TRADITIONAL HEALERS' PERCEPTIONS ON NON–ADHERENCE TO AFRICAN TRADITIONAL MEDICINE AMONG PATIENTS WITH MENTAL ILLNESS WHO CONSULT AFRICAN TRADITIONAL HEALERS IN THULAMELA MUNICIPALITY OF THE VHEMBE DISTRICT.

BY

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IN THE SUBJECT

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AT THE UNIVERSITY OF VENDA

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SUBMITTED ON MAY 2016

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DECLARATION

I, Lufuno Mashamba, declare that this research project submitted by me for the Master of Arts at the University of Venda has not previously been submitted for a degree at this or any other university or institution and that is my own work in design and in execution and that all reference materials contained therein have been duly acknowledged.

Signature..LMashamba..... Date..09/05/2016 (student)

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DEDICATION

TO all African traditional healers who treat mental illness.

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ACKNOWLEDGEMENT

I wish to thank God the Almighty for His grace, love and care and for giving me the strength and courage to work on this project.

Furthermore, I wish to express my special thanks and appreciation to the following people:

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Introduction

Levels of non- adherence to African traditional medicine in person with mental ill-ness in rural African settings have been shown to be comparable to those found in high- income countries. Improved understanding of the underlying reasons can help to inform intervention strategies relevant to the context. Predominant reasons for non-adherence specific to a low- income country setting include inadequate availability of food to counter appetite stimulation and the perceived strength of mental- illness medication. Non-adherence was defined as failing to take prescribed medication and delays in seeking medical care, failure to keep appointments and also failure to follow instructions effectively.

Aim of the study

The aim of the study was to explore the traditional healers' perceptions of non-adherence to African traditional medicines among patients with mental ill-ness who consult African traditional healers in the Thulamela municipality of the Vhembe District in the Limpopo province.

Objectives

- To determine the traditional healers perceptions on non-adherence to African traditional medicine in patients with mental illness who consult African traditional healers.
- To explore the factors associated with non-adherence to African traditional medicine among patients who consult African traditional healers
- To establish the consequences of non- adherence to African Traditional medicine in patients with mental illness who consult traditional healers
- To determine the strategies for reducing non-adherence to African traditional medicine among patients with mental illness who consult African traditional healers

Research questions

- What are traditional healers perceptions non-adherence to African traditional medicines that occur in our community among patients with mental illness who consult African traditional healers?
- What are the risk factors associated with non-adherence to African traditional medicine among patients with mental illness who consult African traditional healers?
- What are the consequences of non- adherence to African Traditional medicine amongst patients with mental illness who consult African Traditional medicine?
- How can non-adherence to African traditional medicine be reduced among patients with mental illness who consult African traditional healer?

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Significance

The significance of this study is in the field of family counselling within the South African context in which mentally ill patients are dealt with. Policy review was also an important aspect to consider, taking into account issues such as individual freedom and accept attention in so far as the patient was aware or informed of the consequences of the decision and is within the law. With the expected outcome this research should produce articles and the results will also be presented at national and international conferences.

Research methodology

The research design chosen for this study was an exploratory research design. The purpose of this design was to become familiar with a phenomenon or acquire new insight into it in order to formulae more precise or develop problem hypothesis. Purposive sampling was used in this study to select traditional healers. The researcher used Thematic content analysis. It identifies the question also chooses the sample for analysis. Purposive sampling was used to select traditional healers The researcher used this approach to qualitative data to identify and review the information presented from the relevant literature and participant's information.

Findings of the study

Improving adherence in mental illness may have a considerable positive impact on patients and society and this can be achieved by correcting the identified multitude of factors driving nonadherence. Traditional healers shoulder a larger burden of patients with mental health problems, this calls for all those who share the goal of improving the mental health of individuals to engage with traditional healers.

Recommendations of the study

There should be development of curriculum that could be used by elementary and post secondary school on the topic of traditional healers.

Key words: African traditional medicine, mental illness, non- adherence; perceptions,

traditional healers.

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List of abbreviations and acronyms

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AD	Alzheimer disease
ADHD	Attention-deficit and hyperactivity disorder
ATM	African Traditional Medicine
DALY	Disability-adjusted life years
DOH	Department of health
ECMP	European college of Neuropschopharmacyl
EU	European Union
HIV	Human Immino Virus
HMC	Harborview Medical centre
IDRC	International Development Research Centre
IMC	International medicine clinic
PTSD	Post traumatic stress disorder
STI	sexual transmitted infections
TB	Tubercolosis
TBA	Traditional Birth Attendant
TH	Traditional Healers
USA	United state of America
WHO	World Health Organisation

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Chapter 1: INTRODUCTION OF THE STUDY

1.1 Introduction.

It is estimated that one in four people in the world will be affected by mental or neurological disorders at some point in their lives. Although many effective interventions for the treatment of mental disorders are known, and awareness of the need for treatment of people with mental disorders has risen, the proportion of those who need mental health care but who do not receive it remains very high. This so-called treatment gap is estimated to reach between 76-85% for low- and middle-income countries, and 35-50% for high-income countries. According to Omonzelele (2003) states that despite the acknowledged need, for the most part there have not been substantial changes in mental health care delivery during the past years. Main reasons for this problem are public health priorities, lack of a mental health policy and legislation in many countries, a lack of resources financial and human resources as well as inefficient resource allocation. In 2011, the World Health Organization (WHO) estimated a shortage of 1.18 million mental health professionals, including 55,000 psychiatrists, 628,000 nurses in mental health settings, and 493,000 psychosocial care providers needed to treat mental disorders in 144 low- and middle-income countries. The annual wage bill to remove this health workforce shortage was estimated at about US$4.4 billion (Rana, 2002).

Many factors including disease, poverty, abuses, political violence, as well as the decay of the traditional value system contribute to the high occurrence of mental health issues in South Africa (Tate, 2003). In a study conducted by the Mental Health and Poverty research program, it was found that approximately 16,5% of the adult population in South Africa suffers from mental illness, with 1% suffering from a severe life debilitating mental disease (Tate, 2003). However, these statistics are most certainly an underestimation. Among the native population, many still hold to the traditional believe that mental illness results from a demonic possession. As a result, many individuals for fear of social ostracism keep their mental illness secret instead of seeking the much needed medical attention (Liebhammer, 2007). This means that there is still a significant population suffering from mental illness that is currently unrepresented in mental health statistics. Probably one of the largest contributors to the high frequency of mental disorders is political violence. In one study of the adult population aged 16 to 64, it was found that 23% were exposed to a traumatic event of political violence in the past year (King, 2010).

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1.2 Background of the study

Global mental health is the international perspective on different aspects of mental health. It is the area of study, research and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide. Osei (1994) stated that taking into account cultural differences and country-specific conditions, it deals with the epidemiology of mental disorders in different countries, their treatment options, mental health education, political and financial aspects, the structure of mental health care systems, human resources in mental health, and human rights issues among others (Morris, 2006).

The overall aim of the field of global mental health is to strengthen mental health all over the world by providing information about the mental health situation in all countries, and identifying mental health care needs in order to develop cost-effective interventions to meet those specific needs. There is a growing body of criticism of the global mental health movement, where some see it as a neo-colonial or missionary project and as primarily a front for pharmaceutical companies seeking new clients for psychiatric drugs

Mental illness is widespread in South Africa (Cumes, 2004). Compounding the problem is the fact that the country does not have relevant policies to address the plight of people with mental illness (Fleck, 2011). South Africa has a history of placing people with mental illness in hospitals and care institutions (Myers, 2010). However, in 1997, the South African government made changes to deinstitutionalise and introduce primary health care for people with mental illness. The expected outcomes have not yet been realised due to lack of trained professionals and lack of communication between primary and district care. In addition, the cultural context of South Africa increases the complexity of the situation (Omozokpia, 2004). Another factor regarding the very nature of mental disorders or mental illness complicates this issue even further (Kale, 2001).The integration of traditional practice and western medicines could prove very beneficial.. A complete cure of mental disorder is nebulous and can only be attained gradually with time. For this reason, mental illness is hard to cure without adequate resources (Myers, 2010). Without the necessary intermediate care and continuity in therapy, many patients regress when released from the hospital. All of these factors contribute to making South Africa mental health care the complicated and involved issue that it is today (Freeman, 2004).

In African traditional medicine, mental ill-health is defined as a situation whereby the victim is prone to interpreting issues haphazardly as registered in his tortured consciousness (Cumes, 2004). Ozekhome (2001) explains that in extreme cases of neurosis, the entire system of the patient is unstable and may be unable to differentiate between realities and imaginations, may

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not pay heed to impending dangers and may be unable to recognise people previously known to him. This is because an extreme neurotic is depersonalised.

Sangomas are legally recognized in South Africa as traditional health practitioners under the Traditional Health Practitioner Act, 22 of 2007 as diviners alongside with herbalists, traditional birth attendants and traditional surgeons (Truter, 2007). The Act calls for the establishment of a national council of traditional health practitioners to regulate and register *sangomas* in the country. However, it was only in December 2011 that the National Department of Health took action and opened nominations for seats on an interim council. In October 2012, the Health Department aimed to have the council up and running by the year 2012, however the interim Traditional Health Practitioners Council was only inaugurated on 12 February 2013 (Richter, 2003).

Levels of non-adherence to African traditional medicine in persons with mental ill-ness in rural African settings have been shown to be comparable to those found in high-income countries. Improved understanding of the underlying reasons will help to inform intervention strategies relevant to the context. Predominant reasons for non-adherence specific to a low-income country setting included inadequate availability of food to counter appetite stimulation and the perceived strength of mental illness medication.

Mental disorder contributes about 14% of the burden of diseases in a country. Neuro-psychiatric condition disorders such as schizophrenia and substance abuse are the number one contributors to the worldwide burden of non-communicable disease. Despite the staggering burden of mental illness, the treatment gap is wide. Kale (2001) explains that a large proportion of mental health problems do not receive treatment and care from a western healthy facility; WHO (2011) showed that 76%-85% of people with serious mental health had received no treatment in the previous 12 months and that for those who did receive treatment, most often it was inadequate. The overall aim of the field of global mental health is to strengthen mental health all over the world providing information about the mental health situation in all countries and identifying mental illness in order to develop cost- effective interventions to meet those specific needs. The current health documents make hardly any mention of traditional healing as a resource to close the treatment gap rather the emphasis is on evidence for interventions but such evidence is scarce for traditional healing.

In the early colonial era of the 19th century, patients suffering from mental ill-ness in the Gold Coast (now Ghana) were usually kept in prisons (Ministry of Health, 2000). Prior to this period, psychiatric patients were left on their own to fend for themselves, or sent off to traditional healers. In 1888 the colonial government passed a legislative instrument. It was not until 1904 that a purposeful psychiatric hospital was built, called the Accra Psychiatric Hospital. The

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hospital was officially commissioned in 1906, initially to accommodate 200 patients. By the late 1940s, with the psychiatric treatment primarily in the form of custodial care, there was soon overcrowding. The Accra Psychiatric Hospital has undergone major expansion in the past 50 years and currently houses about 700 inmates, about one third of them are long-term because they have no place to go (Arden, 2007).

1.3 Problem statement

Non-adherence is defined as failing to take prescribed medication and delays in seeking medical care, failure to keep appointments and also failure to follow instructions effectively (Van Niekerk, 2012). Poor adherence to medical treatment severely compromises patient outcomes and increases patient mortality. According to the WHO (1997), improving adherence to medical therapy for conditions of schizophrenia would yield very substantial health benefits. To improve medication adherence, the multifactorial causes of decreased adherence must be understood. The WHO classifies these factors into 5 categories; socioeconomic those associated with the health care team and system in place, disease- related, therapy- related, and patient- related .

What the researcher has observed in the community in the Vhembe District is that patients with mental illness usually visit traditional healers before seeking treatment in formal health care system largely because the predominant communities attitude to mental illness is that it is a spiritual rather than a medical problem. The researcher wants to find out why people with mental illness sometimes do not adhere to the treatment once they have started. Some patients end up going to western practitioner hoping that they will get better but at the end they go back to the traditional healers.

People with untreated psychiatric illnesses comprise one-third, or 200,000 people, of the estimated 600,000 homeless population. The quality of life for these individuals is abysmal; many are victimized regularly. A recent study has found that 28 percent of homeless people with previous psychiatric hospitalizations obtained some food from garbage bins and 8 percent used these as their primary food source. People with untreated serious brain disorders comprise approximately 16 percent of the total jail and prison inmate population, or nearly 300,000 individuals. These individuals are often incarcerated with misdemeanor charges but sometimes with felony charges as a result of behaviors caused by their psychotic thinking. People with untreated psychiatric illnesses spend twice as much time in jail as non-ill individuals and are more likely to commit suicide. There are approximately 1,600 homicides among the estimated 16,000 total homicides in the U.S committed each year by people with untreated schizophrenia and bipolar disorder. According to a 1994 Department of Justice, Bureau of Justice Statistics Special Report, *Murder in Families*, 4.3 percent of homicides committed in

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1988 were by people with a history of untreated mental illness. Traditional healers also consider those patients missing their appointments as non-adherent, as the patient is supposed to go back for check-ups and to get other dose of medication (Loudon, 2006). In the African setting, when there is a mentally ill person in the family, the patient is treated with or without his or her consent, if a person is violent or destructive, the person is sedated by the traditional healer or by family members in order to commence therapy. Therapy is continued until cure is achieved. In some cases, the patients may be chained, in order to prevent patients either from harming themselves or others.

Non- adherence to medication regiments is a serious problem. It has many serious effects on prognosis of the illness and the effectiveness of the health systems (Osterberg, 2005). Non adherence may signal that patients and traditional healers differ over goals and priorities regarding treatment and its schedule (Rana, 2002). Non adherence patients are more severely ill at the time of their reappointment with their traditional healers and are more likely to stay at the traditional healers' homes and have longer inpatient stays. Increasing the chances of adherence to intervention may have a far greater impact on the health of the population than any improvement in specific treatments, therefore, information regarding factors influencing optimal use of medications is vital (Sabate, 2003). According to Cramer (2008), typical reasons for not taking medications include forgetfulness, other priorities, lack of information and emotional factors. Various reasons for non-adherence need to be monitored by family members including co-mobility, type of illness, cost of treatment, personal factors and side effects of medication being prescribed. Along with these reasons, various social and cultural beliefs regarding psychiatric medication, use of alternative medicine and traditional healers and patients therapeutic alliance or relationship are important factors contributing to non-adherence.

1.4 Aim of the study

The aim of the study was to explore the traditional healer's perceptions of non- adherence to African traditional medicine among patients with mental illness who consult African traditional healers, in Thulamela Municipality of the Vhembe District.

1.5 Objectives of the study

- To determine traditional healers perceptions on non-adherence to African traditional medicine by patients with mental illness who consult African traditional healers.
- To explore the factors associated with non-adherence to African traditional medicine among mentally- ill patients who consult African traditional healers

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- To establish the consequences of non-adherence to African traditional medicine amongst mentally-ill patients who consult African Traditional healers
- To determine the strategies for reducing non-adherence to African traditional medicine among patients with mental illness who consult African traditional healers.

1.6 Research questions

- What are traditional healers perceptions non-adherence to African traditional medicines that occur in our communities among patients with mental illness who consult African traditional healers?
- What are the factors associated with non-adherence to African traditional medicine among patients with mental illness who consult African traditional healers?
- What are the consequences of non- adherence amongst patients with mental illness who consult African traditional healers
- How can non-adherence to African traditional medicine be reduced among patients with mental illness who consult African traditional healer?

1.7 Significance of the study

This study can make important contributions to the field of family counselling within the South African context in which mentally- ill patients are dealt with. Policy review is also an important aspect to consider, taking into account issues such as individual freedom in so far as patients are aware or informed of the consequences of their decision and they are within the law. A general practitioner or hospital doctor can refer people separately for assessment for community care services.

Traditional healers are considered the most important link between the rural people and health care delivery because they use their inherited knowledge of methods and practices that have evolved from social, cultural and spiritual wealth of the community that they serve. There are communities which do not believe in consulting traditional healers, but after receiving information about how traditional healers conduct their practices, they may refer their patients to them.

This study will bring awareness in promoting the inclusion of mental illness topic during community meetings and other meetings. It is intention of this study to make a positive contributing to the Department of Health and to patients with mental illness as well as provide awareness regarding mental illness.

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The societal rejection of individuals with severe mental illness has long been recognized as a significant social problem (Goodyear & Parish, 1978; Philliphs,1966). Although this stigmatization may have evolved over time to become less negative in some regards, it remains specific to the role of the mentally ill (Fracchia, Canale, Cambria, Ruest, & Sheppard, 1976; Skinner, Berry, Griffith, & Byers, 1995). Given this unfortunate state of affairs, it is important to address questions regarding the stigmatization process. One of the most disputed components of this process involves how mentally ill individuals become targets of negative attitudes.

