AN EXPLORATION INTO THE EFFECTS OF TRADITIONAL MEDICINE ON REPRODUCTIVE HEALTH OF RURAL WOMEN IN ALLANDALE VILLAGE, MPUMALANGA PROVINCE.

BY

Mdhluli Ophilile

11633167

Research for the

Dissertation submitted in fulfillment of the requirements

For the degree of

Masters

in the subject

African Studies

at the

UNIVERSITY OF VENDA

2019

DR(ADV) PE MATSHIDZE	**(SUPERVISOR)**	**UNIVERSITY OF VENDA**
DR S L KUGARA	**(CO-SUPERVISOR)**	**UNIVERSITY OF VENDA**

Declaration

I, **Mdhluli Ophilile** hereby declare that the research proposal for the Master of Arts in African Studies degree at the University of Venda hereby submitted by me has not previously been submitted for a degree at this or any other University, and that it is my own work in design and in execution and that all reference material contained therein has been duly acknowledged.

Signed (Student): ..... Date: .....

Dedication

I dedicate this Dissertation to my son Shabangu N.N with love and appreciation, who have been my source of inspiration and gave me strength when I thought of giving up.

Acknowledgements

It is not a fair task to acknowledge all the people who made my study possible with a few words but I will try my best to prolong my paramount appreciation to everyone who has assisted me emotionally, financially and academically on the duration of this study.

I would like to thank the Lord almighty God of all good times and bad times for giving me life, strength, bright light to my future, power to continue striving for greatness through my academics.

My genuine gratitude it is directed to the following people who sustained me during the mammoth task of my studies towards my study and who made the completion of this research possible:

- My Supervisors, Dr Matshidze P.E and Dr Kugara S.L, you have been more than a guiding light to my study. I pray that the Lord keep you healthy so that you have more strength to assist the cohort to come.

- Allow me to specially mention both my parents Mr Lucas and Mrs Jenesy Mdhluli, I have no words to express the love I have for you. I thank you so much for your guiding every day, your everyday prayers even when I do not ask for any but you still pray for my peace, strength and success. May God keep you for me.

- I owe profound gratitude to my husband (Bulletproof) Mr Shabangu M.N whose constant encouragement, limitless giving and great sacrifices has helped me complete my studies, babis you have been everything in my studies, I have no words to express my gratitude, live long. I pray that God blesses you with everything you desire.

- Mzala (T.D Kugara) you deserve everything successful that will come your way, I would have never made it without you being my shoulder, comforter and motivator. You are my diamond achiever.

- My children Mordecai and Ntwisiso, may your love forever make everything seem easy for me. Thank you for allowing mommy to study further and constantly taking our family time. I promise to keep making you proud boys.

- To the entire Mdhluli family, thank you so much for the support, may the Lord almighty bless each one of you for the role you have played in my studies.

- Furthermore I would like to thank NRF for funding my studies and making it possible for me to finish my studies.

- Last but not least, deepest thanks goes to everyone who participated to make this study a reality, may your hearts be filled with love to help others as you have done to me.

Abstract

This study explored into the effects of traditional medicine on reproductive health of rural women. Negative reports associated with traditional medicine due to bogus traditional practitioners expose most women to the harmful consequences of concoctions supplied and administered on them. However, factors such as people's great confidence in traditional medicine and high costs associated with conventional Western medical treatments lead most rural women to traditional medicine usage. The study examined women's perspectives on traditional medicine, factors which led rural women to use traditional medicine, meanings that people make about women and reproductive health, reproductive health implications of using traditional medicine as well as remedies for ensuring that traditional medicine is safe for women's reproductive health. The study was grounded on the critical and socio-cultural theory. An explorative qualitative research was used. Data was collected through open-ended questions, observation as well as focus group interviews and then analysed using the thematic analysis method. The study participants consisted of rural women, traditional healers, elderly people and Western-trained doctors who were all sampled using non-probability sampling methods. The findings of the study showed that African traditional medicine plays a pivotal role in reproductive health care by offering readily available, cheap, culturally-oriented and accessible health care for most rural women. However, it was noted that the use of African traditional medicine by unqualified practitioners and the incorrect usage of the medicine by patients resulted in negative results that could lead to death or barrenness. Thus, the study recommends an introduction of a regulatory framework on the production, storage, use and trade of African traditional medicine.

Key words:

Indigenous knowledge systems, traditional healer, reproductive health and traditional medicine

Abbreviations

1. ABC	:	American Broadcasting Company
2. ATM	:	African Traditional medicine
3. ATR	:	African Traditional Religion (ATR)
4. BBC	:	British Broadcasting Company
5. BMA	:	British Medical Association
6. EU	:	European Union
7. FGI	:	Focus Group Interviews
8. GDP	:	Gross Domestic Product
9. GM	:	Gender Mainstreaming
10. ICPD	:	International Conference on Population and Development
11. IK	:	Indigenous Knowledge
12. IKS	:	Indigenous Knowledge System
13. KH	:	Knowledge Holders
14. MDG	:	Millennium Development Goal
15. SA	:	South Africa
16. TBAs	:	Traditional Birth Attendants
17. THPCSA	:	Traditional Health Practitioners Council of South Africa
18. THPs	:	Traditional Health Practitioners
19. TM	:	Traditional Medicine
20. TM	:	Traditional Medicine
21. TV	:	Television
22. UDHR	:	Universal Declaration of Human Rights
23. UK	:	United Kingdom
24. UN	:	United Nations
25. UNESCR	:	United Nations International Covenant on Economic, Social and Cultural Rights
26. WHO	:	World Health Organisation

Table of Contents

DECLARATION I

DEDICATION II

ACKNOWLEDGEMENTS III

ABSTRACT V

ABBREVIATIONS VI

CHAPTER ONE 1

INTRODUCTION AND BACKGROUND OF STUDY 1

1.1 Background 1

1.2 Problem Statement 2

1.3 Aim of the Study 3

1.3.1 Specific Objectives 3

1.3.2 Research Questions 4

1.4 Rationale of the Study 4

1.4.1 Improving the provision of quality reproductive health - documentation 4

1.4.2 Facilitate Reproductive Health Education Delivery 4

1.5 Definition of key/Technical Concepts 5

1.6 Structure of chapters 6

1.6.1 Chapter One: Introduction 6

1.6.2 Chapter Two: Literature Review and Theoretical Framework 7

1.6.4 Chapter Three: Methodology 7
1.6.5 Chapter Four: Data Presentation and Recommendations 7
1.6.5 Chapter Five: Summaries, Conclusion and Recommendations 7

CHAPTER TWO 8

LITERATURE REVIEW AND THEORETICAL FRAMEWORK 8

2.1 Introduction 8
2.2.1 Social-cultural Theory 9
2.2.2 The Critical Theory 11
2.2.1 Indigenous Knowledge Systems (Traditional Medicine) 13
2.2.3 African Traditional Healing and Practices 18
2.2.4 Right to Health Care 24
2.2.5 Reproductive Health 29
2.2.6 Gender Inequality: Gender Dynamics and Mainstreaming 34

2.7 Chapter Conclusion 38

CHAPTER THREE 39

RESEARCH METHODOLOGY 39

3.1 Introduction 39

3.2 Research Methodology 39

3.3 Research design 39
3.3.1 Qualitative Research Design 40

3.4 The Research Paradigm 42

3.5 Study Area 43
3.5.1 Mpumalanga Province 43

3.6 Population 44

3.7 Sampling 45
3.7.1 Non-probability Sampling 46

3.8 Data Collection Methods 46
3.8.1 Open-ended Questions 47
3.8.2 Focus Group Interviews 51
3.8.3 Observation 55

3.9 Data Analysis Method 56

3.10 Ethical Considerations 57
3.10.1 Honesty 57
3.10.2 Informed Consent 57
3.10.3 Confidentiality 58
3.10.4 Disclosure 58

3.11 Limitation of the Study 58

3.12 Measures to Ensure Trustworthiness 59
3.12.1 Credibility 59
3.12.2 Confirmability 59
3.12.3 Neutrality 59

3.13 Chapter Conclusion 60

CHAPTER FOUR 61

DATA PRESENTATION AND ANALYSIS 61

4.1 Introduction 61

4.2 Demographic Background of Participants 61

4.3 Africa Traditional Medicine 62

4.3.1 Spiritual Causes 64
4.3.2 Physical Sicknesses 64
4.3.3 Mental or Psychological Causes 64
4.3.4 Esoteric Causes 64
4.3.5 Astral Influences 64

4.4 Factors that Lead Rural Women to Use Traditional Medicine 79
4.4.1 Push and Pull Factors 80

4.5 Meanings to Women's Reproductive Health 97
4.5.1 Giving Birth 97
4.5.2 Menstruation 98
4.5.3 Family Planning 98
4.5.4 Sexually Transmitted Diseases/Infections (STDs/STIs) 100

4.6 Implications of Using African Traditional Medicine 102
4.6.1 Death 102
4.6.2 Poor Hygiene Exacerbates Infections 104
4.6.3 Overdose Rise of Other Diseases 105

4.7 Possible Reasons for Adverse Effects of African Traditional Medicine 107
4.7.1 Self-treatment by Patients 108
4.7.2 Bogus and Unqualified Practitioners 108
4.7.3 Incorrect African Traditional Medicine 108

4.8 Chapter Conclusion 109

CHAPTER FIVE 110

FINDINGS, CONCLUSION AND RECOMMENDATIONS 110

5.1 Introduction 110

5.2 Findings 110

5.3 Conclusion 113

5.4 Recommendations 114

5.4.1 Regulation of the Use of African Traditional Medicine 114

5.4.2 Knowledge Management and Innovation of African Traditional Medicine 114

5.4.3 Future Research on African Medicinal Plants and their Therapeutic Properties 115

6.1 References 116

APPENDIX A: CONSENT FORM 132

APPENDIX B: TRANSCRIBER'S CONFIDENTIALITY AGREEMENT FORM 134

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Background

The World Health Organization (WHO) notes that reproductive health concerns the wellbeing of reproductive processes and functions at all stages of human life (WHO, 2012). Reproductive health entails the right of men and women to be informed and have access to harmless, effective, reasonable and acceptable methods of fertility wellbeing. It also includes the rights of women to access appropriate health care facilities that allow women to experience safe pregnancies and childbirths. Thus the thrust of reproductive health should aim at addressing human reproductive functions beyond the gestational period to all stages of life (WHO, 2013; Wisconsin Alliance for Women's Health, 2012).

Based on the above, reproductive health constitutes a major part of global health and forms an inalienable component of women's wellbeing (Patel, Kirkwood & Pednekar, 2006). However, the scarcity of a qualified health workforce in most African countries forms a major setback in the reproductive health and well-being of most women. This particularly holds true for rural women who resort to adopting traditional medicine and customary interventions as alternative forms of reproductive treatment (Ahmed, 2005). Other key obstacles which obstruct the use of conventional medicines include the lack of awareness (unfelt need), exclusion from health institutions due to their non-affordability as well as cultural restrictions which place impositions on women to obligatorily consult their male providers in making decisions on reproductive health care (Ensor & Cooper, 2004).

In light of the afore-mentioned factors, the use of traditional medicine by African women in reproductive health is rife. Most women prefer traditional medicine for reproductive issues because traditional medicines are often seen as less expensive and easily accessible than those in conventional pharmaceuticals. Most midwives are showing an improved interest in combining traditional and western medicine (Belew, 1999). Traditional medicines are usually used for reproductive system related issues such as abortion, breast cancer, cervical cancer, contraception, sexual virility, conception and irregular or painful menstruation (Steenkamp, 2003).

In the South African context, traditional medicine in reproductive health care services continues to play a vital role as it did in the past. The Western oriented medicine in health care systems that was introduced during the colonial era did not eliminate well established systems of traditional medicine usage. As such, many people have learnt to use both health options depending on the availability of medicine and/or the nature of the illnesses (Freeman & Motsei, 1992).

1.2 Problem Statement

Anecdotal evidence reveals that an influx in the use of traditional medicine (TM) in Allandale among traditional health care providers has brought concerns surrounding the reproductive health of most women. The rise in non-expert and extortionate traditional practitioners has resulted in most women becoming reproductive health victims as some studies reveal that some of the medicine is associated with intrauterine growth restriction, decreased fetal survival rates, low birth weight, fetal distress, fetal hypoxia and premature delivery of children because of uterine restless stimulation which may lead to perinatal mortality (Takei, Nagashima and Suzuki, 1997). Such negative reports raise serious concerns on the vulnerability of women to the harmful effects of concoctions and potions that are traditionally administered on them. This has also cast serious aspersions on the efficacy of genuine African traditional medicine and resulted in unwarranted attacks of qualified African traditional practitioners.

Critics of traditional medicine have cautioned the public to approach the issue of traditional medicine with caution. It is generally alleged that in the administration of traditional medicine, dosage calculations are not standardized but are based on the personal intuition of the practitioner. This is definitely one area of concern for the Western medical practitioners and critics who pose rhetoric questions: firstly, what if too much of it is detrimental? Secondly, would consistent dosages be established or benchmarked among traditional healers? It is out of such concerns that reproductive traditional medicine is judgmentally treated as being archaic and inherently faulty. Despite the negative connotations, most women in rural areas have high confidence in traditional medicine and the financial constraints associated with rural life leads them to gravitate towards the usage of traditional medicine for reproductive health.

1.3 Aim of the Study

This study explored into the effects of traditional medicine on reproductive health of rural women.

1.3.1 Specific Objectives

To achieve the above broad aim, the following objectives were examined:

1. To appraise the meaning of African traditional medicine.
2. To establish women's perspectives on African traditional medicine.
3. To assess the factors that lead rural women to use African traditional medicine.
4. To discuss the meanings that people make about women reproductive health.
5. To examine the implications of using African traditional medicine on the reproductive health of rural women.

1.3.2 Research Questions

To achieve the above broad aim, the following questions were examined:

1. What is the meaning of African traditional medicine?
2. What are women's perspectives on African traditional medicine?
3. What are the factors that lead rural women to use African traditional medicine?
4. What are the meanings that people make about women reproductive health?
5. What are the implications of using African traditional medicine on the reproductive health of rural women?

1.4 Rationale of the Study

Carrying out this study envisaged to derive the following:

1.4.1 Improving the provision of quality reproductive health - documentation

This study is likely to improve the quality of health provision in South Africa which is documented as being inadequate and inaccessible for most rural women. The documentation of traditional medicine is going to pave way for the integration with Western medicine thereby improving the issue of efficacy, quality and dosage. Once this information is documented, it will open up more leeway and space for comprehensively discussing the use of African traditional medicine in an open and nonjudgmental way, thus helping patients, traditional health practitioners, policy makers and scholars to discuss about this subject more openly and robustly.

1.4.2 Facilitate Reproductive Health Education Delivery

The study is envisaged to contribute to reducing high maternal and fetal mortality by giving a platform for health education. This can be achieved when factors that cause maternal and fetal mortality are well studied. In this regard, the use of African traditional medicine for reproductive health may be among the contributing factors to maternal and

fetal morbidity and mortality. As such, the study appraised the magnitude at which African traditional medicine is used during reproductive health and its associated effects. Results obtained will be used in health education delivery in antenatal clinics, enlighten the health providers about the magnitude so that they do not attribute all poor fetal outcomes to African traditional medicine and therefore improve obstetric care. Knowledge of the extent and nature of use of African traditional medicine related to reproductive health is necessary for proper guidance in the health interest of the mother, fetus and traditional communities. Furthermore, the study results will help inform the public health discourse about the use of alternative systems of care in the presence of and in juxtaposition with a modern health care system.

1.5 Definition of key/Technical Concepts

The key or technical concepts used in the study are defined below;

1.5.1 Traditional medicine

Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies and manual techniques and exercises applied singularly or in combination to treat, diagnose and prevent illness or maintain well-being (World Health Organisation, 2002). In this study, traditional medicine meant African traditional medicine used in Allandale village.

1.5.2 Indigenous

Occurring or living naturally in a specific area, such as native plants or animals (opposite to exotic); to be differentiated from 'endogenous', which means having its origin within a specific area (opposite of exogenous) (Reijntjes et al., 1992)

1.5.3 Indigenous knowledge systems

Indigenous knowledge system refers to bodies of knowledge, technologies, practices and beliefs generated shared, preserved and transmitted from generation to generation associated with indigenous or local communities and identified with their cultural identity (Mwaura, 2008: 22). In this study, indigenous knowledge meant technologies, beliefs, norms and values of African traditional medicine in Allandale village.

1.5.4 Traditional healer

The WHO (1978) (cited in de Jong 1991:1) defines the "traditional healer" as "a person who is recognised by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and other methods based on the social, cultural and religious background, as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability".

1.5.4 Reproduction health

Reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system (Sylvia, 2016).

1.6 Structure of chapters

This research is structured as follows:

1.6.1 Chapter One: Introduction

This chapter outlines the background of the study, significance of the study, problem statement, objectives, methodology, definition of concepts and likely limitations of the study.

1.6.2 Chapter Two: Literature Review and Theoretical Framework

This chapter focuses on past and present literature that dealt with traditional medicine, indigenous knowledge and reproductive health. In addition, theoretical framework adopted by this research was extensively discussed.

1.6.4 Chapter Three: Methodology

This chapter covers the methodology of the study, description of the study area, research design, study population, data collection methods and data analysis techniques.

1.6.5 Chapter Four: Data Presentation and Recommendations

This chapter presents the findings of the data collected.

1.6.5 Chapter Five: Summaries, Conclusion and Recommendations

The chapter gives recommendations and general conclusions derived from the research. Also, recommendations will be given from the findings.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

"*There is this notion that traditional medicine is some quack thing practised by primitive people... unfortunately 80 percent of our people don't care about 'scientifically proven'.*"

(Manto Tshabalala-Msimang, 2006)

2.1 Introduction

The previous chapter introduced the study on exploring into the perspectives of the effects of traditional medicine on the reproductive health of rural women in Allandale Village, Mpumalanga Province. The laid foundation mainly explored the challenges associated with the usage of traditional medicine in women's reproductive health. These challenges seemingly interferes with the reproductive health of most women as they are 'forced' to abandon their constitutional right and access to quality health care.

Against that backdrop, this chapter reviews the literature on related issues of traditional medicine, reproductive and gender dynamics. The chapter is categorised into two parties. The first part of this chapter addresses the theoretical framework used in this study as a means to sculpture the worldview used in interpreting and understanding the phenomenon of African traditional medicine and reproductive health among rural women. Secondly, the chapter gives an appraisal of literature on the topic under study to provide the reader with in-depth existing arguments in the field as well as gaps that this study will pursue.

A body of knowledge on education exists to provide a good basis for this study. According to Babbie (1998:112), a comprehensive literature review addresses what other scholars have already said about the topic. Furthermore, it assesses the theories

that have been employed to address the topic and whether there have been consistent findings about the topic. The current research reviews literature to investigate whether past scholarly findings complement each other or whether flaws in the existing body of knowledge have been discovered that could be remedied by a new study. This part presents a review of related research on indigenous knowledge systems, traditional medicine, reproductive health, gender dynamics and others. In so doing, it will be identifying the study gaps in past studies and proposes new approaches for closing the gap.

In all qualitative studies, theory should be present because no study can be designed without some questions being asked. As such, a theoretical framework is one of the most important components in the research process. According to Merriam (1998:2), a theoretical framework forms the “scaffolding” or the underlying structure of the study. The value of theory-driven thinking and acting is emphasised in relation to the selection of a topic, the formulation of research questions and the conceptualisation of the literature review. In this study, the choice of the framework reflects important personal beliefs and understandings about the issue of traditional medicine and the reproductive health of rural women. This knowledge is very important in bringing indigenous knowledge systems to the foreground as one of the core knowledge areas that people ought to rely on in reproductive health. The study used the critical theory and the socio-cultural theory in exploring traditional medicine and its impact on the reproductive health of rural women. These are discussed below;

2.2.1 Social-cultural Theory

Vygotsky’s socio-cultural theory is used in this study. It describes learning as a social process that is also linked to cultural practices. This means that social life and cultural practices play a vital role in how people live and follow set patterns of life. This study explored the social and cultural lives of Allandale villages so as to understand traditional medicine, village women perspectives, African reproductive health and its associated implications.

According to Twumasi (2012), culture denotes the kind of behaviour that is exhibited and expected from each individual during the course of conducting their belief system. As such, the cultural life of the individual prescribes the type of medication that one resorts to during their time of need. Some cultural practices demand that an expecting mother gets consent from the husband so as to consult for their health needs. This may be because an expectant mother may not be familiar with the culture that the husband subscribes to since they were not born into the husband's family but adopted it when they got married. If not consulting the husband, the paternal aunties are culturally available to offer help to the wife.

When looked at from various perspectives the idea of collectivism is vital to indigenous knowledge and runs against the idea and spirit of individualism that is advanced by formal schooling systems and Western-oriented frameworks. The idea of expanded networks and family is basic to indigenous communities, and this also holds true for Allandale. Close relatives, uncles and grandparents are surrogate guardians who form interconnected networks of ties, accountability systems and support mechanisms. Thus the community is an expansion of the family and consists of numerous networks of family ties. The expanded network extends ecological interconnections between humans and non-humans and is reflected in their symbiotic reliance and interdependence.

A significant portion of the Allandale villagers start each day by consulting their ancestors or traditional health care practitioners, which encourages them to refine their activities and deeds and do away with bad omens. Such rituals supposedly protect their activities and show a great personality and appreciation for the endowment of living one more day. This custom additionally reminds them to play out their obligations for the advancement of humankind.

Illnesses and health care are viewed as ethnically determinable. For anthropologists who consider culture to be a representative framework, the general population's perspectives of ailment and wellbeing is part of the system (Rankoana, 2012). Despite the majority of the villagers in Allandale having converted to Christianity, some of them still rely on traditional medicine and believe in the protection by their ancestors. As such, the social life and cultural belief of Allandale villagers grounded the study. *Mchongolo* (a traditional dance prominent in Allandale) was also explored as its dancers are known to encourage and also use traditional medicine. The *mchongolo* dancers and knowledge holders subscribe to beliefs that the traditional medicine they prescribe and the exercises of the *mchongolo* dance speed up the process of procreation as they make one strong and help flush out other factors that causes barrenness or delay reproduction.

