

**A FRAMEWORK OF CO-OPERATIVE PRACTICE BETWEEN
RADIATION ONCOLOGISTS AND TRADITIONAL HEALTH
PRACTITIONERS IN THE MANAGEMENT OF PATIENTS WITH
CANCER IN KWAZULU-NATAL PROVINCE**

Pauline Busisiwe Nkosi

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Supervisor : Prof M.N. Sibiyi

Co-supervisor : Prof N. Gqaleni

Date : September 2016

DECLARATION

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

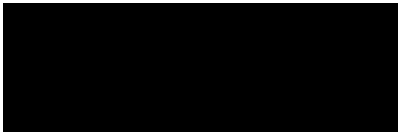


Signature of student

25 September 2016

Date

Approved for final submission



Prof M.N. Sibiya
RN, RM, D Tech: Nursing

25 September 2016

Date



Prof N. Gqaleni
PhD

25 September 2016

Date

DEDICATION

I would like to dedicate this research to my late mother, Judith Thabile Nkosi who passed away on the 25th August 2010. Though she did not have any formal education, her inspiration to value education, dream big and strive for the best that I can as her only child, has motivated me. Nothing was smooth in this journey, both social and work environments were uncondusive but her inspiration helped me to persevere. I hope that she would have been pleased with the outcome.

*"Lala kahle Judith, Thabile, Ntfombi kaNkosi, Dlamini wena wekuNene,
wena wadla libombo ngokuhlehletela, wena ntfaba kayikhonjwa ma
uyikhombfa iyadzilika".*

I would also like to say a special thanks to my children Yoliswa, Mbulelo, Sifiso and his fiancée Thato for all the love and support that they have given me throughout my research journey. I know that you have never stopped believing in me and the strength I draw from this is immeasurable. I also thank my grandchildren Minenhle and Lwandle for the love and smiles they showed me when there was an opportunity to be with them. I hope that when you grow up you will understand why and also value education because it trains your mind to think.

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ABSTRACT

BACKGROUND

Cancer is a global concern because it affects and kills millions of people worldwide. In South Africa, patients frequently move between traditional health practitioners and radiation oncologists to seek cure of cancer, yet these health practitioners do not communicate with each other. Consequently, the treatment is often disrupted and incomplete therefore compromising the survival of patients. The future of the health system in effective treatment of patients with cancer is dependent on health practitioners' changing fundamentally in their co-operative practice. The aim of this study was to explore the practice of traditional health practitioners in the treatment of patients with cancer in order to describe a viable co-operative practice between them and radiation oncologists and ultimately develop traditional health practitioners as a component in the health system in the treatment of patients with cancer.

METHODS

An exploratory descriptive qualitative study using an interpretive phenomenological approach was employed to collect data from 28 traditional health practitioners and four radiation oncologists in KwaZulu-Natal utilising snowball and stratified purposive samplings for the former and latter, respectively. Semi-structured face-to-face and group interviews were employed to collect primary data from traditional health practitioners and data from the radiation oncologists were collected through face-to-face and email interviews. Data were transcribed verbatim and analysed using framework analysis.

RESULTS

It emerged that the referral of patients, in addition to external conditions, individual attributes, trusting attitudes of participants as well as organisational dynamics and philosophy of practice, were the main categories used by participants in their understanding of co-operative practice in KwaZulu-Natal. The patient is the main player in the co-operation between parties, and

coordinates the health practitioners' activities during treatment. Effective co-operative practice is time consuming and requires commitment, co-operation and training of the participants.

CONCLUSION

Considering the problems associated with treatment of cancer when patients move freely between the traditional health practitioners and radiation oncologists, resulting in interruptions in treatment, co-operative practice between the two health practitioners is paramount. The development of traditional health practitioners could result in extending their role in the management of cancer and therefore increasing the accessibility of cancer services. It follows that a workable practice between traditional health practitioners and radiation oncologists in the treatment of patients with cancer could be an inclusive health system where the parties work in parallel with the patient being the main actor in the collaboration. There should be a healthy relationship between all those involved in the collaboration in order to facilitate referral of patients between the health practitioners.