Because particular labels and behaviours frequently co-occur, our everyday experiences and other informal observations do not necessarily allow us to reliably distinguish their unique causal influence or any other observations that allow professionals to differentiate characteristics shared by some, but not all (Andrew, 2009). Patients convey behavioural information, albeit imperfectly, and this information is subject to substantial distortion by those unfamiliar with the true correlates of psychological disorders. Teasing apart the impact of diagnostic labels and the behaviours they denote have serious implications for understanding and alleviating the stigma of mental illness. Thus, it is imperative to carefully examine scientific research on their differentiation, and a wealth of relevant data exist in the psychological, psychiatric, and sociological literatures.

Throughout the world, many people have relied on traditional medicine for generations and communities have found most of these medical practices valuable and affordable and some still depend on them for their health- care needs. The WHO estimates that about 60% of the world's population uses herbal medicine for treating their sicknesses and up to 80% of the population living in the African region depend on traditional medicine for some aspects of primary health care (WHO, 2002). Indeed, in rural communities in Ghana, like other developing countries and elsewhere, traditional medicine will continue to be a vital and permanent part of the people's own health- care system. If someone close becomes mentally distressed, it's likely to provoke strong feelings. It can be painful to see them suffering, and it also is frightening to be with someone who is feeling desperate or acting strangely. It can disrupt life and, sometimes, people find themselves in a caring role they have not chosen. Bamkowski (2007) argues there can be a positive side too. A crisis can bring people together, giving them a chance to express love and affection in a way that has not been possible before. In many cases, people will have the pleasure of seeing their friend or relative make a recovery. It is easier though to support someone well if the caring role is shared with others. Finding someone to talk to about the situation is also very helpful. If your friend or relative has been given an assessment, you may be entitled to have your needs as a carer assessed and taken into account (Bereda, 2002).

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When individuals and family members take decisions without consultation with the community elders, such individuals and families are sanctioned, and such sanctions have social, economic and psychological implications. African life style is highly communal, often times, Africans residents in urban areas go back to their ancestral villages when very important decisions are to be made by them. The government needs to engage traditional healers so that better practices are observed to ensure that the patients benefit.

1.8 Delimitations of the study

The study included traditional healers who have been practicing for a minimum of three years as herbalist, in the Thulamela municipality.

1.9 Expected outcomes from the study

After the study completion, the following contribution is expected

- Two articles will be produced from this study and the articles will be published in peer reviewed journals.
- Dissemination of the findings will be presented at the University of Venda, and in national and international conference.

1.10 Definition of key concepts

This section defines the key concepts of the study

- **African traditional healer**

  A person in a traditional society who uses long-established methods passed down from one healer to another to treat a person suffering from various illnesses, many of which have psychological underpinnings.

- **African traditional medicine**

  Refers to the sum total of all knowledge and practices, whether explicable or not, used to diagnose, prevent and eliminate physical, mental illnesses and these knowledge can be handed down from generation to generation, whether verbally or in writing.

- **Herbalist**

  Refers to someone who specialises in handling herbs for medicinal purpose, in some cases, herbalist focuses on growing herbs, while others may harvest or collect in the wild.

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- **Mental- illness**

  Refers to an illness that effects or is manifested in a person's brain. It may impact on the way a person thinks, behaves and interacts with other people.

- **Non- adherence**

  refers to not taking prescribed medication or delays in seeking medical care, or failure to keep appointment as well as failure to follow instructions.

- **Perceptions**

  refers to the organization, identification and interpretation of sensory information in order to represent and understand an environment.

1.11 Division of the dissertation

Chapter 1 gives an introduction to the study.

Chapter 2 focuses on a review of literature on non- adherence to African traditional medicine, risk factors and consequences of non- adherence as well as strategies for adherence.

Chapter 3 focuses on the research methodology that was used to conduct the study.

Chapter 4 presents the findings of the study.

Chapter 5 discusses the findings, recommendations and conclusions of the study. The chapter also makes recommendations for future research.

1.12 Conclusion

This chapter presented the background and the problem statement regarding non-adherence of African traditional medicine in mentally- ill patients. It outlined the main aim and the objectives, highlighted the significance of the study, and set out research questions. Different concepts were defined and the study delimited. The following chapter reviews the literature on the nature of non-adherence to African traditional medicine.

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2. Introduction

This section discusses the history of African traditional medicine, perceptions of non-adherence, the use of African traditional in healing mental illness, non-adherence to African traditional medicine, risk factors as well as consequences of non-adherence to the African tradition medicine.

2.1 Types of African traditional healers in South Africa.

Twumasi (2003) classifies the African traditional healers of mental illness into the following groups:

The herbalist

Herbalists are the most numerous of traditional healers and they acquire their skills and powers from relatives through training and oral tradition. A herbalist uses mostly herbs from the environment. They are usually the first contact people for clients who manifest mental distress and have herbs for all types of mental disorders. They operate mostly on permanent sites and could be called to attend a patient in crisis situation. Of late, some of them sell their medical preparations in markets and from moving vehicles. For the efficacy of herbs, the clients are normally advised to abstain from certain practices such as sex and foods whilst on those herbs.

Spiritualists/Diviners

Osei (1994) remarked that in the 1930s, the shrines were the first resort of people who were (presumably) mentally ill, whether trivially or gravely, because the sickness is regarded as supernatural and hence outside the province of hospitals. These interveners could be priests and priestesses of cults and other fetish agencies. Common examples of such practitioners in northern Ghana include the 'Bagnabas', Balkol-burgas (soothsayers)'Tigare', and 'Malams'. The Okomfos, another group of spiritualists, dominate the southern part of Ghana. All groups derive their healing powers from the Supreme Being, lesser gods or the ancestors. They mostly use divination in diagnosing the conditions, especially the unexplainable, and assume charismatic roles during healing sessions. They wear particular regalia which serve both therapeutic and identification purposes, for the clients. Although they attend to all types of diseases, they deal mostly with somatoform, dissociative and anxiety disorders.

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Faith healers

According to Osei (1994) the trend of psychiatric clients patronizing both shrines and herbalists started declining in the late 1940s when the indigenous African churches started springing up. Faith healers try to blend traditional values and those of Christianity in their healing rituals and most of the spiritual movements partake in this type of healing. Faith healing is the ritualistic practice of prayer and gesture such as laying on hands that are claimed to elicit divine intervention for spiritual and physical healing, especially the Christian practice. Believers assert that the healing of disease and disability can be brought about by religious faith through prayer and other rituals that, accord to adherents, stimulate a divine presence.

2.2 Origins of mental health issues in South Africa

According to Tate (2003) many factors, including disease, poverty, abuse, sexual violence, as well as the decay of the traditional value system are contributing to the high occurrence of mental health issues in South Africa. In a study conducted by the Mental Health and Poverty research Program, it was found that approximately 16.5% of the adult population in South Africa suffers from mental illness, with 1% suffering from a severe life debilitating mental disease

These statistics however are most certainly an underestimation. Among the native population, many still hold to the traditional belief that mental illness results from a demonic possession. As a result, many individuals, for fear of social ostracism, keep their mental illness secret instead of seeking the much needed medical attention. This means that there is still a significant population suffering from mental illness that is currently unrepresented in mental health statistics (Kale, 2001).

Post-traumatic stress disorder

Probably one of the largest contributors to the high frequency of mental disorders is violence. Of the adult population aged 16 to 64, it was found that 23% were exposed to a traumatic event of violence in the past year. These traumatic events include acts such as fighting a war, being tortured, or participating in violence. Among this population, it was determined that mental illness including symptoms of Posttraumatic stress disorder (PTSD) was 8.5 times more prevalent than among the general population

Substance abuse

Another factor contributing to mental illness in South Africa is substance abuse. Many provinces are used as drug trafficking routes, and as the South African government lacks the necessary

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resources to control this problem, many of these illicit drugs find their way into local populations as drugs. In addition, the availability of the wild growing Cannabis plant allows for its rampant abuse among all age categories. Maiello (1999) found that 52% of street children smoke the Cannabis plant and 22% on a daily basis. Educational campaigns are limited, and as a result, many do not realise the impinging health effects that will result from substance abuse.

Disease as a trigger

Diseases such as malaria, typhoid fever, and HIV provide a significant contribution to the prevalence of mental illness. Some of these diseases such as cerebral malaria can bear a direct physiological effect on the mental functionality of the patient. Mokaila (2007) explained that, even more poignant is the ability of disease to strike a radiating blow to the patient's emotional psyche. For instance, the prevalence of mental illness among those suffering from HIV is 43.7% compared to the 16.5% observed among the general population.[1] This data indicates that disease delivers equal emotional damage as it does physiological harm.

Exposure to Western cultural pressures

An often overlooked yet equally destructive cause of mental illness is the Westernization of African culture. In a research study, it was found that only 6% of women in the urban environments were free from all symptoms of mental disorder. However, in the traditional integrated population 60% were free from mental illness. Both growth of the industrial sector and rapid urbanisation are undermining the social fabric of traditional society. The alluring financial and social prospects of an urban environment draw many young individuals splitting up families and villages. According to Stanley (2004),the family network which was once regarded as the emotional, moral, and social centre of the community is now being undermined. As a result, many who are drawn to the city lose touch with their traditional roots and begin to lose a sense of purpose and direction as their focus is turned to utilitarian and hedonistic endeavors. In addition, they no longer have the invaluable social restraints.

2.3 Difference between western and African traditional healing practices

Western culture attributes high priority to verbal language as a means of communication. In Western-style psychotherapy, verbal communication seems to be the most important feature of the process, typified as a “talking cure”. According to Maiello (1999), words do not seem to have the same value in African culture; music and rhythm are more important ways of communication than words. What Western people think and talk about, African people tend to act and represent

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in dancing, singing, rituals and ceremonies. This implies that psychotherapy, which is mainly based on verbal communication, might not have the same effect in an African context.

Bührmann (2005) also stresses the fact that dream interpretation and analysis are not verbalised as they are in a Western context, but are dealt with in a group situation where the dream is told bit by bit, accompanied by singing and dancing to the beat of a special drum to invoke the help of the ancestors. Within the Western context, psychotherapy is predominantly focused on the individual, with group and family therapy playing a secondary role. Within the African context, therapy or healing is grounded in the collective existence of the microcosmic order, whereby the individual is always seen as an integral part of the community. According to Bührmann (2005), treatment is not individual, especially for any mental dysfunction, but requires the cooperation of the family and at times the active treatment of others in the family. Osternberg (2005) also endorses the fact that African therapeutic systems emphasise collective social responses to afflictions" rather than individualistic diagnosis and treatment. Because of this ethos of collectivism, the Western-trained therapist must be aware of the influence of these social structures on behavior.

Rudnick (2002) draws a comparison between the dynamics of Western psychotherapy and traditional healing and concludes that the same psychological factors play a role in both psychotherapy and shamanic healing. Both Western therapists and African shamans are socially sanctioned healers of their respective cultures and both use rituals to help relieve clients of their distress. It remains, however, an open question whether Western-trained psychotherapists can be made fully aware of cultural differences. Maiello (1999) notes that the knowledge a Western psychotherapist can acquire will inevitably remain superficial in a traditional African environment. In Western-style psychotherapy, verbal communication seems to be the most important feature of the process, typified as a 'talking cure'.

2.4 Prevalence of mental disorder

The prevalence of mental disorder is increasing worldwide. For example, WHO (2003) reports that one in four people in the world will be affected by mental disorders at some point in their lives and that 10% of the world population suffers from depression. The following are statistical estimates of the prevalence of mental disorders in the world:

Out of every 200 children in Africa develop depression but those from non-intact homes or villages, and who are abused or neglected have higher incidence of 5:100

The South African Depression and Anxiety Support Group found that the incidence of depression is 15% higher in South Africa than the global average (Green, 1996).

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International depression rates for school aged students are 78% of all students in a school year and 16-25% of student population experiences it at any given time. Of the students who reported experiencing depressions, the frequency of the bonds for majority could be that the frequency of their bouts was one to two times in a month.

2.5 Types of Mental illness

There are many different conditions that are recognized as mental illnesses. The more common types include:

Anxiety disorders, people with anxiety disorders respond to certain objects or situations with fear and dread, as well as with physical signs of anxiety or panic, such as a rapid heartbeat and sweating. An anxiety disorder is diagnosed if the person's response is not appropriate for the situation, if the person cannot control the response, or if the anxiety interferes with normal functioning. Anxiety disorders include generalized anxiety disorder, panic disorder, social anxiety disorder, and specific phobias. Temerlin (1968) stated that Mood disorders, also called affective disorders, involve persistent feelings of sadness or periods of feeling overly happy, or fluctuations from extreme happiness to extreme sadness. The most common mood disorders are depression, bipolar disorder, and cyclothymic disorder. Psychotic disorders, psychotic disorders involve distorted awareness and thinking. Ventevogel (2006) mentions that two of the most common symptoms of psychotic disorders are hallucinations, the experience of images or sounds that are not real, such as hearing voices, and delusions, which are false fixed beliefs that the ill person accepts as true, despite evidence to the contrary. Schizophrenia is an example of a psychotic disorder.

Eating disorders, involve extreme emotions, attitudes, and behaviors involving weight and food. Anorexia nervosa, bulimia nervosa, and binge eating disorder are the most common eating disorders. Impulse- control and addiction disorders. People with impulse control disorders are unable to resist urges, or impulses, to perform acts that could be harmful to themselves or others. Pyromania (starting fires), kleptomania (stealing), and compulsive gambling are examples of impulse control disorders. Alcohol and drug are common objects of addictions. Often, people with these disorders become so involved with the objects of their addiction that they begin to ignore responsibilities and responsibility. Rosenhan (1973) states that people with personality disorders have extreme and inflexible personality traits that are distressing to the person and/or cause problems at work, school, or in social relationships. In addition, the person's patterns of thinking and behavior significantly differ from the expectations of society and are so rigid that they interfere with the person's normal functioning. Examples include antisocial personality disorder, obsessive-compulsive personality disorder, and paranoid

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personality disorder. Obsessive-compulsive disorder (OCD), people with OCD are plagued by constant thoughts or fears that cause them to perform certain rituals or routines. The disturbing thoughts are called obsessions, and the rituals are called compulsions. An example is a person with an unreasonable fear of germs who constantly washes his or her hands. Post-traumatic stress disorder (PTSD) is a condition that can develop following a traumatic and/or terrifying event, such as a sexual or physical assault, the unexpected death of a loved one, or a natural disaster. People with PTSD often have lasting and frightening thoughts and memories of the event, and tend to be emotionally numb.

Other types of mental illness include Schizophrenia, delusional disorder, brief psychotic disorder, shared psychotic disorder and induced psychotic disorder. These disorders have been grouped together to facilitate the differential diagnosis of disorders that include psychotic symptoms as a prominent aspects of their presentation. Cumes (2012) explaines that other disorder that may present with pyschotic symptoms as associated features are included as Dementia of the Alzheimer. Major severe mental illness is Depressive Disorders, with psychotic features and another severe mental disorder are Mood disorder. Schizophrenia is a disorder that last for at least 6 months. Another type of mental disorder called "Amafufunyane", is a serious disorder described among Zulus and Xhosa and African traditional healers believe that people have been invaded and possessed by evil spirits as a result of witchcraft when they have this disorder (Helwig ,2010).

2.6 Symptoms of mental illness

One or two of these symptoms alone cannot predict a mental illness. But if a person is experiencing several at one time and the symptoms are causing serious problems to their ability to study, work or relate to others, he/she should be seen by a mental health professional. People with suicidal thoughts or intent or thoughts of harming others, need immediate attention.

Cumes (2012) explains that the signs and symptoms of mental illness can vary, can affect emotions, thoughts and behaviors. Examples of symptoms of mental illness include: feeling sad or down, confused thinking or reduced ability to concentrate, excessive fears or worries or extreme feeling of guilt, extreme mood changes of highs and lows, withdrawal from friends and activities, significant tiredness, low energy or problem sleeping, detachment from reality, paranoia or hallucinations, inability to cope with daily problems or stress, trouble understanding and relating to situation and to people, alcohol and drug abuse, major changes in eating habits, sex drive changes, excessive anger, hostility or violence and suicidal thinking. Sometimes symptoms of mental health disorders appear as physical problems, such as stomach pain, back pain, headache or other unexplained aches and pains. In younger children the symptoms

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include, changes in school performance, poor grade despite strong efforts, changes in sleeping and or eating habits, excessive worry or anxiety, hypertension, persistent nightmare, persistent disobedience or aggression and frequent temper tantrums. Mental health problems typically do not cause physical symptoms in themselves; depression, however, can indirectly cause weight loss, fatigue and loss of libido, among others. Eating disorders, a separate class of mental health disorders, can cause malnutrition, weight loss, amenorrhea in women, or electrolyte imbalances caused by self-induced vomiting. This makes eating disorders among the most deadly of mental health disorders.