2.2.2 The Critical Theory

The researcher wishes to employ the critical theory in this study. The critical theory is a type of social theory oriented towards critiquing and changing society as a whole, in contrast to traditional theory oriented only to understanding or explaining it. This theory stresses the reflective assessments and critique of society and culture by applying knowledge from social sciences and humanities. Moreover, by using this theory, the researcher aims to dig beneath the surface of social life and uncover the assumptions that keep rural women prefer traditional medicine with regards to reproductive health care. It is under this underlying theory that Indigenous Knowledge Systems (IKS) will be assessed in trying to remedy the problem being researched.

The critical theory as a tool of inquiry to explore complex issues addressing Indigenous Knowledge Systems (IKS) was a basis in assessing the above social and cultural life of Allandale villagers. Attention was critically focused on the relationships among culture, social life, beliefs, domination, health and other important aspects. Some polarised school of thoughts argue that culture has to be 'viewed as a domain of struggle where the production and transmission of knowledge is always a contested process.' In light of

that, Giroux (1983) stipulates that 'dominant cultures employ differing systems of meaning based on the forms of knowledge produced in their cultural domain'. The researcher introduced numerous questions, many of which may not have answers, making the research inquiry both exciting and challenging. By so doing, the researcher hoped to open the door to alternative possibilities for many people and verify the efficacy of traditional medicines.

Traditionally, IKS promoted practices that were sustainable, community centred, and provided a good life within natural surroundings. Throughout this study, the researcher 'claim' that traditional medicine also poses a challenge to the dominant forms of development by reflecting concepts of balance, policy and governance, and harmony thus, critically examining the implications of traditional medicine on reproductive health of rural women and how traditional medicine can be integrated into the formal health care. Basing on the later submission, Giroux (1983) notes that;

> "In more specific terms, this means developing analyses of schooling that draw upon a critical theory and discourse that interrelate modes of inquiry drawn from a variety of social science disciplines".

In so doing, the researcher did not cast a blind eye on the issue that 'historical events, colonization, and hegemonic practices by various governments have undermined Indigenous life' and had an obligation of correcting past notions. It is because of this that all aspects of Indigenous Knowledge, including colonization were critically examined in an African view and modern accepted view. This will be in part in consonant with what Dakota Elder noted when he said that 'Indigenous Knowledge (IK) is valid in its own right and does not need to be validated by other systems' (Indigenous Knowledge Conference, 2002).

2.2.1 Indigenous Knowledge Systems (Traditional Medicine)

As a new field of study, indigenous knowledge (IK) is 'characterized by a variety of definitions, fragmented theoretical conceptions and a marginalised position vis-a-vis the current mainstream knowledge system. This has resulted in the emergence of a variety of wordings and semantic distinctions alluding to the same phenomena. These include indigenous knowledge systems, indigenous technical knowledge, ethnoscience, people's science and village science (Atte, 1989). However, the terms indigenous, traditional, folk, village or local have a tendency to have negative implications that involve static, traditionalist or archaic connotations. Of the different facets of IK, traditional medicine (TM) is one important component and the researcher shall focus on it. Traditional medicine TM is also known as 'indigenous drug' because it contains medical aspects of traditional knowledge (Triebel, 2002). TM has been created over the years within different social orders. In some Asian and African countries, 80% of the population relies upon it for their health care needs (WHO, 2008).

The World Health Organization explains traditional medicine as;

> "The whole of the information, aptitudes, and practices in view of the speculations, convictions, and encounters indigenous to various societies, regardless of whether reasonable or not, utilized as a part of the support of wellbeing and additionally in the anticipation, analysis, change or treatment of physical and mental illness" (WHO, 2008).

Indigenous Knowledge Systems (IKS) do not incorporate a particular assortment of knowledge but reflect numerous layers of being, knowing, and techniques for articulation. IKS incorporate knowledge about financial aspects, governmental issues, music, administration, transportation, building, space science, craftsmanship, writing/stories, and community norms and values. Articulations of IKS are interconnected; thus, indigenous science information is not separate from indigenous

aesthetic learning. Songs and legends that reflect IK reinforce network and originate before written history. Anzaldua (1999:88) states, “In the ethno-poetics and performance of the shaman, my people, the Indians, did not split the artistic from the functional, the sacred from the secular, arts from everyday life”. For example, the stunning silver dim birch bark container that has been developed and coloured epitomizes an information of science, including designing for quality and natural learning of plant colours. Also, the old pot, produced using the mud of the Missinipe River in northern Saskatchewan, is one that has the logical premise to persevere through the most outrageous heat and cold, and it is beautiful to observe. That being stated, IKS are not something solidified in time.

IK is dynamic and consistently adjusting to mirror the emotional changes happening inside indigenous people group today. A few societies are in a condition of disturbance as their social fibre is disrupted by Western infringement. In particular, societies which have been exploited for their natural endowments through practices such as mining, deforestation, dam construction and tourism have had their social orders which relied on natural resources disrupted. The researcher distinguished these conditions and trust they should be considered engendering a basic part of IKS. My exploration is on traditional medicine which outlies the indigenous knowledge of the communities in Allandale.

This knowledge and world perspectives are presently under threat for various reasons. The communities and people that infused life to this knowledge and its perspectives are being undermined. Imperialism, forced imposed governance, economic approaches and school systems have created hostile conditions for such knowledge to thrive (Zabow, 2006). Some of these practices have been accompanied by human rights abuses which decimated or displaced populations and their cultures. Such environments have made it practically impossible for indigenous societies, including their perspective and values to remain alive.

2.2.1.1 African Traditional Medicine

African traditional medicine (TM) is as old as the making of 'Heaven and Earth'. The Creator made everything on the planet, including forests and creatures which have given traditional medicine over the ages. The utilization of leaves to make medication is even said in the Holy Bible. Ezekiel 47:12 alludes to the utilization of leaves to make solution when he says: "the leaf thereof for medication". Of the considerable number of countries of the world, the African Egyptians are the most acclaimed to South Africans. They are some of the first foremost individuals who invented replicable medicinal practices for human survival and restoration. The Egyptian Africans considered the utilisation of different parts of plants and dead creatures to make medicines. The establishment of medicine as known to the world were laid down by Egyptian Africans (Gumede, 1990:1). Their establishment of traditional medicine has been a wellspring of the art of healing for humankind through the ages, and a key influence to modem healing practices.

African Traditional medicine (ATM) involves 'a variety of products and herbal remedies, animal products such as fats, or oil, skeleton, and mediations and also those which cannot be explained such as the practice of spiritual healing. Hence the use of traditional medicine is continuously spreading in developing countries. Historically, traditional medicine has been looked down upon in many communities due to pressure from missionaries and governments who equate such practices to witchcraft (Kugara, 2017). In contrast to those beliefs, however, traditional medicine has proven to be very productive in treating both chronic diseases and psychological problems (WHO, 2000).

Augustine, Boadu and Asase (2017) argued that in most African countries, ATM is a very crucial component in the health care system. Despite this fact, the indigenous knowledge of ATM in Ghanaian traditions and cultures for example was noted to be understudied by scholars and research institutions. In this study, the researcher aimed to investigate and document ATM as used by Allandale traditional health practitioners to

cure and manage the reproductive health of indigenous women in the villages. It was key to empirically evaluate the herbs used so as to determine their exact impact on the treatment of patients ‘through pharmacological, toxicological, and clinical studies’ so as to guarantee the safety of the users of these herbal plants and for likely drug development. Unlike other researchers in this area who focus on the impact of African traditional medicine using quantitative design, this study was qualitative in nature.

It has been seen that the majority of the issues related to the utilisation of African traditional medicine and prescriptions emerge from the classification of a significant number of these medicines ‘as foods or dietary supplements’ in some countries. Considering all these, proof of ‘quality, efficacy and safety’ of these medicines is not determined before prescribing them. In a similar vein, quality tests and creation measures will in general be less thorough or controlled and at times, African traditional practitioners may not be certified or licensed to operate. According to Kasilo and Trapsida (2011), the security and safety of African traditional medicine has in this way turned into a key concern for both the national health institutions and the overall population.

Until 2011, there were three conceivable administrative procedures by which traditional medicine items could be acceptable to a customer in the United Kingdom (UK). Raynor et al. (2011) allude that unlicensed traditional medicine is the commonest route which does not need to meet explicit models of security and quality nor is it required to be accompanied by safety data for the buyer. As of late, the European Union (EU) actualised a mandate following a 7-year progress period to determine the acceptance of traditional medicine items across the EU and build up a disentangled authorizing framework so as to help the general population to make informed decisions about the utilisation of herbal items. In that regard, Routledge (2008) noted that this necessitates all traditional medicine items to either gain an item permit of the type expected and to manufacture "customary" items or register them as "traditional herbal medicinal products".

The view that traditional medicine is extremely safe and is without negative impact is not just false but also misleading. Traditional medicine has been proved to be fit for delivering a wide scope of unfortunate or unfriendly responses some of which are fit for 'causing serious injuries, life-threatening conditions, and even death'. Various and unquestionable instances of negative implications have been accounted for in some authoritative writings (Vanherweghem and Degaute, 1998).

The utilization of animals for healing purposes is an old practice corresponding to the assortment of information on plant-based medicines, particularly in parts of Asia and Africa, is expanding. Regardless of the ascent of zootherapeutic researches to address a scarcity of data regarding the matter of traditional animal treatments, researches have occasionally unveiled the utilisation of reptiles by African indigenous people (Schleich & Rai, 2012: 48). These interrelationships among people and herpetofauna are alluded to as 'ethnoherpetology'. Reptiles, particularly crocodiles and pythons, are commonly present and every now and again looked for after in African traditional medicine markets (Shah, Kharel & Thapa, 2011: 1-7).

Ethnoherpetological researches and quantitative investigations have been to a great extent dominated by the summed up ethnozoological investigations that report and stock various vertebrate classes. This expansive methodology may connote an inclination towards examining aesthetically satisfying or charismatic species, for example, winged creatures and warm blooded creatures, or fauna that are of preservation concern. Additionally, the shortage of ethnoherpetological records adds to the conventional significance of herpetofauna (and how much they are exploited) being ignored and thought little of (Shrestha, 2012: 280).

It is much of the time expressed in the leading authoritative writing (Birhan et al. 2011 ; Mbatha et al. 2012 & Ekor, 2014), official reality sheets and reports (WHO, 2002 , 2008 & Kasilo et al. 2010) and the press (BBC News 2014) that 80% of individuals in Asian

and African nations utilize traditional medicine and traditional practitioners to meet their primary health care needs. The latter has likewise been utilized in health policy making and defence of traditional medicine usage (ABC News, 2014). Kate Wilkinson followed the utilisation of this percentage and found that it begun in World Health Organization (WHO) course book distributed in 1983, with the first information on which it was based (Traditional Medicine and Health Care Coverage, 1983). Later information however proposes that the utilisation of traditional medicine in some Asian and African nations is generally lower and is on the decrease (Nxumalo 2011; Angmo 2012; Awiti 2014).

African traditional medicine may also be called 'customary medicine, alternative medicine, indigenous remedy or ethno-medicine'. These terms are consistently seen as perfect, regardless of the way that scholars may incline toward either in light of particular recommendations they may wish to include. Out of these terms perhaps simply indigenous medication and customary cures have an undefined significance from 'society medicine', while the others should be seen rather in a bleeding edge or modernized setting (Diane, 2002). Likewise, a 'home cure' is a treatment to cure a contamination or sickness that uses certain flavours, vegetables, or other standard things. Home cures may have therapeutic properties that treat or cure the sickness being alluded to, as they are customarily passed along by indigenous people.

2.2.3 African Traditional Healing and Practices

Traditional medicine involves 'a variety of products and herbal remedies, animal products such as fats, or oil, skeleton, and mediations and also those which cannot be explained such as the practice of spiritual healing'. Hence the use of traditional medicine is continuously spreading in developing countries. On the other hand, traditional medicine has been looked down upon in many communities due to pressure from missionaries and governments who comprehend such practices as witchcraft (Kugara, 2017). Irreconcilable to those beliefs, however, traditional medicine has proven to be very productive in treating both chronic diseases and psychological problems (WHO, 2000).

African traditional healing practices are an essential aspect in the origination of general health care practice in South African. As shown by the World Health Organization (WHO, 2003), some 80% of the nation's nationals engage traditional practitioners as their first contact in looking for health. Mbiti (2003) contends that African traditional healing cannot be isolated from African religion. In this manner, investment in African traditional healing is driven by the conviction that wellbeing can just come to fruition through concordance with the ancestors, the society and the surroundings. This conceptualisation of health is an aggregate methodology, as opposed to the individuality that is clearly displayed in Western healing practices. According to Wyrostok & Barbara (2000), help-seeking designs are impacted by the idea that traditional healing practices offer an all-encompassing (holistic) and incorporated healing experience rather than the atomistic healing approach proposed by Western healing practice.

African traditional healing is characterized by an expansive scope of qualities. Distinct from conventional healing practices, this kind of healing goes past physical wellbeing. According to Mokgobi (2012), it includes different ways to deal with health which incorporate plant and creature-based medicines. African traditional practitioners draw on other worldly (supernatural) powers passed on to them by their ancestors to utilize therapeutic strategies to maintain and/or restore wellbeing. Contingent upon the current issue, these procedures are utilized in mix or all alone (Truter, 2007 & Rudnick, 2002). For instance, a traditional practitioner may make utilization of otherworldly (spiritual) treatment while likewise endorsing African traditional medicine. They analyse, treat and avoid sicknesses, as means to keep up their patients' wellbeing (WHO, 2003).

The South African government formally recognises African traditional practitioners, and has set up an association to oversee, direct and control them (Hewson, 1998). Nonetheless, as noted by Edwards (2004), the role and duty of traditional practitioners in the South African health care system is cleared, and traditional practitioners' services are regularly contrasted with biomedicine, subsequently trading off its validity. Gumede (1990) notes that biomedicine is favoured for its logical and clinical learning while

traditional healing, on the other hand, depends on handy experience and indigenous knowledge passed down through generations.

A few researchers have found out that individuals would preferably use a traditional practitioner over some other options or treatment alternative (Bodibe & Sodi, 1997). A study in Zimbabwe found that Black Africans' first choice is a spiritual leader like a pastor (Sorsdah & Stein, 2009). Besides, Crawford and Lipsedge (2013) observe that the supposition that African individuals would normally seek help from traditional practitioners first as a result of shared understandings of ailment is erroneous as many of them have access to Western practitioners and experts. Sorsdahl & Stein (2009) note that the indicators of the utilization of African traditional practices incorporate being of old age, joblessness and no or little education.

Eagle (2005) writes that African traditional healing practices are progressively predominant in the underdeveloped regions of South Africa. Individuals living in urban zones retain Western culture and utilize both Western and African points of view to comprehend wellbeing and sickness (Ashforth, 2005). They look for mediation dependent on what they trust to be the reason for the cause of the ailment. In this way, Crawford et al.(2013) argues that these two systems can work in symbiosis to reduce ailments.

Help-seeking behaviour among Black Africans mirrors that an extensive number still consult with African practitioners. This demonstrates their social mentalities towards wellbeing and sickness and the certainty that individuals have in customary way of life (Ashforth, 2005). Mpofu, Peltzer and Bojuwoye (2011) found that Black South Africans were persuaded by the apparent individual intrigue and supernatural powers presented by the traditional practitioners and in this manner sought after a full recuperation. Nattrass (2006) states that this elevated adherence to the endorsed treatment routine or custom as they were willing members in the healing procedure. Adherence to treatment

was fortified by the observation that the ancestors are legitimate in every single human issue and in this way any announcements made by a traditional practitioner who can take advantage of the powerful world, are taken as an intense divine disclosure. For some, according to Moagi (2009), adherence is a method for making up for what they did to agitate their ancestors.

The idea of ubuntu and ancestral respect are implanted in the African conviction framework. Ubuntu underscores human relations and the idea that an individual cannot exist without anyone else yet exists as a component of other individuals (Berg, 2001). Ancestor respect includes the understanding that the ancestors are an essential piece of the African's life, and the conviction that the dead are 'living-dead'. The dead assume an extremely vital job in the lives of the living, ensuring them and giving comprehensive wellbeing (Berg, 2003). Mkhize (2001) emphasises that 'a symbiotic relationship' is kept up between the dead and the living; the living venerates and praises the ancestors with services and ceremonies and thusly gets direction, fortunes and great wellbeing.

Ancestors are a piece of a genuine reality in Africa and their reality is not doubted or questioned. They are engaged with the lives of the living as they offer direction and exhortation through 'dreams and visions'. The living are obliged to comply with the directives of their ancestors. Mbiti (1969) notes that the ancestors, in this way, have an imperative job influence on society. The association with the ancestors impact a person's state of mind, relating and living. Africans trust that their reality is reliant on their ancestors and that all that they are is a direct result of their ancestors (Triebel, 2002). Mkhize (2001) indicates that the individuals who disregard their predecessors and do not practice love and follow their direction put their lives in peril.

As indicated by African ideas of ailment, illness is a heavenly wonder controlled by a chain of importance of forces that is esteemed critical in individual well-being. According to Kale (1995), the most incredible is a deity, followed by the ancestors, spirits, living

individuals, creatures, plants and different items. Cooperation among these forces can decrease or upgrade an individual's prosperity and disharmony among them can cause disease (Lopez & Guarnaccia, 2000). Ingredients from creatures, plants and different items are utilized to re-establish an individual to holistic well-being and reinstate what had been lost (Kale, 1995).

African culture apparently is key to sustaining livelihoods and development and fits in with ‘community-based health care’. Yen and Wilbraham (2003) opine that communalism is counterpoised against developments of Western independence which seem progressed or contemporary, yet depend on narrow minded, individualistic interests. When ‘one regards oneself as traditional' and is completely committed to African culture, any sickness is well to be understood culturally. Culture is hence connected as a type of treatment, and ailment is clarified and settled through exceptional ‘participation in cultural traditions’ (Yen and Wilbraham, 2003). According to Edwards (2014), ‘sacrificial rituals are performed for thanksgiving, appeasement, household strengthening, and reintroducing the spirit of a relative to the ancestors’. Zabow (2006) further indicates that even ‘answering the call to become *isangoma* will also alleviate illness as the patient participates in initiation rituals’.

2.2.3.1 Development of African Traditional Medicine and Practices

The development of medicine, similar to current contemporary medicine, started later in Greece and different parts of the world. The Greeks began logical pharmaceutical through the Egyptians' establishment of medicine. As Singer (1928:7) states, the Greeks got numerous medications from Egypt and others were proposed by Egyptian practice, the premise of Greek pharmaceutical, for example, the types of the careful instruments, were of Egyptian birthplace. The African Egyptians assumed such a crucial part in providing guidance to the art of healing, that no investigation of history of medication can be set out to disregard them. They were the primary African individuals to consider medicine and explore the art of healing.

The progressive improvement of traditional medicine practices in the African region emerged from Egypt, and the choice to empower them emerged from the political occasions of the 1960s (Barmerman et al. 1983:209). The African traditional health care practitioners picked up the moral help from the political authorities amid the advent of independence, as the African individuals rediscovered their socio-cultural personality through traditional medicine as a vital part of their legacy or heritage. The Africans were making utilization of traditional medicine since the art of traditional healing was set up by the African Egyptians. Gumede (1990:7) opines that the genesis of South Africa's use of traditional medicine lie in central Africa. The financial impediments in Africa made it unimaginable and impossible for the introduction of current medicine by the western nations to succeed. Henceforth, the utilization of traditional medicine practices increased in the African region 'in order to improve the quality of health programmes'.

African leaders set up the Regional Committee for Mrica to advance traditional medicine practices. As indicated by Barmerman et al. (1983 :209), the board of trustees welcomed part states and the World Health Organization to find a way to guarantee the utilization of fundamental medications and therapeutic plants of the customary pharmacopeia, to meet the essential needs of the networks and guarantee the advancement of the African pharmaceutical industry. The Regional Committee for Africa upheld the customary program at both local and national level of the African continent at large. From that point forward, the different part states are setting up instruments for the customary and regular frameworks to work as an inseparable unit, and are intending to prepare and screen traditional health care practitioners to upgrade their execution and curtail risky practices.

Different from other studies, this study by the current researcher focused on exploring the understanding and meanings given to traditional medicine that is used for reproductive health by Allandale rural women. This enabled the researcher to see if what was in literature was the same with what is on the ground on this rural community. More so, this study examined the meaning of traditional medicine in reproductive health

of rural indigenous women in Allandale. This knowledge was seen as a 'socio-cultural and historical' stand point to acknowledge the indigenous knowledge that is merely dismissed by other groups and institutions without appreciating the value of it. The ethno-science and reproductive health of African indigenous rural women is outstandingly appraised as it is an area that has been neglected and ignored by most scholars thus, adding contributing to the body of knowledge.

2.2.4 Right to Health Care

There is limited research examining African rural women's perception of healthy living or their right to health care from an African perspective. Of the few qualitative researches done, Paluck, Allerdings, Kealy, and Dorgan (2006) noted that women are perceived to be living unhealthy as their physical and mental health well-being is not considered stable. This included emotional problems, stress and exercises. The authors confirmed that elderly women had confidence in an balance of exercises or activities that upheld their physical and psychological wellness, though middle-aged women were more worried about their physical wellbeing.

Musgrave, Allen and Allen (2002) undertook an examination on elderly women and they discovered altogether different outcomes relating to women's' view of health living. These authors found that ladies connect health with spirituality, where spirituality is characterized as "a basic or inherent quality in all humans that involves a belief in something greater than the self and a faith the positively affirms life" (Musgrave et al, 2002: 557). They found that women see wellbeing and sickness (or ailment) as all encompassing (spiritual, moral, physiological, social and mental); the wellbeing and ailment originates from the 'Creator'.

