical medicine.

Studies that examine the complete scope of cultural and religious beliefs and practices to food and health generally conclude that certain beliefs and practices may be beneficial while others might be harmful (e.g. Adams et al. 2005; Barennes et al. 2007; Iliyasu et al. 2006; Liu, Petrini, and Maloni 2014; Lundberg and Thu 2011; O'zsoy and Katabi 2008; Raven et al. 2007). Many scholars argue that existing cultural and religious practices should be discouraged when harmful but promoted when beneficial, as these practices tend to have substantially more support and legitimacy than newly-introduced biomedical recommendations (Steinberg 1996).

Nevertheless, while cultural and religious beliefs and practices have proven to be persistent, they are by no means motionless. Cultural and traditional knowledge evolve continuously in interaction with the changing environment of a society. Hence, belief systems may adapt to new biomedical information by incorporating biomedical recommendations or adapting existing beliefs and practices so as to make them consistent with newly acquired information. Social norms regarding when, how and what type of health care to seek may also adapt to changing circumstances and new opportunities.

In areas where there is little information about the true cause and proper treatment of illness, individuals may choose to combine traditional and biomedical therapies to maximize the probability of effectiveness (Ellis et al. 2007; LeMay-Boucher, Noret, and Somville 2012). Households often first turn to one type of medicine and seek help from alternative medicine when first-line treatment fails (WHO, 2013).

Several studies find that people integrate contemporary health services into the existing cultural belief system, adapting existing beliefs and practices in the process (Adams et al. 2005; Obermeyer 2000; Semega-Janneh et al. 2001; Wiley 2002). Adams *et, al*. (2005) provide an illustrative example in rural Nepal where most women fear giving birth in a hospital because they fear the presence of evil spirits and spiritual pollution due to the presence of blood and death. However, among nomad women a different view has come up, namely that hospitals are a good place to give birth because the polluted blood is quickly and easily removed and remains far away from the home and family of the mother. Biomedical information and recommendations may play an important role in changing the perspectives of specific practices as being beneficial or harmful.

2.6. Integration of Traditional Medicine Gaining Ground Globally

Top research bodies and some health practitioners worldwide are becoming serious about integrating TM into modern healthcare and many countries are working actively to harness and regulate TM. An example of such a body is the US National Institutes of Health which houses an organisation called the National Centre for Complementary and Alternative Medicine (NCCAM) that funds research into how acupuncture, herbal supplements, meditation or osteopathy can help treat conditions such as cancer, cardiovascular disease and neurological disorders (Ragunathan & Tadesse, 2009).

Gilman (2001) advises that developing countries with ancient histories of traditional medicines are also hunting for ways to modernise their own medical heritage. In China, modern and traditional medicines are practiced alongside each other throughout the healthcare system. The government gives equal weight to developing both and China has a large and active research community on integrative medicine.

The African Union has developed guidelines for the coordinated implementation of the Nagoya protocol by African countries which African ministers have recently officially adopted. In February 2013, India and the WHO South-East Asia Regional Office organised an international conference that agreed the Delhi Declaration on Traditional Medicine, which aims to collaborate and strengthen TM's role in health. In the Middle East, the Eastern Mediterranean Drug Regulatory Authorities Conference (EMDRAC) in May 2014 addressed the need to harmonise regulation of medical products including traditional medicines in the region.

Efforts to make traditional medicine mainstream also have to deal with varying regulations. Every country has a national drug authority of sorts but with different rules. The WHO has recorded a steady and marked increase in countries with national policies on traditional and complementary medicine or national regulations on herbal medicines over the past 15 years. But about half the countries that responded to a global survey in 2012 reported regulating traditional and complementary medicine practitioners and there are several obstacles to effective regulation (WHO, 2013).

TM often means different things to different people with a single plant being classified as a food, dietary supplement or herbal medicine. Xue & Zhang (2010) advise that education and research have also advanced with some 39 countries now providing high-level education and training programmes on TM. In South Africa for example, six out of the eight medical schools teach aspects of traditional and complementary medicine at undergraduate and/or postgraduate level. Additionally, programmes such as the EU-funded Multi-Disciplinary University Traditional Health Initiative (MUTHI) in some African universities have boosted practical skills such as how to write a clinical trial protocol.

Since the introduction of Western life styles in Africa through Western colonialism (Bohannan & Curtin, 1995) and now contemporary globalization, there has been a pronounced duality in the way Zambians cure illness. On the one hand and under certain circumstances, the people use indigenous or traditional methods which primarily involve herbs and rituals. On the other hand, they use Western methods and approaches which are prevalent in modern clinics and hospitals. This duality means the two approaches to the diagnosis and treatment of illness coexist among Zambians. There is not much literature on the perspectives of traditional medicine in Zambia but there was a study carried out by Hunger Culture from a community perspective of the Tumbuka people in the Eastern Province of Rural Zambia. A sample of 118 adults responded to a questionnaire which had open ended and structured questions and the findings suggest that the Tumbuka people may have significant dualism in the way they explain the causes and treatment of disease. They characterize certain types of disease as being modern and therefore only treatable at the clinic or hospital. Others are characterized as traditional or indigenous and therefore are only treatable by the "ng'anga" or traditional healer (Hunger for Culture, 2002).

As a process to integrate the use of TM by conventional health workers, it was useful to determine their perceptions of TM and this study was carried out in Zimba District in the Southern Province of Zambia at Zimba Mission Hospital including other health care facilities in the District. This was done to determine the Perspectives of Traditional Medicine Integration into Conventional Medicine by health workers and based on this, subsequently determine if integration of TM would be detrimental or beneficial.

2.7 Conceptual Framework

Since the early 1970s, the WHO has repeatedly advocated for the recognition of TM through the Traditional Health Practitioners (THP) as Primary Healthcare (PHC) providers and for the integration of traditional medicine in national health systems. Several calls have been made on governments to take responsibility of the health of their people and to formulate national policies, regulations and standards as part of comprehensive national health programs to ensure appropriate, safe and effective use of traditional medicine. The idea is to facilitate access to the basic primary care, first –aid instruction – emergency response and health information for communities who are isolated from appropriate medical institutions.

The combination of traditional medical knowledge that is evidence – based when integrated may help in best practices by providing an understandable overview of the full nature and extent of the considered diseases and treatment for improvements in the contextual care systems. Challenges such as efficacy, safety, quality, standardisation, regulation of TM and intellectual property rights, and many more have been reported to hinder better collaboration among countries that are willing to achieve a successful integration process. In trying to overcome these challenges at national level, this study adopted the conceptual framework on integration of interventions by Atun et al., (2010). The aim of using this framework is to promote the role of TM in health systems which seek to promote "integration" of traditional medicine practices and medicine for which evidence on safety, efficacy and quality is available and the generation of such evidence when it is lacking, into health systems.

Integration in this context means the increase of health care coverage through collaboration, harmonisation and partnership-building between conventional and traditional medicine, while ensuring property rights and indigenous knowledge. Drawing from this framework, critical elements that are considered when developing integration programmes into the health system are described and will be utilised by this study to describe the process.

Base on the extensive literature that has been reviewed, the following (see Figure 2.1) has been developed for the study.