2.7 Strategies used in diagnosing mental illness by traditional healers

The spiritually curative medicines prescribed by a traditional healer are called *Muti*. They may be employed in healing as warranted in the opinion of the herbal specialist or *Inyanga*. Muti is term derived from a Zulu word for "tree". African traditional medicine makes extensive use of botanical products but the medicine prescribed by an inyanga may also include other formulations which are zoological or mineral in composition. Traditional medicine uses approximately 3,000 out of 30,000 species of plants of Southern Africa. Mutis are prepared, and depending on the affliction, a number of purification practices can be administered. Helwig (2010) explains the following practices that are administered to diagnose mental illness.

Bone throwing

According to Boom (2002),throwing the bones is one of the rituals performed by a sangoma. Essentially, the bones are scattered by hand usually in a circle and then read. Meaning is deduced in accordance with the position in which the bones fall. While the physical practice of throwing the bones and the items used in addition to bones vary from healer to healer, the practice of throwing bones is both a craft and a calling. Bones when read uncover things; they tell the problems of the patients and they have good and bad stories to tell. Traditional healers use bones to understand and uncover the sickness of the patients they are helping. Bone throwing is not something that a person will sleep thinking of and work up having an ability to read bones; it has to be a gift from the ancestors. Ben (2009) argues that the bones represents all of the forces that affect any human being, anywhere, whatever their culture, but without the spirits bone throwing means nothing, it always has to be conducted by the spirit.

Dime(2007) mentions that it is the ancestor, and not the healer, who is providing the information. The sangoma is just the messenger. There is an understanding between the healer and the spirit as to the meaning of the bones and how they line up in relationship to each other. In fact when the bones are thrown, they do not fall in a random pattern but rather in a distinct arrangement which can be read by the sangoma whose training has taught him to diagnose

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past and present ailments and even predict future occurrences. It seems that a "mini-field" of attention, intention, and coherence is set up between the healer, the patient and the ancestors that allows the bones to lie in an intelligent pattern. The metaphor they represent can then be interpreted by the healer. The reading is usually concerned with what is happening at that moment in the patient's life. Since the healer is reading a metaphor, he may get the wrong image and have to change direction. De andre (2005) argues that divining is like interpreting someone's dream, and only the owner of the dream will know if the meaning rings true. The information is given humbly and democratically. The healer will ask the patient if she agrees and, if so, will continue along the same line of exploration. If the patient disagrees, the healer will read another polarity or look at the same polarity in a different way. Correct interpretation is seldom offered dogmatically. Usually the patient is well aware of what is going on in her life. The bones will often highlight or focus on a problem that requires attention and that may have been ignored or denied.

Physical Examination

The traditional healer begins his assessment with an observation of the patient. Traditional healers have very good clairvoyant abilities. A physical examination is conducted by touching the patient body to gather information about how the patient is feeling; this examination is followed by an interview, which features questions focusing on the client's physical health, family relationships, and community an workplace relationships. For further assessment and diagnosis the traditional healer also should consult his cultural healing instrument and recite traditional divination poems.

Franchia (1976) explains that an experienced traditional healer will generally seek the guidance of an ancestral spirit before embarking on finding and collecting muti. The healer, through dreams, or during prayers, will be advised of an auspicious time for collecting the plants, and in some cases will be told which particular plants to collect for a specific patient and where those plants are located. The healer supplements the advice from an ancestral spirit with their own knowledge, training and experience.

2.8 Causes of mental illness as perceived by traditional healers

Freeman(2008) explains that there are many opinions about what causes mental illness. It is a part of a wider debate about what makes people the way they are, whether their personality is shaped by the life experiences they have gone through, or whether a person mental health problems, could be triggered by stressful or traumatic events. Some factors are determined by their genetic make-up, inherited from their parents. It's possible that some people are more vulnerable possible causes of mental illness. It may be due to any one of these factors, or to a

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combination of them. Dime, (2012) explained the following factors as the causes of mental illness. The causes of mental disorders are generally complex and vary depending on the particular disorder and the individual, although the causes of some mental disorders are unknown. Psychological and environmental factors can all contribute to the development or progression of mental disorder.

Many authorities have it that according to the traditional African thinking, mental disorders are perceived to be results of malevolent intervention of witches or ancestors, and other cosmic forces who wish to correct an inappropriate social behaviour (Danquah, 2002). Senah (2003) explains that mental disorders like schizophrenia and bipolar disorder are perceived by traditional Africans to be caused by infringement of the law of supernatural forces, the supreme being, ancestors or lesser god. Bankowski (2007) explaines that in most traditional African societies, mental illness can also be thought to be induced by human beings by means of sorcery, witchcraft, magic or by divine agents like departed ancestors and angry gods. Many traditionally oriented Africans who are called to become traditional healers are chosen by supernatural agents. Those chosen healers are widely known to display signs like aggression, social withdrawal, or bizarre behaviours until the time they accept the calling and undergo training (Mufamadi & Sodi, 199l). The following are some of the biological factors that causes mental illness:

Biological Factors

Biological factors consist of anything physical that cause adverse effects on a person's health

Neuropathology

Neuropathology refers to damage to the brain tissues itself that results in mental illness. Mental illnesses are placed in this category, since the brains of person diagnosed with mental illness exhibit microscopic changes in tissue structure when viewed under a microscope. Larger changes are seen with strokes, which results when the blood supply is cut off to a specific area of the brain causing localized damage (Van niekerk, 2012).

Prenatal Damaged

(Twumasi, 2003) mentioned that any damage that occurs to a fetus while still in its mother's womb is considered prenatal damage. If the mother uses drugs or alcohol or is exposed to illnesses or infections then mental disorders can develop in the fetus; conditions such as Autism results from a disruption of early fetal brain progression. Environmental events surrounding

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pregnancy and birth have been linked to an increased development of mental illness in the offspring; this includes maternal exposure to serious psychological stress and trauma, conditions of obstetric birth complications, infections and gestational exposure to alcohol or cocaine.

Injury and Brain defect

Any damage to the brain can cause a mental disorder. The brain is the control system for the nervous system and the rest of the body and without it the body cannot function properly. High rates of mood, psychotic and substance abuse disorders have been found following traumatic brain injury. The relationship between the severity and prevalence of subsequent psychotic disorder have been inconsistent, and occurrence has been linked to prior mental health problems as well as direct neurophysiology effects, in a complex interaction with personality and attitude and social influences. Head trauma is classified as either "open" or "closed head injury'. In open head injury the skull is penetrated and brain tissue is destroyed in a localized area in a closed area (Termelin, 1968).

Chemical imbalances

Chemical imbalances can be viewed as disorders of the brain circuits, if there is damage to the neurotransmitters in the brain then mental disorders can develop. Mental disorders possibly associated with chemical imbalances are depression and schizophrenia. Abnormal levels of dopamine activity have been implicated in a number of disorders thought to be part of the complex encoding of important of events in the external world. Dysfunction in serotonin and other neurotransmitters such as dopamine has also been centrally implicated in mental disorder including major depression and obsessive compulsive disorder (ventevogel, 2006).

Heredity

Mental illnesses sometimes run in families, suggesting that people who have a family member with a mental illness may be somewhat more likely to develop one themselves. Susceptibility is passed on in families through genes. Experts believe many mental illnesses are linked to abnormalities in many genes rather than just one or a few and that how these genes interact with the environment is unique for every person even identical twins. That is why a person may inherit a susceptibility to a mental illness but does not necessarily develop the illness. Mental illness itself occurs from the interaction of multiple genes and other factors such as stress, abuse, or a traumatic event which can influence, or trigger, an illness in a person who has an inherit susceptibility to it (vlasnik, 2005).

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Studies have indicated that genetic factors often play an important role in the development of mental illness. A reliable identification of a specific genetic susceptibility to particular disorder through linkage has proven difficult. This has been due to the complexity of interactions between genes, environmental events and early developments. The heritability of behavioural traits associated with mental disorder may be greater in permissive than in restrictive environments, and susceptibility genes probably work through both physiological pathways and behavioural and social pathways. With regard to mental illness, for a long time there has been consensus that a person inherits physical characteristics from parents and can pass them on in the same way. It's possible that a person's genetic make-up can also affect one's personality. There are genes that cause physical illnesses, so there may be genes that predispose a person towards mental illness. There is some scientific evidence to support the idea that one person may be more likely than another to develop a particular problem, such as manic depression or schizophrenia (Thomas, 2001).

Cultural Bound

A person might be called by ancestors to become a traditional healer , but that person might be in denial or is refusing to accept the calling to become traditional healer, therefore that person may start becoming severely. Culture-bound syndromes were seen as causing little damage to humanity, although they might cast light on important but little-understood aspects of human functioning. These syndromes were considered to be rare and exotic, they consisted of unpredictable and chaotic behaviours, and the sufferers were seen as uncivilised. By placing such syndromes in the context of Western diagnostic systems, any links between cultural beliefs, environmental stressors and symptoms were often ignored (Sliep, 2006)

2.9 Strategies used by African traditional healers in the treatment and prevention of mental illness

African traditional medicines still play a large role in African society. It was found that 45% of the black patients who attended a community mental health clinic had consulted a healer for their problems. Additionally, 26% were simultaneously seeking treatment from both the traditional healers and the psychiatrics as traditional healers are often instrumental in treating illness. Psychological healing relies more on a cultural and emotional understanding than it does on possessing medical knowledge. Instead of labelling tradition healers as primitive and demonic. Benn (2001) with over twenty years of experience describes how he has often collaborated with African traditional healers, even trained some of them in specific methods for identifying certain illnesses such as epilepsy and psychosis .Traditional healers are the key partners beyond the patients and their families in gaining an understanding of the psychological experiences and gaining access to social support structures. Beliefs are fundamental to behaviour, and therefore

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a deeper understanding of traditional medicine will help to improve the effectiveness of psychological care. Omozokpia (2004) also recounts how he occasionally refers mild stress cases to the healers as this patient requires a holistic approach from individuals that they know and trust.

The Traditional Health Practitioners Bill in South Africa, No.25 of 2004 made attempts at the formalization, regulation and professionalization of traditional medicine doctors. However, this bill has never been put into effect and collaboration between western and traditional medicine has yet to be established. The western approach to treating mental ill-ness often ends up worsening the patient's condition (Omozopia, 2004). In a three decade long study conducted by the World Health Organization, which includes data from 30 research sites in 19 countries, it was found that people diagnosed with schizophrenia experience better outcomes among developing countries than they did in Europe and the United States. Much of this trend is attributed to socio-cultural conditions such as increased family involvement, informal economics, less segregation of the mentally ill and community cohesion. Effective treatment of mental-illness necessitates the recognition and identification of cultural differences. For example, in western society, many derive a sense of worth from their ability to survive in a competitive economy. Ozekhome (2004) emphasises that however, the informal economies of the developing nations allow for less stressful work related roles. Therefore, conducting therapy in South Africa with an emphasis on valued citizenship does nothing more than create an intangible goal which will simply cause added stress to the individual. Effective treatment must be uniquely targeted to each culture with careful consideration of the socio-cultural conditions and contextually relevant coping mechanisms. Neglect to recognise these essential cultural factors will result inimpotent and detrimental treatment (Dime, 2007).

Social, biological and neurological sciences have provided substantial insight into the role of risk and protective factors in the developmental pathways to mental disorders and poor mental health. Biological, psychological, social and societal risk and protective factors and their interactions have been identified across the lifespan from as early as fetal life. According to Van niekerk (2012) Many of these factors are malleable and therefore potential targets for prevention and promotion measures. High comorbidity among mental disorders and their interrelatedness with physical illnesses and social problems stress the mental disorders and their interrelatedness with physical illnesses and social problems stress the need for integrated public health policies, targeting clusters of related problems, common determinants and early stages of multi problem trajectories and populations at multiple risks.

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Effective prevention can reduce the risk of mental disorders

There is a wide range of evidence-based preventive programmes and policies available for implementation. These have been found to reduce risk factors, strengthen protective factors and decrease psychiatric symptoms and disability and the onset of some mental disorders. They also improve positive mental health, contribute to better physical health and generate social and economic benefits. These multi-outcome interventions illustrate that prevention can be cost-effective. Research is beginning to show significant long-term outcomes.

2.10 Popularity of African traditional medicine

Dime (2007) states that in Africa the importance of traditional healers and remedies causes the indigenous plants to play a crucial role in the health of millions. According to the International Development Research Centre (IDRC), one estimate puts the number of Africans who routinely use these services for primary health care as high as 85% in sub Saharan Africa. The relative ratios of traditional practitioners and university- trained doctors in relation to the whole population in African countries showcase this importance. For example, in Ghana, in Kwahu district, for every traditional practitioner there are 224 people, against one university- trained doctor for nearly 21,000. In Swaziland the same situation applies, where for every healer there are 110 people whereas for every university- trained doctor there are 10,000 people.

Western practitioners have various notions as to why they believe patients opt to consult traditional practitioners, irrespective of the accessibility of western health care facilities and practitioners. The following reasons are attributed to individuals utilising the services of traditional practitioners:

- Belief and trust in Traditional healers,
- Historical accessibility of traditional healers,
- Lack of sufficient knowledge and understanding about mental illness among patients,
- Privacy offered by traditional healers,
- Negative attitudes of western practitioners towards patients,
- Promise of a traditional cure for mental health,
- Inefficient western health care referral system and
- Shared worldview and traditional theories of disease causation with traditional health healers by (Freeman & Motsei ,1990).

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2.11 Reasons for consulting traditional healers

WHO estimates that 80% of Africans use the traditional medicinal sector as their first contact place for all types of mental health problems. The researchers attribute this high patronage to the fact that the treatment is holistic by taking into account the spiritual, physical as well as psychological aspect of health. Studying the health -seeking behaviours of participants in a study from Burkina Faso, Razali (2006) found that a strong belief that modern methods are deemed good for physical illness but powerless against supernatural causes was a source of attraction for traditional medicine. He also found in his study that most participants mentioned that western methods alone deal merely with symptoms to give temporary relief, but the underlying social and moral problems still remain in relation. Relative to the use of herbs and other indigenous medicines, Atindanbila (2008) found out that only 2% of thep psychiatric patients in the hospital used hospital drugs solely for the treatment of their disorders. The remaining patients had visited the traditional healers in addition to the hospital therapies.

Madu (1997) explained that because traditional Africans believe that sickness of an emotional or psychological nature originates as a punishment from the gods for evil, western- influenced models of psychotherapy have limited influence.

According to WHO (2003) the popularity of traditional mental healers is due to the following reasons:

Confidence in the system: The explanations offered to the clients as the cause of their illness are more acceptable than the allopathic medicine. Some even believe that mental illness can be handled better by traditional healers than modern medicine.

Affordability: The cost is cheaper and more flexible than allopathic medicine. Traditional treatment allows the client the opportunity to settle their bills when they can afford it. More often than not patients pay the bills when they are fully recovered and can work towards paying the bills. Through oral traditions, some people also do self medication which reduces the cost.

Accessibility: Traditional healers are found in remote areas where hospital facilities cannot be found. Even in such places where facilities are found, they lack the basic drugs and mental health staff to manage them. WHO statistics has it that in Zimbabwe it is estimated that the ratio of traditional healers to the population is 1:234 in the urban areas and 1:956 in rural areas. The estimated proportions for the continent as a whole is 1:200 as compared with 1:100,000 for western-trained medical doctors and 1:1,000,000 psychiatrists.

The WHO estimate that up to 80% of the population in Africa use traditional medicines. In sub-Saharan Africa, the ratio of traditional healers to the population is approximately 1:500, while

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medical doctors are 1:40 000 to the population. It is clear that traditional healers play an influential role in the lives of African people and they have the potential to serve as crucial components of a comprehensive health-care strategy. The WHO formally recognised the importance of collaborating with traditional healers in 1977. It has organised a number of expert consultations and conferences, and has issued guidelines on traditional medicines, traditional healers and collaboration between biomedicines and traditional medicine. Because traditional medicines use biological resources and knowledge of traditional groups, it is often linked to biodiversity conservation and indigenous people's rights over their knowledge and resources.

2.12 Adherence to medication

There are times when patients do not adhere to both western medicine and traditional medicine and this section discusses this issue.