Richards et al. (2008) stipulates that;

> "Socio-economic status, specifically (a) lower income levels, (b) lower levels of education, and (c) marital status, have been shown to have a considerable effect on changing and maintaining health promoting behaviours."

Various specialists have discovered a relationship between wage levels and smart dieting (Eyler et al., 1998: 45; Fitzgerald and Spaccarotella, 2009: 16 ; Shepherd et al., 2006: 72). Access to proficient reproductive health services is one of the rights, Amin and Hossain (1994) recommend that conceptive rights help manufacture a base for social change. The idea of reproductive health rights is established in the cutting edge of human rights framework created under the sponsorship of the United Nations (UN) and reproductive health and rights as essentials for sound financial improvement and poverty alleviation (Hossain et al., 2011). Reproductive rights rely upon the acknowledgment to the fundamental rights of every single person and couples to choose freely with respect to the number and spacing of their children, and to have information and rights to achieve the most elevated standard of reproductive health services (Amin and Hossain, 1994). In spite of the fact that information of family planning is broad in South Africa, its training is restricted and frequently rural indigenous women are uninformed of their fundamental reproductive rights.

Generally, ill-health was thought to be an indication of poor spiritual worth, or just divine will. However, through the advancement of the natural sciences, the connection between the hidden determinants of wellbeing and ailment was unveiled. This in the end prompted good health being perceived as crucial for the activity of other basic human rights and intricately interlinked to human dignity (Chirwa, 2003). In this way, one of the primary verbalizations of the 'right to health' in international law was the wide depiction contained in the 1946 Constitution of the World Health Organization:

> “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”

This definition has been critiqued by many scholars for being excessively wide, in that no State government can ever genuinely guarantee complete well-being (Pieterse, 2005). While it has additionally been condemned for being excessively obscure, such an expansive definition highlights that human health implies more than essentially getting to medication and health care services. More improvement of the significance of the right to health occurred in 1948, with the adoption of the Universal Declaration of Human Rights (hereinafter referred to as the "UDHR"). This instrument mirrored the developing international appreciation for the need to secure crucial human rights, especially after the horrors that were executed amid the Second World War. While the status of the UDHR is fairly contentious, this instrument contains various arrangements that identify with equality and health.

As far as accessibility, health care services should be workable with and be accessible. The Committee has called attention to this prerequisite of accessibility as it additionally applies to the basic determinants of health, for example, safe and consumable drinking water, sufficient sanitation facilities and satisfactory doctor's facilities and centres (hospitals and clinics). Availability of health care services has three measurements, containing physical openness, monetary availability and access to information. The general comment expresses that ‘health facilities, goods and services’ must be available to everybody without segregation. This has consequences for the most helpless individuals from a general public, for example, rural women.

As far as the acceptability of health care services in a country, 'health facilities, goods and services' ought to be conscious of medical ethics and morals, and culturally proper and sensitive issues. This ought to incorporate affectability to sexual orientation and life-cycle prerequisites, and in addition being intended to regard secrecy and confidentiality. In connection to the nature and quality of health care services, such administrations must be culturally worthy and scientifically and medically fit and proper. This requires the accessibility of gifted restorative work force, scientifically endorsed drugs and adequate healing facility hardware or equipment. It likewise involves access to protected and consumable water, and satisfactory sanitation. In such manner, The United Nations International Covenant on Economic, Social and Cultural Rights (UNESCR) has particularly brought up that the quality measurement of the right to health is an essential element of the international right to health.

These universal standards feature parts of the worldwide ideal to health that are worrisome to South Africa. For instance, the heightening of private social insurance costs and the ascent in maternal mortality, outlines that entrance to quality medicinal services administrations is as of now confined for some South Africans. Given the grim condition of the South African public health care system, as featured in chapter one, the commitment to logically understand the constitutional fundamental right to access to health care services essentially involves an obligation to enhance the nature and the quality of the health care services that are given. Regarding health-related freedoms, women in South Africa ought to have the capacity to practice control over their own body, including sexual and reproductive freedom. This right likewise incorporates the privilege to be free from obstruction, for example, the privilege to be free from torment, non-consensual therapeutic treatment and experimentation.

The General Comment (2006, No 14,paras 3, 12(b) and 1) goes ahead to expound on the interrelationship between the right to non-segregation and the right to health, notwithstanding the health care needs of women. The General Comment expresses that balance of access to health care services should be stressed and that States have an

extraordinary commitment to give the individuals who do not have adequate intends to get to health care services with the important medical coverage and health care facilities that they require. The General Comment additionally calls attention to ‘inappropriate resource allocation’ that can prompt discrimination that is not really unmistakable.

As to the commitment to ensure the socio-economic rights, South Africa should be obliged to find a way to dispense with partialities, indigenous customary practices and other African norms and values that propagate the idea of inferiority of both genders. States are additionally required to remove the legal and different hindrances that keep indigenous rural women from getting to access proper health care services on a basis of equality. The researcher submits that this can also be achieved by giving proper legal recognition to African traditional medicine, especially that which is used by rural indigenous women for reproductive health. The ignorance or side-lining of the African traditional health care facilities in addressing reproductive health of rural women is similar to their violation of fundamental rights as they have access to these places, have faith in them and afford the services offered there, which is cultural heritage to them. Women’s perceptions of the barriers to healthy living are directly related to the determinants of health (World Health Organization, 2012). Women are affected primarily by the social and economic environment, the physical environment, and the women's individual characteristics and behaviours (World Health Organization, 2012). These determinants were assessed in Allandale to check if they were still barriers to access African traditional medicine in their reproductive health care services.

African traditional health care providers, such as ‘traditional birth attendants (TBAs), traditional male circumcisers, bonesetters, soothsayers and herbalists’, are practitioners of all kinds of traditional medicine (MOH 1999, 2006). In the rural areas of Allandale, similar to other rural locations in Pakistan, Botswana, Zimbabwe, India and Lesotho, most childbirths are attended by untrained, or perceived to be untrained health care professionals, including TBAs (Campana 2003; Shaikh and Hatcher 2005). Although TBAs offer important services to their communities, they have been severely criticized

by the biomedical health care system as bearing responsibility for the high maternal mortality rates in the country and are often asked to stop their practice (Kruske and Barclay 2004; Yakong 2008). This traditional sector of the health care system has been neglected by government with regard to technical support and training that would upgrade their skills and allow them to meet the needs of the populace in Allandale and other villages. This was an area the researcher explored to see a way to recognise the rights of rural women to have to their right to health care.

2.2.5 Reproductive Health

Vast majority of literature notes that young mothers are shy to show their pregnant bodies (Hira, Bhat, and Chikmata, 1990). In this way, they are less inclined to seek health care from a specialist, medical attendant, or birthing assistant contrasted with urban ladies, 'as they depend more on their husband's and in-law's choices and decisions' (Rafiqul, Islam, Gulshan, and Chakrabarty, 2007). Indigenous rural women's reliance on their husbands and in-laws towards health care services regularly determines their access to health. Such shows that spouses and in-laws are persuasive components for women's reproductive health results (Dudegeon and Inhorn, 2004). Studies in Bangladesh in this unique circumstance, proposed that rural women, whose spouses were not worried about pregnancy complexities, had been one and a half times inclined to look for health care services from professionals (Rafiqul et al., 2007; Gertler et al., 1993; Dujardin et al., 1995).

Reproductive health is 'one of the significant key areas of global health and is a pivotal and natural piece of women's health because of its association with child-bearing' (Patel, Kirkwood and Pednekar, 2006). Parenthood at an exceptionally youthful age involves a danger of maternal mortality that far surpasses the normal, and have a tendency to have more elevated levels of 'morbidity and mortality' (Shizha, & Charema, 2011:15). There are different components that impact the reproductive health matters, for example, societal position, monetary position and access to assets (Patel, et al., 2006).

The aspect of reproductive health is characterised as an organisational system that fuses maternal and child health programs, family planning, fruitlessness, sexually transmitted ailments, post-natal infection and maternal and child-health related concerns (Dudgeon and Inhorn, 2004). With a specific end goal to direct readers of this investigation, the researcher interpreted reproductive health to be:

> "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (International Conference on Population and Development [ICPD] 1994)".

The World Health Organization (WHO, 2012) expresses that reproductive health carter's reproductive 'process, functions and frameworks' at all phases of life. Furthermore, reproductive health alludes the right of all genders to be educated and have access to 'safe, effective, affordable and acceptable' strategies for fertility direction of their decision and the privilege of access to appropriate health care services that will empower women to encounter a safe pregnancy and labour during child-birth. To put it plainly, reproductive health points to the reproductive procedure, capacities and frameworks at all phases of life (WHO, 2013; Wisconsin Alliance for Women's Health, 2012). Reproductive health care services are therefore obliged to furnish couples with the most obvious opportunity with regards to having a sound new-born child (WHO, 2012). A positive reproductive health care services guarantees safe pregnancy, safe delivery process and gives unhindered 'access to the full scope of reproductive health care options' (Wisconsin Alliance for Women's Health, 2012).

In some Asian nations for instance in India, Pakistan and Bangladesh, there is a high rate of marriage amid youthfulness, bringing about a high rate of adolescence child-bearing (South-East Asia's Population in a Changing Asian Context, 2002). Among the South Asian nations, Pakistan women's health indicators have not been persuading because of 'high maternal illness trouble, high reproductive burden, low usage levels of family planning techniques, poor nutritious status and lower future life expectancy' (Ahmad, 2012). It has been illustrated that 'social, political, religious, geographical and ethnic dimensions' must be considered in understanding women's reproductive health in any nation (Ahmad, 2012). This is one bind spot that the researcher explored in Allandale to unveil barriers that affect or influence women to access Africa traditional medicine for reproductive health.

The situation in regards to reproductive health care services in Allandale is like the setting in Pakistan and Bangladesh. Given the deficiency of qualified health workforce in Bangladesh and the imbalance of their dissemination, individuals want to look for health care services from non-qualified suppliers of African traditional medicine in the informal sector, particularly poor people and the disadvantaged (Ahmed, 2005). On the request side, different boundaries likewise obstruct the utilization of qualified suppliers, for example, absence of access to information on accessible services, absence of health awareness, absence of chance because of exclusion from social and health organisations, social-economic elements disallowing females from looking for care outside the home from male suppliers, and failure to pay (Ensor and Cooper, 2004).

Indigenous rural women tend to get to private, casual health care services, for example, homeopaths, customary health care practitioners, spiritual healers, botanists and other non-qualified suppliers, for example, medicinal experts and pharmacy dispensers (Gadit, 2003; Khowaja, 2009). So also, rural women frequently consult traditional healers and spiritual healers for their reproductive health and life-threatening issues (Sibley et al., 2009). In Allandale, the reproductive health care services are lacking and are frequently described as traditional. This challenging issue is made worse because of

lack of or an absence of sexual and/or reproductive health education. Indigenous rural women and children can be easily side-lined because of deficient primary reproductive health services and education. In addition, there is still extremely poor literacy among rural indigenous women relating with their reproductive health. For instance, the researcher found that many Allandale women gave birth at home without the help of a trained birthing attendant and these mothers do not have the knowledge expected to guarantee protection of their own well-being and the health of their children.

This lack or absence of health understanding has additionally been strengthened by the way that indigenous rural women frequently do not have the opportunity to get access specialists. Moreover, even for life-threatening issues, these indigenous rural women may end up consulting unregistered African traditional healers and spiritual healers (Sibley et al., 2009). In Bangladesh, there are social and religious convictions that impact on how an individual comprehends health problems. These beliefs affect on the decisions made to get to different health care services including ‘specialists, quacks and spiritual healers’ (Rafiqul, Islam, Gulshan, and Chakraborty, 2007). Effects of the use of African traditional medicine is explored on reproductive health care services provided by African health practitioners.

South Africa aimed to accomplish the Millennium Development Goal (MDG 5) target that aims to ‘reduce the maternal mortality ratio by three-quarters by 2015’. Be that as it may, the yearly rate of decline needs to triple. Women in rural settings endure most as far as delayed labour, familiarity with risk indications of delivery are misconstrued, distance to delivery service and the cost of the delivery procedure (Anwar et al. 2008). Stuckler, Basu, McKee (2010) have clarified the explanations behind being unequal in accomplishing MDG 5 in developing countries and especially Sub-Saharan African countries. Stuckler et al. (2010) found that funds given from rich nations are distributed to different types of social spending or military use as opposed to health facilities (i.e., low health spending for every dollar of GDP). Ultimately, when funds enter the health care system, the administration faces low absorptive limit with respect to spending

because of absence of specialists, pharmaceuticals, or healing facilities (Stuckler et al., 2010). Despite the fact that there have been numerous impediment regarding reproductive health care services in South Africa, one applauds that most numbers of infant deaths have been lessened (Lawn et al., 2012). With a specific end goal to have a superior comprehension of the reproductive care services in Allandale, it is relevant to have a general picture of the socio-cultural settings.

Health-related beliefs likewise rely upon social standards. For example, taboos that can regularly keep rural indigenous women seeking for health care services from outside their home for themselves and their children (Rashid, Hadi, Afsana and Begum, 2001). The way that Allandale is a prevalently Christian and African Traditional Religion (ATR) represents women' lives to various degrees of control with governing rules that diminish a pregnant woman's movement and choices (Darmstadt et al. 2006). This has additionally been bolstered by Anwar et al's (2008) study that found that indigenous rural women are not looking for formal health care facilities amid pregnancy period since some cultures discourage them from consulting male doctors.

There is an impression that male members of the family reckon it as a loss to spend money on female reproductive health, particularly on rural indigenous women (Schuler et al., 2002). On the other hand, research findings unveiled that male individuals in the family regularly do not take it lightly for their wives or sisters to go alone to consult a male doctor because of their cultural beliefs and also the female's restricted movements (Schuler et al. 2002). Movement during pregnancy is confined due to having beliefs in witchcraft, evil and taboos (Edmonds et al., 2011). Sibley et al's (2009) clarified this and found that rural indigenous women trust that malicious spirits are the reason for bleeding and that women should look for assistance from a traditional healer. Chakrabarty et al's (2003) research shows the role and acceptability of a traditional health practitioner in treating life-threatening conditions, for example, over-bleeding among the rural indigenous women. Along these lines, ‘health-related beliefs, individual

attributes and socio-cultural constraints make a strong contribution to the treatment of women's reproductive health' in Allandale.

Reproductive health education among rural indigenous women may act as an intermediary variable for various foundation factors representing women's socio-economic status, subsequently empowering them to look for legitimate therapeutic care at whatever point they think that its fundamental (Chakrabarty et al., 2002). Reproductive wellbeing training, as an intervention, could assume an imperative part to enhance the present status of reproductive health. Chakrabarty et al. (2002) further notes that reproductive health training assumes an essential part in the use of health care services by upgrading women's learning about maternal morbidity and accordingly makes a consciousness of women's health. 'Recognition of danger signs such as prolonged labour, postpartum bleeding, obstetric complications, obstructed labour during the birthing process,' mirrors a low familiarity with the pregnant women and her family as an immediate medical attention is required to react to this hazardous difficulty (Anwar et al., 2008). There is a general hesitance to plan for the delivery or to seek for care amid pregnancy in rural Bangladesh as there is a conviction this would make additionally postpone of the delivery of the child. It is additionally viewed as a humiliation for the woman (Darmstadt et al., 2006).

2.2.6 Gender Inequality: Gender Dynamics and Mainstreaming

Poverty makes women more defenceless against human trafficking, violence and ill-health. This raises the requirement for the researcher to explore the basic issue of gender and to effectively advance the social, economic and cultural norms and values of rural indigenous women to shield them from exploitation and abuse with regards to reproductive health.

Gender Mainstreaming (GM) was hailed as another way to deal with gender inequality and women's empowerment in the post-Beijing time (Porter and Sweetman, 2005), the

inquiry is the means by which it has been utilized to propel gender equality and women's empowerment in developmental agendas. Stienstra (1994) contends that GM can occur in various ways: it could occur inside an association, which is restricting as the authoritative parameters would decide the limits of this activity. An alternate way is to separate the association and lobby for GM from outside. Her inclination is for the last strategy, as she questions that substantive gender transformation can happen inside prohibitive authoritative parameters.

Benschop and Verloo (2006) dispatch a very similar comparative contention: Gender Mainstreaming brings about specific changes inside an association, however it does not prevail with regards to evolving its "genderedness". For their case study of the Human Resource Management segment in the Ministry of the Flemish Community in Belgium, they found that power relations are a deciding variable in the fruitful usage of GM and that power relations, and the power contrasts between parties, extremely decided and thwarted the effect of GM in the association.

The adoption of the concept of 'gender' rather than 'women' is very noteworthy in Gender Mainstreaming. Prügl and Meyer (1999) battle that gender rose as a significant idea as a component of the women's movement, while Staudt (1998) contends that utilisation of the term 'gender' as a social development rather than 'women' began with the enthusiasm in mainstreaming in development. The move towards the term gender demonstrates that both men and women must be interdependent, involved and engaged with changing gender relations in institutional settings. It likewise infers an emphasis on worries with manliness and womanliness (masculinity and femininity). Eveline and Bacchi (2005) recommend that the issue of manliness and men in GM can be a source of strain. While carrying men into the equation should adjust the relatively programmed relationship of women with gender, there is the danger of 'depoliticising' gender in that the spotlight could be too emphatic on how men can profit by being included. This concentration, they contend, could lead individuals to disregard the significant issue of 'gendered power politics'.

Gender Mainstreaming is a perplexing procedure – Thege and Welpe (2002) are of the conclusion that it includes ‘a gender perspective, gender knowledge and gender research, if substantive gender equality is to be achieved through this approach’. It along these lines makes sense that it will be a significant test to effectively actualize GM in any association. Furthermore, they contend that GM does not happen automatically; particular mediations, for example, educational trainings to make individuals gender-aware and gender-sensitive are required. Individuals likewise must be encouraged how to actualize GM as a component of a change procedure. To buttress this, a critical viewpoint is monitoring and appraisal of gender policy implementation. Thege and Welpe (2002) contend that mainstreaming policies cannot prevail by being forced from above, in light of the fact that the individuals who need to actualize them require a sound comprehension of what the policies entail. Additionally, there should be lucidity on who needs to actualize the policies in question and how to do it. This, the researcher contends, is a challenge and a draw-back for South Africa. The researcher posed and answered the question; will South Africa be able to adapt to present circumstances by effectively actualizing GM, especially in rural areas that adhere to cultural norms and values?

The battle for gender equality is not a new phenomenon to South Africa. South Africa glories in a long history of women’s battles for freedom and gender equality as a feature of the national democratic struggle for democracy in South Africa. This is evident in section 9 (equality clause) of the Bill of Rights in the South African Constitution (Act 108 of 1996) and other national laws that were enacted. Accordingly, Gender Mainstreaming (GM) as a way to deal with accomplishing gender equality appears nearly 'natural' development for South Africa. Worldwide gatherings and development writings on Third World nations have influenced GM to an integral part of the present talk on gender equality (Gouws, 2005a). It has been viewed as the approach that will effectively empower the government to implement gender equity as cherished in the South African Constitution since the late 1990s. Along these lines, in this light, the researcher contend

that both patriarchy and masculinity could be utilized as a part of gender analysis, as long as their usage adds to taking the gender equality battle forward.

2.2.6.1 Patriarchy

As indicated by Cranny-Francis et al. (2003: 15), “patriarchy is a social system in which structural differences in privilege, power and authority are invested in masculinity and the cultural, economic and/or social positions of men”. They contend that both the idea and its widespread were a consequence of the women's activist discussions in the 1970s, and that it supplanted the idea of sexism. Patriarchy as an idea focused on institutional instead of individual gender abuse. Feminists utilized it as a logical structure to clarify control relations in the public eye, by inspecting how frameworks support men and disadvantage women.

Tiessen (2007) opines that men who have the vast majority of the power in a patriarchal system dominate the public and private circle, and are the chief decision makers in both. More than this, the uneven power relations for men are fortified after some time, in light of the fact that people with significant influence (men) can strengthen them. She separates ‘between public and private patriarchy’. Public patriarchy isolates men and their jobs from women, while private patriarchy alludes to the unequal power relations inside the home that favours men to the detriment of women. Through the institution of marriage, women progress towards becoming 'unpaid workers' regarding the reproductive roles they satisfy in the private circle, 'liberating' men up to centre around their occupations in public circle. Others are more questionable about the utility of the term.

Burris (1996), for instance, contends that patriarchy as an idea has been questionable; it has been characterized in a wide range of routes, with a few feminists dismissing it totally. Different feminists have utilized the term yet changed the meaning, and still

others utilize it freely as a general term for male predominance. The researcher figures the utilization of the concept patriarchy as a general term for male dominance would need to assess diverse settings. As such, the researcher assessed, the following; reproductive choices, reproductive consultations by rural indigenous women who take and do not take African traditional medicine for reproductive health care.

2.7 Chapter Conclusion

The chapter reviewed numerous literature findings on indigenous knowledge systems, traditional medicine, reproductive health, gender dynamics and reproductive health. The literature showed several factors with regard to women's lack of control over their lives. On the other hand, it also underpinned in the theoretical framework how girls and women are generally forced to live their lives for the benefit of their husband's families and for society, rather than for their own benefit, a situation that robs women and girls of their rights and dignity in several dimensions of their lives – reproductive health. This situation has been culturally taken for granted in order to serve the interest of the dominant male group. Despite the existence of social laws purported to protect women, the literature suggests that the mere existence of laws is not enough to help vulnerable rural indigenous women unless certain factors available to enhance the proper implementation of those laws and policies are assured. Having seen such gaps in the use of African traditional medicine use in the reproductive health of women, the following chapter shows how the researcher collected data for the study.

CHAPTER THREE

RESEARCH METHODOLOGY

"The value of scientific research is partially dependent on the ability of individual researchers to demonstrate the credibility of their findings."