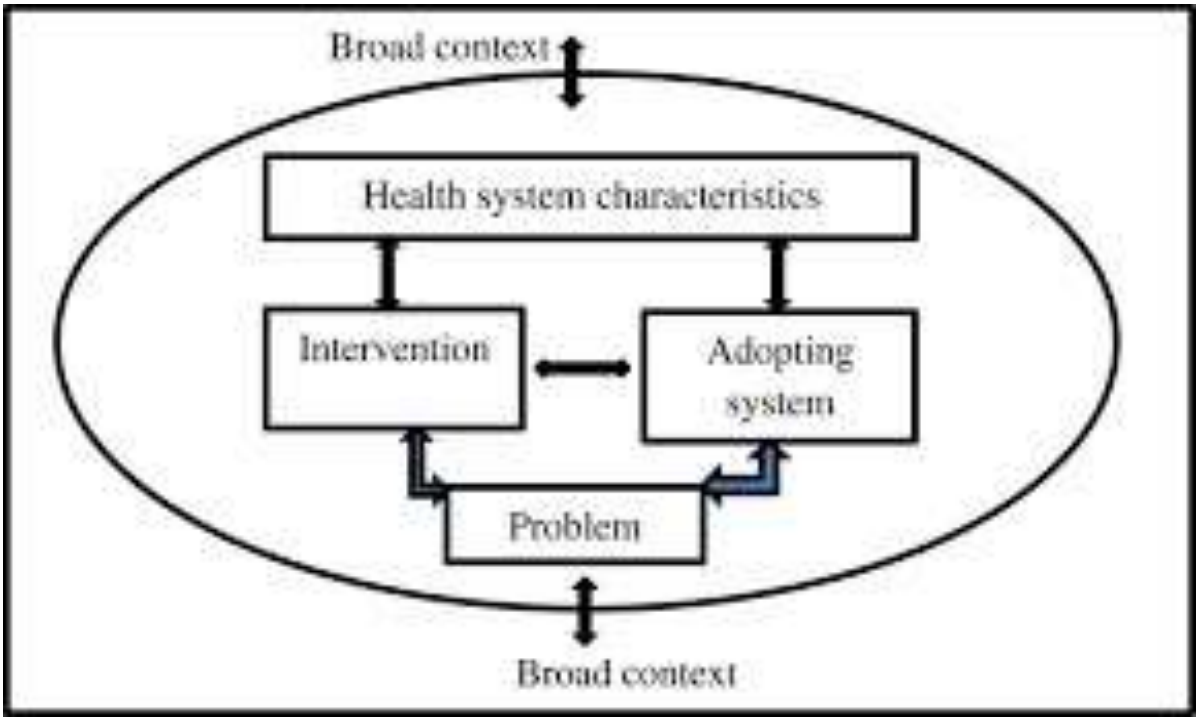

Figure 2. 1 Conceptual framework for analysing integration process (adopted from Atun et'al, 2010).

The highlights of this framework (Figure 2.1) are that in order to integrate interventions into the national health system, the researcher should first mention the nature of the problem such as safety effectiveness to be addressed in the study. Despite the health benefits such collaboration could bring to the population, decades of disregard of traditional medicine practices and products has created mistrust between the two sectors hampering all the efforts being made to promote this potential partnership. Secondly, the attributes of the intervention may influence integration or collaboration for instance TM therapies have the potential to contribute to a better health care system in many places. This is particularly true in countries' rural areas, Zambia inclusive, where access to basic conventional health care is extremely limited. Fully including these treatments into health care programmes would ensure that safety, quality and efficacy studies are available and regulated. Thirdly, integrating interventions into the health system goes with its characteristics. Characteristics such as resource, infrastructure and regulatory systems go hand in hand with the broad context elements which include, strategic planning, governance, financing, human resources, supply chain and logistics, demand generation,

and monitoring and evaluation. Finally, the adoption system composed of donors, ministry of health, advocacy groups from the two sectors, the private sector, communities' patients and nongovernmental organisations may be vital for the integration process.

CHAPTER THREE: METHODOLOGY

3.1 The Study Area

The research was conducted in Zimba district located in Southern Province of Zambia, it lies between 17° and 18° Latitudes South and 26° and 27° Longitudes East. The district covers approximately a total area of 5,245.01 square kilometres in size. Zimba is one of the thirteen (13) districts of the Southern Province in Zambia. Zimba is predominantly rural area sharing boundary with Kalomo to the East, Kazungula to the South West. The district also shares an international border with Zimbabwe through the Zambezi River (Chomba and Sichingabula, 2015). The district has a total of 11 health facilities according to the Zimba district health office serving a population of over 85,000 people according to (CSO, 2016).

The economy of the district is mainly dependent on agriculture with 85% of the Population in Zimba dependant on agriculture for livelihood thus sustainable water development and management is key. Economically, Zimba district is rated among the poorest districts in the country. To this effect, the poverty scenario in Zimba is basically attributed to many factors among them lack of access to clean water and sanitation. The study targeted six (6) health facilities in the district which included Zimba Mission Hospital and also from the rural health facilities found in the district. Figure 3.1 below shows map of southern province indicating location of Zimba district.

3.1 Research Design

This was a qualitative research that utilized a case study research design on understanding the perspectives on the integration of TM with conventional medicine among the health workers at the Zimba Mission Hospital and rural health facilities in Zimba District.

3.2 Study Population

The target population of the study includes health workers and healthcare providers in Zimba District which included the following categories of health workers; nurses, doctors, clinical officers and community health assistants. This category of health workers was considered because they handle patients from screening up to discharge or institutional exit

and as such encounter the patient's lived experiences. These health workers were best suited to render an opinion on the study being the medical service providers.