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GLOSSARY

African regions: Countries in the **North** (Algeria, Egypt, Libya, Morocco, Sudan, Tunisia, and Western Sahara), **East** (Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, La Reunion [France], Madagascar, Malawi, Mauritius, Mozambique, Rwanda, Somalia, Tanzania, Uganda, Zambia, and Zimbabwe), **Middle** (Angola, Cameroon, Central African Republic, Chad, Democratic Republic of Congo, Republic of Congo, Equatorial Guinea, and Gabon), **South** (Botswana, Lesotho, Namibia, South African Republic, and Swaziland), and **West** (Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, Gambia, Ghana, Guinea-Bissau, Guinea, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, and Togo) of Africa (American Cancer Society 2011a: 2).

Allopathic medicine: The dominant medical system which refers to the conventional, Western, biomedical, modern medicine, mainstream, orthodox, or regular (Bodeker and Kronenberg 2002: 1582).

***a priori* themes or categories:** Themes or categories formulated in advance using a conceptual framework (Caroll, Booth and Cooper 2011: 3).

Chemotherapy: The killing of cancer cells using cytotoxic drugs.

Dysphagia: Difficulty in swallowing food.

Fiduciary: "Someone with power or property to be used for the benefit of another and legally held to the highest standard of conduct" (Rowe and Moodley 2013: 4).

Incontinence: Inability to hold urine.

Integrative oncology: A combination of conventional and evidenced-based complementary therapies delivered using a comprehensive approach (Cramer *et al.* 2013:1). It is both science and philosophy that focusses on the complications of the patient diagnosed with cancer and proposes many approaches to combine with cancer conventional therapies to strengthen the health system (Sagar 2006: 27).

Lifetime risk: The probability that a person will develop or die from cancer, over the course of his or her lifetime (Ahmad, Ormiston-Smith and Sasieni 2015; American Cancer Society 2011b).

Oncologist: A central clinical figure in cancer care that plays an important role to ensure valued care and to assist to make resource allocation decisions (Wenger and Vespa 2010: 45).

Palliative treatment: An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (World Health Organisation 2010a: 6). It is a treatment intended to alleviate the symptoms of cancer in order to improve quality of life.

Prophylactic treatment: Treatment of part of the body which is the common site of spread of cancer in order to prevent the spread of cancer.

Radiation: A physical agent, which is used to destroy cancer cells (Baskar *et al.* 2012: 194).

Radiation Oncology: A discipline in which various health and science professionals from numerous disciplines like radiotherapy, surgery and chemotherapy work together (Baskar *et al.* 2012: 194).

Radiation therapy, also known as **radiotherapy**: A recognised medical specialty in Radiation Oncology discipline at the hospital (Baskar *et al.* 2012: 194).

Radical treatment: Treatment intended to cure cancer.

Radiotherapy machines: Machines that use radiation to treat patients with cancer.

Recurrence: Appearance of cancer in an area which was previously treated for cancer.

Sub-Saharan Africa: Combined Eastern, Middle, Southern, and Western regions (Lockhat, van Rensburg and du Toit 2014; American Cancer Society 2011a).

Surgery: Removal of cancer.

Traditional medicine: 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 (World Health Organisation 2013: 15). The indigenous system of health care delivery where people from diverse cultures utilise a variety of herbal plants, plant extracts, animal products and mineral substances in order to prevent, treat and or control a disease (Aniah 2015: 20). The term represents indigenous health traditions such as alternative and complimentary medicines primarily outside the biomedical mainstream (Bodeker and Kronenberg 2002: 1582).

Traditional health practitioner: Any person registered under the Traditional Healers Act of 2007 in one or more of the categories of traditional health practitioners (Republic of South Africa 2008: 8).