(LeCompte and Goetz, 1982: 31)

3.1 Introduction

After reviewing the literature and the theoretical framework used in the study, this chapter describes the research methodology employed in this study. The research design, study area, population and sample are described so as to make one understand why such choices were taken. To add, specifics about qualitative data collection processes in the field of indigenous knowledge are fully discussed and include: selection of the study participants, the African indigenous protocols and interview procedures. The researcher also explains the measures taken to maintain validity and reliability of the research instruments used to collect data.

3.2 Research Methodology

Research methodology is the approach selected to obtain information for a study and describe the approach to the work (Mouton, 2002). This part of the study will outline the research design, data-collection tools, study area, population, sampling technique and data-analysis technique. It also explains the rationale behind the methodology employed, instruments of collecting data, also the limitations encountered.

3.3 Research design

A research design is understood to be a systematic process of research that entails intensive planning of events prior to conducting the actual study. The main aim of the

research design is to provide solutions to an existing problem. According to Kothari (2002), a research design constitutes 'the blueprint that guides the researcher in the process of organizing, analysing and interpreting data'. The study adopted a qualitative research design.

3.3.1 Qualitative Research Design

Shank (2002:5) alludes the following about qualitative research design,

> "… qualitative research is "a form of systematic empirical inquiry into meaning". By *systematic* he means "planned, ordered and public", following rules agreed upon by members of the qualitative research community. By *empirical*, he means that this type of inquiry is grounded in the world of experience. Inquiry into meaning says researchers try to understand how others make sense of their experience'."

A qualitative research design is deemed to be the most suitable to explore traditional medicine and its impact on reproductive health of rural women. This is because the study aimed to provide detailed insights of the goings-on in Allandale village with regards to traditional medicine, their beliefs and the implications of traditional medicine to reproductive health. Moreover, an explorative qualitative design was opted for in this study.

3.3.1.1 Explorative Qualitative Research Design

An explorative qualitative research follows a design that seeks and describes new observations, where no prior information existed, or convoluted issues are involved (Seaman & Baxter, 2008). The study at hand sought to unveil traditional medicine that has been negatively reported in the media thus, giving genuine views of it within

traditional communities. It also directs the researcher in the selection of relevant study material (relating to African traditional medicine), respondents and the examination of material collected (Mouton & Babbie, 2001).

The strength of this design in this study was that it incorporated a comprehensive strategy which empowered the researcher to profoundly think about unique issues related to African traditional medicine. In addition, it was adaptable and it spared time and expenses on the part of the researcher. The explanations for picking an exploratory research design were diverse for this particular study. To start with, it was picked in light of the fact that it is suitable for this investigation, as it gives a coherent strategy to gather dates, break down the data, and to likewise report the outcomes, thus subsequently leading to a more profound comprehension of a specific circumstance. Secondly, it was picked as a result of its capacity to give a clarification of 'how' and 'why' rather than just 'what' (Yin, 2003). This was key for this investigation so as to recognize how viable African traditional medicine is in its use for reproductive health among rural women.

As indicated by Gray (2014), an exploratory design is useful in uncovering a causal connection between the phenomenon being examined and the setting in which it happens. Yin (1994) states that an exploratory design is equipped for giving a rich and detailed depiction of the subject matter being examined, which enables the researcher to have numerous and evolving elucidations, something that would have been outlandish in a quantitative research design. In addition, this design empowered the researcher to examine the implications of using African traditional medicine on reproductive health from different points of view – a component which recognizes it from different techniques (Yin, 2003).

This study sought to investigate, inquire and understand the implications of using African traditional medicine by rural women. Different women, who were in their

conceptive years, were allowed the opportunity to think about their experience of pregnancy, unsuccessful labours and different issues that were linked with reproductive health matters. Amid the hands on work process, I remembered that I was exploring a social phenomenon that required reflection, comprehension and clarification. There was no room for suppositions which may lead towards inclination towards a specific gathering that could make an incomprehensible circumstance in subjective research, as both the participants and the researcher can control individual data (Baez, 2002). More often than not, the exploration inquiries on the off chance that reviews are presented by 'how' and 'why' (Yin, 2003), similar to the case in this examination.

3.4 The Research Paradigm

This study explored the various realities of the community's lived encounters that were socially built with respect to social norms, values and cultural beliefs. The procedure that encourages the elucidation of numerous substances of various members is depicted as an interpretive worldview (Sarantakos, 2005). In that regard, the researcher adopted the interpretive worldview which had its foundations rooted in the African way of doing things.

Numerous truths were uncovered in this examination as every participant uncovered their alternate points of view and conclusions of their encounters of addressing reproductive health using African traditional medicine. So as to understand reproductive health and their respective health care services, the study participants must be fit in working as free people – independently indigenous believers. It was imperative to distinguish whether the members had any confinements in getting access to reproductive health or not. So as to investigate what are the confinements or boundaries that obstructs women's access reproductive health care services, it was appropriate for the researcher to examine whether the study participants are able to work uninhibitedly as having an ordinary life. To contextualize the point of the investigation, it was essential to pick up the understanding of rural women's convictions

about traditional medicine and reproductive health and the manner in which these convictions shape the recognitions about their reproductive health.

As such, the community members were invited to express their varied convictions on the use of African traditional medicine on reproductive health. As a researcher, my objective was to decipher the lived realities experienced by the participants, which implied interpreting their experiences from the literary information. The encounters that were incorporated by the participants give the ontological point of view which is one of the philosophical presumptions of the investigation (Sarantakos, 2005). Then again, the epistemology of the examination subtleties the procedure utilized to research and find information (Punch, 2004). To affirm the epistemological assumption of learning (Bryman, 2012) this examination included fieldwork about where the study participants lived and do for a living (Cresswell, 2007). The epistemological point of view of this study was exemplified by the viewpoints of the members that participated in open ended question interviews and focus group discussions, which uncovered their convictions, learning, discernment and comprehension of the use of African traditional medicine on reproductive health.

3.5 Study Area

The study was conducted in Allandale village, Mpumalanga province.

3.5.1 Mpumalanga Province

Mpumalanga province is located in the North-eastern part of South Africa, having international borders with Mozambique and Swaziland in the east, and local borders with KwaZulu-Natal and Free State in the south, Gauteng in the west, and Limpopo in the north'. The economy of the province is mainly sustained by the farming, natural attractions and mining in the province. The province is positioned strategically in its relative proximity and strategic interactions with the afore-mentioned countries and provinces. The study area is unevenly distributed with people who speak '*siSwati*, the

language of neighbouring Swaziland, *isiZulu*, *isiNdebele*, Northern *Sotho* and *Xitsonga*'. Out of the entire province, the researcher nominated Allandale village.

3.5.1.1 Allandale Village

Allandale village is found under Bushbuckridge municipality. The researcher chose this place because this area, in the view of the researcher, is rich with traditional medicine and traditional healers who specialise with reproductive health. Besides that, the place is within the area of residence of the researcher and the researcher is well conversant with the languages spoken in the area in question. The following three (3) sub-villages were targeted; Lepong, Ludluw and Viewpoint.

3.6 Target Population

According to Silverman (2013), a population of the study is the total members of a defined class of people, objects, places or events selected because they are relevant to the research question. Also, Potter (2011) defines population of the study as a study of a group of individuals taken from the general population who share a common characteristic such as age, sex or health condition.

The study population included 'all accessible people who possessed some common characteristics, uses traditional medicine and had indirect ways of influencing its use or are custodians of it. For this study the population consisted of rural women, some men, traditional health practitioners, elderly people and traditional leaders in Allandale. Table 1 below is a diagram that gives justification for the participants selected in the study;

Table 1: Justification of the Participants

Category	Justification
1. **Rural women**	They are affected by reproductive issues.
2. **Traditional healers** (Diviners, faith healers, herbalists and traditional birth attendants)	They are knowledgeable about traditional medicine.
3. **Elderly people (above 61 years)**	They have the knowledge about the history in the use of traditional medicine and still uphold the cultural norms for traditional medicine use.
4. **Western-trained doctors**	They are the ones that are usually at the receiving end of victims of traditional medicine.

3.7 Sampling

Sampling is a process of selecting a portion of the main population for the study (Seaman and Baxter, 2009). The sampling process assists in the collection of specific information from the study participants, the chosen sample of the study. The non-probability sampling method was employed for the purposes of this study.

3.7.1 Non-probability Sampling

Burns and Grove (2001:281) indicate that non-probability sampling is described as one method in which not every element of the population has an opportunity of being selected. Under non-probability sampling, the researcher selected purposive sampling and snow-ball sampling. These are discussed below;

3.7.1.1 Purposive Sampling

Purposeful sampling technique helped to ensure that the participants with the knowledge of traditional medicine and reproductive health issues are identified and included in the study. The categories of respondents included women, some men, traditional healers and elders, all of whom are believed to be better custodians of IK because of their age and experience. This method was preferred because it enabled selection of participants based on their role in the communities and the knowledge they possess. Above all, this method was economical because only a part of the population that had vital knowledge to the area of study was sampled. The purpose in the mind of the researcher was targeting people who used African traditional medicine.

3.7.1.2 Snow-ball Sampling

Snowballing is whereby the researcher approaches the desired participants and those participants who were approached act as informants and identify other members who are experts in the field (Siedman, 2006). The researcher made use of the snowball sampling because the researcher was directed to more knowledgeable participants by the other participants.

3.8 Data Collection Methods/Tools

The research methods are the ways in which the researcher collects data, whether by questioning, measuring or observation. The chosen method of data collection, the problem being studied, and the research design are all related. Qualitative interviews

provide a detailed account of the problem under study, protect the anonymity of respondents and enable the researcher to clarify any uncertainty with the interviewees (Marczyk et al., 2005). The study utilised the following methods to collect data;

3.8.1 Open-ended Questions

Siedman (2006:582) defines open-ended questioning as a set of questions posed to the participants in which the researcher always probes for further elaboration. The study presented open-ended questions to traditional healers and rural women, with the purpose to gather information on the topic and to allow them to elaborate in detail with greater flexibility. Since the study was based on the metaphysics of traditional healing and traditional medicine, open-ended questions were hugely beneficial. It enabled in-depth understanding of the topic, revealing much information on traditional healing and especially on the dynamics of African healing – reproductive health.

3.8.1.1 Fieldwork Experience

Building up rapport with the members is imperative so as to pick up their trust (Frey and Fontana 1994). In their investigation, Frey and Fontana (1994) expressed that the benefit of knowing a community language with the end goal of information accumulation is that it encourages one to have better correspondence with individuals. Connections just with the members did not generally help in setting up a decent association with the participants. The other relatives probably might not welcome strangers in their home. Subsequently, so as to set up adequacy in the family, the researcher introduced herself and her assistance to the traditional leadership and seniors of the divisions of family alongside the members. There were times when I talked for quite a long time with the mother-in-law and with the sister-in-law just to set up a reliable relationship. Building affinity with the relatives likewise facilitated the way towards talking with the participants of this study. Now and again we even ate together amid information gathering as it is part of the community's way of showing togetherness.

This examination did not endeavour to pick up measurably critical outcomes, rather it endeavoured to explore about rural women's understanding and convictions that they frame either from family or society, and their mentalities towards those convictions. This study was qualitative in nature, and becoming acquainted with the participants was important to create insights of knowledge and reflection on people's encounters (Brockington and Sullivan, 2003). An ethnographic scientist, Alejo (2003) battles that investigating on a community issue is an additional preferred standpoint of unheard and underestimated voices of the rural people. Consequently, this study focused on a various scope of rural women who may have diverse convictions and frames of mind, in light of their experience and setting, in regards to the impact of African traditional medicine on reproductive health (Desai and Potter, 2006).

Amid data collection, the researcher kept up constant contacts with supervisors through messages and talked about the everyday encounters, progress and sought guidance to gather rich data and have a smooth flow. The researcher encountered different challenges, for example, money related limitations, transportations and distances, and travelling to inaccessible data collection sites. Following literature (Rashid, 2006), the researcher additionally sensibly analysed the assets expected to lead and finish the data collection effectively. Subsequently, the researcher confined this study undertaking to three villages, just, as it was effectively accessible and also rich in data.

In an exploratory qualitative study, Rashid (2006) notes that it is normal to experience issues in getting acceptance from research communities. The researcher confronted comparable circumstances as the members were at first hesitant to partake in this study. Be that as it may, their refusal and absence of endorsement did not discourage me from convincing them. The three villages that the researcher visited took a couple of days to open up to me. Amid the initial couple of days, the researcher just went to acquaint herself with them, acclimatise herself with the network and construct an association with them. Some community members suspected that the researcher was a family planning officer who had come to give them the preventative pill while others felt

that the researcher was a specialist who had come to discuss anti-conception medication techniques. A few members additionally felt that I was from a television (TV) station that had been coming to make a narrative film on the lives of rural women. The researcher came to thoroughly understand these when she began the interviews, and appreciated these perceptions and starting anxieties with the participants.

Most of the rural women whom the researcher met had no clue about the importance of this study, nor did they comprehend the core issue of this exploration. To set the participants at ease, the researcher disclosed to them that she was writing a book on the lives of rural women, where she would talk about their wellbeing, pregnancy, traditional medicine and related convictions and implications. In the first place, the researcher confronted challenges to pick up trust from the members from all the three villages. When the researcher uncovered her goal that she had not come to change their convictions and dispositions about reproductive health and traditional medicine but rather needed to comprehend their reproductive health beliefs, the researcher was somewhat acknowledged and welcomed by the participants and it turned out to be simple for the researcher to construct a decent affinity with the participants in the villages. When the villages acknowledged and accepted the researcher, the researcher did not think that would be difficult to get participants for the study. The news spread rapidly about the researcher in these villages and the message that went viral over was that "there is a woman who is discussing traditional medicine and reproductive health..."

Amid my hands-on work, I elected to offer some help to a couple of ladies, whom I interviewed – giving them a lift and money to get a taxi to come back. This could give rise to ethical concerns and undermine the study’s legitimacy. From an ethical perspective, their monetary circumstance was miserable to the point that my moral obligation was to help them. From an African indigenous protocol, this is not an unprecedented practice in a village like Allandale whose cultural norms and values are produced through demonstrating graciousness and consideration for the poor and

needy. Indeed, even the business people feel constrained to help their customers fiscally and set up funds for the poor from their month to month earnings.

On a comparable note, Desai and Potter (2006) proposed that paying incentive or some kind of blessing is useful in a lower salary network since individuals' time is restricted by pay procuring exercises. Allandale culture esteems standard giving and exchanging gifts. Giving gifts or an incentive where appropriate is likewise an indication of kinship that fortifies the servitude of shared comprehension and furthermore shuts the hole between any hierarchal relations. According to Frey and Fontana (1994), picking up trust is critical in generally hierarchal relations and wipe out doubt or confusion. This trust was built not through the procedure of formal talking but rather through trade of perspectives and the sharing of regular day to day existence that made our relationship insinuate and carried the researcher close with almost all of the participants.

So as to make the questioning increasingly practical, the researcher rephrased and re-explained the questions to participants. While undertaking the interview, the researcher pursued the recommendation given by Desai and Potter (2006) with respect to directing agreeable, conversational and loosening up meeting. The researcher constantly remembered that an interview is not a cross examination and it ought not be undermining to the interviewees. Additionally, the researcher remembered that the data collection instruments (i.e., open-ended questions and focus group discussions) are critical to assemble thick and rich distinct information with regards to an exploratory qualitative research design. Specifically, building up the inquiries for this examination and contextualizing those by following the foundations of every individual respondent amid information gathering required a great deal of diligent work and was a thought amid transcription. Before data gathering phase, the researcher’s visits and subsequent stay with these communities have given her a decent introduction about their way of life and cultural beliefs.

Rashid (2006) recommends pondering one's own experience at that point and then ask applicable follows up inquiry to the respondents. This encourages respondents to open up their different views, particularly, open-ended questions and focus group discussions. This additionally directs respondents to what sorts of data is asked for from them, particularly, when the respondents are generally uneducated. The researcher used to begin the discussion by considering my experience of achieving parenthood and labour, which made the participants to the study to take an interest. The researcher met the participants close to their homes and sit on the grass for the interviews. As the researcher and her team strolled along the village, now and then women stopped them, began asking questions and after that shared their reproductive matters and traditional medicine.

The researcher constantly kept up the situation of a decent audience and never let her own thoughts impact the participants. More often than not, the exchange proceeded on a scope of points from reproductive health problems and traditional medicine to regular survival techniques of women in the village. The researcher never interfered with the stream of the dialogue, yet endeavoured to bring back the discussion to the impact of traditional medicine on reproductive health issues, when members have begun long talk about issues not applicable to this examination.

First and foremost, the spouses of the participants were exceptionally suspicious of the researcher’s visits. They believed that the researcher was giving exhortation on contraception and adversely impact their sexual relationship. They used to remain beside the researcher amid the initial couple of visits that the researcher made. In the end, the spouses felt agreeable and quit staying nearby where the meeting occurred.

3.8.2 Focus Group Interviews

Kelly (2007) defines focus group interviews as a qualitative research method that involves a way of listening to people and learning from their personal narrations. Focus

group interviews were used for the purposes of gathering data. During these interviews, the use of traditional medicine and its implications on reproductive health on rural women were explored. Focus group interviews generated diverse qualitative information (Vanhatalo, 2014). The researcher made use of a tape recorder and transcribed data. This method of gathering data was used because it allowed the researcher to gain insights into people's shared understandings. The researcher held only one focus group interview. Members were drawn from different categories of the targeted population. One focus group interview was preferred because it was time consuming but still the best instrument for in-depth gathering of data.

A key unmistakable element that distinguishes 'focus group interviews' from in-depth interviews is that the focus group interview underlines the interaction among participants with the facilitator just directing the talk, whereas the in-depth interviews stress interactions between the questioner and a participant. Despite the fact that the focus group interview is 'engaged' on an collective action (Duggleby, 2005, Reed and Payton, 1997, Kitzinger, 1994), there is space to utilise the focus group interviews to examine members' perspectives in a gathering, since the gathering shares basic societal perspectives. Focus group interviews are commonly utilised in pre-or post-interviews to elicit itemized participant perspectives about specific issues. One preferred standpoint of utilising focus group interviews is the usage of gathering communications, which permits the accumulation of exceptionally broad and precise information about the encounters of individuals in general (Webb and J, 2008, Barbour, 2005). Focus group interviews capture data that would be generally difficult, or unimaginable to acquire from individual interviews (Kitzinger, 1995).

Focus group interviews played a pivotal role in investigating issues on implications of traditional medicine. These variables included unintended pregnancy and its results, gender roles and sexual attitudes, gender inequality, and healthy seeking behaviours and stumbling blocks to accessing formal health care services in preference of traditional health care services.

In the present investigation, the focus group interview encouraged the sharing of an abundance of detailed information and profound understanding on how culture and patriarchy takes the central role in determining reproductive choices for women. The researcher, alongside selected experienced research assistants, facilitated the focus group interview. The size of focus group interview was nine participants. Participants were formed to be as homogenous as possible; 'structured by sex (3 males), age group (18 years to 72 years) and marital status (married or unmarried)'. This gathering arrangement was intended to best help with giving a comfortable environment to enable sharing of ideas to different people. It also limited the effect of social chains of importance that could hinder dialogue on touchy issues, for example, sexual and reproductive health (Patton, 2014).

3.8.2.1 Sampling for FGDs

Participants were recruited from a wide assortment of work settings, for example, schools/colleges, women's groups and non-government organisations. So as to select eligible participants, the research team exclusively reached the relevant local authorities in these associations and sought for verbal authorisation to approach potential participants. Potential members were notified about the purpose of the study and those who were willing to take part in the study were informed with respect to planned dates, place and time for the focus group interview. The authorities in these work environments had no impact about whether or not an inferior in their association took part, nor knew about who had consented to take part. Participation was altogether voluntary and commitment free.

3.8.2.2 Interview Procedures: Informed Consent

Sessions started with the researcher introducing the study by giving out the information sheets and then reading out loudly the information sheet which contained the topic of the study, purpose of the study, its importance, all safety and ethical issues to the participants and asking them if they understood and were willing to be part of the study.

No one objected or refused save for a new questions to clarify some few things in the information sheet (information sheet is attached at the end of the research and marked as annexure). After that, almost everyone was interested to take part in the focus group interview. The informed consent forms were distributed and signed by all participants present. After this, the ground rules were also outlined as indicated in the information sheet and the focus group interviews commenced in a private room at the selected site. The whole session was audio-recorded with permission from the participants.

Study participants were reminded not to reveal their identities throughout the focus group interview. All in all, most of the study participants in the focus group interviews were noted to participate actively and the research team safeguarded that no one participant could dominate the interview. They ensured that by giving all participants equal opportunity to share their views.

3.8.2.3 Interview Procedures

So as to guarantee that the members felt as loose as possible about talking about sensitive issues around the themes of traditional medicine and reproductive health, the focus group interviews were held far from the work places or schools or where the members were initially selected. Participants were requested to complete their demographic information secretly. The researcher facilitated the focus group interview while one research assistant was note-taker and was responsible for taking notes and audio-recording the interview, which was estimated to have lasted for 90 minutes. The interview guide was adaptable to enable related, however, unanticipated issues to be explored. To encourage open dialogue, participants were welcome to highlight personal encounters and stories that they had found out about from other individuals.

3.8.3 Observation

Observation is an ‘organised method of recording the behavioural patterns of participants without questioning them’. The researcher chose to use observation because ‘it enabled her to gather data on physical and human settings’ that would aid presenting data on some issues that that may not been utterly been said verbally and to show hard evidence (Cohen, Manion & Morrison, 2000). In that regard, the researcher used a non-participant observation.