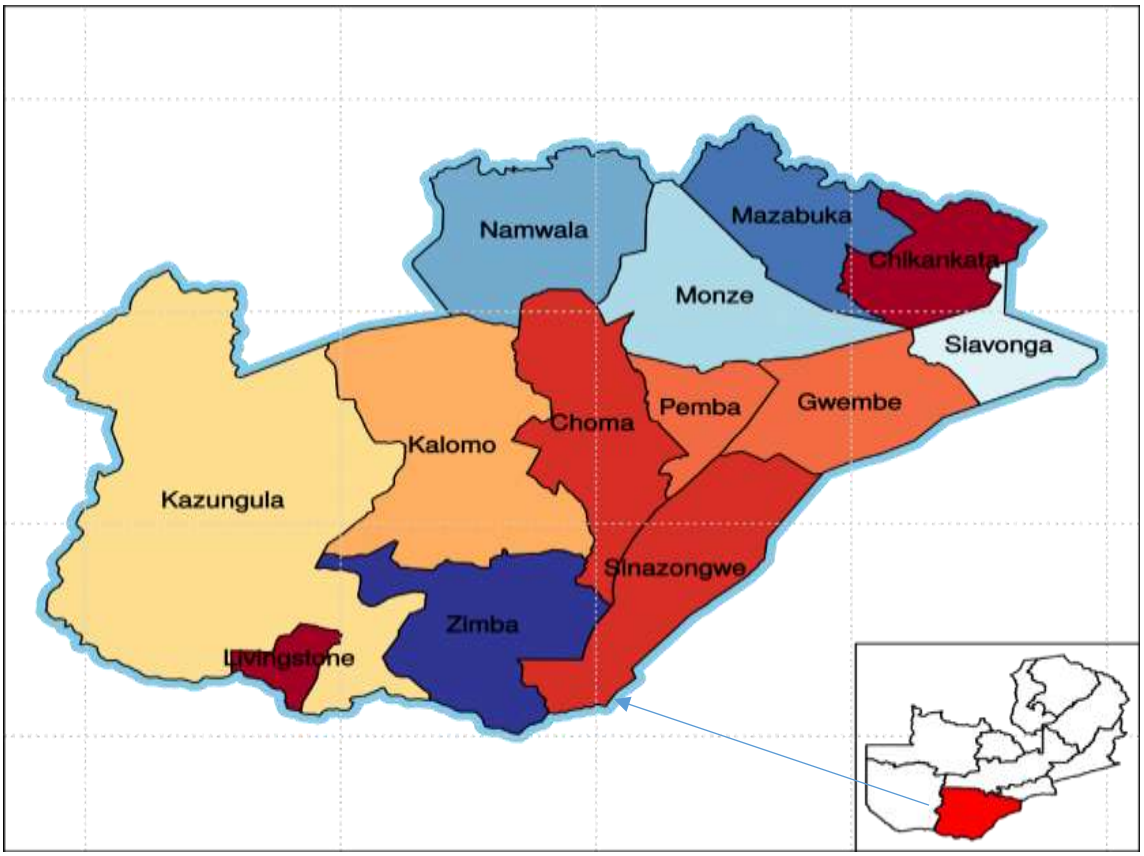

Figure 3. 1 Map Showing Location of Zimba District. ***Source:*** *Innocent Chomba (2017).*

3.3 Sampling Procedure

A purposive sampling strategy was employed in the study which involved selecting participants on the basis of their occupation. Cresswell (2014) argues that purposive sampling is used when the researcher selects individuals or a site because they can purposefully inform an understanding of the research problem or central phenomenon of the research study. Using purposive sampling for the study enabled the researcher to select health workers whose occupations were nurses, doctors, clinical officers and community health workers. These persons were considered appropriate for the interviews due to their experiences in their respective jurisdictions as far as medical systems are concerned. In doing so, the participants were able to inform the researcher on the use of TM and CM,

experiences on the healing power of TM, the risks and benefits associated with use of TM as well as how TM and CM can be integrated. Further, 6 out of 11 health facilities drawn from ministry of health database were purposely selected for the selection of participants.

3.4 Sample Size

The study consisted of 20 health workers (healthcare providers) selected from the study 6 health facilities in Zimba district according to their occupation and knowledge about TM and its integration in CM. As such, sample size included nurses (5), medical doctors (3), clinical officers (3) and community health workers (9) from 6 health facilities in Zimba district.

Inclusion Criteria

The primary inclusion criterion was front line health workers with experience and knowledge of TM. Further, participants were selected based on their occupation as indicated above in line with Given's (2008) definition of purposive sampling that obtains information and insights from those especially knowledgeable about a topic. A knowledgeable participant in this study was defined as one who has interaction with TM, CM, traditional healers and practitioners and was familiar with integration of TM with CM. In addition, the person could also have experience in the use of TM and CM in healthcare facilities (Cresswell, 2011).

Exclusion criteria

Participants were excluded if they were not in the category of the four occupations the researcher was interested in namely nurses, community health workers, doctors and clinical officer and if they had not worked in health facilities in Zimba for less than 6 months and above and were working in private health facilities.

3.5 Data Collection Procedure

In order to get the required data, ethical clearance was sought from the Ethics Committee and an introductory letter was obtained from the University of Zambia, School of Public Health which was first presented to the provincial health office of southern province, Choma to be specific. Thereafter, a letter from the provincial health office was obtained

which was then taken to Zimba district health office. Another letter of introduction was collected from Zimba district health office. This letter together with the introductory letter from the university was then presented to every participant (interviewee) in all the 6 health facilities that were purposely selected.

3.6 Data Management and Analysis

All individual interviews with health workers/providers were audiotaped with the permission of the participants. Analysis was conducted simultaneously with data collection with initial analyses of early interviews informing the themes explored in those that followed. The analysis process began with transcription of the audio recordings and going through the audio against its transcript repeatedly in order to capture the context and meaning and for data quality control. Transcripts were imported into Nvivo 11 data management software for data management. Further, Yes and No questions were asked to health workers on whether they believed in witchcraft, whether diseases were caused by supernatural powers or whether they supported integration of TM and CM. These responses were entered into excel, analysed, quantified and presented in form of tables and figures using frequencies and percentages. Background characteristics were entered and analysed in Excel and presented in form of tables and figures using percentages.

Thematic analysis was performed through the process of coding in six phases in order to create recognized and meaningful patterns. These phases are: familiarization with data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes, and finally producing the final report.

Data was familiarized by reading and re-reading of the transcribed interviews while paying attention to patterns and occurrence. At this point, the researcher focused on data that addressed the research question. This marked the coding process. Generation of initial codes was done by documented information on use and integration of TM with CM, risks and benefits associated with TM among other themes. This involved listing items from the data set that had a reoccurring pattern. Meaningful parts of data related to the research question were organized and examined. The lists of themes were combined to the coded data with proposed themes. Some themes emerged from the data in cases where the

following issues occurred; repeated ideas, indigenous terms, metaphors, analogies as well as similarities of the participants' linguistic expression. The researcher critically looked at how the themes supported the collected data.

Finally, the revealed final themes and the report was written according to the sub-themes that made meaningful contributions to answering research objectives. The researcher presented the dialogue connection with each sub-theme in support of increasing constancy of the results.

3.7 Ethical Considerations

The study involved key informants from the Ministry of Health and the policy of voluntary participation was strictly adhered throughout the research. All participants in the interviews were well informed about the purpose of the research and how the information and data collected would be handled. Permission was sought from the Ministry of Health to conduct the study at Zimba Mission Hospital and also from other health providers' like the community health workers within Zimba district.

3.7.1 Clearance

Clearance was gotten from the Ethics committee UNZABREC and to allow the researcher to carry out the study

- Confidentiality and anonymity of participants was maintained. Thus, there will be no link between the respondent and the data collected from the participants. The participants will also be assured of the same.
- Participants were informed that participation in the research was not compulsory. Furthermore, participants were notified that they were free to withdraw from the study at any point.
- There was no provision of any direct benefits to the participants during the study. However, their responses are expected to generate information that will contribute to health care provision in Zambia and also the information may contribute to scientific knowledge about the use of tradition medicine.

3.8 Study Limitations of the study

A key limitation of this survey concerns generalization. The study cannot be generalised to the whole of Zambia because of the small sample size and it was limited to one setting. The intent of the qualitative approach was used to elucidate a better understanding of issues surrounding traditional medicine and conventional medicine. However, in spite of this limitation, the findings from this study provide information about understanding of traditional medicine perceptions among health care providers and use in conjunction with conventional medicine. The next step is to continue this research further in a larger sample size. It is recommended that a much wider study be conducted.