ACRONYMS

ABET	Adult Basic Education and Training
AIDS	Acquired immune deficiency syndrome
AM	Allopathic medicine
AMPs	Allopathic medicine practitioners
HIV	Human immunodeficiency virus
IPA	Interpretive phenomenological analysis
KZN	KwaZulu-Natal
NHI	National Health Insurance
ROs	Radiation oncologists
THPs	Traditional health practitioners
TM	Traditional medicine
WHO	World Health Organisation

CHAPTER 1 : OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

It is estimated that one in five South Africans will develop cancer in their lifetime, and the number of new cancer cases is growing every year. In 2012 there were estimated to be between 40 000 and 70 000 new cases of cancer and this is estimated to grow to over 94,000 by 2020 (Department of Health 2016: 2). In the South African population, the five most common cancers diagnosed in males include cancers in the prostate, lung, colorectum, oesophagus, breast and Kaposi sarcoma, while breast, cervical, colorectal, uterus cancers and Kaposi sarcoma are common in females (Moodley *et al.* 2016: 609). In 2013, there were approximately 14.9 million new cases of cancer and 196.3 million disability-adjusted life-years (DALYs) attributable to cancers globally (Naghavi 2015: 508). Despite the growing burden of cancer, it continues to receive low public health priority in developing countries (American Cancer Society 2011a; Orang-Ojong *et al.* 2013) because in recent years the health systems' focus has been on communicable diseases such as acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV), malaria, and tuberculosis (Stuckler *et al.* 2008: 1566). In South Africa, the prevalence of non-communicable diseases is overwhelming for poor communities in urban areas (Groenewald *et al.* 2008: 63). In response to this, interventions were developed at legislative, policy, health service management and community levels in order to manage these diseases exclusively in poor communities (Mayosi *et al.* 2009: 941).

The most recent cancer incidence data for South Africa reported that the country has a population of 49 320 500 with 129 oncologists in both private and public hospitals and only 67 linear accelerators (Erasmus and Fitchen, 2010: 4). The same author maintained that of these, KwaZulu-Natal (KZN) Province has the second largest population of 10,449,300, with 21 radiation oncologists (ROs) and six linear accelerators in the public hospitals. This discussion on the integration of traditional medicine (TM) into allopathic

medicine (AM) remains significant in South Africa because there are insufficient allopathic medicine practitioners (AMPs) and treatment machines to provide services to all South Africans; the radiotherapy service is inaccessible to patients in rural areas.

It is worth noting that there are approximately 15 000 traditional health practitioners (THPs) practicing in the KZN province (Gqaleni *et al.* 2007: 178). The THPs' role in their communities has long been acknowledged although their practices were illegal (Ross 2010: 48). Nonetheless, the THPs sustained their practices in their communities (Campbell-Hall *et al.* 2010: 625). Previous studies have reported that THPs are willing to cooperate with AMPs (Steyn and Muller 2000; Mngqundaniso and Peltzer 2008; George, Chitindingu and Gow 2013; Van Niekerk *et al.* 2014) in the treatment of HIV and AIDS, cancer and in rehabilitating other medical conditions. With patients reported to access both AM and TM simultaneously (De Ver Dye *et al.* 2011: 728) and insufficient ROs to effectively address the radiotherapy needs for patients in South Africa (Levin, Sitas and Odes 1994: 350), it is crucial that the two groups of health practitioners find approaches to cooperate in the treatment of patients with cancer.

In order to reduce morbidity and mortality attributable to cancer, and to improve the quality of life of patients and their family members, the Department of Health developed a South African National Policy Framework and Strategy on Cancer 2016-2021 which aims to:

- Reduce the occurrence of cancer (primary prevention) by controlling major avoidable cancer risk factors.
- Improve early detection of major types of cancer that are amenable to early diagnosis and screening.
- Optimize early diagnosis and treatment, particularly linked to early detection programmes or curable cancers.
- Improve access to cancer treatment services – Indicator: Number of health facilities that offer treatment for cancer.

- Improve survivorship and palliative care for cancer, with a particular focus on community and home-based care.
- Recognize that childhood cancers are distinct from adult cancers and are given the necessary attention and resources.
- Strengthen cancer registration, reporting and surveillance.
- Promote appropriate research that will inform future programs and policy development (Department of Health 2016: 48).