2.12.1 Factors associated with non-adherence to African traditional medicine

Non-adherence is a poly-faceted problem related with therapeutic relationship between the patient and the healers, factors related to medication and factors related to the patient and their illness. Healers sometimes contribute to non- adherence because of failure to prescribe simple regimes, explain the benefits and side effects of medication and consider patients lifestyle and medication cost involved. Morris (2006) states that in addition, typical reasons for not taking medications include forgetfulness, presence of other priorities, deliberate decision to omit doses, lack of information and emotional factors such as distress. Non–adherence to mental illness treatment undermines treatment effectiveness, increases risk of relapse and leads to poorer outcomes. Psycho education programmes, family therapy and community based interventions have been used successfully to improve adherence. A systematic review of studies done in the USA found out that non-adherence was 41, 2%. The same review showed that poor insight, negative attitudes or subjective response towards medication, previous non-adherence, substance abuse, shorter duration of illness, inadequate discharge planning or aftercare environment, and poorer therapeutic alliance were factors associated with non-adherence to medication (Morris, 2006).

A study in India showed that the most common reason for poor medication adherence were financial problems (41%), long distance to facilities (35%), improvement in symptoms (28%) and other causes like side effects, lack of caregiver, lack of insight about the illness, and the nature of the patients 's job. Another study which was done in Pakistan revealed that the prevalence of non-adherence was around 39% and the most prevalent reason for non-adherence included sedation (30%), medication cost (22%), forgetting to take medication

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(36%), failure by the healer to explain timing and dosage (92%) or benefit of medication (76%) (Andrew, 2009).

Below are some of the factors associated with non- adherence to African Traditional medicine

Patient-Centred Factors

Several patient-related factors, including lack of understanding of their disease, lack of involvement in the treatment decision-making process and suboptimal medical literacy contribute to medication non-adherence. In the United States alone, an estimated 90 million adults have inadequate health literacy, placing them at risk for increased rates of hospitalization and poorer clinical outcomes. The patient's beliefs and attitudes concerning the effectiveness of the treatment, their previous experiences with pharmacological therapies, and lack of motivation also affect the degree of medication adherence. Medication adherence continues to decline even after a catastrophic event such as mental illness, thus it is not surprising that treating asymptomatic conditions to prevent the possible occurrence of adverse events years later, presents an even greater challenge.

Poverty

According to Didlake (1988) states that the most frequent reason for non-adherence to mental illness medication is lack of adequate and proper food. Some medicine are very strong and requires good food in order to counter balance their side effects. If taken on an empty stomach it could cause harm to the body. As a consequence, patients are liable to stop their medications whenever there is shortage of food. Lack of food is also another important perspective, as some of these medications lead to an more increased appetite and this has two negative effects, either as a burden on the family because of increased food consumption by the patient or, in the event of limited food availability, the experience of hunger. A patient is forced to discontinue their medication because they find the increased hunger difficult to tolerate.

Educational level

The effect of educational level on non-adherence was equivocal after reviewing some articles which focused on the impact of educational level even though different criteria for higher and lower education were used. Several studies have shown that patients with higher educational level might have higher adherence (Fleck, 2011), while some studies found no association. Intuitively, it may be expected that patients with higher educational level should have better knowledge about the disease and therefore be more compliant. However, Di Matteo (2000) found that even highly-educated patients may not understand their conditions or believe in the benefits of being compliant to their medication regime.

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Treatment methodologies of traditional healers

Komla (1997) explains that some clients believe that a healer cannot treat any illness without adequately dealing with the spiritual factors that ultimately account for the diseases manifestation. Therefore, there is tendency to look beyond the physical treatment of illness towards the spiritual. Thus treatment often includes abstaining from particular types of food, alcohol and sex during and after treatment.

Traditional pharmacopoeia

Traditional healers and particularly herbalist believe that every disorder has a corresponding plant or animal product that can neutralise its effect (Senah, 2001). They use elements of plants like leaves, roots, seed and barks. They may be used in isolation or combined with mud and earth and small animals; these herbs are thereafter processed into medicines or ointments.

Restraints and occult therapy

These are methods used to control psychotic patients who are aggressive or in the acute stage. They include physical measures like using ropes or chains to immobilize them. Some even resort to beating them to make them weak in order not to harm themselves or others. Sedative herbal preparations are also forced down their throats as concoctions or instilled into their noses. Others use spiritual restrains like prayers (Fleck, 2011). Senah (2001) also has it that the traditional African believes that mental illness which has supernatural origins can only be managed by large doses of magical-religious forces. Each traditional healer in his or her own orientation has been equipped with varied forms of weapons to fight the invisible forces.

2.12.2 Factors associated with non- adherence to western medicine

Non-adherence is a prevailing problem throughout the world. Proper adherence to therapies in developed countries averages 50% and the figures are much lower in developing countries given the reduced access to health care and educational resources. Philips (1966) explains that, many chronic illnesses that require long-term medication regimens have low adherence rates worldwide: depression (40-70%), asthma, (43%) for acute treatments and 28% for maintenance) and HIV/AIDS (37%-83%). Only 51% of American patients adhere to their treatment regimen for high blood pressure.

Langer and Alberson (1974) explain that, many patients visit the doctor only when they have physical symptoms. These symptoms may be due to an acute ailment or the effects of a chronic condition, such as asthma, hypertension, or diabetes. Patients from urban areas of developing countries are often accustomed to receiving medications at every doctor's visit to alleviate acute

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symptoms, but are unaccustomed to long-term treatment regimens to manage chronic conditions. As a result, refugees who receive treatment for chronic conditions in the United States may believe themselves to be cured once symptoms stop. This false perception often leads to a sudden discontinuation of medication which can cause withdrawal or restarting side effects, as with medications like metformin, SSRIs and beta blockers. Patients may also discontinue a course of antibiotics when they begin to feel better.

Among immigrants In rural areas of home countries, there is very often poor access to health care, even to treat somatic symptoms. Medical care can be expensive and far away. As a result, Western health care as a whole may be a foreign experience to immigrants. In the United States, care and coverage can be complex and expensive. Some patients may find themselves not knowing how to schedule appointments or fill a prescription. Some patients may assume timing of refills will correspond with timing of scheduled visits with the care provider (Goodyear & Parish, 1978).

In general, pharmaceuticals such as antibiotics are readily available without a prescription in the urban areas of many refugee patients' countries of origin. Medication is acquired from pharmacists, family members and friends often through unrestricted dispensing. Certain medications, such as laxative, aspirin and antibiotic are commonly kept on hand in homes, and some people continue this practice in the United States. In Seattle in 2007, a news investigation reported about a black market of prescription medicines that are sold without prescription in local shops that mainly serve poor, uninsured Hispanic customers who may believe they have no alternative to accessing needed medications.

Moore (2002) argues that due to perceived strength or incompatibility, Western medication regimens are sometimes reduced or discontinued by the patient. Immigrants who subscribe to the humorally based (hot/cold) conception of illness, usually of Asian or Hispanic origin, report that Western medicine is too strong for their physiologies, causing them to become too hot and suffer an internal heat, and therefore are not recommended when the patient already has low internal strength. For example, penicillin is considered a hot medicine. Some Vietnamese believe that traditional medicines and even French medicine are more tolerable than American medicine, which may lead them to reduce their dose or seek more appropriate treatments from local community members or abroad.

However Linden (2008) argues that in the U.S., patients often have complicated treatment regimens involving a multitude of medications that need to be administered at different times throughout the day. For some patients, taking multiple medications at the same time simplifies these treatment regimens. Other patients believe that combining different types of Western

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medicine is dangerous and they refrain from taking multiple medications at the same time, even when it is harmless. Some patients fear that medications taken for an extended period of time will build-up in the body over time, causing harm to one's health. Patients who believe this often discontinue medication earlier than prescribed.

According to Langer (1974) patients may believe that Western medicine is capable of treating conditions better and faster if the dosage is large enough. If a patient believes his current regimen of cholesterol medication is proving ineffective, for example, a patient may increase the dosage himself. In such cases, the provider should emphasize that medication is most effective when it is followed according to the prescription. Additionally, the provider should stress the importance of behavioral changes, in this case, diet and exercise, such that the patient does not view his medication as the only way to manage his condition.

Just like the general population, some refugee or immigrant patients perceive name brands to be better. Some patients believe they are not receiving the best medication available if they are prescribed a generic or cheap brand. Patients identify their medication by both appearance and name, although by appearance is more common. As red is a strong color, red medication is thought to be especially strong by those who subscribe to a hot/cold conception of illness. Patients may prefer certain colors and use color as a factor to gauge medication effectiveness. For instance, when the International Medicine Clinic (IMC) at Harborview Medical Center (HMC) switched from red and yellow name-brand capsules to a plain-colored generic brand with the exact same ingredient, patients complained that they wanted the red and yellow medicine n because it worked better for them. Likewise, medicine dispensed in a container different than what a patient is used to receiving, may be perceived as being less effective even though the medicine itself did not change.

Freeman (2008) mentions that Larger pills, often vitamin supplements, tend to have lower adherence rates. In one instance, a Vietnamese patient suffering from potassium deficiency was prescribed potassium pills by her physician. On return visits, the patient's potassium levels were not increasing while the patient reported taking the pills as prescribed. Taking the patient's word at face value, the physician continued to increase the dosage at every visit until it reached the maximum allowable intake. The patient then tearfully admitted that she never took the medication because the large size of the pill made it difficult to swallow .

Patients with heavily- stigmatized diseases such as TB, HIV/AIDS, STDs and mental illnesses may experience social labeling and isolation. Some diseases are traditionally equated with a low quality of life or with death and patients may be unaware of Western medicine's ability to manage and/or treat such conditions. Antidepressants are highly stigmatized, and may be seen

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as appropriate only for those defined as "crazy" and some patients may believe taking antidepressants will actually lead them to become crazy. Patients who are affected by stigmatized conditions often attempt to hide the disease by privately consuming their medication In turn, the and sometimes although the treatment may be effective, social pressures may lead some patients to skip doses or discontinue it altogether.

Even when all members of the family have the knowledge to deal with mental illness, the family is often reluctant to discuss their family member with others because they do not know how people will react.

2.13 Definition of African Traditional medicine

Traditional medicine (also known as "indigenous" or "folk medicine") comprises knowledge systems that developed over generations within various societies before the era of modern medicine.

The World Health Organization WHO (2003) defines traditional medicine as:

The sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness. The WHO notes however that inappropriate use of traditional medicines or practices can have negative or dangerous effects and that further research is needed to ascertain the efficacy and safety of several of the practices and medicinal plants used by traditional medicine systems. Core disciplines which study traditional medicine include herbalism, ethnomedicine, ethnobotany, and medical anthropology (Milas, 1995). Komla (1997) explains that in some Asian and African countries, up to 80% of the population relies on traditional medicine for their primary health- care needs. When adopted outside of its traditional culture, traditional medicine is often called complementary or alternative medicine. Practices involving traditional medicines include *Ayurveda*, *Siddha* medicine, *Unani*, ancient Iranian medicine, Irani, Islamic medicine, traditional Chinese medicine, traditional Korean medicine, acupuncture, Muti, Ifá, and traditional African medicine.

Traditional medicine may include formalized aspects of folk medicine, that is to say longstanding remedies passed on and practised by lay people. Folk medicine consists of the healing practices and ideas of body physiology and health preservation known to some in a particular culture, transmitted informally as general knowledge, and practiced or applied by anyone in the culture having prior experience. Folk medicine may also be referred to as traditional medicine, "alternative medicine", "indigenous medicine", "complementary medicine",

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or natural medicine. These terms are often considered interchangeable, even though some authors may prefer one or the other because of certain overtones they may be willing to highlight. In fact, out of these terms perhaps only indigenous medicine and traditional medicine have the same meaning as folk medicine, while the others should be understood rather in a modern or modernized context. Similarly, a home remedy is a treatment to cure a disease or ailment that employs certain spices, vegetables, or other common items. Home remedies may or may not have medicinal properties that treat or cure the disease or ailment in question, as they are typically passed along by lay persons.

2.14 Traditional healer's perception of healing

Bereda (2002) states that western practitioners are divided in their stance on whether or not traditional healing has any benefits as well as on the nature of such benefit. By and large the Kbenefits of traditional healing are perceived to be directly proportionate to an individuals belief in traditional healing, especially in the theories of disease causation upon which the traditional healing system is founded. Blanket - sliep (1980) states that some western practitioners believe that traditional healing is beneficial only in addressing psychosomatic and psychological aspects of illness, as opposed to providing scientifically significant physiological changes in the health of patients.

De Andrade, V.& Ross, E. (2005) states that the prolonging seeking appropriate health care when the illness is very severe and the traditional treatment not producing the desired effect, can be perceived as a manifestation of a sense of denial on one's mental- illness status. This sense of denial is reportedly sustained and nurtured by traditional healers lack of sufficient knowledge of the complexity of mental illness. Dalasile, Ramgoon, Paruk, & Patel (2011) state that a sense of denial of one's mental status creates room for the belief that one will return to one's natural state of health eventually. This belief is supported and fueled by the notion held by many traditional practitioners, namely, that all recurrent illnesses diseases have a supernatural cause and based on the correct diagnoses and, thus adherence to the appropriate treatment, all diseases are curable.

2.15 Challenges facing traditional medicine

In the past, the African governments did not recognize these contributions made by traditional medical programs, however with cuts in foreign aid, they were forced to consider the advantages of African traditional medicines. Gascon (2004) notes that In July 2001, at Lusaka, Zambia, the African Union declared 2001-2010 to be the decade for African traditional medicine. The goal was to bring all the stake- holders altogether in an effort to make safe,

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efficacious, quality and affordable African traditional medicine available to the vast majority of the people.

Diagnostic difficulties and lack of doxology

Most traditional healers are not highly educated and do not have a sound knowledge of the anatomy and physiology of the body, therefore they find it difficult to come up with the correct patho-physiological processes and diagnoses. They rely mostly on the signs and symptoms, ancestors and dreams. Senah (2001) also notes that the traditional African believes that mental illness which has supernatural origins can only be managed by larger doses of magical-religious forces. Each traditional healer in his or her own orientation has been equipped with varied forms of weapons to fight these invisible forces.

Most of the healers have no dosage guidelines. In addition to ensuring that the proper dosage of any pharmaceutical is prescribed, this dosage information can benefit the client-healer relationship when symptoms either are not relieved or when other symptoms arise.

Unhygienic preparation of herbs and lack of doxology

Since they have little or no knowledge about personal hygiene, microbiology and their effects on health, most of their drugs are prepared under unhygienic conditions. This results in some of the patients contracting nosocomial infections and traditional healers at times infecting themselves.

Loss of knowledge and herbs

The plants used for the herbs are diminishing at an alarming rate due either to the degradation of the environment or human activities like farming and improper methods of harvesting. Apart form that, there is a loss of indigenous knowledge as the elders die without having passed the knowledge to the younger generation. This is partly explained by the fact that western education looks down upon their practices (Dime, 2007).

Lack of a code of ethics in African traditional medicine.

One of the main constraints of African traditional medicine is the lack of a uniform code of ethics to protect the clients, practitioners and the society. The practitioners are also given to paternalism in which they decide everything for the client which does not allow the client any confidentiality. Healers are known in some countries, like Ghana, to discuss the health problems of their clients in public as means of advertising their therapies in violation of confidentiality of in therapies (Green, 2006). Due to lack of ethics to enforce legitimate

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membership, charlatans who cannot cope with economic woes have moved to urban areas as a means of survival but have no knowledge of the herbs.

Attitudes of public officials and Allopathic practitioners towards African traditional healers and referrals

According to Green (2006) public officials and allopathic practitioners tend to be biased against working with African traditional healers due to prejudices or fear of competition. Hence their services are not officially supported or recognized in national health systems. Some also argue that although some herbs have beneficial effects, they may interact with western drugs and prove lethal. Others also fear that if government officially recognizes the collaboration, it will legitimize unproven or harmful practices. Many orthodox hospitals complain of receiving patients with mental disorders that have been delayed longer than desirable in the clinics of incompetent traditional healers who are ignorant of their own power.

2.16 Psychological factors

Patient-prescriber relationship

Patient-prescriber relationship is another strong factor which affects patients' non-adherence Kim (2002) emphasises that a healthy relationship is based on patient's trust in prescribers and empathy from the prescribers. Studies have shown that adherence is good when traditional healers are supportive, giving reassurance or respect, and treating tne patient as an equal partner (Moore, 2004). Rubin (2005) mentions some situations that may negatively influence patient's trust in their healers, for example, those who ask their patients only few questions and seldom make eye contact with patients and patients who find it difficult to understand the traditional healer's language. More importantly, too little time spent with patients was also likely to threaten patient's motivation for maintaining treatment and also poor communication with health care providers had a similar effect (Vlasnik, 2005).