3.8.3.1 Non-participant Observation

Non-participant observation is generally depicted as actively seeing participants and other phenomenon wherein the participant is not actively involved in the activity being studied. The researcher employed non-participant observation method to understand the phenomenon under study by entering the Allandale community and/or social system known, and followed the strategy described below;

> "The observation process is a three-stage funnel, according to James Spradley, beginning with descriptive observation, in which researchers carry out broad scope observation to get an overview of the setting, moving to focused observation, in which they start to pay attention to a narrower portion of the activities that most interest them, and then selected observation, in which they investigate relations among the elements they have selected as being of greatest interest. Observation should end when theoretical saturation is reached, which occurs when further observations begin to add little or nothing to researchers' understanding. This usually takes a period of days or months, but, depending on the phenomenon in question, sometimes several years." (Liu & Maitlis, 2010)

The researcher had the opportunity to gather information that participants were not free or uncomfortable to explain during interviews. During interviews, the participants had

the luxury to select what to let out or not. However, with non-participant observation, the researcher found valuable unsaid information for the study. Through non-participant observation, the researcher had valuable opportunity to collect first-hand information happening in Allandale, real life situation, and later go and observe to confirm what participants said. According to Cohen, Manion & Morrison (2000), observation information allows the researcher ample opportunity to 'gather "live" date from "live" situation'. Observational information empowers the researcher to enter and comprehend the circumstance that was being depicted in an interview (Patton, 2002).

Through the observation schedule, the researcher gathered information on traditional medicine and the implications associated with the use of traditional medicine. The researcher also had the opportunity to observe events such as the *mchongolo* dance, the kind of traditional medicine they use, the medicine preparations and consumptions and the magnitude of *mchongolo* dancers. An annexure of the observation schedule is attached. Audio and visual recorders or cameras were used to aid capturing raw data in the field. To take photos of some traditional medicines, some rituals had to be followed as to allow the capturing thereof (the ritual cannot be described to keep the sacred oath given by the researcher to the traditional health practitioners and the ancestors who allowed the capturing).

3.9 Data Analysis Method

According to Mouton (2002:108), the choice of data-analysis methodology for a study is influenced by certain factors. Data analysis entails organising information into segments to form meaning and establish trends, for interpreting the data and relating the findings to existing theory to show whether they support or refute interpretation. The researcher used a combination of content and narrative analysis to understand the perceptions, roles and impact of traditional medicine on reproductive health of women. Jorgensen (1989), as contained in Seidel (2009), states that the aim of this process is to assemble or reconstruct the data in a meaningful or comprehensive fashion. Themes used were

derived from the research questions and other prominent issues that emerged from the participants' responses.

3.10 Ethical Considerations

Based on the nature of the study as well as the research methodology used, it is essential for one to highlight the ethical issues of the study. Ethics have become a cornerstone for conducting effective and meaningful research. As such, the ethical behaviour of individual researchers is under unprecedented scrutiny (Best and Kahn, 2006; Field and Behrman, 2004; Trimble and Fisher, 2006). In today's society, any concerns regarding ethical practices will negatively influence attitudes about science, and the abuses committed by a few are often the ones that receive widespread publicity (Mauthner, Birch, Jessop and Miller, 2003).

It was considered that the information collected from Allandale village should meet certain ethical considerations. Therefore, it was prudent to observe the community values hence the following ethical issues were followed:

3.10.1 Honesty

The principle of honesty was observed throughout the research process whereby works of other people cited in the research were properly acknowledged.

3.10.2 Informed Consent

Some participants in the study signed consent forms while other participants in the study gave their verbal consent to participating in the study. The study sought the participants' consent to be part of the study by informing them what the study was all about as well as assuring them of their right to participate or not to participate in the study. They were also informed of their right to withdraw from the study.

3.10.3 Confidentiality

The participants were not required to reveal their names or besides general personal identity and their responses were treated with utmost confidentiality. This helped protect subjects' interests and personal rights. As such, codes (participant 1) were used.

3.10.4 Disclosure

The researcher provided some information about their study to potential subjects before data collection to help them decide whether or not they wished to participate in the study.

3.11 Limitation of the Study

The following limitations were faced during the research study;

At first, the participants were not willing to talk freely because they were fearing that the researcher and her research assistants were government officials who were investigating them. However, with time they gained trust and spoke freely.

Secondly, other participants would cut the interview short and leave before the whole completion of the interview. Time and cost factors were also major genuine challenges faced by the researcher. Nevertheless, some other means were devised by the researcher to overcome these limitation to maintain the effectiveness of the data collection stage. Some of the devised strategies included assurance of 'confidentiality of the information given in order to winner the confidence of the participants, working extra-time in order to overcome the time limitations'.

3.12 Measures to Ensure Trustworthiness

The following measures to ensure trustworthiness of the data were followed;

3.12.1 Credibility

Credibility is principally concerned with questions like, 'How congruent are the findings with the reality' (Shenton, 2013). According to Guba and Lincoln (2012), guaranteeing credibility in a study is one fundamental ingredient in ensuring trustworthiness. In this study, the researcher and research assistants were fully cognizant that most of the rural women could not read and write in English but they were Knowledge Holders (KH). As such, the researcher and the research assistants made sure that they simplified and/or translated the questions to the languages that the participants were comfortable with. In this regard, the researcher made sure that the translation was accurate by liaising with language experts in the field of the language translated.

3.12.2 Confirmability

In research, confirmability denotes esuring efficacy of the study (Edgerton, 2012). Similarly, confirmability speaks to the 'objectivity or neutrality of the data' collected by the researcher. Additionally, this 'objectivity and neutrality' was pursued by the researcher to ensure the 'checks and balances on whether the data is relevant and is meaningful'. In that way, the research team made sure that the data collected and deduced findings of the study are accurate and indeed reflecting the views expressed by the participants during data collection. To guide against misrepresentations, the research team made sure they previewed the study outcomes through replaying the tape recordings and proof-reading interview notes to make sure the study findings are a true reflection.

3.12.3 Neutrality

According to Nachmias (2011), neutrality is 'not supporting either sides or impartial'. In other words, this means that the researcher would be impartial and not take a side of some participants during the data collection and analysis process. In this way, the

research teams' bias and interest were not incorporated but only the views of the participants interviewed. During this process, the research team pledged and remained bound by the duty of good faith. The reporting was done without any feelings attached.

3.13 Chapter Conclusion

This chapter gave a description of the research methodology used in the study. The chapter clearly outlined that the main thrust of a 'research design is to maximise valid answers to a research question'. The study data was collected by using an exploratory qualitative design. In that regard, data was collected by means of open-ended questions, focus group interviews and non-participant observation. Ethical considerations were also factored in to meet the African values and protocols which are key and acceptable in collecting data among indigenous rural communities of Allandale. In the process, the researcher ensured that the participants were morally and ethically protected from the beginning up to the end of the study. The next chapter presents and analyses data that was collected using the summarised methods given.

CHAPTER FOUR

PRESENTATION OF FINDINGS AND ANALYSIS

"The exploitation of Africa, Asian and Latin American countries by the core capitalist nations of Europe through colonial and non-colonial linkages like globalization is identified as the root cause of underdevelopment of health and medical care resources of those nations. Africa had its own system of health care before the advent of colonialism and the introduction of western medicine".

(Yankuzo 2014: 5)

4.1 Introduction

This chapter builds from the previous chapter of how data was collected and presents the findings and its analysis. The findings are mainly qualitative and were collected using the following methods; open-ended questions, focus group interviews and non-participant observations. The chapter answered the research questions that were introduced in chapter one of the study;

4.2 Demographic Background of Participants

A total of 21 participants took part in the study. This was made up of nine (9) rural women, seven (7) traditional practitioners (diviner [2], herbalists [2], traditional birth attendants [2] and faith healer [1]), three (3) elderly people and two (2) western trained doctors. In addition, nine people participated in focus group discussions – all drawn from the groups above.

The table below summaries what has been said above.

Table 2: Demographic Background of Participants

Category	**Age**	**Marital Status**	**Number**
Rural women	Ranging from 18 – 35 years	4 married, 2 unmarried, and 2 single mothers	9
Traditional practitioners	28, 32, 33, 35, 48, 49 and 51 years	4 married 3 unmarried	7
Elderly people	58 – 72 years	1 divorced 1 Widow 1 married	3
Western-trained doctors (1 male; 1 female)	36 years 42 years	Both married	2

4.3 Africa Traditional Medicine

The researcher did not want to make an assumption that people understood what traditional medicine was in Allandale villages. In that regard, she posed a question to participants to get their views, understandings and convictions of what it was so that whenever they mentioned of African traditional medicine, it would be clear what they meant. The researcher was surprised with the responses that came out. The diverse

responses given by participants indicated that African traditional medicine include the following in diagnosing and effecting healing on a human being: plants, animals, minerals, spiritual connections with deities and sacred movements or exercises. This matched with the definition given by Elujoba (2003) which alludes that African traditional medicine is defined 'as the health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being'. Rosa and Alves (2014) stipulated that,

> "The connection between eating and healing is common in traditional folk medical systems, and the multiple possibilities resulting from the combination of biodiversity and culture confer a wealth and complexity in terms of knowledge of the flora and fauna as to their potential as food medicine."

The researcher learnt that use of plants, animals and minerals for healing purposes is part of Allandale traditional knowledge which is becoming more relevant to discussions on conservation biology, public health policies, sustainable management of natural resources, biological prospection and patents. The researcher also noted that most of the traditional practitioners were secretive and did not wish to disclose the contents of their preparations and products to the researcher for fear of piracy and rendering the medicines impotent or ineffective. In that regard, the researcher did not disclose in this study all these in cases where they disclosed to the researcher in confidence.

The African traditional practitioners noted that for one to have better understanding of African traditional medicine, one should have a good understanding of the causes of diseases in the African set-up. The following are the responses from the exploratory inquiry the researcher had with the participants:

4.3.1 Spiritual Causes

'Evil thoughts, evil desires and machinations by enemies (i.e.by remote influences, for instance, hypnotism) including soul projection or evil telepathic messages are all grouped together under spiritually caused diseases'. Illnesses caused by black magic or witchcraft are classified into this class.

4.3.2 Physical Sicknesses

These are maladies caused by harmful components entering the human framework through substances, drink, skin, and so forth. These causes for such ailments are baffling to most Western-oriented health practitioners.

4.3.3 Mental or Psychological Causes

Grouped under this title are sicknesses caused to an individual when his/her will is not in congruity with the laws of nature. The infected body is said to be influenced by an unhealthy condition of the psyche. Few people will in general trust that they are incapacitated when it is established that nothing is not right in their mental system.

4.3.4 Esoteric Causes

These are diseases starting from the spirit, or those caused by the deeds of a person in his previous life (before rebirth, reincarnation).

4.3.5 Astral Influences

'It is known in occult science that the radiations from cosmic agents e.g. sun, moon and planets have influence on human beings either for good or evil. The moon is said to influence the mind, and it is said that therefore mentally deranged people turn out to be wild and act irregular when the new moon shows up. It is largely accepted, in Mpumalanga as well as in some parts of Southern Africa that mentally disturbed people turn out to be progressively vicious at the introduction of the new moon.

Having been well informed of the causes of sickness within the African setup, the participants explained what constitutes African traditional medicine as indicated above. Their responses are discussed in the themes below.

4.3.1.1 Plants

Among participants who indicated that African traditional medicine is derived from plants, indications were that most medicinal properties are derived from different parts of a plant including 'leaves, roots, bark, fruit, seeds, flowers'. Besides the healing power that is contained in such different parts, they indicated that different parts of the same plant can contain a variety of different active ingredients. As such, one part of the plant could be highly toxic to the human body while another part of the same plant could be very harmless and be used medicinally or as food.

Most herbalists indicated that this hidden knowledge of the plants that can be used as medicine is sacred and such knowledge is passed from generation to generation through word of mouth. The utilisation of plants goes back a huge number of years to the earliest organisation of human culture into clans, groups, orders, and other social gatherings. Throughout the centuries, individuals found, utilised, and shared regularly expanding learning of psychoactive plants and growths and their belongings to the human body, mind and soul. African health practitioners indicated that that the plant world offered nourishment, dress and shelter, as well as curatives, pain killers, narcotics, stimulants, and mind-changing passage into other mental conditions of being and understanding.

The pictures below clearly illustrate some of the plants the researcher was able to capture during the data collection phase after proper African rituals were followed. The researcher did not disclose the procedures of making the African traditional medicine for reproductive health care as a way of protecting and respecting their indigenous

knowledge from being stolen and patented by unscrupulous people. In that regard, the open-ended questions with African traditional health practitioners unveiled that medicinal properties can be derived from the plants parts as discussed below:

Figure 1: Bark of a Plant (Tree)

By bark, the participants meant the defensive external layer of a tree trunk that is framed by layers of living cells over the wood. Ingredients that are used for healing are frequently found in higher composition in the bark area.

Figure 2: Bulb or Knob

According to health practitioners, this is as a fleshy structure containing various layers of leaf bases also called bulb or knob scales. Onion species and garlic bulbs or knobs are well known for restorative , preservative or medicinal uses.

Figure 3: Oil

These are denoted as ‘volatile’ or non-volatile oils that are taken from plants utilizing different African formulas or process. Known examples include pregnancy oil for belly stretch marks. Some of the oils are crushed and pressed from the seeds or fruits of plants and are insoluble in water. castor oil, olive oil, and safflower oil.

Figure 4: Flowers

The flowers or blooms of plants have dependably been well known in African traditional medicine. Some examples of these include clove and chamomile blooms. Flower parts are additionally utilized, for example, saffron stamens, the stigma of maize or millet, or pollens.

Figure 5: Fruit

Fruits have been intensely utilized for healing purposes. Fruits of many plants are encouraged to be eaten by pregnant mothers as food but at the same time carrying some strong healing effect.

Figure 6: Leaf

The leaves of plants, bushes, and trees can be utilised for African traditional medicine. These leaves, can be utilized or can be blended with twigs, stems, and buds.

Figure 7: Resins

These are a mixture of fundamental oils and terpenes that are normally not dissolvable in water. They are discharged by particular cells or in conduits of plants. Known resins include, myrrh and frankincense.

Figure 8: Roots

The ‘fleshy or woody roots’ were noted to be used by African health practitioners for medicinal purposes.

Figure 9: Rhizome

Rhizomes are known as a fleshy or woody lengthened stem that generally develops on a level plane beneath the ground. Rhizomes frequently produce leaves over the ground and roots into the ground. A few therapeutic plants are utilized fundamentally for their rhizomes including: ginger, wild columbine and bloodroot.

Figure 10: Seed

The seeds of numerous plants are utilized for their therapeutic properties. Seeds might be contained inside a fruit.

Figure 11: Tuber

A tuber is characterized as a ‘swollen, fleshy structure’ growing underground. Tubers mainly stem origin. However, originally they can be partly stem and root. Tubers utilized for medicinal use include among others the African potato.

4.3.1.2 Animals

The participants who spoke about animals’ use in African traditional healing indicated that ‘entire organisms or their flesh, fat, excretions, bones, teeth, feathers, hair, horns and shells’ are utilised as African traditional medicine in Allandale. Neto (1999) stipulates that researches on ‘animal based medicines are sporadic, despite the fact that traditionally many animal based drugs are administered all over the world.’ Health care practitioners and other knowledgeable elderly women indicated that ‘animal based medicines have always played a significant role in the healing practices, magic rituals, and religions of indigenous communities in Allandale’. In the modern world, the healing of persons’ ailments using therapeutics taken or derived from animals is termed zootherapy (Eraldo & Costa-Neto, 2005).

Some elderly people noted that folk traditions in the past were spread by oral literature through generations on the use of fauna for ailments such as ‘asthma, night blindness, paralysis, leprosy, impotence etc’. In that regard, they could speculate and not say precisely that the use of animal organs were in some exceptional circumstances used for transplantations. The researcher probed through it and merely got few examples like the use of goats or sheep eyes. The others noted that some great African practitioners were known for forging various tools used for ‘diagnostic purposes as well as surgical management’. On the other hand, in the past, people were encouraged to keep as many pets as they could at a household as it was noted to contribute to the healing of people in the home. Pentenero (2001) stipulates that by ‘playing with pets, children learn how to be respected, how to develop by themselves, and how to face new changes and situations’.

a) Flesh and Blood

Participants noted that flesh and blood of animals is used as medicine in many occasions. Some traditional practitioners noted that roasted flesh of some animals is used to cure diseases and the blood used to massage some parts of the body to bring healing.

b) Fat and Excretions

Fat and excretions of some animals was used for healing through applying it externally to the body.

c) Bones and Teeth

Bones and teeth of different animals were noted by practitioners to treat diseases. For example, horns of different animals are used for the purpose of bloodletting.

d) Feathers/ Fur/ Skin/ Hair

Traditional practitioners noted that the skin of animals is used for many things in the treatment of many diseases.

e) Horns

Traditional practitioners noted that different horns of different animals are used for different healing purposes. These practitioners noted that even though horns of animals could be used independently for healing, they are generally used together with other medicinal ingredients. They could not mention any animals for the purposes of trying to protect conservation and not disclose the secret but mentioned they treat they following;

- Treating “hot blood”
- Balancing body temperature
- Eliminating poisons
- Controlling fever

f) Shells

A shell was noted by traditional practitioners to be a form of medicine. A shell is generally defined as a hard external covering, mainly of animals. Participants noted that some shells could be used to prepare medicine that one could drink or apply on their bodies. On the other hand, some noted that shells should be made to music tools that had supernatural powers through the melodies that it emitted.

4.3.1.3 Spiritual Connections with Deities

Participants noted that spiritual connections were considered as medicine and/or a form of healing. In this regard, some traditional practitioners noted that since time immemorial, ‘steam therapy’ has been used by traditional practitioners around Allandale village to ‘improve and maintain good health and beauty’. These traditional practices incorporated diverse forms of steam therapy but concentrated on one ‘whereby a

woman squats or sits over steaming water in a bucket or basin containing herbs.' Another one mentioned included one where the patient was covered totally by a cloth under a smoking prepared medicine. One diviner said the following;

> "Is a unique blend of herbs specially formulated to relieve discomfort associated with the female cycle, provide relaxation and detoxification, and reconnect women with the wisdom of their bodies."

> *Iku hlanganisiwa ka matluka yo hlawuleka lawa ma endleriweke vavasati leswaku vati tshuxa eka kutwa kuvava loku va hlanganaka na kona kaku kongomana na vona ntsena. Swi nika ku wisa naku susa leswi nga lavekiki e mirini wa wansati swi tlhela swi vuyisa vutivi bya yena na miri wa yena nakambe.*

In addition to the above, some traditional practitioners noted that the use of African x-rays as medicine to bring healing was also key. In that regard, diviners were noted to specialise in that form of healing as they noted in connected them with the ancestors.

a. Sacred Movements or Exercises

Figure 22: *Mchongolo* Dancers – Exercising

Participants noted that *mchongolo* dancing is also medicine for reproductive health. In addition to the concoctions which they drink, the exercises done through dancing are 'expressed in a more aerobic or dynamic way'. The elderly participants noted that the dances are particularly operative for supporting the reproductive immune system of both men and women. In addition, the *mchongolo* sacred space and its spirituality are used alongside the dance to 'heal the mind, body, and spirit.' This is in line with what Hanna (1995) noted when she said;

> "Dance involves the culturally mediated body, emotion, and mind. So do illness and pain. Dance may promote wellness by strengthening the immune system through muscular action and physiological processes. Dance conditions an individual to moderate, eliminate, or avoid tension, chronic fatigue, and other disabling conditions that result from

> the effects of stress. Dance may help the healing process as a person gains a sense of control through (1) possession by the spiritual in dance, (2) mastery of movement, (3) escape or diversion from stress and pain through a change in emotion, states of consciousness, and/or physical capability, and (4) confronting stressors to work through ways of handling their effects."

In light with the above, the participants noted that with *mchongolo* dance 'old women become young again.' In that way, they noted that they will still be able to conceive through exercising and the spirituality of the dance.

4.4 Factors that Lead Rural Women to Use Traditional Medicine

The above themes explored what traditional medicine is generally according to the participants in Allandale village. Also, it explored how Allandale village women understand reproductive health. The researcher made a conclusion from the information that she got that with regards to reproductive health, rural women rely on African traditional medicine than men. This is in line with Buor (1993) and Fosu's (1981) findings that unveiled that;

> "Women are less likely than men to consult modern health services, less willing to wait longer than men to seek treatment when ill, less reluctant to spend limited resources on their own needs, and often cope with illness by self-treatment or consulting traditional healers."

Having laid such a foundation and uncovered such information, the researcher went on to ask the Allandale rural women the factors that make them to use African traditional medicine for reproductive health. The researcher learnt that they were both pull and push factors that made Allandale village women to resort to African traditional medicine

for reproductive health. The findings reveal the both the pull and push factors simultaneously. Push factors refer to circumstances or conditions 'which force people' to resort to African traditional medicine. On the other hand, pull factors are the circumstances or conditions 'which attract people' to resort to African traditional medicine.

4.4.1 Push and Pull Factors

With regards to the push factors, most participants indicated the following as the factors that influenced their use of African traditional medicine for reproductive health issues; easily accessible, less costly, more effective and that its part of their cultural heritage. These factors are discussed below;

4.4.1.1 Easily Accessible

According to participants, it is accessible. Accessibility is defined to mean people's 'overall ability to reach services and activities'. The participants who indicated that African traditional medicine was easily accessible in Allandale village cited the following reasons to show is accessibility; found in every community, closeness to home, absence and/or distance of hospital/clinic. These are also discussed below;

a) Found in Every Community

Some participants noted that the majority of caregivers obtain African traditional medicine from relatives, friends and health practitioners. Moreover, they indicated that this African traditional medicine is all over the communities around Allandale village and is even obtained from the village farms or backyard of the homes. The researcher also observed various indigenous plants growing at the backyard, close to the water source or outside toilets. Some of these plants appeared as decoration (just like flowers) to

beautify the place but in actual fact they were African traditional medicine. The picture below was one of the pictures the researcher captured;

Figure 23

b) Closeness to Home

One woman in the focus group interviews noted the following about African traditional medicine being close to homes:

> *Murhi lowu wa matluka wu kumeka lula ngopfu, xikombiso loko sweswi ndzo hlaseriwa hi vuvabyi bya vusati eka nkarhi waku ndzi bihile e mirini, ndza kota ku jika hi yindlu ni lava matluka lama ma tivekaka. Nawu sila ivi wu kota ku tirhiseka hi tlhelo rin'wani loko no lava mirhi leyi yi tirhisiwaka swibedlhele nita boheka kufamba niya ndzhawini ya vaongori kunga kliniki leyi ngale kule ngopfu swinene kambe na ndlela ya hina ayi kahle hambi ku omile kungari na mpfula aku fambeki.*

"Herbal medicine is more accessible to me because, for instance, when all of sudden I am attacked by vaginal infection during pregnancy, I just look around my backyard for some known leaves (The tree was withheld for secrecy), grind it and use it. If on the other hand I want to access orthodox medicine, I would have to walk from here to the clinic which is very far (more than 10 km).You know our road is very bad, whether in the dry or rainy season".

c) Distance (in Kilometers) to the Nearest Health Facility

According to most participants in the study, Allandale village only has few hospitals around it. The distance that patients travel to their nearest facility is long for poor indigenous people.