CHAPTER FOUR: RESULTS

This chapter presents the results of the research in relation to the perception of health workers on traditional medicine and its integration in conventional medicine in Zimba district. For easy understanding, themes were used to present the results and where necessary, tables and figures were also used to present and summarise the key findings.

4.1 Characteristics of Respondents

Table 4.1 below shows the basic characteristics of respondents. It presents the age category, sex and education level and occupation of respondents.

Table 4. 1: Background Characteristics of Respondents.

Age category	18-25	26-35	36-45	46-55	Above 55
	1	10	4	2	3
Sex of Respondents	**Male**	**Female**			
	12	8			
Level of Education	**Primary**	**Secondary**	**Tertiary**		
	2	3	15		
Occupation of Respondents	**Nurses**	**Community health workers**	**Doctors**	**Clinical Officers**	
	6	7	3	4	

4.2. Healthcare Providers Beliefs in Witchcraft, Cause of illnesses and Traditional Medicine

Health workers showed divided opinions on whether or not some diseases could be caused by witchcraft. Some believed that witchcraft in an African setup was responsible for some of the diseases that could not be treated at a hospital or clinic. They noted that some community members still believed that witchcraft was a form of weaponry that was used to cause harm one's enemy or even as an expression of jealousy over the enemy's success.

> "*Having lived in a rural set up, I have come across people with ailments that society has ascribe to witchcraft or supernatural and that its cause is not natural. Hence, I believe that the existence of illnesses that ascribe to supernatural causes or to witchcraft is real and examples of such illnesses like mental illness (musala in our local language). It's believed that if you get mad probably you would have been bewitched. So with that in the background and having experienced such I know*

that certainly there are traditional illnesses or illnesses that would ascribe to maybe traditional beliefs in that regard witchcraft or supernatural forces" ID14 Doctor.

4.3 **Common Diseases That TM Can Cure According to Health Workers Interviewed**

Despite being in the biomedical health sector, some of the health care providers still believed that traditional medicine was equally important in treating some of the health conditions. They noted that diseases among others such as anal growth, bronchitis, asthma and diarrhoea could be treated by traditional medicine (Refer to Table 4.2 for other diseases that are perceived to be curable using traditional medicine).

> *"I remember at one point when I was very asthmatic and had problems breathing, my mother made a certain concoction were she put a herb in the water and after boiling and forming steam, she then asked me to cover myself in a blanket with a pot containing the mixture and open and close the lid and ask me to sniff the steam. As you sniff the vapour, the airway opens up and you would feel relieved" Verbatim from ID6, a nurse.*

> "*there are certain trees that traditional healers use especially if one is lacking blood or if one is having anaemia for instance there is a certain tree they call it "mulombe" when you cut it, it has red barks and it produces reddish kind of water so they would get that and squeeze it. It is biter when you take but they say it helps to form blood, they believe that it helps to form blood so we would take that. I might not say that I have experienced, I have actually confirmed that one has had more blood after using it. I know that they use it, meaning that they believe this can cure anaemia*". Extracts from ID4, a clinical officer.

Table 4. 2: List of commonly identified diseases by health workers in Zimba district

SN	**Common Diseases that TM can Cure according to Health Workers**		
1	Asthma	7	Anal growth
2	Scabies	8	Snake and insect bites
3	Diarrhoea	9	STIs i.e. Syphilis
4	Bronchitis	10	Mental health
5	Menstrual Pains	11	Infertility
6	Epilepsy	12	Conditions of blood

4.4. Experiences and Attitudes of Healthcare Providers towards Integration o& CM.

Results indicate that some study respondents were willing to work hand in hand with each other, provided a mutual working relationship is established between those dealing with traditional and conventional medicines. However, the respondents also acknowledged some challenges that may hinder the integration of the two forms of treatment such as agreement on the dosage for different medicines, who refers clients to the other, developing an all-encompassing policy framework and issues to do with specialty.

> *I think it is possible to have the two work together. The only challenge I can foresee is the question of who should refer patients, who am the two should patients go to first? Should they go to the clinic first then if it fails go to a traditional healer? This will be the biggest question." ID14 Doctor.*

> "*in terms of using TM and CM hand in hand, I would be a bit sceptical, I would be a bit doubtful to say yes because for them to be used hand in hand there is a possibility that you would actually overdose someone because certain traditional medicines would also be there in conventional medicine, for instance in traditional medicine, there are pain killers known of certain herbs that when you give pain would actually go, so if you want to manage pain for instance you take a traditional herb that relives pain, you also take at the same time for instance you also take conventional medicine maybe there would be drug toxicity".* ID10 clinical officer.

4.5. Perceived Benefits and Risks of TM among Healthcare Providers

Some of the health workers noted that despite traditional medicine being credited for healing 'certain' diseases, it was difficult to come up with a proper dosage to give patients. The health workers also noted that majority of patients that take traditional medicines usually do not understand the side effects of the drugs. They explained that the issue of dosage and side effects in conventional medicine has been dealt with in that patients are usually given specified quantities in dosage depending on the severity of the condition and are able to predict the side effects because the medicines have been tried and tested before being offloaded on the market.

"Okay, my experience that the best thing is to use conventional medicine, because conventional medicine is weighed on the benefits and side effects so we can say for this you can use this kind of medicine with a certain dose, if you like can exceed and know what kind of side effects the medicine has compared to traditional medicine where there is no dosage and all you do is just go boil this and this then take. In other words, the side effects of TM as well as proper dosage are not known", ID 6, a nurse.

"TM can be best used as first aid especially in a situation where maybe a place where you can seek conventional medicine is not within reach they can actually be used to kindly stabilize someone as they are going to seek further management to establish exactly what is really wrong where the pain is coming from, so they can be used as first aid and I do see people use them especially in rural places where the clinics are not very near", ID20 CHW.

4.6. Motives for Referring Patients to Traditional Healers/Herbalists

Some health workers acknowledged referring some patients to take up traditional medicine. They explained that in instances where the patients shows no signs of recovering from illness after using conventional medicine, they would refer the patient to seek treatment from traditional healers.

"At the moment it is not explicitly to see health provider referring a patient to traditional doctors but the motive would be caused if the patient is not getting better after trying all forms of treatments and that there is no improvement and all necessary medical tests have been done and the cause is not found or known. Only after that referral of patients to traditional doctor, or healer or a spiritualist for it is possible to ascribe the cause to the supernatural. But normally, health workers prefer traditional doctors to refer their patients to medical practitioners". ID 20, a community health worker.

CHAPTER FIVE: DISCUSSION

5.1 Introduction

The purpose of the discussion is to interpret and describe the significance of the findings in light of what was already known about the research problem being investigated and to explain any new understanding or insights about the problem after taking the findings into consideration. The discussion is connecting to the introduction by way of the research questions and the literature that was reviewed. The discussion will make reference to the results presented in the preceding chapter.