1.2 PROBLEM STATEMENT

The World Health Organisation (WHO) estimated that 80% of the population globally is dependent on TM for treatment of any ailment (WHO 2002: 1) and that TM is often utilised exclusively in rural areas in economically developing countries (Hughes *et al.* 2012: 484). The clinical evidence of TM's efficacy and safety in use by users is sparse (Olaku and White 2011; Mahomoodally 2013). Many studies reported an extensive utilisation of TM in the management of patients with cancer (WHO 2002; Elliott, Kealey and Olver 2008; Broom *et al.* 2010; Oh *et al.* 2010; Davis *et al.* 2012). The rationale for using TM was affected by several factors including access, affordability, cultural views of the disease, and traditional healing methods (Broom *et al.* 2010; Muhamad, Merriam and Suhani 2012; Muriithi 2013).

The available sources of healing are TM and complementary alternative medicine (CAM) in addition to AM. Though TM was used many centuries ago, it was extensively marginalised in economically developing countries. Nonetheless, some patients still preferred TM or use it with AM. Ngwenya *et al.* (2012: 315) reported that preference for TM is influenced by positive references based on the effectiveness of treatments and explicit competencies of a particular THP. This indicates that TM has a role in the treatment of cancer (WHO 2002: 2). THPs will have lived in the village or district for a reasonably long time and are embedded in their communities (Ngwenya *et al.* 2012:315), thus patients will always consult with them.

In acknowledgement of the potential role of TM, the WHO has urged countries to promote and integrate TM into their health systems (WHO 2002: 8). In South Africa, patients have the right to access a recognised health practitioner of their choice and to choose how they access it (Republic of South Africa 1996; Health Professional Council of South Africa [HPCSA] 2008). Therefore, the utilisation of TM in the treatment of cancer should be accepted by stakeholders in any country.

Patients with cancer are anxious for cure and relief from the effects of cancer, therefore would consult with any source of healing available in a country. They move between health practitioners when there is no improvement in their disease (Abubakar 2013: 17). In so doing, they refer themselves consecutively and simultaneously between THPs and ROs, so the two health practitioners end up working in parallel and against each other (Kale 1995; Puckree *et al.* 2002). They doubt each other's practices, hence will not refer patients (Mngqundaniso and Peltzer 2008:7). Additionally, due to their antagonistic relationship, patients do not inform them of their visits to the other health practitioner.

Additionally, due to their antagonistic relationship, patients do not inform them of their visits to other health practitioners. Consequently, there are delays and interruptions in their treatment which reduces the rate of survival (Clegg-Lamprey, Dakubo and Attobra 2009; Auwah 2010; Ezeome 2010; Merriam and Muhamad 2013; Pace *et al.* 2015). It is imperative that cancer patients complete treatment in order to cure their disease or improve their rate of survival. Furthermore, patients can be guided and referred properly if there is communication between health practitioners.

However, previous studies found that most THPs had no formal education and lack knowledge about the diseases they treat. Therefore, they suggested that THPs should first undergo basic education and training to facilitate co-operation and cross referral of patients (Gqaleni *et al.* 2007; Kayombo *et al.* 2007; Audet *et al.* 2013). Also, a study exploring the possibility of co-operative practice between THPs and AMPs in the management of cancer, in Gauteng

Province, found that THPs do not differentiate the conditions that they are able to treat and those that they specialize in (Steyn and Muller 2000: 5). The authors suggested that THPs could be trained to facilitate their specialisation in the management of cancer. It follows that, effective treatment of patients with cancer there should be co-operation between the various health practitioners involved, and the THPs should be developed.

1.3 AIM OF THE STUDY

The aim of the study was to explore the practices of THPs and ROs in the treatment of patients with cancer in order to describe a viable co-operative practice framework between these health practitioners in the treatment of patients with cancer, and to develop THPs in the treatment of cancer patients in KZN Province.

1.4 RESEARCH QUESTIONS

The study was guided by the following questions:

1.4.1 Main research question

What would constitute a workable practice framework between THPs and ROs in the treatment of patients with cancer that would improve the outcome of treatment?