A seamstress who took part in the open ended interviews stressed that:

"African traditional medicine is closer to me than orthodox medicine because the doctors and nurses are inadequate. Look at the situation when one or two midwives stationed at the clinic attend to people in the other villages. We mostly see them only once in a week and by chance. If there is any emergency or serious illness, how will they assist me when they are that busy. This is very bad".

Murhi wa xintima wule kusuhi na mina ku tlula wa xilungu hikuva dokodela na vaongori va kala. Languta xiyimo xaku loko kuri na un'we loyi angana vutivi bya vanhu vo biha mirini va vekiwe e ndzhawini ya vuongori ku languta vanhu lava vangale ka switikwana swin'wana swale kusuhi, hina hiva vona kanwe a vhikini loko swi kotekile. Loko

kova na mhangu kumbe vuvabyi bya nkoka bya xihatla vata kota njhani kuni pfuna vari karhi vangari na nkarhi na vona, swa tika leswi.

In that regard, the majority of participants agreed that the distance in kilometres made most rural women to prefer African traditional medicine. It is only in serious situations wherein African traditional practitioners would have failed that they resort to clinics and hospitals. In other cases, it was observed that the participants would first go to African traditional practitioners and thereafter rush to the clinic and hospital. Some noted that this was important because African traditional practitioners would address the spirituality of the matter and then nurses would attend to the physical body challenge.

4.4.1.2 Less Costly

The researcher noted that one of the factors why Allandale villages women consult African traditional medicine for reproductive health was because it was less costly. Furthermore, the researcher was made aware that there was 'no specific tariff set by any regularatory body' determining the costs for consulting traditional practitioners. Almost all Allandale women who took part in the study said that the services of acquiring African traditional medicine from traditional practitioners are cheaper than what they pay for western medicine when they consult for reproductive health. One faith healer (also referred to as prophetess by some) mentioned that she works close to surgeries around Thulamahashe and found that her charges are by far very lower than what patients paid for medical services with regards to reproductive health. When asked about how she charges compared to the western doctors whom she knew, she noted that her rates for payment for consultation services varied from R50 to R150 and were a once off payment compared to western trained doctors who charged about R450 to R600 per every consultation.

A female teacher who stays in Allandale from focus group interview had this to say:

> "With what I have seen in life, I think traditional medicine is cheaper. I am saying this because even the nicely packaged herbal medicines in the drug stores cost much less than the western drugs. You can't tell me that African traditional medicine meant for treating reproductive diseases is more expensive than the orthodox ones meant for treating the same ailments. For instance, I pay more than R 1 500 for examination for child-bearing tests and no medication for it. Meanwhile …. (herbal product for treating bareness) cost R 250 or better still I can boil some tea leaves and the bark of ….(name withheld) tree and drink without paying for it".

> *Hileswi ningaswi vona la vuton'wini ndzi hleketa ku murhi wa xinto hi wona wo xaveka, ni vula leswi hikuva na leyiyingale switoloyinga vekiwa kahle na yona ya xaveka kuri naya xilungu. Ungeni byeli ku murhi wax intima waku tshungula vuvabyi bya vu velekelo wule henhla hi nxavo ku tlula wa xilungu wo fana na wona waku wu fanele wu tshungula swaku fana. Ahinge ni hakela mali yo ringana R1500 ku hloriwa kaku bebula n'wana ninga nikiwi swaku hanyisa kumbe murhi mara matluka yaku horisa vunyumba swinga lava ni humesa mali yo ringana R250 laha ningata kuma na matluka yo sweka nin'wa na mahanti ya nsinya wokarhi ninga hakelangi.*

The researcher also learnt that the differences between rural and urban charges that were offered by the above-mentioned prophetess were based on the fact that rural women were perceived to be poorer. In that regard, whenever Allandale rural women consulted the prophetess, it appeared they were allowed to negotiate based on what the client (patient) was able to afford. It also emerged through the focus group discussions

that the inability to pay for services by patients in Allandale village did not impede them from getting health care. Some women even noted that in case one was not having money, they could pay in kind or defer the payment for a later date.

One young mother who had two children noted that,

> "In most cases, our traditional practitioners do not charge fees for their services, but rather accept gifts as token of appreciation from their clients after they have been successfully treated. In some cases, we even pay by instalment and the prescription of payment is according to level of income or rather one pays in kind".

> *Hi xitalo, vanhu lava va tshungulaka swa xintima ava hakerisi loko vaku pfuna mar ava pfumela ntsena tinyiko ta mikhenso ku hum aka vanhu lava vava pfunaka ntsena loko munhu a hanyile. Kotala hi laha hi hakelaka ka tsongo ka tsongo na kona ko tala va langutisa xiyimo leswaku unga kota ku hakela ku fika kwini kumbe a hakela hi vunene nakuti twela.*

The study findings in Allandale showed that most families adhered to cultural practices regarding the handling of reproductive health. Lewin, Hodgkinson, Wates, Prempeli, Beers & Feinberg (2015:143) note that 'cultural practices are the basic world view and life ways of a group of people, this lifeway's expectations must be adhered to and fulfilled because they determine interventions needed'. As such, the majority of the Allandale populace survive on low income or none at all. Hence they would prefer African traditional medicine as it is less costly.

4.4.1.3 More Effective

From the interviews conducted with knowledge holders (traditional practitioners), the participants noted that African traditional medicine was mainly preferred by Allandale village women because it is more effective in use. Of the many benefits they gave, the following emerged; improved health and safety. These are discussed below;

a) Improved Health

Almost all traditional health practitioners agreed to the fact that African traditional medicine has incredible benefits in relation to their women patient's wellness and improved health. One woman herbalist indicated that,

> "My African traditional medicine improves health of women because my medicine is plant-based and has active ingredients. When treating an illness the health of the body is improved".

> *Murhi wa mina waxi ntima wu antswisa rihanyu ra vavasati lava va lavaka murhi wa vusati hikuva murhi wa mina iwa swimilana naswona wu tlharihile loko swita kaku tshungula vuvabyi bya rihanyura miri wu antswisiwa.*

The herbalist also said that African traditional medicine was 'an important benefit for unlike western medicine, which treats just a symptom; traditional medicine helps to improve other aspects of the body'. The researcher noted that African traditional medicine has the holistic healing effect thus helps in improving health as it does not only focus on the part that is not all but addresses the root cause of the sickness.

b) Traditional Medicine is Safe

All the traditional practitioners interviewed shared the sentiments that African traditional medicine is safe, especially the one for reproductive health of women. One traditional birth attendant indicated that the good thing that attracts most women in Allandale to African traditional medicine is that it is free from side effects compared to western medicine. When the researcher asked whether African traditional medicine was really free from side effects, she indicated that despite some side effects that people speak of but if administered correctly it does not carry any side effects.

Perception of safety and efficacy of African traditional medicine among Allandale women varied. When quizzed of their views, the following answers came out;

- Most African traditional medicine is not safe for reproductive health;
- Most African traditional medicine is natural;
- There are illnesses or conditions for which African traditional medicine is more effective than Western medicine; and
- There are reproductive ailments or conditions for which African traditional medicine can only cure and not cured by Western medicine

According to Darko (2009), the 'functional scope of each medical system is largely determined by its ability to get results in specific cases of illness'. According to some participants, the weaknesses in African traditional medicine include unclear measurements and preparations, which could cause overdosing and enhance harmful effects on the reproductive health of women.

As such, the prophetess in the open-ended interview noted that people who used African traditional medicine under guidance of the genuine healers and not charlatans found it to be safe. When asked if the issue of integrating African traditional medicine and western medicine could help carter to do away with side effects, she raised a comment that was ‘cautionary relating to physical wellbeing and traditional medicine’. She indicated that complications emanate in such cases where patients seeking reproductive health mingled African traditional medicine and western medicine for cure. In elucidating this challenge, she confidently noted that some patients sought cures from traditional practitioners for reproductive challenges. Nevertheless, in cases where they think that it is taking too long to work, they would abandon traditional practitioners and consult western doctors. Her analysis for that was African traditional medicine ‘could not work simultaneously with western medicine’.

From her 20 years of experience, when patients mingle these two systems, the reproductive health challenge worsened as she regarded it an abomination. Contrary to the prophetess’ submissions, the majority of the indigenous women users of African traditional medicine in Allandale agreed that ‘the integration of African traditional medicine into modern health care system could help address most of the myriad problems confronting the modern health care system, reproductive health’. In support of this, a young female diviner in the focus group contradicted the prophetess’ submission by noting the following about the above issue;

> “There is no need to leave one system behind because one hand alone cannot cover one’s face and one head does not make decisions. We need to pull each of them along so that what one system cannot solve, the other will or better still, the two practitioners will collaborate to remedy the situation. After all we always say that united we stand, divided we fall.”

Aswi bohi ku hi tshika ndlela yin'wani ndzhaku hikuva xiandla xinw'we axikoti ku pfala xikandza xa munhu nakambe nhloko yin'we ayi endli swiboho.hi fanele hi koka hinkwato tindlela leswaku loko ndlela yin'we yinga koti ku lunghisa leyinga kona yin'wana yita kota ku tirhisana ku kota ku lunghisa xiyimo. Hiri loko hi hlanganile hinga kota ku pfuna kambe loko hi hangalakile swinge koteki ku humelela.

4.4.1.4 Allandale Cultural Heritage

With regards to African culture, one diviner noted the following;

"Culture plays a very important role when one is living their lives in a society. A person can be seen that he or she is from a certain culture by the clothes they wear and cultural behaviour. With regards to medicine, most cultures, still today they believe that traditional medicine is the only remedy that cures and with youth growing up in this century wherein western medicine has taken over it becomes difficult for them to visit an African traditional practitioner".

Ndhavuko wu tlanga xiyimo xa nkoka lexikulu loko munhu a karhi a hanya e ndhawini yaka vona. Munhu iwa vonaka swaku I huma ka ndhavuko wihi hiku vona mambalelo na vutikhomi bya yena. Loko swita ka murhi, ka mindhavuko yo tala na namuntlha va tshemba eka murhi wa xinto kuva kuri wona lowu kotaka ku tshungula. Nakona vana lava va kulaka eka masiku ya namuntlha laha murhi wa xilungu wunga teka ndhawu swava tikela leswaku vangaya eka munhu loyi a tshungulaka hi swa xintima.

Most participants in the study believed that African traditional medicine is well accepted by the community as it is generally part of their cultural heritage. Whilst one of the orthodox healthcare professionals interviewed strongly believed that African traditional medicine is well received and also accepted by the community of Allandale. However, she gave three categorises with regards to her experience with some patients who come to their clinic;

- Most of the women somehow believe in it, and
- None of them do not believe at all.

When asked to substantiate why she had said so, she indicated that,

> "The reasons for such belief and no absence of belief was because of such as high public patronage, efficacy, affordability and long usage by forefathers".

> *Xivangelo xo tshemba noka vanga tshembi hikuva nseketelo awuri henhla, ku humesa mihandzu leyinene ya kahle, ku kumeka hi nxavo wale hans naku tirhisiwa hiva kokwani vahina lava vanga famba khale la misaveni.*

One *sangoma* noted that African traditional medicine 'has been used from generation to generation and that society cannot do without it'. She stated the following in a focus group discussion;

> "I was born into African traditional medicine. This is what has really entered my body and I am used to it. This is because we the people in the rural areas were trained with African traditional medicine and so it has become part of our lives. It is our food, our snack and our everything."

> *Ndzi beburiwe eka murhi wa xintima. Murhi lowu hi wona wunga nghena eka miri wa mina nakona se ndzi toloverile. Leswi swi endla hiku hina vanhu vale matiko xikaya hi kurisiwe hi dyondzisiwa hi wona se swi endla leswaku hi kota ku hanya hi swona. I swakudya swa hina, na swaku hungasa hi swona eka hina I swilo hinkwaswo.*

This *sangoma* noted that what they do with traditional medicine is not for profit making but to serve humanity with their gifts. She showed why women preferred their African tradition medicine than western medicine with what she said;

> "Herbal medicine is more accessible because sometimes you will walk through pain and climb the clinic hill and there will be no nurse to attend to you. Sometimes they will insult you, as if you have committed a crime. When it happens like that you will not even feel like going there again".

> *Murhi wa matluka wu kumeka lula hikuva eka minkarhi yinwana uta famba ukarhi utwa kuvava u khupuka na swiganga uya endzhawini ya vuongori u kuma ku kuhava vatirhi vakuku ongola. Minkarhi yinwani vataku rhuuketela, swi endla ngaku hiloko u johile. Loko swi endla tani ungehe tsakeli ku tlhelela nakambe.*

In line with what this *sangoma* said, most women agreed that poor human relations of western trained medical practitioners, 'the complex registration processes one has to go through before consulting a doctor, laboratory tests and the long procedures of getting medications as restrictions which make western health care system less desirable and therefore push women to African traditional medicine'.

On a different note, most traditional practitioners strongly felt the Allandale community is part of them and benefited them and their community through their services. Unlike western trained doctors who were cited as money mongers, traditional practitioners live in their communities and are able to render services immediately as they have an attachment to the clients. Though most of them 'charge' for their services, they do so as a token of appreciation and do not feel as though they were commodifying their traditional medicine – this was emphasised and deemed so because their charges are deemed reasonable. More so, the traditional practitioners noted that they are merely 'custodians of African knowledge and this knowledge of African traditional medicine was for communal benefit'. One young lady participant said the following in a focus group,

> "Culture defines who we are and it plays a very important role in our lives. Traditional medicine and culture they go together, yes we as youth we do not value traditional medicine but because we are still living with our grandmothers we still use traditional medicine and that too help us but I do not think traditional medicine is the best remedy for certain diseases."

> *Ndhavuko wu kota ku hlamusela ku hi hina vamani, wuna nkoka eka vutomi bya hina. Murhi wax intima na ndhavuko swi famba xikanwe, inah ku hina lavanthswa ahi voni nkoka wa murhi wax into mara hiku hi tshama nava kokwana wa hina va xisati hawu tirhisa murhi wax into*

nakambe swahi pfuna mara ani hleketi ku murhi wax into wu kahle ka man'wana mavabyi.

The researcher noted that the realisation that most Allandale women were raised through the use of African traditional medicine makes them defenceless and render their objections unsuccessful to its use as it is part of their culture. However, some Allandale mothers displayed 'some sense of trust, belonging and pride in their tradition'.

4.4.1.5 Lived Experience by Women

Recurrently, Allandale women underscore the strength of 'living experiences' where they have learnt more about their reproductive health illnesses. It is during this period that women become more receptive to information given by those who are more experienced than them. The general perception presented was that with reproductive health, most women in Allandale 'acknowledge their inexperience, and allow more knowledgeable and experienced elders to guide them through the necessary processes'. One participant noted that,

"A lot of mothers here in Allandale constantly consult with elders when their children are ill, in search of advice. It's in exceptional cases where they conceal but once they open one, elderly women are there to teach them how to go about it".

Va manana vaku tala la Allandale va vulavurisana na lavakulu loko van ava von ava vabya, va lava ku pfuniwa hi miehleketo. Aswi talanga ku va fihla mara loko va pfula va vulavula hi swona, lavakulu va xisati va kona kuva dyondzisa maendlelo ya swona.

The study unveiled that most of the elderly people they consult with always lead them to use African traditional medicine. At the end, these junior women gain new knowledge and 'personal experiences', thus empowering themselves with some expertise which in turn they will pass to their juniors. The researcher also noted that 'young mothers may also learn from experiences of those around them.' In that regard, women actively participate in the care of that child or their relative's reproductive health challenge and in the process acquire the much need experience.

4.4.1.6 Education

The majority of participants noted education as a factor that influences whether one should use African traditional medicine or not. Falconer, Wilson, Asante, Lartey, Acquah, Glover, Beeko, Nketiah, Ossom & Lamptey (2012) submit that the level of education of patients is 'a determinant of the use of African traditional medicine'. In other words, Falconer and colleagues emphasise that there 'is a strong inverse relationship between educational attainment and the use of African traditional medicine'. The participants in the focus group discussion echoed similar sentiments by noting that Allandale rural women 'with little or no formal education patronise African traditional medicine more than those with higher education'.

A young mother noted the following about issue of education;

> "Most of us have not been to school and we cannot read the instructions (prescriptions) on the orthodox medicines. But herbal medicine is our own and we can use it well, whether we can read or not."

> *Votala va hina ahi yanga xikolweni nakona ahi koti naku hlaya milawu leyi pimiweke ya matirhiselo ya murhi wa xilungu. Kambe murhi waxi*

ntima iwa hina ha kota kuwu tirhisa kahle hambi loko hi kota nakuka hinga koti kuhlaya.

The researcher was made aware that most women are at cross-roads because of lack of education when it comes to choices of using African traditional medicine. It is because of lack of education that some of the Allandale women are immersed with information that carries 'hearsay, facts, stories and witnessed events in relation' to reproductive health. In addition, 'the possessors and expressers of this vast information have the ability to channel certain thoughts, actions or reactions' which lead Allandale uneducated women to make negative or positive decisions over their reproductive health. The researcher deduced that much of the education of rural women on reproductive health comes in the form of beliefs and education imposed on the by culture they subscribe to. In addition to this, numerous groups in the community also were noted to have influence on the information reception; 'family members, friends, fellow church members and health practitioners'. It was noted that these people's extended information could be overwhelming to the recipient especially when the person is facing a critical reproductive health challenge. In most cases, the information received will be contradictory and the mother has to decide fast on what to adopt.

i. Observations

I lived in Allandale for the data collection phase for about three to four months, which is a village within 15-20 minutes' drive from Thulamahashe. My participants informed me that it is an old village and had better infrastructure than some of the communities where I conducted the interviews for my honours study. For instance, I had to stay at my uncle's place where there were generators to help relieve the constant interruption of the electricity. The road was not good and few taxis operated in the area.

Many times I was exposed to African traditional medicine which people were selling for reproductive health without me looking for such information. At one time, we met some man walking around the shops selling reproductive health concoctions. We laughed our lungs out at the way he advertised some of the products. Most of the medications he had were those of sexual enhancement. He claimed that all his clients were happy and were also referring him to new clients. He said the African traditional medicines which were on high demand were the ones that boosted immunity and male sexual performance. This appeared to be true because while we were there more than ten men and three women purchased some African traditional medicine from him. On selling, some clients would come and say we want 'sweets, chappies, jacket, etc'. Upon asking him, he alluded that these are secret names that he uses for his clients so that they do not get embarrassed when buying or if someone wants to send someone to buy for them. Unfortunately, he had to send us away saying we would chase his clients away. This came up when some female youths came and started to just roam around. On asking the shop owner about her observations about the man's business, she attested that most women would come to him secretly and she attested that the African traditional medicine he was using seemed efficacious and safe as there were no complaints from clients.

On another occasion, while walking to attend *mchongolo* dance, I observed some elderly men selling African traditional medicine displayed on a table. Most of the medicine was composed of plant material that included dried cut up branches and bark. I did not spot any animal parts. These were the only occasions I witnessed African traditional medicine being sold.

At the *mchongolo* dance the researcher noticed several men and women consuming some concoctions that were in a plastic bottle. From the look of it, it seemed sour based on the drinkers' facial expressions. At first I thought it was beer but was informed by a

confidante that it was African traditional medicine. From my hasty glance, their African traditional medicine seemed to be plant products - I was a bit far from the scene where they were consuming it thus could not see properly. Upon asking I was told the African traditional medicine they were taking boosts libido and flushes out toxic substances that cause infertility through sweating and the physical exercises that the participants will be engaging in.

4.5 Meanings to Women's Reproductive Health

The researcher wanted to hear the understanding of women on reproductive health. This was key in the study so that when they start giving implications of the use of African traditional medicine, the connection of the two would be clear. In this regard, women were asked to give the meanings they attached to reproductive health. Their responses were diverse and included giving birth, menstruation, infertility, abortion, birth complications, sexual transmitted diseases and contraceptions. These responses are discussed in lengthy below;

4.5.1 Giving Birth

Some of the women indicated that they understood reproductive health as giving birth with the help of African traditional medicine. To them, when the term reproductive health is mentioned it denotes giving birth. This was so because most women were of the view that this was an issue directly affecting reproductive organs of the woman. Some participants noted that some of the women cannot give birth without the help of traditional medicine. They indicated that there are four methods of helping women to give birth. This included using traditional medicine through oral intake, anal administration, inserting traditional medicine through the vagina and taking a bath. The researcher did not probe more on this issue as it would be going much in details with information that would not relevant to the study.

.

The participants indicated that it is very common in Bushbuckridge for women to utilise African traditional medicine to help them to give birth faster. Some said that they mix the herbs and insert it in the rectum, and some of them consume it orally so that it works faster. The majority of women indicated that consuming of African traditional medicine works faster than inserting the herbs in the rectum.