5.2 Healthcare Providers Beliefs in Witchcraft, Cause of illnesses and Traditional Medicine

The study found that community health workers who formed majority of the respondents believed that some sicknesses are caused by witchcraft or supernatural powers as such they do not require conventional medicines but rather traditional medicine for them to be treated and healed. Eleven Health Workers had belief in in existence of witchcraft as compared to 9 who did not. Fourteen health workers had belief that traditional medicine works sometimes. Eleven agreed that they would refer a patient to a traditional healer and 17 agreed that traditional medicine should be integrated with conventional medicine **(**Table 4.2**).**

This belief in witchcraft or supernatural cause of sicknesses can be explained by the large number of respondents believing in the existence of witchcraft as seen in Table 4.3 in Chapter Four. Further, the study found that apart from community health workers, some nurses and clinical officers believed that traditional medicine works in several instances and on some common diseases although most health workers interviewed did not believe that TM can cure serious illnesses such STIs, HIV and cancer among others. A submission is given by ID14 in the results of belief in illnesses that ascribe to TM under section 4.3.

However, not all health workers interviewed ascribed illness to supernatural power or witchcraft. This finding is in line with several studies such as Maslove et, al (2009), Quinlan and Nolan (2009) who found that TM use and integration with CM among health workers and patients cultural or religious beliefs had an impact on people's beliefs and

perception of cause of illnesses. Maslove et al. (2009) for instance document beliefs in Sub Saharan Africa about malaria being caused by excessive heat, wind or cold, eating certain foods and witchcraft. Another study carried out in Dominican Republic had similar findings and established that in rural Dominica, for instance, it is believed that the human body contains an organ called the 'worm bag' which houses worms; if not controlled properly, worms may grow in size and number, spread into other organs and cause disease and are ascribed to supernatural powers (Quinlan, Quinlan, and Nolan 2002). Nevertheless, TM was extensively used to treat the same and the five commonly used plants to treat intestinal worms showed biochemical properties that suggest them to be effective treatments and these were administered by health workers and traditional medical practitioners and healers.

The study found that majority of respondents accounting for 75% believed some illnesses (sicknesses) are caused by witchcraft while minority 25% did not believe in witchcraft or super natural cause of illnesses. This was based on Yes and No questions asked to health workers on whether they believed in witchcraft, whether they believed diseases were caused by supernatural powers or whether they believed that TM works. These responses were entered into Excel, analysed, quantified and presented in form of tables and figures using frequencies and percentages.

The results of this study agree with results of a study carried out by WHO (2017) which found that at least 70% of health workers in Zambia have encountered patients using traditional medicine. Traditional and complementary/alternative medicine is used and accepted by a great majority of the population, regardless of ethnic, religious, or social background and this could explain why the level of education has no impact on belief in witchcraft or TM as shown in Table 4.1. Further, the study by WHO found that there are more than 35 000 members of the Traditional Health Practitioners' Association of Zambia, founded in 1978 and thousands of non-members. Currently, herbal medicine, naturopathy, traditional Chinese medicine, reflexology, spiritualism, and other forms of medicine are practiced in Zambia. Both Zambians and foreign nationals practice traditional and complementary/alternative medicine (WHO, 2017). Globally, the World Health Organization (WHO) estimates that one-third of the world's population has no regular

access to essential modern medicines; in some of African, Asian, and Latin American, as much as half of the population faces these persistence shortages. However, in these situations, the rich resources of traditional remedies and practitioners are available and accessible. This therefore accounts for the large number of health care practitioners that believe in witchcraft and also in the healing power of traditional medicine.

In terms of beliefs that traditional medicine works, the study found that majority of respondents who accounted for 70% believed that traditional medicine sometimes works in certain illnesses or conditions. Additionally, 20% of respondents had no doubt that traditional medicines works all the time, 5% of respondents did not believe that traditional medicines works at all while another 5% of respondents didn't know whether traditional medicine works or not. Therefore, the study found out that majority of respondents believe that traditional medicines work and must be used simultaneously with conventional medicines because many people depend on it.

This finding is in line with sentiments by the then WHO Director General, Dr Margret Chan at the International Conference on Traditional Medicine for South-East Asian Countries in February 2013 who stated that "traditional medicines, of proven quality, safety, and efficacy, contribute to the goal of ensuring that all people have access to care. This is because for many millions of people, herbal medicines, traditional treatments and traditional practitioners are the main source of health care and sometimes the only source of care. This is care that is close to homes and is accessible and affordable. It is also culturally acceptable and trusted by large numbers of people. The affordability of most traditional medicines makes them all the more attractive at a time of soaring health-care costs and nearly universal austerity. Traditional medicine also stands out as a way of coping with the relentless rise of chronic non-communicable diseases". Regardless of reasons for seeking out TM, there is little doubt that interest has grown and will almost certainly continue to grow, around the world (WHO, 2013). Moreover, this study also established that the use of traditional health care remains widespread, both in rural and urban areas of Zimba district with 17 out of 20 health workers interviewed stating that they have encountered patients using TM and CM while admitted in hospital. In addition, the WHO (2017) also reported that 70% of Zambia's population use TM and this has

important implications for the provision of public health care and this finding is in tandem with studies carried out by (Adams *et al*, 2005; Barennes *et al*, 2007; Iliyasu et al. 2006) who argue that traditional medicine should be promoted as it tends to have substantially more support and legitimacy than newly-introduced conventional medicines.

5.3 Experiences and Attitudes of Healthcare Providers towards Integration of TM and CM

Understanding the views of health care provider's experiences and attitudes about the use of TM will help in assessing the willingness in the process of integration. In addition, the information provided may help where training in terms of using TM may be needed alluding to a number of participants mentioning that some type of training needs to take place before the integration could be done. Understanding their experiences and attitudes gave the assurance that health providers would help in the guidance of the proposed integration. For instance, an interesting revelation came out during the interview where a medical doctor mentioned to say practitioners of TM are not trained.

According to four categories of health care providers (Doctors, nurses, clinical officers, and community health workers) interviewed, community health workers came out to be the most group with the positive opinions and attitudes having more experiences and knowledge with traditional healing powers compared to the doctors, nurses and clinical officers. For instance, the study found that majority of the respondents (17 out of 20 health workers interviewed) seven (7) community health workers, four (4) nurses, one (1) medical doctor and three (3) clinical officers perceived that integrating TM with CM would have positive impact on the health sector as TM acts as first aid for those without access to medical facilities. The study also found that healthcare providers required a deliberate policy and political commitment to bring traditional healers and professional health providers and guide the integration and use of both TM and CM. Further, the study found that, of those interviewed, community health workers had had more exposure and experience regarding patients using TM.

Nonetheless, nurses, clinical officers and doctors also admitted that they had patients using both traditional and conventional medicines while admitted in wards or before being brought to a health facility. However, most doctors, nurses and clinical officers interviewed

were also sceptical because the use of both TM and CM made it nearly impossible to determine which type of treatment was responsible for healing and treating various ailments. The untested nature of TM also raised several questions on the viability of TM which has not been trailed and its effects unknown. In summary, the study established that community health workers had generally a positive attitude on TM integration with CM as well as more experience encountering the use of TM in communities compared to nurses, doctors and clinical officers who had a somewhat negative attitude towards TM integration with CM.