Health Literacy

Health literacy means patient's ability to read, understand, remember medication instructions and act on health instruction (Vlasnik, 2005). Patients with low health literacy were reported as being less compliant with their treatment. On the contrary, patients who can read and understand drug labels were found to be more likely to have good compliance.

Patient knowledge

Patient knowledge about their disease and treatment is not always adequate. Some patients lack understanding of the role of their treatments, others lack knowledge about the disease and

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consequences of non-adherence (Aim-Roijer et al, 2004) or lack understanding of the value of visits to their healers. Some patients thought the need was intermittent, so they stopped the medication to see whether medication was still needed. For this reasons, patient education is very important to enhance compliance. Health providers should give patients enough education about the treatment and disease (Haynes et al, 2001).

Treatment- related factors

Therapy- related factors include, route of administration, treatment complexity, duration of treatment period, medication side effects, degree of behavioural change required, taste of medicine and requirements for drug storage.

Route of administration

Medication without a convenient way of administration is likely to make patients not comply. Studies in patients with mental-illness compared compliance between oral and inhaled medication and found that patients had better compliance with oral medication (Bender, 2005). Likewise, difficulty in using inhalers contribute to non-adherence in patients with mental disorders.

Treatment complexity and duration of the treatment

Complex treatment is believed to threaten the patient's adherence. However, adherence does not seem to correlate with the number of drugs prescribed, but the number of dosing times every day of prescribed medications. The rate of compliance decreases as the number of daily doses increased. Acute illnesses are associated with higher compliance than chronic illness (Gascon et al, 2004). In addition, longer duration of the disease may adversely affect adherence. Similarly, a longer duration of treatment period might also compromise patient's compliance and this may also indicate that compliance is improved because patients attitude of denying the disease is reduced and they accepted treatment after years of suffering from the disease.

Medication side effects and degree of behavioural change required.

Linden et al (2004) explaine that in a German study, the second most common reason for non-adherence with patients with mental illness treatment, may be explained in terms of physical discomfort, scepticism about the efficacy of the medication, and a decrease in trust in traditional healers. The degree of behavioural change is related to patient's motivation to be compliant with treatment (Milas et al, 2001)

2.17 Social and economic factors

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Time commitment

Patients may not be able to take time off for treatment as a result, their rate of adherence could be threatened (Bosley, 1995). Therefore, a shorter travelling time between residence and health care facilities could enhance patient's compliance. A study suggested that white collar patients have poor adherence because they have other priorities.

Social Support

The general findings showed that patients who had emotional support and help from family members, friends or health- care providers were more likely to be compliant to the treatment. The social support helps patients in reducing negative attitudes to treatment, have motivation and remember to implement the treatment (Boom , 2002).

Smoking or alcohol intake

Several studies about compliance among mental-illness have found that patients who smoked or drank alcohol were more likely to be non-compliant (Okuno et al, 2000). Violent behaviour among individuals with severe mental illness has become an important focus in community based- care, this examines the joint effect of substance abuse and medication non adherence on the greater risk of serious violence among persons with severe mental illness. A combination of medication non- adherence and alcohol or substance abuse problems was significantly associated with serious violent acts in the community. Alcohol or other drug abuse problems combined with poor adherence to medication may signal a higher risk of violent behaviour among persons with severe mental illness

Forgetfulness

Forgetfulness is a widely reported factor that causes non-adherence to medication or healers appointments (Cummings et al, 2002). Non- adherence to African traditional medicine is a major obstacle in the effective treatment of mental illness. A significant proportion of mentally- ill patients prematurely in both special and traditional care settings. It has been found that as many as 60% of primary- care patients stopped taking their medicines before completing the recommended period as they forget to take their medication because of other duties.

2.18 Consequences of non- adherence

Evidence on impact of no-nadherence on outcomes for psychiatric patients has been consolidated within new research. Non- adherence has been found to predict poorer outcomes for patients, including visitation to traditional healers, violence, suicide and premature mortality. Non-adherence has also been associated with premature mortality in mental illness and non-

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adherence can also be a risk factor for violence in illness as confirmed by traditional healers which is associated by including a range of measures such as reported aggression and arrest.

A need for more prospective and intervention studies was identified as patients with lack of insight into their mental disorder have also been found to be at risk of non- adherence. These studies demonstrate that motivation extends beyond knowledge of medication efficacy and adverse effects, hence attempts to improve adherence by tackling practical barriers alone may not be successful if perceptual barriers like doubts about medication necessity or concerns about adverse consequences are salient for individual. Lack of insight and in particular low recognition of the need for treatment, was strongly associated with non-adherence within a sample of patients with mental illness.

2.19 History of African traditional healers in colonial era

Modern science has, in the past, considered methods of traditional knowledge as primitive and backward. Under the colonial rule, traditional healers were outlawed because they were considered by many nations to be practitioners of witchcraft and declared illegal by the colonial authorities who created a war against witchcraft and magic (Helwig, 2010). During this time, attempts were also made to control the sale of herbal medicines. After Mozambique obtained independence in 1975, attempts to control traditional medicine went as far as sending traditional healers to re-education camps. As colonialism and christianity spread through Africa, colonialists built general hospitals and Christian missionaries built private ones, with the hopes of making headway against widespread diseases (Mokaila, 2007).

Stanley (2004) states that little was done to investigate the legitimacy of these practices, as many foreigners believed that the native medical practitioners were pagan and superstitious and could only be fixed by inheriting western methods. During times of conflict, opposition to traditional medicine was particularly vehement as people are more likely to call on the supernatural realm during such times. Consequently, doctors and health practitioners have, in most cases, continued to shun traditional practitioners despite their contributions to meeting the basic health needs of the population.

In various countries, traditional healers have been drawn on in primary health- care strategies before the advent of awareness of mental illness. With rapidly escalating mental illness prevalence rates in sub-Saharan Africa, it is foreseeable that people's expectations of traditional healers and the subsequent workload of traditional healers are dramatically increasing. According to Rana (2002) it would thus follow that traditional healers need the support, education and cooperation that formal health- care systems might be able to offer, while the

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latter could potentially expand the reach and efficacy of their mental illness prevention and treatment programmes by enlisting the help of traditional healers.

Therefore Razali (2006) argues that it is difficult to estimate how many South Africans make use of traditional healers and how many traditional healers practice their trade. While a number of other countries have made early attempts to formally recognise traditional healers and to set up traditional healer organisations, the South African government has only recently embarked on this process- notably with the drafting of the Traditional Health Practitioners Bill.

2.20 Theoretical perspectives

There are different theories which have been developed to aid our understanding of mental illness and its treatment.

Psychoanalytic theory

Psychoanalysis is commonly used to treat depression and anxiety disorders. The aim of psychoanalysis therapy is to release repressed emotions and experiences, for example. make the unconscious conscious. It is only by having a cathartic (healing) experience can the person be helped and cure.

Traditional healers all over the world believe that by altering consciousness through activities like trance dancing or taking certain herbs, they can enter worlds in which they can meet and work with spirit helpers who guide them in bringing healing, whilst Freud(1916) explains that dreams have been interpreted since biblical times, and even before. They were often seen as prophecies or divine revelations. But to Freud, the evolutionary biologist, dreams were a product of the individual psyche. He saw dreams as pieces of hints about the unconscious, and in his study of minds he examines its interplay with the human personality, which he categorized as the 'id', 'ego', and the 'superego' (Howard, 2012). African traditional healers take a similar view. They believe dreams are a form of communication with the spirit world, for instance with the ancestral spirit. Sigmund Freud's (1913) interpretation of dreams suggest that the primary psychological function of a dream is to fulfil unconscious and unacceptable wishes and desires.

The unconscious is the portion of the mind of which a person is not aware. Freud said that it is the unconscious that exposes the true feelings, emotions, and thoughts of the individual. There are variety of psychoanalytic techniques used to access and understand the unconscious, ranging from methods like hypnosis, free association, dream analysis. Dreams allow us to explore the unconscious; according to Freud, they are the royal road to the unconscious.

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Dreams are composed of latent and manifest content. whereas latent content is the underlying meaning of a dream that may not be remembered when a person wakes up, manifest content is the content from the dream that a person remembers upon waking and can be analyzed by a traditional healer.

- **Existential-humanistic theory**

One area in which existential-humanistic approaches have had a tremendous effect is among people facing life-threatening illnesses. In South Africa small groups of similarly- affected people now commonly come together for weekly intimate discussions. In these groups, people typically disclose their fears and anxieties about bearing pain and facing death, consistent with the existential emphasis on actively facing such challenges (Wachala, 2007). Franklin opinies that the mind is perpetually in need of meaning for its relevant existence.

According to Abraham Maslow self-actualization implies that a person is experiencing reality with all of their faculties and feeling a sense of connection with the rest of humanity and their (Maslow, 1971). The question is: Who or what is the entity that is going through this experience? It is the self. The construct of self, also called self-concept, plays a very important role for all humanistic psychotherapists. The self is constantly evolving and changing from childhood and eventually it incorporates the self-image into one whole self. Humanists believe that a person has the capacity to change their behavior and have the internal mechanism to heal and grow as individuals. Each person is viewed as an indivisible whole - a gestalt. Humanistic psychology is monistic in its approach and does not believe in the dualism of the body and mind; the person is interconnected and integrated.

Each individual has the capacity to choose and to determine a course of action. There are a number of steps that can reinforce the confidence factor in individuals making choices and improving their self-esteem. According to Carl Roger (1965) the client first starts to believe in their abilities to induce a change and then they develop the confidence in making decisions that will change their behavior and at the same time create the foundation of living a socially-dependent life. Choices play an important part for a person to function. All humanistic therapies view each person's reality as unique. It cannot be categorized nor can it be compared to someone else's. The therapist must show genuine concern and respect towards the client's subjective experience.

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African perspective

The meso-cosmos

The meso-cosmos is situated in the world of the individual and in the collective imagination. It involves the ancestors, the living reality (animals and humans) and the natural physical reality (forests, bushes, trees, rivers etc). Africans are inclined to explain all conflict and events such as sickness and death, with reference to this level. This is a kind of no- man's land, where coincidence and the forces of the ancestors, malignant spirits, sorcerers and shamans influence and determine human behaviour. Throughout Africa, the most important of these intermediary forces are the ancestors, who mediate between the living and the dead and the remembered dead or ancestors. Contrary to Western belief, the ancestors are not experienced as deities or spirits, but as persons who influence the lives of the living and with whom a speaking relationship can be attained

According to Sow (1980) the meso-cosmos can be called the 'structured collective imaginary'. It is the place that gives rise to all good and bad fortune, the site of dramatic events and the source of worldly success. This level is of the utmost importance for the personologist, because it is the level from which an African perspective explains human dynamics. In contrast to some Western-oriented theories that explain behaviour as the outcome of intrapsychic dynamics or interpersonal dynamics the African perspective attributes behaviour wholly to external agents outside the person; In this regard, the African view corresponds more with behaviourism. Therefore, individuals cannot hold themselves responsible or accountable for their own behaviour because the causes of all behaviour and events are ascribed to external, supernatural beings or powers. This view has grave implications for people who do not take responsibility for their own actions and behaviour, and therefore are not held accountable for their behaviour.

It also implies that personal initiative in searching for solutions is repressed since people are at the mercy of supernatural beings and powers. Behaviours and to events can therefore not always be explained on empirical and rational grounds in the traditional context, and one has to look for invisible powers and beings behind the empirical and rational reality. One of the problems of modernisation is the destruction of the historical rootedness found in the macro- and meso-cosmic orders that serve as a guideline for the daily lives of traditional Africans. Although even But even among educated and modernised Africans, the influence of the ancestors does not seem to be completely lost. Even among those who are professed Christians, many still firmly believe in the spirits of their ancestors and grope for some link with them when they seek moral guidance, inspiration and hope.

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3. Conclusion

Alcohol or other drug abuse problems combined with poor adherence to African traditional medicine may signal a higher risk of violence behaviour amongst person with severe mental illness. Reduction of such risk may require carefully targeted community intervention, including integrated mental health and substance abuse treatment . poor insight is common in mental – illness. Approximately one half of all mental illness exhibit severe, pervasive, and persistent problems with insight. Mental illness results in a poorer course of illness and problems with treatment, simplification of dosing, increased supervision and possible, long- acting injectable medication .

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3. Chapter 3: Research Methodology

3.1 Introduction

This chapter presents the research methodology to be followed in conducting the study. The researcher will discuss the approach and the design, the sampling techniques that was used to select participants, the data collection and data analysis methods. Finally, the ethical issues that the researcher took into consideration when conducting this study and the trustworthiness of this will also be discussed.

3.2 Research approach

This study was qualitative in nature. Qualitative methods collect information in the form of words which give us an in-depth understanding of the nature of what people experience. Qualitative researchers use in-depth, open- ended interviews; these interviews allow participants to speak about their experiences in their own words (Higson, Bless and Smith, 2010). Participants can speak at length, in detail and in a way that will be quite personal and unique. To get meaningful information, the participant must trust the interviewer and feel respected. The main focus of this approach is to understand, explain, explore, discover and clarify situations, feelings, perceptions, attitudes, values and experience of groups of people.

The qualitative approach was adopted because the study is based on the experiences of the participants. The researcher had to overcome, some hesitation from the participants by assuring them that the research will follow ethical principles such as the right to privacy, protection from harm and anonymity of the participants. This encouraged the participants to speak freely.

3.3 Research design

The research design chosen for this study was the exploratory research design. A research design is a plan, structure and strategy of a conceived investigation to obtain answers to research question or problems. The purpose of the research was to gain familiarity with a phenomenon of traditional healers and mentally-ill patients or acquire new insight into it in order to formulate a more precise or develop problem hypothesis. For instance, the participants may decide to withdraw from the interview because they might feel that the study was too personal or sensitive. Some participants may feel that there was bias. This problem was addressed in this study by assuring them that the information provided in this study was going to remain confidential (Wellman, 2005).

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3.4 Population and setting

The study targeted traditional healers who have been practising for a minimum of three years. The population chosen is the Vhavenda ethnic group who are found in the Northern part of the Limpopo Province. Thulamela Municipality has three hospitals, namely, Tshilidzini, Donald Fraser as well as Malamulele hospital. There is only one organization for Traditional healers namely, The Traditional Health Practitioners Act of 2007 (Act of 22 of 2007). The Vhavenda are among a few groups in the Limpopo Province who still honour their traditional cultural practices, including consultation with traditional healers.

The population of the study comprised of traditional healers either male or females who had been practicing for a minimum of three years, who had been treating diseases such as schizophrenia, post- traumatic stress disorders and Alzheimers as well as dementia and amnesia. The study was undertaken in Thulamela Municipality in Vhembe District Municipality of the Limpopo Province. Thulamela Municipality is regarded as a semi-rural municipality because it has different locations, such as villages and townships as well as Malls, municipal office, and shopping centres. Most people who reside in the townships are educated since there is a university in the vicinity. There are people who are either employed, unemployed and or self- employed.

3.5 Sampling and sample size

All traditional healers who could be reached in the Thulamela municipality were included in the study and according to the register, at the time of the study there were 5 traditional healers.

According to De Vos (2005), sampling involves the process of choosing an element of the population to be considered for actual inclusion in a study. This present study used purposive sampling to select the traditional healers. Purposive sample rely on researcher's experiences, ingenuity and previous research findings to deliberately obtain units of analysis in such a manner that the sample they obtain may be regarded as being representative of the relevant population. This type of sampling is based entirely on the judgement of the researcher. In purposive sampling, the sample was composed of elements, which contain the most characteristics representative or the typical attributes of the population. Black (2009) justified the use of such sampling method as being most appropriate for it enables a researcher to select members of the culture who are specially knowledgeable, insightful and articulate, or who had specialised knowledge, which was not shared by the rest of the community. Therefore using purposive sampling in this study allowed the inclusion of participants in the study who have been taking care of the mentally ill for some time and have knowledge about taking care of the

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patients. Five traditional healers with information regarding the taking care of the mentally- ill patients were interviewed in the Thulamela Municipality.

3.6 Inclusion criteria

The study focused on traditional healers who were willing to participate and have been practicing for a minimum of three years. In this study, the researcher only focused on registered traditional healers who practice as herbalists.

3.7 Research instrument

An interview guide was used to elicit information regarding participant's no- adherence experiences in caring for patients with mental illness. In semi structured interview the researcher has a list of themes and questions to be covered, although these vary from one interview to the next because of probing questions. An interview guide was used in a semi-structured interview; the guide contained a list of topics that had a bearing on the given theme and those that the researcher raised during the course of the interview. Semi- structured interview is a type of interview which is commonly used in qualitative studies. This technique assisted the researcher to gather in-depth, descriptive data from the participants based on their personal experience of the subject under study. There were four questions open ended questions.