4.5.2 Menstruation

The rural women also explained that when they hear of reproductive health they know that it also entails menstruation. Menstruation among African indigenous peoples is a very sensitive thing or even a taboo. This makes the menstruation period to hold negative connotations in women's lives. The participants indicated that if a woman sees her periods monthly or for the first time it means that the woman can give birth - it is a positive sign. Some respondents indicated that menstruation has negative and positive results in individual's body. Menstruation is sometimes painful and the intensity can resemble labour pain. Some women were asked if there is a way to stop the pains during menstruation and they indicated that it is possible to stop the pains. The respondents indicated that to stop the pains, African traditional medicine should be used. Some women noted that they used African traditional medicine to induce the periods. Once it is induced, the blood will come out. However, the pain would be relieved and at sometimes there would be no pain at all.

4.5.3 Family Planning

Women were asked of what they understood by the term reproductive health. The majority pointed that this meant issues of family planning. Some women answered that family planning is the prevention of the pregnancies. Family planning was noted to be a sensitive matter and decisions around it could only be the prerogative of the husband. However, because of increased awareness on reproductive rights, some women highlighted that they also took autonomous decisions on family planning. These women noted that reproductive health meant how many children one wanted to have and how

to prevent pregnancies. Two other groups also emerged and categorised reproductive health as having to do with infertility and abortion. These two categorised are discussed below;

4.5.3.1 Infertility

The first group interpreted reproductive health to mean infertility issues. In African cultures, having more children is held in high esteem as it is considered for social and economic reasons. Therefore fertility plays a major role in African women's lives. When a woman is infertile, she tends to be discriminated by her family and the in-laws'' family. Some of the women are infertile because of the uterus problems. Some of the women have fibroids in their wombs, which they referred to as 'balls in the stomach' which prevented them from conceiving.

The participants indicated that infertility could be treated with traditional medicine. One woman said the following:

> "If you take traditional medicine while you have uterus problems (reproduction health) after taking the traditional medicine the things in the uterus will be removed and the womb will be healed completely".

> *Loko u teka murhi wa xinto uri karhi uri na nkigha ya xivelekelo e ndzhaku ka loko u teke murhi wax into leswi swingale ka xivelekelo swita suka hinkwaswo nakona uta sala u horile.*

Some women indicated that there are men that are also infertile (meaning facing reproductive health issues) but traditional medicine is used to address mainly women's

issues. There are different recipes (African traditional medicine) that women consume to help them to be fertile, to solve reproductive health challenges.

4.5.3.2 Abortion

The other group indicated that abortion is the main issue that they think of when they talk of reproductive health. Among African cultures, abortion is a taboo as women are expected to have a child and not to kill the unborn child. Abortion is legal in South Africa but in African culture it is a very sensitive topic. They indicated that abortion is when a woman has an unwanted pregnancy and decides to kill that child before the world sees or knows. One African traditional practitioner said the following,

> "I do abortion secretly and use traditional medicine to help the women to remove the child out of the uterus safely".

> *Ni susa khwirhi hi xihundla ni tirhisa murhi waxinto ku pfuna vavasati ku susa n'wana a ndzeni ka xivelekelo hi ndlela ya kahle.*

Women were asked why they choose to do abortions at home (with the assistance of traditional practitioners) and they indicated that the use of African traditional medicine was safe. In addition, they indicated that hospitals are expensive and nurses judged them as opposed to indoors where they do it secretly without them being questioned, judged or condemned.

4.5.4 Sexually Transmitted Diseases/Infections (STDs/STIs)

The other group noted that when they speak of reproductive health, they will be referring to sexually transmitted diseases. In African communities like Allandale,

sexually transmitted diseases are very serious illnesses and a reproach to women. Women in polygamous marriages they are mainly susceptible to such risks. Other STDs like gonorrhoea and syphilis are taken very seriously. These have a negative effect on a woman's reproductive health. At times they lead to acute illness, infertility and long term disability, and can also facilitate the spread of the HIV/AIDS.

Some women indicated that women's reproductive organs should be cleansed to prevent sexually transmitted diseases. Most women also indicated that women should clean their vaginas after having sexual intercourse. Some women indicated that they use African traditional medicine for this because it prevented the 'absorption' of infection.

Some respondents indicated that after cleaning, every foreign substance was flushed comes out. One woman said,

> "By cleaning the vagina it is against the bad smell, there are whitish things coming out and if it is not cleaned they are smelly. When you clean the vagina it makes the vagina to be small and tight."

> *Hiku babisa xirho xa wansati, kuna swilo swo basa basa leswi swi humaka nakona loko kunga basisiwanga ku sala ku nuha. Loko u hlamba xirho xa wansati swi endla ku xirho xiva xitsongo nakona xi kota ku tlhelela matshanwini ya kona.*

It is because of the secretive nature of sexually transmitted diseases that most of these women concluded that when they hear of reproductive health, they insinuate that is concerns sexually transmitted diseases.

4.6 Implications of Using African Traditional Medicine

Since the above theme mainly focused on the advantages of the use of African traditional medicine, this section focused on the negative effects associated with the use of African traditional medicine on the reproductive health of rural women. In addition, the above section laid understanding on what is meant by reproductive health by Allandale women thus, a platform to explore the implications laid bare. Despite the disagreements by African traditional practitioners who took part in the study, the patients and western trained doctors gave the following responses:

4.6.1 Death

The study unveiled that there were cases where some pregnant women were reported to have died after taking African traditional medicine made by traditional practitioners. One western trained doctor said;

> "Personally I have a lot of faith in traditional medicine, although at times there are a lot of misgivings about it. Nevertheless, traditional medicine has its own part to play in the modern day society. People have relied on it for a long time to protect and restore their health. Even now, I think it still has a very vital rule. The side effects of it are still to be addressed so it means not all of it is suitable to our health. No matter the advantage traditional medicine has, I think it ought to be well policed and regulated in order to stop deaths caused by it."

> *Hixi mina nina ku tshemba eka murhi waxintima, hambi leswi eka minkarhi yin'wana kuna kuka yinga tshembiwi. Hambi swite tan, murhi wa xinto wuna nkoka eka kuhanya ka hina ka siku na siku. Vanhu va tshembele eka wona nkarhi waku leha ku sirhelela noaku vuyisa rihanyu ra vona. Na sweswi naha vona wuri na nkoka swinene.*

Leswi swinga lavekiki hi murhi lowu swahata lunghisiwa kambe aswivuli swaku hinkwawo murhi awu kahle eka rihanyu ra hina. Hambi murhi wax into wuri na leswinene, ndzi vona swiri kahle loko wu vekiwa milawu kahle ya matirhiselo na pfumelelo wa kona ku kuta ku hunguta nhlayo ya rifu loeri vangiwaka hi murhi lowu.

Most western trained doctors indicated that some traditional medicine prescribed by some traditional health practitioners was poisonous and highly toxic. As such, the patients consume them and get worse and it destroys some body cells and other systems important for the body to function resulting in the death of a patient. Also, the western trained doctors noted that 'the inappropriate use of some African traditional medicine is associated with liver problems which the traditional practitioners are not well versed with thus, resulting in the patient's death. Almost all the interviewed western trained doctors indicated they had encountered deaths of associated with African traditional medicine in patients' endeavours to seek reproductive health assistance. Unfortunately, the researcher could not get comprehensive details with regards whether this was indicated on the death certificate as cause of death and whether inquests into the deaths were lodged.

Some women noted that they are encouraged by traditional practitioners to eat traditional fruits or vegetables that help in reproductive health. Unfortunately, they noted that some women pick substances that are poisonous. To add, participants reported some pregnant women who were advised to eat certain species of mushrooms (African traditional medicine) ended up dying or suffering miscarriages.

4.6.2 Poor Hygiene Exacerbates Infections

Traditional practitioners were labelled by some participants as unhygienic and this at times created problems and exacerbated infections. A female teacher, who was part of a focus group discussion, indicated that because of this, it was rare for her to go and seek reproductive help. She noted the following in her argument:

> "When I decide to visit a traditional practitioner, I think twice because of their huts and the way it is decorated with those animal skins and other scary stuff. I sometimes go there covering myself so that I do not catch certain diseases or get contaminated, I can never allow them to open my vagina and insert their fingers as they are not sanitised."

> *Loko ndzi famba ndzi vona munhu loyi a tirhaka hi murhi wax intima, ni hleketa kambirhi hi mhaka ya tiyindlo ta vona la va tirhelaka kona ku sasekisiwile hi swikhumba swa swiharhi na swin'wana swaku chavisa. Nkarhi un'wana nati pfala miri lowu leswaku ninga kumiwi hi mavabyi yo karhi kumbe ku tluleriwa, ninge pfumeli va pfula xirho xa mina xa vusati va faka swintiwana swa vona hikuva ava basanga.*

Another woman in the focus group discussion noted that;

> "Reasons why I never visit traditional healer is because they never clean their huts, how can I be sure that I will not get diseases by just entering the hut? They should work on their hygienic skills or else they will not have lots of customers, especially reproductive health is key."

Xivangelo ku ningayi kuya vona vanhu vo tshungula hi xinto ikuva ava basisi laha va tirhelaka kona, nitava naku tshemba njhani leswaku ninge kumi mavabyihiku nghena ntsena eka yindlu leyi va tirhelaka eka yona? Va fanele va tirha na mhaka yaku basa handle kaswona vange kumi vanhu vaku tala vakuva hanyisa ngopfu vuhlayiseki eka mhaka ya vumunhu ibya nkoka.

Considering what participants said in open-ended interviews and focus group discussions, it became apparent that patients consider hygiene to be the first priority for their reproductive health when being attended to by traditional practitioners and in that regard they should prioritise it when handling African traditional medicine. Some participants also noted that they were worried over the fact that they might be infected because they felt that African traditional medicine was inherently unhygienic. These participants noted that despite the fact that African traditional medicine is natural and has been used in some Allandale communities for generations, it does not guarantee their reproductive safety.

4.6.3 Overdose Rise of Other Diseases

Some participants noted that the measurements used by traditional practitioners who attend to their reproductive health are not similar hence traditional medicine could lead to over-dose which could lead to other diseases. By overdosing, the participants meant the 'ingestion or application of a drug or other substance for reproductive health in quantities greater than are recommended or generally practiced'. In an open-ended interview one woman said;

"It raises a lot of questions how our practitioners measure their medicines. When I wanted a child and was not falling pregnant I was given 2 litres of medicine (name withheld). A close friend of mine went

to the same traditional practitioner with the similar problem and was given 5 litres. I really wonder if they know measurements or they just pour whatever quantities they want. There is a problem there. Because I got pregnant but my friend did not but instead had a serious running stomach where her stool was like blood. I think she had an overdose. And I don't know if she can give birth again."

Swi tisa swivutiso swo tala ku vanhu lava va tyshungulaka va kota njhani pima murhi wa vona. Loko ni lava n'wana aninga koti ku kuma n'wana ni nyikiwile ti litara timbirhi ta murhi wa kona. Munghana un'wana wa mina na yena aya eka munhu wo fana ku tshunguriwa swofana na swa mina, yena u nyikiwe ntlhanu wati litara. Swini emdla niti vutisa ku va kota ku pima kumbe va cherisa leswi vaswi lavisaka xiswona hi nkarhi wolowo, kuna nkigha kwalani. Hikuva mina ndzi kotile kuva ni biha mirini kambe munghana wa mina ive nale ndzeni laha a tsutsuma laha aswikomba ku ahumesa na ngati. Ni hleketa ku I'nwe ku hundza mpimo. Nakona ani tshembi ku iwahata kota ku pfuka a beburile vana.

In line with the above participant's view, one western trained doctor said the effectiveness of African traditional medicine may give rise to the possibility of adverse effects on the reproductive health of women;

"The clinical manifestation, laboratory findings and histological findings of four persons admitted to the hospital for acute hepatitis taking … (name withheld) preparation for months, met diagnostic criteria of toxic hepatitis. Upon discontinuation of the African traditional medicine, liver enzymes returned to normal level. So, that African traditional medicine

they were using should be considered as a causative agent in hepatitoxicity."

Swikombiso, mivuyelo laha ngati yi kambiwaka kona na mivuyelo ya laha swirho swa vanhu swi kambisisiwaka laha vanhu va mune vanga khomiwa xibedlhele eka yimiyo xo biha xa vuvabyi bya xivindzi lebyi nga lunghiseriwa tin'wheti ta mune swi hlangane na vuvabyi bya xivindzi bya xiyimo xo tika swinene. E ndzhaku ka loko vangaha tirhisi murhi wa xintima, xivindzi xi tlhelele matshan'wini. Leswi vulaka swaku murhi wa xinto lowu ava tirhisa wona wunga vuriwa leswaku hi wona xivangelo xa mavabyi lama.

Participants and doctors indicated the following adverse effects of the usage of African traditional medicine for reproductive health: digestive system upset, oil to the private organs can cause irritation, drowsiness, changes in heart rhythm, muscle spasms, skin rashes, asthma attacks, increased blood pressure, diarrhoea, euphoria, nervousness, nausea, vomiting, difficulty in urinating, dizziness, constipation, hallucinations and seizures, heartburn and general stomach discomfort.

4.7 Possible Reasons for Adverse Effects of African Traditional Medicine

Traditional practitioners noted that they are called to use African traditional medicine and are well informed of how it works. Like western trained doctors, they indicated that they also go for training as well but unlike their western- oriented practitioners, traditional practitioners graduate in the 'African way'. They indicated that it had hazardous effects if not used according to the dictates of the ancestors. Most traditional practitioners however seemed to differ with the preceding view and cited a number of possible reasons on how and where the adverse effects of African traditional medicine emanated from. These included self-treatment by patients, bogus and unqualified practitioners as well as ingesting incorrect medicines. These are discussed below:

4.7.1 Self-treatment by Patients

Participants noted that home grown African traditional medicine is easily accessible and can be obtained without prescription. Thus patients who are not expert knowledge holders use it indiscriminately. Then again, African traditional medicine is sometimes disseminated through street corner advertisements as a miracle treatment with no side effects as a way to incite individuals to buy. The patients who are desperate for healing are drawn into African traditional medicine and use it without the knowledge of traditional practitioners hence the adverse effects. Concerns about personal well-being drive some people to self-administer traditional medicine as a prophylactic to prevent the onset of certain diseases. Subsequently, countless numbers of Allandale women are pulled towards African traditional medicine and they begin self-treatment without the help of traditional practitioners.

4.7.2 Bogus and Unqualified Practitioners

Bogus traditional practitioners have penetrated communities in search of money and take advantage of the separation of people and are prescribing African traditional medicine to patients. According to these traditional practitioners, some gullible people in Allandale are attracted towards these bogus and unqualified practitioners and start taking counterfeit African traditional medicines. These bogus and unqualified practitioners do not know about dangerous plants and animals, minerals and the dosages that should be prescribed for the patient.

4.7.3 Incorrect African Traditional Medicine

There are many sub-standard ‘African traditional medicines’ that are accessible in the market of Allandale. The reason is that these medicines are not proved or inspected for quality as expected by true and genuine African traditional practitioners. Some traditional practitioners noted that some ‘medicines’ used are similar to real plants (incorrect identification of medicine by the bogus practitioner). Other practitioners noted that bogus practitioners are use ‘phoney instead of original plants’ and the adverse effects are felt. Another group of practitioners (herbalists) indicated that the improper

storage of African traditional medicine has toxic effects as they lose their efficacy and become poisonous.

Traditional practitioners also noted that it is not true that they do not have measurements. However, people seem not to be aware of the African measurements which they themselves are accustomed to. With that in the public domain, bogus practitioners memorise some measurements and prescribe them to patients with no regard for age, weight, condition and the ancestors' word. In addition, traditional practitioners also indicated that most of these bogus practitioners have no idea of the period a patient should continue using a plant as medicine (especially the reproductive plants). As a result of that, some reproductive health patients persist in arbitrarily using some plants for days, weeks, months or years leading to deleterious effects on the reproductive health of women.

4.8 Chapter Conclusion

It can be noted from the foregoing analysis that African traditional medicine is not a single element but is denoted 'as the health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being'. In that regard, it was seen to include biota that is flora and fauna. African indigenous women still use it because it is easily accessible, less costly and regarded as more effective. Despite it being part of the cultural heritage of the community, it was noted to have some negative implications on women's reproductive health. Malpractices such as poor hygienic conditions, overdose, impostors posing as traditional practitioners, self-treatment and incorrect usage of medicines resulted harmful consequences on the health of patients. The following chapter summarises the main findings, establish conclusions and outline possible recommendations on the use of African traditional medicine in reproductive health on the basis of the established conclusions.

CHAPTER FIVE

FINDINGS, CONCLUSION AND RECOMMENDATIONS

"African traditional medicine will need to be mainstreamed so that it can benefit from advances in the other sciences. It's not a science you quack... it's make-belief!"
(Anonymous, 2014)

5.1 Introduction

This study explored into the effects of traditional medicine on reproductive health of rural women in Allandale village, Mpumalanga province. The following objectives were examined: to explore traditional medicine; to determine women's perspectives on traditional medicine; to assess the factors that lead rural women to use traditional medicine; to discuss the meanings that people make about women reproductive health and to determine the implications of using traditional medicine on the reproductive health of rural women. The aim of this chapter is to discuss the findings, conclusion and recommendations of the study.

5.2 Findings

The study findings on the implications of African traditional medicine on reproductive health of rural women in Allandale village are summarised below.

5.1 African Traditional Medicine and Women's Views

The diverse responses given by participants indicated that African traditional medicine include the following in diagnosing and effecting healing on a human being: plants, animals, minerals, spiritual connections with deities and sacred movements or exercises. This matched with the definition given by Elujoba (2003) which alludes that African traditional medicine is defined 'as the health practices, approaches, knowledge

and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being'. The participants, especially the African traditional practitioners, were secretive and did not wish to disclose the 'contents of their preparations and products to the researcher for fear of piracy and rendering the medicines impotent or ineffective'. Only the general aspects of it were shared. These consisted of the fact that African traditional medicine is derived from plants ('leaves, roots, bark, fruit, seeds, flowers') and animals ('entire organisms or their flesh, fat, excretions, bones, teeth, feathers, hair, horns and shells'). Ancestors played a key role in the usage of African traditional medicine. Most users (rural women) were of the view that African traditional medicine is effective in treating and curing women's reproductive health challenges. What was worthy noting was the simultaneous use of African traditional medicine and scientific medicine to address the reproductive health challenges of women in the rural communities of Allandale.

5.2 Factors that lead rural women to use African traditional medicine

The participants in the study indicated that African traditional medicine was easily accessible in Allandale village. More so, they also cited the following reasons to show is accessibility: found in every community, closeness to home, absence and/or distance of hospital/clinic. In addition, there are no specific tariffs set by any regularity body determining the costs for consulting traditional practitioners. They would pay in kind and/or when they get the money. In other instances, they would just give a token of appreciation. Another factor on why rural women preferred African traditional medicine was because village women noted it to be more effective in use. African traditional medicine and their practitioners were noted to be a key part of the African cultural heritage hence they were more preferred as practitioners of choice unlike Western medicine with attracts 'complex registration processes before consulting a doctor, laboratory tests and the long procedures of getting medications'. Reasons such as the following were rampant;

- Most African traditional medicine is natural;

- There are illnesses or conditions for which African traditional medicine is more effective than Western medicine; and

- There are reproductive ailments or conditions for which African traditional medicine can only cure and not cured by Western medicine

The study findings also showed that the level of education of the rural women had a direct or indirect influence on the use of African traditional medicine.

5.3 Meanings that people make about women reproductive health

The researcher wanted to derive understandings of women on reproductive health. This was key in the study so that when effects of the use of African traditional medicine would be explored, the link of the two would be clear. Women were thus asked to give the meanings they attach to reproductive health. Their responses were diverse: giving birth, menstruation, infertility, abortion, sexual transmitted diseases, pregnancy preventions and family planning. The diverse views showed that women understood partly what reproductive health was. Each had a component of what constituted reproductive health and these components cumulatively created a more holistic picture on reproductive health. Thus there was no one dimensional definition to reproductive health due to different levels of awareness and interpretations in a multi-cultural set up such as Allandale.

5.4 Implications of using African traditional medicine on the reproductive health

Despite some disagreements by African traditional practitioners who took part in the study, most patients and western trained doctors indicated that there were cases where some pregnant women were reported to have died after taking African traditional medicine made by traditional practitioners. Furthermore, participants noted that some African traditional medicines prescribed by some traditional health practitioners were poisonous and highly toxic. As such, when patients ingested them, they succumbed to them due to the harmful effects of the medicine on the bodies' physiological systems. Some participants noted that the measurements used by traditional practitioners who attend to their reproductive health were not standardised. Such significant variations led to overdose and gave rise to other diseases. In defence of African traditional medicine, African traditional practitioners argued that bogus traditional practitioners have penetrated the communities in search of money and take advantage by irregularly prescribing African traditional medicine to patients. Resultantly, bogus practitioners use 'adulterants instead of original plants thus resulting in adverse impacts on the reproductive health of women'.

5.3 Conclusion

In conclusion, it is noted in the study of African traditional medicine plays a pivotal role in reproductive health care by offering a readily available, cheap, culturally-oriented and accessible health care for the rural people. However, it was noted that the use of African traditional medicine by unprofessional practitioners or incorrect usage can result in negative results that can even lead to death or bareness. With an essential framework and support, African traditional medicine could be a force to reckon with in the health care delivery of rural indigenous women with regards reproductive health care. As such, the fact that African traditional medicine has been used for a long time in indigenous communities shows that it is important and its consumers are strongly attached to it. However, there is need for this medicine to be recognised and accepted for proper use by African indigenous communities without any negative attachments to it.

5.4 Recommendations

Taking from the study findings, the study gives the following recommendations:

5.4.1 Regulation of the Use of African Traditional Medicine

The study noted that some practitioners use adulterant instead of original plants thus resulting in adverse impacts on the reproductive health of women. It is because of such adverse effects on the reproductive health of women that the formal health care system ought to introduce a regulatory framework on the use and trade of African traditional medicine. In addition, such regulatory frameworks must be done with the input of the traditional practitioners. This should result in licensing and/or control of the use of such African traditional medicines.