These findings agree with a study carried out in Ghana among healthcare workers and users to explore the integration of TM which found that health care providers had positive attitude towards integration of TM with CM. Their experiences with TM towards the implementation of intercultural health care policy revealed that there is a wider positive attitude to and support for integrative medical care in the country, although inter-provider communication in a form of cross-referrals and collaborative mechanisms between healers and health professionals seldom occur and remains unofficially sanctioned. It went on to say that the traditional healers and health care professionals are sceptical about intercultural health care policy, mainly due to inadequate political commitment to provide education. Furthermore, mistrust was found to be serious between the practitioners due to the diversity of healing approaches and techniques and weak institutional support, lack of training to meet standards of practice, poor registration and regulatory measures as well negative perception of integrative medical policy (Mohammed Gyasi et AL., 2017).

5.4 Healthcare Providers Perception of TM Healing/Curing Diseases

The participants had different views about traditional medicine and healing of some ailments in that some had negative responses while others were positive in their responses. Furthermore, another group of health workers were reluctant to let their views known on traditional healing.

The study found that a large number of respondents (14 respondents) perceived that traditional medicines can be used to heal some but not all illnesses and illnesses that TM

can treat include diarrhoea, madness, STIs, menstrual pains, headache, to name a few. An example is given by ID8**,** a Community Health Worker in chapter four, section 4.5.

Furthermore, ID10 a clinical officer in a verbatim in chapter four, section 4.5 noted that indeed traditional medicine has the power to heal several sicknesses but cannot be used to treat serious illnesses hence in such circumstances, conventional drugs must be applied;

This finding is critical as it supports the findings of Edwards, et al., (2012) and WHO (2002) who acknowledge that "traditional or alternative medicine has many positive features among community health workers and that traditional medicine and its practitioners play an important role in treating chronic illnesses and improving the quality of those suffering from minor illness and certain incurable diseases". Traditional medicine is not only a vital source of health care, but also an important source of income for many communities where it can form an integral part of a community where it does not just regard human health as a purely physical entity but takes into consideration patients' social and cultural environment (David, 2013).

5.5 Common Diseases That TM Can Cure According to Health Workers Interviewed

Most of the health care providers in the study were very informative in their mentioning of what TM is capable of doing where they attached some type of medical conditions that could be effectively treated by THs as indicated in Table 4.5.

According to all community health workers, 2 clinical officers, 4 nurses and 2 doctors interviewed in Zimba district, they strongly believed that TM can cure some common diseases. For instance, ID6 a nurse submits that "TM can be used to treat fever, pneumonia, asthma and bronchitis. The ID6 further notes that there are some traditional medicines that people use for asthma related kind of conditions, such as bronchitis, asthma itself or just chest congestion.

Further, ID3, a community health worker also states that TM can be used to treat insect bites, ringworms, scabies and snake bites. ID3 explains that with scabies, "I remember there was one time might not really know exactly what concoction that was but there is a concoction I remember during the times that we suffered from scabies "*mpele*" as we call it

in Nyanja, they would actually apply some chemicals on our bodies it was only later on when my parents moved to some other place in a town setup when we got exposed to conventional methods of treating that where we were given a chemical now we know what it is but that time we didn't know but before that they could apply some black stuff on the body".

ID4, a clinical officer also observed that TM can also be used to treat blood related conditions such as anaemia and provided a submission as can be reviewed in the verbatim results, chapter four section 4.6.

Other healthcare workers interviewed also identified menstrual pains and sexually transmitted diseases (STIs) as other diseases than can be cured with TM with a medical doctor ID 11 providing a verbatim submission included in the results chapter, section 4.6.

Some of these findings agree with a study by Gupta et, al (2014) which indicate that traditional medicine can and has been used to treat some illnesses. For instance, in their study they carried out in Western India titled "*Comparative Evaluation of the complementary and Alternative Medicine (CAM) Therapy and Conventional Therapy use for Musculoskeletal Disorder Management (MSD) and its association with job satisfaction among dentists*" revealed that dentists using CAM therapies had greater overall health and more life satisfaction compared to Conventional Therapy users. Further it was recommended that CAM education should be incorporated in the dental curriculum to train the budding dentists about better management of MSD and says education and additional research are needed to promote an understanding of the complexity of the problem and to address the problems' multifactorial nature. It goes on to say dentists should adopt a holistic way of treating their musculoskeletal complaints in that knowledge and training of alternative therapies is very much required (Gupta *et al*, 2014).

5.6 Perceived Benefits and Risks of TM among Healthcare Providers

The study found that most health workers interviewed believed that TM had more risks than benefits. In terms of benefits, health workers interviewed viewed TM beneficial due to the fact that it is found in close proximity to the people and acts as first aid before people can access a health facility especially in rural areas. Thus, the benefits of TM according to

health care providers lies in the fact that these drugs are usually close to the people because if someone has a know-how of which herb in the bush could actually treat what they would easily walk to the bush and pick them. Other benefits associated with TM in this study included the fact that TMs are within reach and also cheaper than CM because most of people in rural areas would not go to the drug store or even hospital to get CM, but rather just go to nearby bushes as all one needs to have is knowledge various herbs and what they do.

The study also established that majority (19) health workers interviewed perceived that TM posed serious risks while minority (1 health worker) did not know the risks as TM has not been widely tested or trialled. Overall, the study found that majority health workers perceived that TM risks were mostly in terms of the high toxicity the herbs might pose on the body because we still do not know the side effects of most TMs and what they do. Further, respondents were concerned that most drugs when taken are deactivated either by the liver or the kidneys and that's where the potency is. If mishandled, TMs are too potent or too toxic to the body and the body channels them to liver and you end up finding that at the end of the day it's the liver that tends to suffer the consequences and in the long run you find that maybe someone may have liver damage if the body channels to the kidneys. Other risks associated with TM in this study included lack of proper dosage, side effects not fully known, may cause infections when improperly applied on open wounds, lack of established guidelines on usage to name a few. Overall, majority of respondents agreed that TM has both benefits as well as risks. These findings are backed by a study carried by the WHO (2017) which found that TM had several risks such as causing infections when improperly applied on open wounds among other risks such as those highlighted in the perceived benefits and risk table in chapter three.

For instance, ID6, a nurse provided a verbatim submission regarding the risks and benefits of traditional medicine as can be seen in the verbatim results, ID6 in chapter four, section 4.7.

In addition to ID6 submission, ID20 in similar manner notes that despite the risks of toxicity, unknown side effects, lack of dosage, he submits that TM can also be beneficial and submits a response per results in chapter four, section 4.7.

5.7 Motives for Referring Patients to Traditional Healers/Herbalists

Health workers were asked a yes and no question on whether they have, can or would refer a patient to a traditional medical practitioner or to try TM. Their responses were quantified in Excel and presented in Table 4.8. The study found that 55% of respondents stated that they can refer and they had seen other practitioners refer patients to try traditional medicines (healers) when all conventional medicines fail while 45% of the respondents stated that they cannot refer a patient to TM because it is against health ethics and government and ministry of health policy **(**see Table 4.8).

It was revealed that health workers are guided by well-regulated rules and regulations code of conduct as well as ethics. ID20, a community health worker provided a submission as seen in the results in chapter four, section 4.8.