1.4.2 Sub-questions

- a) What are the practices in the treatment of patients with cancer by both health practitioners?
- b) What is the knowledge of THPs with regard to the treatment of patients with cancer?
- c) What are the perceptions of each health practitioner about the other in terms of treatment of patients with cancer and co-operative practice?
- d) What co-operation is required between the two healthcare practitioners in cancer treatment?

1.5 SIGNIFICANCE OF THE STUDY

The study can develop and propose a co-operative practice framework between THPs and ROs in the treatment of patients with cancer in KZN. This will benefit the patients with cancer in that in exercising their right to access any health practitioner of their choice, they can do so with proper guidance and need not fear disclosing this to the other health practitioner. Consequently, they will complete their treatment and improve their rate of survival and quality of life.

The results in this study can assist to establish the roles and practices of THPs in the treatment of cancer as well as identify the types of cancers that are treated by the THPs in KZN. With further education regarding signs and symptoms of cancer, THPs can improve their practices and their role in cancer management, and can extend their practices to other types of cancers. This research study can assist to establish a protocol for the treatment of cancers using integrated oncology. The health practitioners involved can improve on this protocol which can be a starting point for co-operative practice between THPs and ROs in the treatment of patients with cancer in KZN.

The outcome of the study will contribute to the pool of knowledge on traditional healing in South Africa because it can help to identify what training the THPs require to treat patients with cancer, and can establish rules to be followed in the co-operative practices between the THPs and ROs in the treatment of patients with cancer. The relationship between the health practitioners can improve, and a proper referral system can be established. Other economically developing countries can benchmark and improve on the co-operative practice framework between THPs and ROs in the treatment of patients with cancer in order to increase the capacity of cancer control in their countries. Co-operation allows for sharing of information, thus both health practitioners can benefit from each other. This study will contribute to the guidelines and scope of practice of THPs in the treatment of patients with cancer. This information is crucial for the Council of THPs to be able to regulate THPs in this regard. When their practices in the treatment of patients

with cancer are known, they can be developed and improved so that they can be specialists in the treatment of specific types of cancers. The Consumer Protection Act, Section 61, requires that health practitioners be liable for any harm as a result of their treatment (Rowe and Moodley 2013: 7). If the THPs are regulated and practise according to their guidelines and scope of practice, ROs can refer without fear of litigation as a result of treatment failure or side effects. The strengthening of health systems is central to implementing a successful cancer prevention and control programme.

1.6 STRUCTURE OF THE THESIS

This thesis is presented in eight chapters, as outlined in Table 1.1.

Table 1.1: Structure of the thesis

Chapter	Title	Content description
1	Overview of the study	<ul style="list-style-type: none"> Orientation to the study, research background, overview of the research problem, aims and objectives, research questions, significance of the study.
2	Literature review	<ul style="list-style-type: none"> An in-depth review of the literature related to the topic under investigation to give the researcher information on what is published or discussed in the literature about the subject. Selection and discussion of the theoretical framework that was used to guide the study.
3	Conceptual framework	<ul style="list-style-type: none"> Conceptual framework used as the base from which to build or extend the understanding of co-operative practice between THPs and ROs in the treatment of patients with cancer.
4	Research methodology	<ul style="list-style-type: none"> Research methodology that underpins the study.
5	Presentation of results	<ul style="list-style-type: none"> Presentation and interpretation of the research findings.
6	Discussion of results	<ul style="list-style-type: none"> Discussions of research findings. Triangulation of the study result. Mixing/ converging of the two data sets. Conclusions and recommendations based on the research findings. Limitations of the study.
7	Development of the practice framework	<ul style="list-style-type: none"> Presentation of the practice framework for co-operative practice between THPs and ROs in the treatment of patients with cancer.
8	Summary of the findings, limitations of the study, conclusion and recommendations	<ul style="list-style-type: none"> Presentation of the summary of findings, limitations of the study, conclusion and recommendations.