3.8 Entry negotiation

Prior to data collection, the researcher asked for permission from the royal chief to obtain data from traditional healers. After that the researcher went to the participants to ask their permission to collect data and for their contact details regarding setting the date for interviews.

3.9 Pre-testing

Pre-testing was conducted with two traditional healers before the main study was conducted. The pre-test helped the researcher to assess the applicability or relevance of the main research questions. This helped the researcher to minimise the errors caused by the question. (Durkeim, 2006).In this case, there was no question that needed to be revised; every question was clear.

3.10 Data collection

The study was carried out using semi- structured interviews. All participants were requested to voluntarily sign a consent form to indicate their willingness to participate in the study and the tape recording of their responses. During the interview the researcher observed the participant's reaction. The interview lasted for one hour each and took place at the traditional healers

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houses. A voice recorder was used to record the interviews and they were conducted in Tshivenda and were later transcribed and translated into English (Ranjit, 2011). Semi-structured interviews are ideal because they allow participants to freely provide information. The researcher was free to ask the question in whatever sequence the researcher wished. The researcher also had complete freedom in terms of the wording the interview questions and the way the researcher explained questions to the participants. The researcher was able to formulate questions and raise issues on the spur of the moment, depending on what occurred in the context of the discussion (Black, 1999).

Semi- structured interview are valuable when dealing with emotional processes and personal issues (Bless, 2008). The researcher opted for this interview method as it allowed the researcher to probe for clarity. The semi-structured interviews was ideal because it allowed participants to freely provide information. The researcher also had complete freedom in terms of wording the interview questions and the way the researcher explained questions to the participants.

A interview is the most appropriate approach for collecting data on sensitive topics. The researcher had the opportunity to prepare the participants before asking sensitive questions and to explain complex questions (Cresswell, 2007). In this study, semi- structured interviews helped the researcher to obtain in depth information through probing. This, in situations where in-depth information is required, interviews are the preferred method to collect data. Furthermore, it was possible to supplement information obtained from the participants with information gained from the observation of non-verbal reactions(Ranjit 2011). It was likely that a question may be misunderstood during an interview. In this case, the researcher was able to either repeat a question or put it in a form that was understood by the participants.

3.11 Data analysis

The researcher used Thematic Content Analysis. This method allowed the researcher to identifies the question, choose the sample/s for analysis, determine the types of analysis, reduce the text to categories and codes for patterns, explore the strengths, signs and direction of the relationship. The researcher used this approach to analyse the information presented from the relevant literature and participants information. All themes and discussions were based on the results from the data collected and related themes were grouped together to form a theme (Cresswell, 2007).

The following steps adapted from Ranjit (2011) were used to analyse data manually The researcher transcribed the interview into text and formatted the document so the margin

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Step 1: Read the text and note items of interest perform

An inductive approach to thematic analysis allowed themes to emerge from the data, rather than searching for pre-defined themes. During the first reading the researcher had to make notes of major issues as they come to mind in order to acquire a sense of the various topics embedded in the data.

Step 2: Sort items of interest into proto- themes

That was where themes started to emerge by organizing the items related to similar topics, into categories. The categories had to be modified, developed and new ones allowed to emerge freely. At that stage having kept the themes as simple as possible assisted flexibility in the categorization process whereby any re-ordering of the clusters of categories helped create and redefine the initial themes.

Step 3: Examine the proto-themes and attempt initial definitions

This phase of trawling back through the data helped to examine how information was assigned to each proto-theme in order to evaluate its current meaning. A provisional name and flexible definition was created for each emerging theme.

Step 4: Re-examination of the text carefully for relevant incidents of data for each proto-theme

This second process of trawling back through the data was also called" axial coding". It involved contextualisation whereby any data was now considered in terms of the categories developed through this analysis. Taking each theme separately and re-examining the original data for information related to that theme was a vital in the analytic process because human perception was selective and the relevance of data can be easily overlooked. Furthermore, pieces of data previously assigned to a theme may in fact be contradictory.

Step 5: Construct the final form of each theme

The name, definition and supporting data was re-examined for the final construction of each theme, using all the material relating to it. This stage of re-contextualisation focused more closely upon the underlying meaning of each theme.

Step 7: Report each theme

The researcher, wrote its description and illustrated each theme it with a few quotations from the original text to help communicate its meaning to the reader.

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3.12. Trustworthiness of findings

Credibility

Credibility involved establishing whether the results of the qualitative research are credible or believable from the perspective of the participants in the research (Wellman, 2005). As qualitative research studies explore meaning, it is believed that the participants are the best judge to determine whether or not the research findings have been able to reflect their opinions and feelings accurately. Credibility, which is synonymous to validity in qualitative research, was judged by the extent of participant concordance whereby the research took the findings to those who participated in the study for confirmation determination of, congruence, validation and approval. The higher the outcome of these, the higher the validity of the study (Ranjit, 2011). The researcher presented the final findings to the participants and the findings were revised on the basis of the feedback received from the participants.

The researcher also spent sufficient time with the participants and requested them to clarify issues as categories of themes continued to emerge; a phenomenon referred to as prolonged engagement (Bless & Higson, 2000). The voice recorder was used so that the information could be transcribed verbatim. The information was then compared with the notes that the researcher had taken to ensure consistency. This also helped the researcher to ensure investigator triangulation. Flexibility will be ensured by writing down the participants' beliefs and practices on their traditional healing (Du Plooy, 2002).

Transferability

This refers to the degree to which the results of qualitative research can be generalised or transferred to other contexts or settings (Dillman, 2008). Although it is very difficult to establish transferability, primarily because of the approach a researcher adopts in qualitative research, to some extent, this can be achieved if the researcher extensively and thoroughly describes the process adopted for others to follow and replicate (Du Plooy, 2002). The researcher provided in detail a description of the population, sample and research context, data collection and analysis methods and issues of trustworthiness were clearly described to achieve this purpose.

Dependability

It is concerned with whether the researcher would obtain the same results if the same things were observed twice. Again, as qualitative research advocate, flexibility and freedom, it may be difficult to establish unless the researcher kept an extensive and detailed record of the process for others to replicate in order to ascertain the level of dependability (Ranjit, 2011). Again, the research processes for this study were clearly described to ensure this.

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Conformability

This refers to the degree to which the results could be confirmed or corroborated by others. Conformability is also similar to reliability in quantitative research. It is only possible for the result to be compared if other researchers' follow the process in an identical manner (Ranjit, 2011). Confirmation of the study findings by the participants further ensure conformability in the study.

3.13 Ethical Consideration

The proposal observed the following institutional ethical issues: the proposal was presented in the Department of Psychology, and then presented before the School of Health Sciences Higher Degrees Committee. It was then submitted to the University Higher degrees Committee (UHDC) for approval. Finally, it was submitted to the University's ethics committee for ethical clearance and the final step will be sending the project report to the external examiner.

Informed consent

The researcher obtained the permission from the participants after the researcher had thoroughly and truthfully informed them about the purpose of the study. This information was contained in the consent letter. In this case, the participants signed consent forms which explained the focus and purpose of the study. The consent forms were signed before the participants in the study. Participants were told that they could withdraw from participating in the study anytime they want to (Ranjit, 2011).

Right of privacy and protection from harm

The participants were informed that their identity would remain anonymous at all times. Therefore, the names and other identifying details of the participants would not be published in this research report (De Vos, 2001). The participants were given assurance that they would be free from physical and emotional harm (Wellman, 2005). This was be achieved by ensuring that the information that they provided would be kept confidential. The researcher was also on the lookout for any signs of extreme emotional reactions during the interviews

Confidentiality, anonymity, privacy and respect for participants

The researcher should protect participants confidential communication, such as papers or grants submitted for publication, personnel records, trade or military secrets and patient records. A researcher should respect participants and treat them fairly. Protecting the rights and welfare of those who volunteer to participate in research therefore is a fundamental tenet of ethical research. A great deal of progress has been made in recent decades in changing the

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culture of research to incorporate more fully this ethical responsibility into protocol design and implementation

Non- harm to participants

Do not use unpublished data, methods or results without permission. Give credit where credit is due and give proper acknowledgement or credit for all contributions to research. The researcher should tell the participants aim of the study and to ask permission to gather data within than community

4 Conclusion

This chapter explained the exploratory research design that was used to explore patients' nonadherence to African traditional medicine. Purposive sampling was used to select the participants and semi- structured interviews were used to gather data on the topic under study. Data were analysed using thematic content analysis.

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CHAPTER 4: PRESENTATION OF RESULTS FINDINGS

4.1 Introduction

In this chapter the researcher presents the collected data the presentation and it is divided into various section. Data were presented in tabular and narrative forms. The sections introduced in this chapter are as follows: the demographic information of African Traditional healers, and various themes on non- adherence to African traditional medicine among patients with mental illness.

4.2 Demographic Information of participants

There were five female participants aged between 44 and 55 years. Four of them were unemployed and one was employed. All participants have children.

Table 4.2. Summary of their demographic information.

Participants	Age	Occupation	Number of years in practice	Area of specialization	Qualifications
1.	44	Employed	6	Herbalist	Grade 12
2.	49	Unemployed	4	Herbalist	Grade 7
3.	55	Unemployed	7	Herbalist	Grade 9
4.	53	Unemployed	4	Herbalist	Grade 8
5.	50	Unemployed	3	Herbalist	Grade 11

There were five participants, 4 of them were females and 1 male traditional healers, aged between 44 and 55 years. One was employed and 4 were unemployed. All of them are herbalist. The participants that the researcher had chosen had a minimum of three years experiences in their practice

4.3 Summary of the themes and subthemes that emerged from this study

Themes	Sub themes
1. Perception of non- adherence to African traditional medicine	• Lack of insight to illness • Belief about medication • Substance abuse • Poverty • Delaying in seeking appropriate health

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	care • Lack of motivation from family members • Inaccessibility to African traditional medicine • Ignorance of ancestor's calling to become a traditional healer • Improvement of mental illness symptoms
2. Factors associated with non adherence	• Negative attitude towards the medicine • Aftercare environment • Failure by the healer to explain timing and dosage • Inadequate discharge planning
3. Consequences associated with non-adherence to African traditional medicine	• Increased in suicide rate • Stigmatisation • Decrease in emotional attachment • Improvement of symptoms • Mismanagement of mental illness • Loss of job because if illness • Public indecent amongst patients with mental illness • Prognosis to mental illness
4.Strategies used by traditional healers to reduce non adherence	• Adherence to African traditional medicine • Restraint and occult intervention by traditional healers • Patient adherence to African traditional medicine • Patient traditional healer relationship

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Perception on non- adherence to African traditional medicine

The main theme that emerged from the data analysed was the perceptions on non- adherence to African traditional medicine in patients with mental illness. The subtheme below supports the main theme which emerged from the data

4.3.1 Lack of insight into the illness

The findings of the study showed that many patients with mental illness have poor or no insight into their illness and they are not aware of the symptoms and consequences of their illness and this lack of illness insight was associated with non-adherence. Traditional healers rated poor illness insight as the most important factor contributing to non-adherence. Another traditional healer reported that patients who dealt with the stress of their illness by ignoring their illness or their symptoms were less adherent to their medication .Some patients who accepted being ill may not believe that their symptoms are something that can be managed and therefore motivated to take steps to resolve their symptoms, such as taking medication.

"Some….some patient are not aware that they are mentally ill and do not want to drink medicine that we give them. umm…as you can see that mental ill patient's' state of mind is altered, so they do not know what is happening around them" … (Participant *1)*

"Most of the patients do not know that they are sick unless if the sickness becomes too severe and do not adhere to medication" … (Participant 2*)*

4.3.2 Improvement in symptoms

Participants responded that the signs and symptoms of mental illness can vary depending on the particular illness, therefore when a patient gets better the patient tend to stop the intake of medication and when the patient stops taking medication the illness gets worse; when they get better they feel that they are healed.

"My patients feel that when the symptoms get better is then that they are healed and stop taking medication" … (participant 4)

4.3.3 Stigma attached to consulting traditional healers

Participants indicated that when the patient gets better they experience stigmatization from members of the community who condemn them for consulting traditional healers. This demolisales them from adhering to their treatment because traditional healers are labelled as "witches".

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"(mmm) patients tend to stop taking medicine when they are told that they are consulting traditional healers as traditional healers are perceived as witches" … (Participant 4)

Participants continued to state that most of those patients feel isolated, as traditional healers we decide to stay with them to give them support and making sure that they adhere to their medicine

Participant continued to state that patients with highly stigmatized diseases and mental illnesses may experience social labelling and isolation because some are defined as "crazy" people and if that is the case some patients end up skipping doses and or discontinue the medication altogether.

"(emm) in my case what do is that I emphasize that family members should not leave the patient unattended because they might consider to commit suicide" ..(Participant 2*)*

4.3.4 **Decrease in emotional attachment**

It was explained by the participants that relationships become strained between the patient and other family members then there is a decrease in emotional attachment between them.

"My patient once told me that his family members no longer regard him as one of their own because of the illness e.g they leave me behind when going to social gathering and by that it makes me loose the attachment we once had". ..(Participant 3)

4.3.5 **Beliefs about medication**

Participants indicated that patient perception of whether medication works or not appeared to contribution to adherence rates. Participants reported that one of the predictors of non-adherence problem was that patients believe that when they feel better that they have been healed and they stop taking the medicine.

"(Eee)…when patients looks better I release them. When they arrive at home they think they are healed and stop taking medication sometimes family members do not make follow up to make sure that the patient continue to take medication" … (Participant *1)*

4.3.6 Substance abuse

The participants mentioned that due to substance abuse some patients do not adhere to their medication. The participants continued to indicate that non-adherent patient with mental illness were usually substance users. The participants emphasised to non-adherence to taking medication can lead to relapse, which means more visits to the traditional healer and increased need for intervention.

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Other family members experience challenge when the patient abuse substance as they forget to take medication and that makes them to brings back the patient when the patient relapsed. And sometimes the patient does not even know that he has been brought back because he would have been intoxicated" …. (Participant 4)

4.3.7 Poverty

The findings of the study showed that one frequent reason for non- adherence to African traditional medicine is lack of adequate and proper food. Some medicines are very strong and requires good food in order to counter balance their side effects.

"Most of my patience do not take medication because they do not have enough food since the herbs that we as traditional healers use are very strong. Most of our herbs require food because they stimulate appetite" … (Participant 1*)*

*My patients complained that African traditional medicine requires more food since the herbs are too strong and if you don't have anything to eat it becomes a problem because you will not be able to drink your medication with such high side effects..(*Participant 2*)*

*"Lack of food is also another important perspective, and these medications lead to more increased appetite and this has two negative effects, either a burden on the family because of increased food consumption by the patient or, in the event of limited food availability and the experience of hunger, therefore the patient is forced to discontinue their medication because they find the increased hunger difficult to tolerate" ..(*Participant 3)

Moreover, other participants indicated when they help mentally ill patients they charge them lot of money because is not easy to treat patients with mental illness hence some patients make use of their livestock to pay their traditional healer. The participants indicated that others disappear without settling the payment and they no longer come to fetch the medications.

"Some of my patients do not come back for treatment as they have not settled the balance thus lead to omitting doses for reappointment"…(participant 5*)*

4.3.8 Delaying in seeking appropriate health care

The results of the study revealed that prolonging seeking appropriate health care when traditional medicine treatment can produce the desired effect, can be perceived as a manifestation of a sense of denial of one's mental illness status. Not only does this show social stigmatisation which could lead to abuse, it also discourages the affected populations from seeking mental healthcare.

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(Ehh)" my patients comes to me when the illness is too severe which makes it difficult for me to treat the disease within a specific time".

4.3.9 **Lack of support from family members**

Participants indicated that due to lack of support from family members patients to omit doses forget to take their medicines or neglect the medication.

"(Ehh) the problem with my patient is that family members do not have time to prepare medicine for the patient as a result the patient end up not taking the medicine" … (Participant 2)

4.3.10 **Accessibility to African traditional healers**

Participants indicated that some patients travel far because they might feel they do not want to consult within their village; they prefare to consult other traditional healers from other villages in order for them to remain anonymous. The money they use to travel and also to consult make the cost of consulting the traditional healer very expensive. Such patients when they leave, they no longer come back to fetch medication; they only come back when they relapse.