5.4.2 Knowledge Management and Innovation of African Traditional Medicine

The study unveiled that participants, especially the African traditional practitioners, were secretive and did not wish to disclose the 'contents of their preparations and products to the researcher for fear of piracy and rendering the medicines impotent or ineffective'. It is because of this that such indigenous knowledge is disappearing as it is no longer shared from generation to generation thus, affecting usage. The study, therefore, suggests that stakeholders both in government and private institutions ought to devote resources for the managing of African traditional medicine and ensure that the knowledge holders are acknowledged and have fair and equitable benefits accruing from their enterprise. In that way, training and educational centers on how to document indigenous plants, animals and minerals for therapeutic properties need to be organized and implemented with the help of the traditional practitioners. This will promote transactional relationships that are in line with the African values and norms of the practitioners. To add, African traditional practitioners ought to be schooled to meet the current standards of dosage administration, hygiene, branding and packaging of African traditional medicine to have universal acceptance.

Observing from the magnitude of the use of African traditional medicine in Allandale village, the pressure on the natural resources is soon going to lead to the unregulated destruction of the Africa's bioresources in the name of procuring African traditional medicine. This will surely pose stress on natural resources and the threat of extinction on the plant, mineral and animal species. Thus, the state of plant and human resource extinction needs proper management.

5.4.3 Future Research on African Medicinal Plants and their Therapeutic Properties

The current study focused on the effects of African traditional medicine on the reproductive health of rural women. In this study, many unnamed medicinal plants, minerals and animals were mentioned and said to heal many reproductive challenges. In that regard, there is a need for future researchers to focus on the types of plants, minerals and animals that are used for reproductive health. Such studies should go in-depth to assess the efficacy of such medicines and in turn introduce new drugs.

6.1 References

ABC News. (2014) . War against natural medicine . http://www.abc.net.au/news/2012-02-21/schwager-war-against-natural-medicine/3840682 , accessed 3 November 2018

Ahmed, S. M. (2005). Exploring health-seeking behaviour of disadvantaged populations in rural Bangladesh: Institutionen för folkhälsovetenskap/Department of Public Health Sciences, Solna.

Alejo, A. (2003). *Social Research Methods*. Oxford: Oxford University Press.

Alves, R. R. N. & Rosa, I. L. (2014). "*Zootherapeutic practices among fishing communities in North and Northeast Brazil: a comparison," Journal of Ethnopharmacology*, vol. 111, no. 1, pp. 82–103.

Angmo, K., Adhikari, B.S & Rawat, G.S. (2012). Changing aspects of traditional healthcare system in Western Ladakh, India . Journal of Ethnopharmacology 143 : 621 – 30.

Ashforth, A. (2005). *Witchcraft, violence and democracy in South Africa*. Chicago: Chicago University Press.

Augustine A. Boadu & Asase, A. (2017). Documentation of Herbal Medicines Used for the Treatment and Management of Human Diseases by Some Communities in Southern Ghana.

Azriani, A. B. (2008). Prevalence and pattern of use of herbal medicines during pregnancy in Tumpat district, Kelantan Malaysian Journal of Medical Sciences; VOL. 15, NUM. 3, PP. 40-48 .

Awiti J. (2014). Poverty and health care demand in Kenya . BMC Health Services Research 14.

Baez, C. (2002). *A handbook for teacher research*. New York: McGraw-Hill International.

Barbour, B. P. (2005). *Nursing research: principles and methods.* Phildelphia: JB Lippincott Company.

BBC News. (2014). Witnessing a South African healer at work . http://www.bbc.co.uk/news/world-africa-22306869 , accessed 3 September 2018.

Belew, C. (1999). Herbs and the childbearing woman. Guidelines for midwives. J Nurse Midwifery; 44 (3): 231-252.

Berg, A. (2003). Ancestor Reverence and Mental Health in South Africa. *Transcultural& utilization*. 4th edition. Philadelphia: WB Saunders.

Best, J. W. & Kahn, F. (2006). *Standards of Quality and verification. Qualitative inquiry in research design.*

Birhan, W., Giday, M. & Teklehaymanot, T. (2011). The contribution of traditional healers' clinics to public health care system in Addis Ababa, Ethiopia: a cross-sectional study .Journal of Ethnobiology and Ethnomedicine 7: 39.

Bodibe, L. & Sodi, A., (1997). Notions of spirits as agents of mental illness among the Akan of Ghana: A cultural psychological exploration. Department of Counselling Psychology. Virginia Commonwealth University.

Brockington, D & Sullivan, S. (2003). Qualitative research. In: Scheyvens, R. & Storey,

Bryman, A.S. (2012). Combined quantitative and qualitative approach. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delport, C.S.L. 2nd ed. *Research at grass roots for the social sciences and human service professions*. Pretoria: Van Schaik Publishers.

Burns, N & Grove, SK. (2001). *The practice of nursing research: Conduct, critique*

Chauqúe, M. (2010). Análise da comercialização de animais ou partes dos mesmos para fins medicinais na cidade de Maputo [Analysis of marketing animals or parts thereof for medicinal purposes in Maputo]. Maputo: Eduardo Mondlane University; 2010. Portuguese.

Cohen, L, Manion, L., & Marrison, K. (2000). *Research methods in education (5th Ed*.).Routledge falmer. London: Paul Chapman.

Cohen, L., Manim, O., & Morrison, E.R. (2000). *Practice of social research*. Belmont, Calif.: Wadsworth.

Crawford, T., & Lipsedge, M. (2013). Seeking help for psychological distress: the interface of Zulu traditional healing and western biomedicine. 7: 131-140.

Creswell, J. W. (2008). *Research design: Qualitative, quantitative, and mixed methods approaches:* SAGE Publications, Incorporated.

Desai, J. & Potter, B. (2006). Focusing on fear: the use of focus groups in a project for the Community Forest Unit, Countryside Commission. Area, 130-135.

Duggleby, Y. (2005). Introduction: Entering the Field of Qualitative Research" y "The Fifth Moment" en Handbook of Qualitative Research: California, Sage Publications.

Eagle, G. (2005). Integrating African and western healing practices in South Africa. *American journal of psychotherapy*, 48(3), 455.

Edgerton, D. (2012). *Validity and Reliability. Doing Qualitative Research: A Practical Handbook.* London: Sage Publications.

Edwards, S. (2004). Integral approach to South African psychology with special reference to indigenous knowledge. Psychology Department, University of Zululand. South Africa.

Edwards, S. (2014). A psychology of indigenous healing in Southern Africa. *Journal of Psychology in Africa*.

Ekor, M. (2014). The growing use of herbal medicines: issues relating to adverse reactions and challenges in monitoring safety . Frontiers in Pharmacology 4 : 177 .

Ensor, T. & Cooper, S. (2004). Overcoming Barriers to Health Service Access: Influencing the Demand Side. Health Policy and Planning. 19 (2). 69-79.

Eraldo, M.& Costa-Neto, L. (2005). *Animal based medicines biologicalprospection and the sustainable use of zootherapeutic resources*. An Acad Bras Cienc, 77.

Falconer J. Wilson, E., Asante, P., Lartey, J., Acquah, S.D., Glover, E.K., Beeko, C., Nketiah, S., Ossom, K. and Lamptey, M. (2012). Non-timber Forest Products in Southern Ghana. Draft report to ODA.

Field, N. & Behrman, R. (2004). Understanding reliability and validity in qualitative research. The qualitative report, 8(4), 597-606.

Fontana, J. M. (1994). The unstructured interactive interview: Issues of reciprocity and risks when dealing with sensitive topics. *Qualitative inquiry*, 9(3), 335-354.

Freeman, M. & Motsei, M. (1992). Planning health care in South Africa- is there a role for traditional healers? Soc Sci Med; 34 (11) 1183-1190.

Frey, J. H., & Fontana, A. (1994). Interviewing: the art of science. *Handbook of qualitative research*, 361-376.

Gray, P. R. (2014). Design and analysis of pilot studies: recommendations for good practice. *Journal of Evaluation in Clinical Practice*, 10(2), 307-312. doi: 10.1111/j..2002.384.docx.

Guba, T. & Lincoln, E. (2012). Purposive sampling. The Sage encyclopedia of qualitative research methods, 2, pp.697–698.

Gumede, M.V. (1990). *Traditional Healers; A Medical Doctor's Perspective*. Cape Town, South Africa; Skotaville.

Hannah, J. L. (1995). The Power of Dance: Health and Healing *The Journal of Alternative and Complementary Medicine* Volume 1, Number 4, pp. 323-331 Mary Ann Liebert, Inc.

Hewson, M. G. (1998). Traditional healers in southern Africa. *Annals of Internal Medicine*, 128(12_Part_1), 1029-1034.

http://dx.doi. org/10.1016/S0378-8741(02)00377-X

Jewkes, R., Abrahams, N. & Mvo, Z. (1998). Study of the health care practices of pregnant women in Cape Town. Report 4. Summary of findings, conclusions and policy actions. Tygerberg: CERCA, Women's health. Medical Research Council.

Jorgensen, H. (1989). *Introduction to Research Methods in Psychology.(3rded.)* Martins the Printers. London.

Kale, R. (1995). Traditional healers in South Africa: a parallel health care system. *BMJ: British Medical Journal*, 310(6988), 1182.

Kasilo O. M. J., Trapsida J. M. (2011). Decade of African traditional medicine, 2001–2010. Afr. Health Mon.(Special Issue) 14 25–31.

Kelly, M. (2007). *The good research guide: for small-scale social research projects.* Open University Press.

Kitzinger, C. M. (1994). Men's Influence on women's Reproductive Health: Medical Anthropological Perspectives. *Social Science and Medicine*. 59 (7). 1379-1395.

Kothari, A. A. (2002). Health services delivery by shamans: a local experience in Pakistan. *International Journal of Mental Health*, 63-83.

Krog, M.P, Falcâo, M.P & Olsen, C.S. (2006). Medicinal plant markets and trade in Maputo, Mozambique. Hørsholm: Christian Ejlers; 2006.

Lev, E. (2003). Traditional healing with animals (zootherapy): Medieval to present day Levantine practice. J Ethnopharmacol, 85:107–118.

Lewin, A., Hodgkinson, S., Waters, D.M., Prempeh, H.A., Beers, L.S. & Feinberg, M.E. (2015). "Strengthening Positive Coparenting in Teen Parents: A Cultural Adaptation of an Evidence-Based Intervention". *The Journal of Primary Prevention*, 36(3):139–154. doi: 10.1007/s10935-015-0388-1.

Liu, F., & Maitlis, S. (2010). Nonparticipant Observation. In Albert J. Mills, G. Durepos, & E. Wiebe (Eds.), Encyclopedia of Case Study Research. (pp. 610-612). Thousand Oaks, CA: SAGE Publications.

Liu,V., & Maitlis, V. (2010). Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3:77-101.

Lopez, S. R., & Guarnaccia, P. J. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual review of psychology*, 51(1), 571-598.

Marezyyk, G. A. (2005). Preparing a qualitative research-based dissertation: Lessons learned. *The Qualitative Report*, 10(2), 208-222.

Marshall, N. (1998). Searching for a cure: Conservation of medicinal wildlife resources in East Southern Africa. Cambridge: Traffic International.

Mauthner, J., Birch, E., Jessop, C. & Miller, N. (2003). A pragmatic view of thematic analysis. The Qualitative Report, 2(1), p.3.

Mbatha, N., Street, R.A.A, Ngcobo, M. & Gqaleni, N. (2012). Sick certificates issued by South African traditional health practitioners: current legislation, challenges and the way forward . South African Medical Journal (Suid-Afrikaanse tydskrif vir geneeskunde) 102(3 Pt 1) : 129 – 31 .

Mbiti, J. (2003). Some Resting Points in African Theology. *In Unpublished essay read at African Theologies in Transformation Conference. University of the Western Cape, South Africa.*

Mendonça, L.E.T, Vieura W.L.S & Alves, R.R.A.(2014). Caatinga ethnoherpetology: Relationships between herpetofauna and people in semiarid region of northeastern Brazil. Amphib Reptile Conserv. 2014;8(1):24–32.

Mkhize, L.P. (2001). *Path ways to mental health care in KwaZulu-Natal province South Africa*. Unpublished Master's Thesis, University of Natal: South Africa.

Moagi, L. (2009). Transformation of the South African health care system with regard to African traditional healers: The social effects of inclusion and regulation. *International NGO Journal*, 4(4), 116-126.

Mokgobi, M. G. (2012). *Views on traditional healing: Implications for integration of traditional healing and Western medicine in South Africa* (Doctoral dissertation).

Mounton, N. (2002). The strategy of risk approach in antenatal care: evaluation of the referral compliance. *Social Science & Medicine*, 40(4), 529-535.

Mpofu, J., Peltzer, C. & Bojuwoye, R. (2011). Conceptualising psychosis in Uganda: the perspective of indigenous and religious healers. *Transcult Psychiatry*.44(1), 79-114.

Nachmias, B. (2011). *The scope and contribution of qualitative research. In introducing qualitative research*., London: SAGE Publications.

Nattrass, N. (2006). *Who consults sangomas in Khayelitsha? An exploratory quantitative analysis*. Centre for Social Science Research, University of Cape Town.

Nxumalo, N., Alaba, O., Harris, B., Chersich, M. & Goudge, J. (2011). Utilization of traditional healers in South Africa and costs to patients: findings from a national household survey . Journal of Public Health Policy 32 : s124 – 36 .

Patel V, K. (2006). Gender disadvantage and reproductive health risk factors for common mental disorders in women: A community survey in India. Archives of General Psychiatry, 63(4), 404-413. doi: 10.1001/archpsyc.63.4.404.

Patton, C.R. (2014). *Research Methodology: Methods and Techniques*. 2nd ed. Medicine (Editorial).

Patton, M. (2002). *Qualitative research and evaluation methods*. California: Sage Publication.

Pentenero, L. (2001). Los animales ayudan a afrontar problemas. La Nación, Bogotá.

Potter, C. (2004). Participatory research. In Malcolm, C. (Ed.), *Human rights, democracy, and social justice: Science and mathematics literacy in disadvantaged communities* (pp. 57–64). Durban, South Africa: University of KwaZulu-Natal Press.

Punch, S.K. (2004). *The practice of nursing research*. 3rd edition. Philadelphia: Saunders.

Rashid, K. (2000). *Research methods in education*: Routledge.

Raynor D. K., Dickinson R., Knapp P., Long A. F., Nicolson D. J. (2011). Buyer beware? Does the information provided with herbal products available over the counter enable safe use? BMC Med. 9:94 10.1186/1741-7015-9-94.

Reed, V., & Payton, R. (1997). *Doing development research*. SAGE Publications Limited.

Routledge P. A. (2008). The European Herbal Medicines directive: could it have saved the lives of Romeo and Juliet? Drug Saf. 31 416–418

Rudnick, T. (2002). *Popular Conceptions of Mental Health: Their Development and Change*. New York: Holt, Rhinehart and Winston, Inc.

Sarantakos, S. (2005) *The practice of nursing research: Appraisal, synthesis and generation of evidence*. 6th Edition, Saunders Elsevier, St. Louis.

Schleich, H. H., & Rai, K. (2012). *Amphibians and Reptiles of Nepal - SNAKES. A children's book*. ARCO-Nepal. pp. 48.

Seaman, A., & Baxter, O. (2008). Focus groups. *Social research update*, 19(8).

Seaman, A., & Baxter, O. (2009). Content analysis: *An introduction to its methodology*: SAGE Publications, Incorporated.

Segniagbeto, H. A, Petrozzi, F., Aïdam, A. & Luicelli, L. (2013). Reptiles traded in the Fetish Market of Lomé, Togo (West Africa). Herpetol Conserv Biol. 2013;8(2):400–408.

Shah, K. B., Kharel, F. R., & Thapa, B. B. (2011). Status, Distribution and Conservation of the Snakes in Nepal. *Biodiversity Conservation Efforts in Nepal*. GoN, MFSC, DNPWC, Special issue published on the occasion of 16th wildlife week 2068: 1–7.

Shank, C. (2002). *The interpretation of cultures: Selected essays* (Vol. 5019): Basic books.

Shank, G. (2002). Qualitative Research. A Personal Skills Aproach. New Jersey: Merril Prentice Hall.

Shenton, A. K., (2013). Strategies for ensuring trustworthiness in qualitative research projects. *Social Sciences Research. Education for information*, 22(2), 63-75.

Shizha, E. & Charema, J. 2011. Health and wellness in South Africa: Incorporating indigenous and Western healing practices. *International Journal of Psychology and Counselling*, 3(9): 167-175.

Shrestha, T. K. (2012). *Herpetology of Nepal. A field Guide to Amphibians and Reptiles of Trans-Himalayan Region of Asia*. Kathmandu, Nepal. pp. 280.

Siedman, G. (2006). Grounded theory and sensitizing concepts. *International Journal of Qualitative Methods*, 5(3), 12-23.

Silver, B. (2013). *Research methodology* 3 rd Edition . Cape Town: Oxford University Press Southern Africa.

Sorsdahl, K., Stein, D., & Myer, L. (2009).Traditional healers in the treatment of common mental disorders in South Africa. Department of Psychiatry and Mental Health and School of Public Health and Family Medicine. University of Cape Town: South Africa.

Steenkamp, V. (2003). Traditional herbal remedies used by South African women for gynaecological complaints. J Ethnopharmacol, 86: 97- 108.

Takei, A., Nagashima, G. & Suzuki, R. (1997). Meningoencephalocele associated with Tripterygium wilfordii treatment. Pediatr Neurosurg; 27: 45-48.

Traditional Medicine and Health Care Coverage. (1983). (ISBN 92 4 154163 6), WHO Geneva , (35 Swiss Francs) (reprinted in 1988).

Triebel, A. C. (2002). Traditional African1 Beliefs and Customs: Implications for AIDS Education and Prevention in Africa. *South African Journal of Psychology*, 31(2), 60-66.

Trimble, E. & Fisher, B. (2006). *Finding your way in qualitative research* (pp. 19-22). Pretoria: Van Schaik.

Truter, I. (2007). African traditional healers: Cultural and religious beliefs intertwined in a holistic way. *SA Pharmaceutical Journal*, 74(8), 56-60.

Twumasi, P. A. (2015). Social Research in Rural Communities, Second Edition. Accra: Ghana University Press, pp. 29-35.

Vanhatalo, N. K. (2014). *Interpretive biography* (Vol. 17): SAGE Publications, Incorporated.

Webb, M., & Juro, D. (2008). *The beginnings of social understanding*. Cambridge, MA: Harvard University Press.

World Health Organisation. (2003). Investigating Mental Health. Department of Mental Health and Substance Department. Geneva: World Health Organisation.

Wyrostok, E. & Barbara, S. (2000). African religions and philosophy. Garden City, N.Y.: Anchor Books.

Yen, J., & Wilbraham, L. (2003). Discourses of Culture and Illness in South African Mental HealthCare and Indigenous Healing, Part II: African Mentality. *Transcultural Psychiatry*, 40(4), 562-584.doi:10.1177/1363461503404006

Yin, M. A. (1994). Sampling in Qualitative Inquiry. In F. Crabtree, B & Miller, L. W (Ed.), *Doing Qualitative Research* (2nd Ed.). Thousand Oaks, CA: Sage.

Yin, M. A. (2003) Focus groups: A practical guide for applied research. Thousand Oaks: Sage.

Zabow, T. (2006). Traditional Healers and Mental Health in South Africa. *International Psychiatry*, 4(4), 81-83.

Appendix A: Consent form

AN EXPLORATION OF TRADITIONAL MEDICINE AND ITS EFFECTS ON REPRODUCTIVE HEALTH OF RURAL WOMEN IN ALLANDALE VILLAGE, MPUMALANGA PROVINCE.

You are invited to be a part of a research study that is exploring the challenges of incorporating traditional health care into the modern health care system. This study is not for commercial gain but to academic purposes at the University of Venda under school of Human and Social Sciences.

- If you agree to be part of the research study, you will be requested to participate in an in-depth interview at the location of our choice. The interview should take about one hour. I would like to audiotape the interview to make sure that our conversation is noted correctly. You may still participate in the research even if you decide not to be taped.

- While you may not receive a direct benefit from participating in this research. I hope that this study will contribute to by recognized by the government and aid at incorporating traditional health care into the modern health care system.

- The University of Venda may publish the findings of this study at the library of the university and other third parties. However, will not include any information that will link back to the participant, unless agreed to be identified. For the protection of the participant's identity, the participant's real name may not be used in the written copy of the discussion.

- By signing, the person concerned is hereby, agreeing to be part of the study and participate. Participating in this research is fully voluntary. The participant can choose to stop participating at any time they wish should they feel the need to.

Be sure that questions you have about the study have been answered and that you recognize what you are being enquired to do. You may contact the researcher if you think of a question later.

I agree to participate in the study and to be audiotaped as part of the study.

_____ _____

Signature **Date**

Appendix B: Transcriber's Confidentiality Agreement Form

AN EXPLORATION OF TRADITIONAL MEDICINE AND ITS EFFECTS ON REPRODUCTIVE HEALTH OF RURAL WOMEN IN ALLANDALE VILLAGE, MPUMALANGA PROVINCE.

- I, the undersigned transcriber, fully understand that I am the one to transcribe the information given to me and that the information to be transcribed calls for my good will and utmost confidentiality.
- I further oblige myself to confer the transcribed information in black and white to the researcher of this study.
- I consider myself guilty and responsible if any original or copies of either the transcripts or tape recordings leak to third parties while under my control.
- I, therefore, bind myself to the conditions given above.

Transcriber's name : _____

Transcriber's signature: _____

Transcriber's personal details (if appropriate):

_____

_____

_____

_____

Date : _____

(**Note:** ***The Transcriber should retain a copy of this form***.)