This finding agrees with that of Shamila Suliman Latif in his study titled, "*Integration of African Traditional Health Practitioners and Medicine into the Health Care Management System in the Province of Limpopo"* who argued that many doctor prefers traditional healers to refer patients to a medical doctor and not the other way round. The traditional healer (referee) must give a full detail of the medical symptoms, in order for a proper diagnosis. The doctor suggests that THPs need to refer patients to primary health care clinics and not directly to the hospitals. The doctor still seems to believe that when a patient is referred from a traditional healer, the medical treatment must begin from primary care and healers need some medical background to relate to the medical profession (Shamila Suliman Latif, 2010).

5.8 Healthcare Providers Perception of Integrating TM and Conventional Medicine

In terms of health care providers' perception of Integrating TM and CM, the study found that 85% of respondents perceived that TM must be integrated with CM while 10% of respondent were not sure if it should be integrated due to various reasons such as a lack of policy on the integration of TM with CM by the government while 5% of respondents did not agree or perceive that TM should be integrated with CM at all as the perceived that TM was incompatible with CM.

Overall, majority of respondents had a positive perception and actually encouraged integration of TM with CM. Further, most respondents submitted that further research must be promoted aimed at understanding some common TM and how they can be used side by side with CM. A submission in line with this was provided by ID15, a Clinical Health Worker as indicated in the results.

This finding is supported by a study of the use of TM among health workers by Hunger for Culture (2002) that argues that in Zambia, the use of western methods and approaches by health workers is prevalent in modern clinics and hospitals in Zambia. The study further notes that this duality means the two approaches to the diagnosis and treatment of illness coexist among Zambians. There is not much literature on the perspectives of traditional medicine in Zambia but there was a study carried out by Hunger Culture from a community perspective of the Tumbuka people in the Eastern Province of Rural Zambia which also interviewed health workers which also agrees with the findings of this study. A sample of 118 adults responded to a questionnaire which had open ended and structured questions and the findings suggest that the Tumbuka people may have significant dualism in the way they explain the causes and treatment of disease. They characterize certain types of disease as being modern and therefore only treatable at the clinic or hospital. Others are characterized as traditional or indigenous and therefore are only treatable by the "ng'anga" or traditional healer (Hunger for Culture, 2002).

The people interviewed also stated that TM must be integrated with CM because there are traditional diseases that can only be treated with TM and not conventional medicine. This is particularly true for what may be considered indigenous diseases that may not easily relate to a conventional diagnosis and poses issues regarding patient centred communication (Saifur, 2017).

It was interesting to note that traditional and complementary/alternative medicine is used and accepted by a great majority of the population, regardless of ethnic, religious, or social background and this could explain why the level of education has no impact on belief in witchcraft or TM. Zambians practice traditional and complementary/alternative medicine (WHO, 2017).

The findings regarding traditional beliefs that traditional medicine works are in line with sentiments by the WHO director general Dr Margret Chan at the International Conference on Traditional Medicine for South-East Asian Countries in February 2013 who stated that "traditional medicines, of proven quality, safety, and efficacy, contribute to the goal of ensuring that all people have access to care. Regardless of reasons for seeking out TM, there is little doubt that interest has grown, and will almost certainly continue to grow, around the world (WHO, 2013; 2017; Adams *et al*, 2005; Barennes *et al*, 2007; Iliyasu et al. 2006).

The experiences and attitudes of healthcare providers towards integration of traditional medicine and conventional medicine shows that communities depend on both systems for their health care even though there were some divergent views among the practitioners and this was a consistent finding with so e previous research like Mohammed Gyasi et al. (2017).

Just like research elsewhere in Africa, healthcare providers' perception of TM healing/curing common diseases, there are notable disagreements regarding the efficacy of traditional medicine. These disagreements or doubts have been shown in previous research (see Edwards, et al., (2012; WHO, 2002; David, 2013; Gupta et, al (2014). Traditional medicines were viewed as posing serious risks and these findings were not far from what WHO (2017) posits.

While this is the case, we ought to admit that the Zambia society is not far from other African society. Many societies in Africa integrate specific types of traditional healers for collaboration with their modern hospital systems. Such healers are expected to share in the workload of the modern doctors and provide people with more choices of care (Courtright, 1995; Ovuga et al., 1999; Bureau of Indigenous Thai Medicine, 2009). However, as for the weak and lack of integration the authority and structure of community healthcare organizations in the Zambian setting, is due to the design which does not to accommodate cooperation with traditional healers. Many researchers such as Antweiler (1998), Phongphit (1982), and Chuengsatiansup et al. (2004), show this but are in support of the development of healthcare resources at the grassroots level in order to build the self-reliance of communities.

In reality, modern healthcare teams have mistrust in the knowledge and roles of traditional healers because they have no recognised medical licenses. As Sermsri (1989) discusses, modern health providers view traditional healers as illegal healers whose medical knowledge and treatment methods are questionable. This stigmatizing of traditional healers makes heath care providers to hesitate in referring patients to them. Modern health care providers would rather promote the use of modern medical services, especially since these facilities are more available to lay people at the community level than ever before. These findings are mirrored in studies of other societies (Kale, 1995; Ovuga et al., 1999; Nelms and Gorski, 2006).

In the interest of protecting customer safety, Kayne (1995) and the World Health Organization (2001) are in support of the idea that all medical health practitioners must obtain a license. This is recognised as a supportive factor in building their cooperation with modern health professionals. But this study has clearly shown that such mandatory licensure can also prevent traditional practitioners from cooperating with modern medical practitioners.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

In conclusion, the results of this study highlight a certain degree of use of traditional medicine. The participants in the study reported some extent of use using TM for both acute and chronic condition. The use of TM with CM is widespread in Zimba and Zambia in general. Therefore, there ought to be some integration between the two systems and further, this is because the practice of traditional medicine in Zambia is probably on the increase in spite of the great advances in orthodox medicine. This is evident by more advertisements in the Press, on the streets and in our townships of advertisings and this study establishes the same trend continuing in Zimba district.

6.2 Recommendations

The integration of TM with CM has gained credence world-wide and this study has also established that most health workers are of the view that TM must be integrated with CM. The study therefore recommends that:

6.2.1. Implications for Policy Making

1. Traditional health care providers should be placed on the proposed National Health Insurance Scheme (NHIS) so as to help in the integration of both medical systems. This will assist in lessening the burden of the poor seeing as the services of the TMPs as well as herbal products are relatively cheap. This will become beneficial to majority of people if traditional medicines become an integral part of the health system in the country.
2. The study suggests that integration should begin at the grass roots level to effectively integrate traditional medicine into a modern healthcare system. A recommendation would be to have a properly implemented Act implemented in the country to enable the formal training of TM and possibly include it in school curriculums.

3. The Government needs to establish and update mechanisms for the regulation of traditional medicine and its practitioners and put in place requirements to support decision making
4. It is recommended that modern TM practitioners and researchers should be required to achieve adequate education and awareness of the practice, principles and context of TM.

6.2.2 Direction for Future Research

Based on the key findings and conclusions, the following recommendations are made for future research.