(yaaa) "my patients most of them resided in other province , so it was difficult for them to come for reappointment as money is too tight, that is the difficult part" .(participant 3)

4.3.11 **Ignorance of ancestor's calling to become a traditional healer**

Participant showed that when ancestors call an individual to become a traditional healer, may inflict mental illness on that person before the period of spirit possession begins. According to the traditional healer the extend beyond the illness itself, so as traditional they first treat the illness if the patient has to do the rituals they help the patient to do it

"it is true that a person gets mental disturbed if they do not do their rituals or traditions and as traditional healers we can help patients who have mental illness caused by African reason"

..(Participant 4*)*

4.**4 Consequences associated with non-adherence to African Traditional Healers**

Many patients may feel well following their withdrawn from traditional medicine, potentially became the undesirable side effects have disappeared. However relapse is a risk for such behaviours

The subthemes below underpin the main theme emerged from the data analysed.

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4.4.1 Suicide ideation

Participants stated that due to untreated mental illness, suicide is one of the leading causes of premature death in patients with mental illness. Non-adherence to African traditional medicine was one of the risk factors for the development of suicidal behaviour in patients with mental illness. And patients sometimes get stigmatised and if it is a woman, they tend to be victim of rape.

…patients who do not take their medication mostly they experience suicidal thoughts. Because they think that they are different from others because they are ill and women are in danger of getting raped… (Participant 3)

4.4.2 Mismanagement of mental illness

Participants indicated that mental illness is the second cause of loss of productive life. It goes without saying that for the multitude of individuals who are not treated for their mental illness challenges, there is a greater likelihood that they will not lead healthy lives in comparison to those who receive such care.

"My patient once said that he thought that the illness would go away that is why he took time in seeking help because mental illness can become too difficult to heal if the illness is too severe"

..(Participant 2)

4.4.3 Job loss as result of illness

Participants mentioned that mentally- ill people may lose their jobs, making them incapable of caring for their families. Also the participants acknowledged that mentally- ill patients are often ridiculed by community members and become very lonely and isolated in their community. However, a mentally- ill person requires a great deal of caring and support, and it is usually the family who must take on this responsibility.

"Healing can be expensive and families end up paying for the patient. They just want them to be better no matter what. I had a patient once whose family was desperate for cure because that patient would throw things at neighbours house and starts fights and some of the community members would be laughing" ..(Participant 1)

4.4.4 Bad public behaviour by patients with mental illness

Participants indicated that consulting with ancestors can aid in diagnosing patients from their extreme public behavioural problems, most frequently seen problems behaviours include picking up garbage, talking randomly, walking for long periods of time and undressing in public.

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" My patient is a lady that never bathed herself, she didn't want to, she did not even use the toilet , she was always gallivanting because she hears people calling her, that are luring her towards them, she was very violent trying to fight with people all the time" ..(Participate 5)

4.4.5 Prognosis in mental illness

Participants mentioned that non-adherence may cause mental- illness symptoms in patients, thus leading to serious consequences such as depression. Particularly in the early stages mental illness may worsen the course and prognosis of the patient as it may result in them being resistant to traditional medicine and developing chronic mental illness symptoms.

"I am concern about patient with mental illness who are very sick that sometimes they may die because of ignorance and sometimes they pick food from dustbin and eat. In this case this is where the medicine takes a longer period to cure the disease if the illness is too severe"...(Participant 4)

4.5 Strategies used by traditional healers to reduce non adherence

There are problems that come with non-adherence to medicine instructions to mental- illness, but traditional healers have come up with strategies to reduce non-adherence. Non-adherence to medication is a recognized problem and may be the most challenging aspect of treatment. The following are subthemes that emerged from this main theme

4.5.1 Regular use of daily doses of traditional medicine

Participants indicated that medication is most effective when it is used according to the prescription, additionally, the traditional healer should also stress the importance of behavioural changes, in this case, diet and exercise, such that the patient does not view his medication as the only way to manage the condition

"I tell my patients to follow their prescriptions accordingly because it they do not adhere to their medicine they will not get healed. Family members should moniter the patient's adherence to make sure that they are drinking their medicine in the right way as prescribed by their healers"

..(Participant 1)

4.5.2 Restraint and occult intervention by traditional healers

Participants mentioned that there are methods used to control mentally- ill patient who are aggressive or in the acute stage; the traditional healer uses ropes or chains to immobilize them. Some even resort to beating them to make them weak enough not to harm themselves and

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others. Sedative herbal preparations are also forced down their throats as concoctions or putting into their nose.

"(Ehhn) Some of my patient are dangerous in such a way that I keep them in my house for as long as they get better because they are a danger to themselves and others. So I stabilize them by giving them sedatives to calm them down" … (participant 3)

4.5.3 **Patient adherence to African Traditional medicine**

Participants indicated that they possessed the skills and knowledge required to cure mental illness and often treated the patient by encouraging them to live with them in their home or to visit them on regular basis. The duration of this treatment ranged from 2 weeks to a year and a half. This ensured the patient adhered to the treatment and that someone was there to take care of the patient. The participant also stated that in situation where a patient becomes very violent and would not take their treatment, forceful methods such as tying them up with ropes and chains were used.

"I have a mentally ill patient, who had gone to the western doctors and did not get cured. His family took him to me and he stayed with me for 5 months. He took 1 teaspoon of medicine 3 times a day with food, although he does not live with me anymore, he still takes his medicine, he is much better now and he soon be cured". ..(Participant 5)

4.5.4 **Patient-traditional healer relationship**

Participant showed that Patient- traditional healer relationship is another strong factor which affects patient non- adherence. The participant emphasized that a healthy relationship is based on patient's trust in their traditional healers and empathy from them. Participant further indicated that adherence is strong when traditional healers are supportive, giving reassurance or respect and treating the patient as an equal partner

"I think patient- traditional healer relationship play an important role in illness management. Good communication patterns are associated with better adherence, greater levels of social support particularly mental illness support from spouses and other family members are associated with better adherence… (participant 3)

5. Conclusion

Improving adherence in mental illness may have a considerable positive impact on patients and society and this can be achieved by correcting the identified multitude of factors driving non-adherence. In addition, assessing causes and consequences of non-adherence together may highlight the importance and complexity of adherence to medication in mental illness.

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Traditional healers shoulder a large burden of care of patients with mental health problems; This calls for all those who share the goal of improving the mental health of individuals to engage with traditional healers

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CHAPTER 5: DISCUSSION OF FINDINGS

5.1 Introduction

This chapter discusses the findings of the study. The results in the previous chapter were presented and a discussion of these results will follow suit. The discussion is linked to the literature, which either supports or disagrees with the findings of the current study. The discussion in this chapter also includes information regarding intervention strategies and their effects.

5.2 Perception on non- adherence of African traditional medicine

The main theme that emerged from the data analysed was the perceptions on non- adherence to African traditional medicine in patients with mental illness. The subthemes below support the main theme that emerged from the data.

There were five participants, 4 of them were females and 1 male traditional healer, aged between 44 and 55 years. One was employed and 4 were unemployed. All of them were herbalist. The participants that the researcher had chosen had a minimum of 3 years in experience their practice.

5.2.1 Lack of insight to illness

The findings of the study showed that many patients with mental illness have poor or no insight into their illness and they are not aware of the symptoms and consequences of their illness; lack of illness insight was associated with adherence. Traditional healers rated poor illness insight as an important factor contributing to adherence. A traditional healer reported that patients who dealt with the stress of their illness by ignoring their illness or their symptoms were less adherent to their medication. According to Rudnick (2002) Patient's lack of awareness of having a mental illness was another barrier that was observed by traditional healers for not adhering to medication. Patients who accept being ill may not believe that their symptoms are something that can be managed; These are motivated to take steps to resolve their symptoms, such as taking medication. Senah (2003) agrees with Morris (2006) when he said poor insight is among the best predictors of non- adherence to treatment. It is common that poor insight also predicts a poorer course of illness, increased number of relapse and hospitalization and deteriorating work performances, social skills, quality of social relationships. Unawareness of illness is associated with a range of problems, not the least of which is non-adherence to medication.

Non-adherence is a poly-faceted problem related with therapeutic relationship between the patient and the healers, factors related to medication and factors related to the patient and their

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illness. Healers contribute to the non- adherence because of failure to prescribe simple regimes, explain the benefits and side effects of medication and to consider patients lifestyle and medication cost involved. Morris (2006) states that in addition, typical reasons for not taking medications include forgetfulness, presence of other priorities, decision to omit doses, lack of information and emotional factors such as distress. Non–adherence to mental illness treatment undermines treatment effectiveness, increases risk of relapse and leads to poorer outcomes. Psycho education programmes, family therapy and community- based interventions have been used successfully to improve adherence.

5.2.2 **Improvement in symptoms**

Participants showed that the signs and symptoms of mental illness can vary depending on the particular illness, therefore when a patient gets better is then that patients tend to drop down from the medication intake and when the patient stop taking medication the illness gets worse. Langer and Alberson (1974) explain that, many patients visit the traditional healer only when they have physical symptoms. These symptoms may be due to an acute ailment or the effects of a chronic condition, such as asthma, hypertension, or diabetes. Patients from urban areas of developing countries are often accustomed to receiving medications at every traditional healer's visit to alleviate acute symptoms, but unaccustomed to long-term treatment regimens to manage chronic conditions. As a result, Stanley (2004) agrees with Langer and Alberson (1974) that patients who consult traditional healers may believe themselves to be cured once symptoms stop. This false perception often leads to a sudden discontinuation of medication which can cause withdrawal or restarting side effects. Patients may also discontinue a course of traditional medicine when they begin to feel better.

5.2.3 **Stigmatisation**

Participants indicated that when the patient gets better they experience stigma from members of the community by telling them that they are consulting traditional healers which makes them not to adhere to their treatment because traditional healers are labelled as witches. Most of those patients feel isolated, as traditional healers we decide to stay with them to give them support and making sure that they adhere to their medicine. Participant continued to state that patients with heavy stigmatized diseases and mental illnesses may experience social labelling and isolation because some are defined as crazy people and if that is the case some patients ends up skipping doses and or discontinue it altogether. Rosenhan (1973) stated that three out of four people with mental illness report that they have experienced stigma . Stigma is a mark of disgrace that sets a person apart. When a person is labelled by their illness they are seen as part of a stereotypes group. Negative attitudes create prejudice which leads to negative actions

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and discriminations. Van niekerk (2012) agrees with Rosenhan (1973) that stigma brings experiences and feelings of shame, blame, hopelessness, distress and misrepresentation in the media.

Rubin (2005) indicates that patients with heavily stigmatized diseases such as Tb, Hiv/Aids, Std's and mental illnesses may experience social labelling and isolation. Some diseases are traditionally equated with a low quality of life or with death. Patients may be unaware of Western medicine's ability to manage and/or treat such conditions. Anti-depressants are highly stigmatized, and may be seen as appropriate only for those defined as crazy, some patients may believe taking antidepressants will actually lead them to become crazy. Patients who are affected by stigmatized conditions often attempt to hide the disease by privately consuming their medication and, although treatment may be effective, social pressures may lead some patients to skip doses or discontinue them altogether.

5.2.4 **Beliefs about medication**

The study indicated that the other most frequent reason for patient perception of whether medication works appeared to contribute to adhere rates. Participant reported that one of the predictors of adherence problem was the patients' belief that when they feel better that they are healed and they stop taking medicine. Twumasi (2003) explained that diagnosis is reached through spiritual means and a treatment is prescribed usually consisting of a herbal remedy that is considered to have not only healing abilities but also symbolic and spiritual and spiritual significance. Razali (2006) agrees with Twumasi (2003) that African traditional medicine, with its belief that illness is not derived from chance occurences, but through spiritual or social imbalance, differs greatly from modern medicines, which is technically and analytically based. In the 21 century, modern medicines and medical procedures remain inaccessible to a large numbers of African people due to their relatively high cost and concentration of health facilities in urban centres.

WHO estimates that 80% of Africans use traditional medicinal sector as their first contact place for all types of mental health problems. Studying the health- seeking behaviours of participants from Burkina Faso, Razali (2006) found a strong belief that modern methods are deemed good for physical illness but powerless against supernatural causes. He also found in his study that most participants mentioned that western methods alone deal merely with symptoms to give temporary relief, but the underlying social and moral problems will remain. In relation to the use of herbs and other indigenous medicines, Atindanbila (2008) found out that only 2% of the psychiatric patients in the hospital used hospital drugs solely for the treatment of their disorders. The remaining patients had visited the traditional healers in addition to the hospital. Madu (1997) explaines that because traditional Africans believe that sickness of an emotional or

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psychological nature originates as a punishment from the gods for evil, western -influenced models of psychotherapy have limited influence.

5.2.5 Substance abuse

The study revelled that several studies about lack of compliance among patients with mental illness are patients who smoked or drank alcohol who were likely to be non- compliant because forgetfulness was a widely reported factor that caused non adherence with medication and appointment; substance abuse, makes some patient not to adhere to their medication. The participant indicated that non-adherent patient with mental illness were usually substance users. The participant emphasised non-adherence to medication can lead to relapse, which mean more visits to the traditional healer and increased need for intervention. A very common factor contributing to mental illness in South Africa is substance abuse. Many provinces are used as drug trafficking routes, and as the South African government lacks the necessary resources to control this problem, many of these illicit drugs find their way into local populations as a drug. In addition, the availability of the wild growing Cannabis plant allows for its rampant abuse among all age categories. Maiello (1999) found that 52% of street children smoke the Cannabis plant and 22% on a daily basis. Educational campaigns are limited, and as a result, many do not realise the impinging health effects that will result from substance abuse.

Substance abuse was also a common reason for non- adherence. Patients who drank alcohol had low level of adherence to African traditional medicine. Boom (2002) agrees with Komla (1997) that in a dual diagnosis, both the mental health issue and the drug or alcohol addiction have their own unique symptoms that may get in the way of one's ability to function, handle life's difficulties, and relate to others. To make the situation more complicated, the co-occurring disorders also affect each other and interact. When a mental health problem goes untreated, the substance abuse problem usually gets worse as well. And when alcohol or drug abuse increases, mental health problems usually increase too. Thomas (2001) states that having mental illness can make a person more likely to abuse drugs, to make their symptoms feel better in the short-term. Other people may have drug problems that may trigger the first symptoms of mental illness. Some drugs cause a condition called drug-induced Psychosis, which usually passes after a few days. However, if someone has a predisposition to a psychotic illness such as Schizophrenia, these drugs may trigger the first episode in what can be a lifelong mental illness. Using drugs can also make the symptoms of mental illnesses worse and make treatment less effective.

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5.2.6 Poverty

The findings of the study states that most frequent reason for no adherence to African traditional medicine is lack of adequate and proper food. Some medicines are very strong and requires good food in order to counter- balance their side effects. One frequent reason for non-adherence to mental- illness medication is lack of adequate and proper food. If taken on an empty stomach some medication could cause harm to the body. Omosede (2004) argue that as a consequence, patients are liable to stop their medications whenever there is shortage of food. These medications can also lead to more increased appetite and this has two negative effects, either this becomes a burden on the family because of increased food consumption by the patient or, in the event of limited food availability, the experience of hunger. Patients are forced to discontinue their medication because they find the increased hunger difficult to tolerate.

Participants indicated that when they help patients they charge them lots of money because is not easy to treat patients with mental illness; some patients make use of their livestock to pay their traditional healers. The participant indicated that other disappear without settling the payment and they no longer come to fetch the medications Omokzopia (2004) argued that the cost is cheaper and flexible than allopathic medicine. It affords the patients the opportunity to settle their bills when they can afford. More often than not they pay the bills when they are fully recovered and can work towards paying the bills. Through oral traditions, some people also do self medication which reduces the cost.

Omokzopia (2004) again argues that traditional healers like any other profession are rewarded for their services. In African societies, the payment for a treatment depends on its efficiency; healers do not request payment until after the treatment is given. This is another reason many prefer traditional healers to western doctors who require payment before the patient has assessed the effectiveness of the treatment. The payment methods have changed over time with many practitioners now asking for monetary payment, especially in urban settings, rather than their receiving good in exchange, as happened formerly. Rana (2002) agrees with Omokzopia (2004) that people with mental illness face many barriers over their lifetime including stigma and experiencing a mental illness can seriously interrupt a person's education or career path and result in diminished opportunities for employment. A lack of secure employment in turn affects one's ability to earn adequate income and as a result, people may drift into poverty.

Helwig (2010) supports that individuals with serious mental illness are frequently unable to access community services and supports due to stigma gaps in service or challenges in system navigation. Lack of sufficient primary health- care and community mental health care services, shortages of affordable housing and inadequate income support further alienate them from life

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in the community. Exclusion from these social and economic supports results in social isolation, significantly increasing their risk of chronic poverty.