1. Future study must focus on social and economic factors that are likely to influence the choice and use of medical systems in the country. Some of these factors include but are not limited to; age, sex, income, educational background and employment status.
2. Traditional healers must be prevented from referring to themselves as ‘doctors ‘or ‘professors’.
3. Traditional health practitioners must realize that they are holistic healers and must be addressed as such. They must not be allowed to mislead people into believing that they are allopathic doctors.
4. Co-operative relationships between modern medical doctors and traditional practitioners need to be developed, the use of exchange workshops between the two professionals can be implemented.
5. The use of TM for self-treatment and specific herbs that are used to treat various diseases must be looked at to determine if it is more effective in certain areas than others.
6. The current research focused on the integration of TM and CM from the perspective of the health care providers. It is suggested that future research look at this integration from the perspective of the users.

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APPENDICES

Appendix I: Information Sheet

Introduction

This serves as a formal request for you to take part in a research study, the purpose of the study is finding out on the perspectives of Traditional Medicine on integration with Conventional medicine by the health personnel (Doctors, Nurses and Community health workers) .The procedure, purpose, benefits and what is expected of you will be explained below.

Purpose

It is a requirement of every master's student to do research in line with their specialist, the purpose of the research is to find out the perspectives of traditional medicine by health practitioners and whether there can be some integration with conversional medicine.

Procedures

If you agree to be in this study you will .be asked to answer some questions related to the research under consideration and provide answers as free as you can.

Risks

You may wish to know that there are no obvious known risks involved in taking part in this research.

Benefits

Your involvement in this study will help us to understand how best traditional medicine can be integrated with conversional medicine where people with low or non-economic status cannot afford medical bills and this may improve health to most people more especially those in rural areas.

Alternative Procedures and Voluntary Participation

If you do not wish to be in this study, you don't have to participate. Remember, your participation in this study is voluntary and you will not be held accountable for not.

Confidentiality

All information provided in this research study will not be availed to non-research team members. For purposes of confidentiality, only anonymous names shall be used.

Contact

This study has been approved by the University of Zambia Biomedical Research Ethics Committee **(UNZABREC)** and permission has also been obtained from Ministry of Health. Should you have any questions or want clarification about the study, you can contact the Principal Investigator, **Namuyaba Hamanyanga** on **+260 979 222 717 or email:** miyoba.nh@gmail.com, or alternatively you can call the Chairperson of the University of Zambia Biomedical Research Ethics Committee at **+260211256067.**

Appendix II: Informed Consent Form

By signing below, I _____, agree to take part in this study willingly. I understand the purpose of the study as well as the usefulness of the findings. I know my rights as a participant and I know the risks and benefits of this research.

Participant's signature/ thumbprint: _____ Date: …….

Witness signature/ thumbprint: _____ Date: …….

Appendix III: Interview guide for research participants

Perspectives of use of traditional medicine by the health workers

1. Please describe for me your beliefs about illness and traditional medicine.

a) Belief in the existence of causes of illness is caused by witchcraft or from supernatural powers (God or Gods).

b) Belief in the following that they work.

- Treatment by Folk Healers: These are traditional practitioners who use remedies in form of artefacts: food, water, drinks for treatment.
- Diviners or diagnosticians. An inquiry about future events or matters, hidden or obscure, directed to a deity who, it is believed, will reply through significant tokens like a mirror.
- Herbalists: Ordinary people who have acquired an extensive knowledge of magical technique and who do not, typically, possess occult powers. They are practitioners that have extensive knowledge of medicines and rely heavily on the power of plants to heal.
- Spiritualists/ prophets or faith healers

c) **Exploring the health care providers experiences and attitude towards the integration of traditional medicine with conventional medicine.**

Describe your experiences and attitude towards treatment of the following by nonconventional means.

i. Conditions of the respiratory system: e.g. colds and flu; hay fever; pneumonia; asthma; bronchitis;

ii. Emphysema; tuberculosis.

iii. Conditions of the gastro-intestinal system: e.g. diarrhoea; dysentery; constipation; heartburn, indigestion; ulcers; haemorrhoids, worms.

iv. Conditions of the cardiovascular system: e.g. angina; high blood pressure; palpitations.

v. Conditions of the central nervous system: e.g. headache; migraine; stroke (traditional treatment is given after discharge from hospital).

vi. Conditions of the skin and hair: e.g. acne; eczema; boils; insect bites and stings; ringworm; scabies.

vii. Conditions of the blood: e.g. anaemia; blood cleansing (routinely given following treatment to help cleanse the body of the original cause of the disease).

viii. Conditions of the urogenital system: e.g. sexually transmitted diseases; cystitis; menstrual pain; vaginitis.

ix. Conditions of the eyes: e.g. "pink eye".

x. Conditions of the musculoskeletal system: e.g. arthritis; backache; muscular pain; gout; sprains and strains; rheumatism.

xi. Other conditions such as cancer; HIV/AIDS (some cultural beliefs state that there is no such thing as HIV/AIDS alcoholism.

Perceived benefits

Please comment on your own perceived benefits and risks associated with traditional medicine than conventional medicine.

i. Conventional medicine is preferred in the treatment of trauma and emergencies while alternative medicine excels in the treatment of chronic disease, although homeopathy can also be very effective as a first-aid. ii. Conventional medicine focuses on the relief of symptoms and rarely places emphasis on prevention or the treatment of the cause of a disorder. Alternative therapies are also much more focused on prevention.

iii. Conventional medicine is organ specific, hence ophthalmologists, cardiologists, nephrologists, neurologists, etc. Traditional medicine, without exception, considers each person as a unique individual and uses a holistic approach in treatment.

iv. Conventional medicine believes in aggressive intervention to treat disease. It revels in terms such as "magic bullet" and "war" ("the war on cancer"), and prefers quick fixes (as do many patients). Traditional medicine believes in gentle, long-term support to enable the body's own innate powers to do the healing.

v. Conventional medicine's main "arsenal" consists of surgery, chemotherapy, radiation, and powerful pharmaceutical drugs. Traditional medicine uses time-tested, natural remedies and gentle, hands-on treatments.

vi. Conventional medicine practitioners are guided in their treatment by strict rules set out by the Colleges of Physicians and Surgeons. This often leads to a "one size fits all" approach. Practitioners of Traditional medicine, on the other hand, treat each patient as an individual and do what, in their opinion, is best rather than what is specified in a "rule book".

vii. Conventional medicine prefers patients to be passive and accept their treatment without too many questions. Traditional medicine, in contrast, prefers and indeed, in many cases, requires the patient to take a highly active part in both prevention and treatment.

viii. Conventional medicine generally resists the use of natural remedies long after their efficacy has been scientifically. Most Traditional medicine practitioners eagerly embrace new remedies and, in many cases, can point to years of safe use.

Motives among health workers for referral of patients to traditional health practitioners

Please tell me the motives among health workers for referral of patients to traditional health practitioners.

i. Sociocultural and personal (health status, belief, attitude, motivation, etc).

ii. Dissatisfaction: Patients are dissatisfied with conventional treatment because it has been ineffective, has produced adverse side effects, or is seen as impersonal, too technologically-oriented, and/or too costly.

iii. Need for personal control: Patients seek alternative therapies because they see them as less authoritarian with more personal autonomy and control over their health care decisions

iv. Philosophical congruence: Alternative therapies are attractive because they are seen as more compatible with patients' values, world-view, spiritual/religious philosophy or beliefs regarding the nature and meaning of health and illness.