5.2.7 **Lack of support from family members**

According to Kale (2001), another reason for non- adherence was lack of support by family members; this makes the patient to omit doses to forget to take their medicines as well as neglecting the medication altogether. Some traditional healers mentioned lack of support from family members as one of the important reason for discontinuing treatment and follow up because adherence was impossible without the active involvement of the family members competing work demands was another reason for non-adherence. Razali (2006) argues that some family members used to take care of patients when they are ill, but when the patient ask them to accompany them to the traditional healer for follow up, none of the family members would cooperative, the patients had to plead and beg with them. Most family members do not realize that if patients gets too sick , they are also going to suffer.

Exclusive reliance upon family is also problematic when such support is not consistently present. Accessing effective treatment was one of the most important factor in alleviating burden. Green (1996) supports the point that Care givers support family members and friends who have mental illness, for some carers it is more than a full time employment. Most carers found that they experience reduced physical, mental and emotional health once they start caring for mentally- ill patient. Reasons for this decline are many, and include, lack of time for carers to maintain their own health, putting the health and care of the person being cared for first, lack of training to prevent injury and being able to afford necessary health care. Care givers often become disconnected from friends, social networks and other family members because of the time and demands involved with caring. Fleck (2011) found that individuals who had more socially- accepted and commonplace disorders did not get strong reactions to their conditions from friends, family members or others that they had contact with. It is believed that there is a reluctance to provide caregiving from an individual's support network as diagnoses become more complex. Furthermore, it was found that family members and friends may experience difficulty in accepting or excusing a sufferer of common mental health disorders, if their behaviour deviates from the norm.

5.2.8 **Ignorance of ancestor's calling to become a traditional healer**

The study showed that when ancestors call an individual to become a traditional healer, they inflict mental illness on that person before the period of spirit possession begins, and according to the traditional healer the extend beyond the illness itself, so as traditional healers they first treat the illness if the patient has to do the rituals they help the patient to do. This was

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supported by Okuno (1999), when he stated that some healers learn the trade through personal experience while being treated as patient who decided to become healers upon recovery. Others become traditional practitioners through a spiritual calling and therefore, their diagnoses and treatments are decided through the supernatural. In some cultures, a sign of calling can come from mental disarrangement said to be caused by the spirit of divining through which the leader gains inspirations, through this training, psychological stability is eventually attained. But Atindanbila (2008) mention that some traditional healers obtained their healing from their fellow traditional healers.

5.3 Consequences associated with non-adherence to African Traditional Healers

In this section, there will be a systematic review of factors that influence adherence and the consequences of non-adherence to patients, healthcare system and society, in patients with mental illness. The following are some of the consequences related to non- adherence:

5.3.1 Suicide rate

The study notes that suicide is one of the leading causes of premature death in patients with untreated mental illness. Non-adherence to African traditional medicine was one of the risk factors in the development of suicidal behaviour in patients with mental illness. And patients sometimes get stigmatised and if it is women, they tend to be victims of rape. Freeman (2004) looked into suicide rates as a results of non-adherence and reported where non-adherence was related to a significant increase in the risk of suicide. Although all mental disorders are associated with an elevated risk of suicide, certain disorders carry with them remarkably high life time risk. Infact 80-90% of people who commit suicide have a mental illness. Hospitalization for a mental illness is quite prevalent in the suicidal population.

According to Ventevogel (2006) alcohol and substance abuse problems contribute to suicidal behaviour in several ways. Persons who use and abuse substances often have several other risk factors for suicide. In addition to being depressed, they are also likely to have social and financial problems. Substance use and abuse tend to occur more often among people who are prone to act on impulse. They also occur often among those who engage in many types of high-risk behaviours that can cause self-harm. In addition, people who are intoxicated may make suicide attempts are impulsively and aggressively that they would if they were not intoxicated. However, Thomas (2001) argues that there are effective ways to lower the risk of problem drinking and drug abuse among young people. There are also effective treatments, which often combine medications with various forms of psychotherapy and support groups, for alcoholism and substance abuse. New treatments, tailored to people with both substance abuse problems and suicidal tendencies, are forthcoming. These may offer greater promise for saving many

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individuals. People who drink too much often seem to die by suicide in the throes of severe relationships difficulties. Accordingly, for people at risk of suicide who drink too much, marital or couples- based treatment is showing particular promise.

5.3.2 **Mismanagement of mental illness**

The study indicated that mental illness is the second cause of loss of productive life. It goes without saying that for the multitude of individuals who are not treated for their mental illness challenges, there is a greater likelihood that they will not lead healthy lives in comparison to those who receive such care. It was explained by the participant that due to strained relationship between the patient and other family members because of the illness, there was a decrease in emotional attachment between them.

Freeman (2004) mentions that mentally ill people may lose their jobs, making them incapable of caring for their families. Participant acknowledged that mentally ill patients are often ridiculed by community members and become very lonely and isolated in their community. However, a mentally- ill person requires a great deal of caring and support, and it is usually the family who takes on this responsibility. Beresford(2001) observes that people who are poor and affected with mental illness may not be able to send their children to school, buy them uniform and school books or pay for their related cost even if education is free. Those who are at school may be forced to drop out in order either to care for parents who are gravely ill or to look for employment in order to support the family. Most participants indicated that in consulting with ancestors to aid in diagnoses they are able to identify mental illness from patients extreme behavioural problems such as picking up garbage, talking randomly, walking for long periods of time and undressing in public. Linden (2002) argued that, there is still a belief that humans with mental disorders are untreatable, dangerous and unintelligent, or incapable of making decisions. Not only does this social stigma lead to abuse, it also discourages affected populations from seeking mental healthcare.

5.4 **Strategies used by traditional to reduce non adherence**

There are problems that come with non-adherence to mental illness, but traditional healers have come with strategies to reduce non-adherence. The following are subthemes that emerged from the main themes.

5.4.1 **Following instructions to Adhere to African Traditional Medicine**

Komla(1997) indicates that the traditional healer should emphasize that medication is most effective when it is followed according to the prescription, additionally, the traditional healer should stress the importance of behavioural changes, in this case, diet and exercise, such that

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the patient does nct view his medication as the only way to manage his condition. Patients should be told to follow their prescriptions accordingly because if they do not adhere to their medicine they will not get healed. Holdstock (2000) agrees with Boom (2002) that family members should moniter the patient's adherence to make sure that they are drinking their medicine in the right way as prescribed by their healers. Working together, the patient and traditional healers can decide which treatment may be best, depending on the patient symptoms and their severity, traditional healer personal preferences, medication side effects, and other factors. In some cases, a mental illness may be so severe that a traditional healers or loved one may need to guide the patients care until they are well enough to participate in decision-making.

5.4.2 **Patient adherence to African Traditional medicine**

Kale (2001) indicates that traditional healers possess the skills and knowledge required to cure a mental illness and they often treat the patient by encouraging them to live with them in their home or visiting them on regular basis. The duration of this treatment could ranged from 2 weeks to a year and a half. This ensured that the patient adhered to the treatment and that someone was there to take care of the patient. The participants stated that in situation where patients become very violent and would not take their treatment, forceful methods such as tying them up with ropes and chains were described

5.4.3 **Patient-traditional healer relationship**

Participants showed that patient- traditional healer relationship is another strong factor which affects patient non- adherence. The participant- emphasized that a healthy relationship is based on patients trust in their traditional healers and empathy from them. Adherence is good when traditional healers are supportive, giving reassurance or respect and treat the patient as an equal partner. Poor communication with traditional healers was also likely to cause a negative effect on patient. Morris (2006) shows in a study that patients who are non- compliant felt that traditional healers lack concern for their problems. In addition traditional healers prescribing medications might decrease patient's confidence in treatment. These findings demonstrate the need for cooperation between patients and traditional healers. Boom (2002) supports the point that patient- traditional healer relationship play an important role in illness management. Good communication patterns are associated with better adherence, greater levels of social support particularly mental illness support from spouses and other family members are associated with better adherence.

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6. Conclusion

Traditional healers believe that the management of patients with mental illness can be improved by addressing the reasons for non-adherence as highlighted in this study. However, more qualitative research needs to be undertaken in various contexts similar to and different from this study. It will provide an understanding about the socio demographic variables that effect medication adherence. Plants, herbs, and ethnobotanicals have been used since the early days of humankind and are still used throughout the world for health promotion and treatment of disease. Plants and natural sources form the basis of today's modern medicine and contribute largely to the commercial drug preparations manufactured today. About 25% of drugs prescribed worldwide are derived from plants. Still, herbs, rather than drugs, are often used in health care. For some, herbal medicine is their preferred method of treatment. For others, herbs are used as adjunct therapy to conventional pharmaceuticals. However, in many developing societies, traditional medicine of which herbal medicine is a core part is the only system of health care available or affordable. Regardless of the reason, those using herbal medicines should be assured that the products they are buying are safe and contain what they are supposed to, whether this is a particular herb or a particular amount of a specific herbal component. Consumers should also be given science-based information on dosage, contraindications, and efficacy. To achieve this, global harmonization of legislation is needed to guide the responsible production and marketing of herbal medicines. If sufficient scientific evidence of benefit is available for an herb, then such legislation should allow for this to be used appropriately to promote the use of that herb so that these benefits can be realized for the promotion of public health and the treatment of disease.

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CHAPTER 6: LIMITATIONS OF THE STUDY, IMPLICATION FOR THE STUDY, RECOMMENDATION AND CONCLUSIONS

6.1 Introduction

This chapter presents the limitations of the study, implications for the study, recommendations which are based on the findings of the study and finally the concluding remarks.

6.2 Summary of the findings

The main aims of the study was to explore traditional healers perceptions of non-adherence to African traditional medicine among patients with mental illness who consult African traditional healers in Thulamela Municipality of the Vhembe district. The following were the objectives of the study:

- To determine the traditional healers perceptions on non-adherence to African traditional medicine in patients with mental illness who consult African traditional healers.
- To explore the factors associated with non- adherence to African traditional medicine among patients with mental illness who consult African traditional healers
- To establish the consequences of non- adherence to African traditional medicine amongst patients with mental illness who consult African traditional healers
- To determine the strategies for reducing non-adherence to African traditional medicine among patients with mental illness who consult African traditional healers

Both the aims and the objectives were achieved

6.3 Limitations of the study

Participants were not at ease when talking about mental illness. Their uneasiness could be due to their culture, where issues of mental illness are not discussed. That was when the researcher had to explain to them the ethical principles of research and make them to understand their word will remain confidential. The researcher's participants were people without education, who have received knowledge of medicinal plants and their effects on the human body from their forebears hence poor educational level has led to poor record keeping, furthermore, most of them have little knowledge but they have a deep and personal involvement in the healing process; to protect their therapeutic knowledge, they thought it necessary to keep the whole thing a secret .

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6.4 Implications for the study

The results indicated that necessary data was collected and all questions that they were asked, relevant answers were provided. Some participants were giving irrelevant answer but the researcher had to repeat the questions again in order to get the right answers. Sometimes the researcher would go to see the participant and found that the participant was not there while the researcher would have made an appointment or find that the participant was busy with a patient and the researcher had to wait for hours.

6.5 Recommendations from the study

i. The department of education should make sure that all African traditional healers should obtain at least senior school certificate in order to be able to read, write and make use of the libraries

ii. There should be development of curriculum that could be used by elementary and post secondary school on the topic of traditional medicine

iii. The stake holders should make introduction of professional development and conferencing of healers or elders through accessing universities, health facilities and stake- holders of traditional medicine who support the elders or healers to enhance their skills; learn from one another and develop solid networks;

iv. The traditional health practitioners board members should see that all traditional medicine have to fulfil the same uniform standards, tests and trails before being made available to the public;

v. More resources and infrastructure need to be committed and promote the use of safe efficacious traditional medicine;

vi. There is a need for a campaign that raises awareness of the rights of patients to adequate care, treatment and support by traditional healer by family members

vii. It is vital that the traditional healing professional be regulated and be brought into the ambit of current legislation;

viii. It is necessary to make effective programmes and policies widely available which would provide countries and communities with a spectrum of preventive tools to tackle mental disorders. It is therefore imperative to develop an accessible and integrated system of international and national databases to provide governmental and non-governmental agencies with information on evidence-based programmes and policies, their outcomes and conditions for effective implementation by traditional healers.

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7. Conclusion

Non-adherence remains a challenge for patients with mental -illness and their traditional healers, resulting in poor outcomes. Fortunately there are strategies to reduce non-adherence to mental illness. Traditional healers can recognise symptoms of mental illness, and they express strong beliefs in supernatural factors as a cause of mental illness. Nevertheless, African traditional healers have to come up with strategies to reduce non-adherence. The findings clearly indicate that despite western practitioners' negative views towards use of traditional medicine, patients continue to sought traditional healers services. Perhaps patients' motivation to utilize traditional medicine stems from their strong Afrocentric beliefs that the spiritual world can help in healing their illnesses or it could be their appreciation of the approach taken by the traditional practitioners. There is much to be learnt about patients' interaction with the traditional practitioners. Patients are of the opinion that traditional practitioners have a greater understanding to their problem and take time to listen and explain what the problem is. Whilst this is not to say that western medicine is less beneficial than traditional medicine, it is clear that what the patients are saying is that there is a need for a more integrated approach that caters to the physical as well as spiritual concerns. There is therefore a need to develop models of collaboration that promote a workable relationship between the two healing systems in treating mental illness. A limitation of the study is that the numbers were small and therefore cannot be generalized to the wider psychiatric population. It however provides a useful starting point when exploring common perspectives among practitioners about psychiatric patients use of alternative and traditional medicine especially in a specific context. Patients are in strong favour of traditional and alternative medicine.

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Appendix 1; Interview Guide

1. Share with me your understanding of non- adherence to African traditional medicine by your patients.
2. Tell me the factors associated with non-adherence to African Traditional medicine among your patients
3. In your view, how does non- adherence affect your patients
4. Share with me how you reduce non-adherence in African traditional medicine among your patients

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Appendix 2: Permission Letter

P.O. box 1248

Thohoyandou

0950

Dear Sir / Madam

Request for permission to conduct a research study at Ha Tshikonelo village, Limpopo province, South Africa.

My name is Lufuno Mashamba; I am a Master of Arts candidate at the university of Venda, Thohoyandou. I wish to conduct a research for my Masters studies on *Traditional healers perceptions on non adherence to African traditional medicine in patients with mental illness who consult African traditional healers*. The aim of this study is explore the traditional healers perceptions on non- adherence to African traditional medicine in patients with mental illness.

I am therefore, asking for permission to obtain data from the traditional healers for the purpose of my research. I hope to use unstructured type of interview as a method to collect data. All the information that is going to be collected from the traditional healers will be kept strictly confidential. Anonymity will be assured to all participants and participants will be allowed to withdraw from the study anytime if they wish to do so since participation is voluntary.

At the end of my research. I will share my findings with you so as to provide useful data that will assist in the management of patients. I pledge to abide by any code of conduct that applies to me during my interaction with traditional healers.

Thanking you in anticipation

Kind regards

....

Lufuno Mashamba (student)

Dr. J. Takalani (supervisor)

Mrs M.D Mushwana (co- supervisor)

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Appendix 3: Consent Letter

INVITATION TO PARTICIPATE

You are being asked to participate in this research study which forms part of the requirements for the fulfilment of my degree, in Masters of Arts at the University of Venda.

The purpose of this study is to investigate the traditional perceptions of non- adherence to the African traditional medicine by patients with mental illness in the Thulamela Municipality of the Vhembe District in Limpopo Province.

PROCEDURES

As a participant, you will be required to provide information on your experiences as a traditional healer. Your honesty and cooperation will be relied upon to gather valuable data in this study.

RISKS

Some of the questions that will be asked may touch on sensitive areas, however, every effort will be made by the researcher to minimise your discomfort. You are encouraged to discuss with the researcher any negative or difficult feelings or experiences you have as a result of participating in this research project. If, at any time, you feel you would like to stop your participation in the research study, you are free to do so.

COST AND FINANCIAL RISKS

There are no financial costs directly associated with participation in this project.

BENEFITS

There are no guarantees that you will benefit directly from the study, however, the researcher believes that mere participation in this study will provide you with an opportunity to express your thoughts, feelings and opinions about being a traditional healer.

COMPENSATION

You will not receive any compensation for participating in this study

ALTERNATIVES

Participation in this research project is entirely voluntary and you may choose not to participate

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CONFIDENTIALITY

The researcher will make every attempt to keep all information collected in this study strictly confidential. Only the results of the study will be used. If any publications results from this research are published, you will not be identified by name.

..... Date.....

Signature of researcher

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Appendix 4 :Consent Form

I..... hereby consent to participate in a research study entitled" Traditional healers perceptions on non-adhererance to African traditional medicine in patients with mental illness". I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this interview at any point should i want to discontinue. The conditions of the study have been fully explained to me and I fully understand the circumstances of my participation.

..... Date.....

Signature of participant.

..... Date.....

Signature of researcher

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