1.7 SUMMARY OF THE CHAPTER

This chapter presented the background of the study which discusses co-operative practice as the key driver to enhance access to cancer treatment and improve the survival of patients with cancer. The problem statement shows how significant it is for health practitioners from TM and AM professions to collaborate in order to improve access to treatment, avoid patients presenting with advanced cancer, and to ensure that patients complete their course of treatment. The main purpose of the study is to describe a practice framework between the THPs and the ROs in the treatment of patients with cancer, and develop THPs as a component of the health system. The next chapter is a literature review showing the gaps in the knowledge of co-operation between THP and RO practices regarding cancer management.

CHAPTER 2 : LITERATURE REVIEW

2.1 INTRODUCTION

The literature review is a process whereby a researcher evaluates the existing knowledge about the topic under research in order to provide the overall context and identify gaps for further study in the knowledge (Polit and Beck 2010: 95). The literature review frames the problem in the study (Creswell 2009: 26) demonstrates the reason for conducting the research, and helps form the research questions that guide the study and the choice of research methodology. Further, the chapter assesses the literature to show the gaps in the knowledge of co-operative practices between THPs and ROs in the treatment of patients diagnosed with cancer. This chapter presents the vocabulary, theories, and key variables of the phenomenon under study as well as its methods and history (Randolph 2009: 2).

2.2 PROCESS OF REVIEWING THE LITERATURE

After identifying the topic of the study, the researcher began the search for literature related to the topic. According to Creswell (2009: 27), literature is used to frame the problem in the introduction and to plan the study. To embark on the literature search in the current study, key words such as coordination, collaboration, integration and co-operation identified in the study were utilised to find materials such as books and journals in the institutions's library. With the aid of Google Scholar, Summon and ScienceDirect, relevant journals, books, conference proceedings, dissertations, theses and web pages were identified. The researcher skimmed through the items to ensure that they had a meaningful contribution to the understanding of the topic.

All information from these resources was collated and grouped according to their priority in the study. Journal articles unavailable in full text form locally were located and obtained through the inter-library loan service.

2.3 CANCER, ITS PREVALENCE AND IMPACT IN THE POPULATION

Cancer is one of the main chronic non-communicable diseases (Ali *et al.* 2013: 1) along with cardiovascular disease, diabetes, chronic respiratory diseases, obesity and mental disorders (Pahari *et al.* 2012: 2095). In 2010 cancer accounted for 15% of the 65% global deaths resulting from non-communicable diseases (Lozano *et al.* 2012: 2120). In South Africa, the prevalence of non-communicable diseases is overwhelming for poor communities in urban areas (Miranda *et al.* 2008; Mayosi *et al.* 2009). It is therefore imperative that cancer should be given the same priority as communicable diseases and the focus should be on low income to middle income earners from both urban and rural areas.

Cancer is a life-threatening and complex disease characterised by abnormal cells which grow and spread nonstop and which, if left untreated, will result in the death of the patient diagnosed with the disease (Chaffer and Weinberg 2011: 82). Cancer spreads to other organs and often recurs following treatment (Anders and Carey 2010; Moreno-Smith, Lutgendorf and Sood 2011). Management of cancer is a major concern worldwide because of the impact of cancer in an individual diagnosed with the disease.

2.3.1 Incidence of cancer

The occurrence and dissemination of cancer differs significantly across the world due to varying cultural, social and environmental factors such as risk factors for cancers, accessibility to healthcare and infrastructure (Jemal *et al.* 2012: 4373). Globally, the majority of cancers in males are lung, prostate, liver, stomach, and colorectal and in females are breast, stomach, cervix uteri, and colorectal (Torre *et al.* 2015; WHO 2015). In the United States of America, the number of lung, breast, prostate, colorectal, pancreatic, liver, thyroid, non-melanoma, melanoma and uterine cancers surpass all other cancers (Rahib *et al.* 2014; Siegel *et al.* 2014).

Economically developing countries are unduly affected by cancers of cervix, liver, and stomach (Jemal *et al.* 2010: 1903). In Africa, common cancers are of prostate, liver, lung, colorectal, oesophagus, urinary bladder, non-Hodgkins, Karposi sarcoma, stomach and leukaemia in males and in females cervical, breast, liver, colorectal, non-Hodgkins, ovary, oesophagus, stomach, Karposi sarcoma and leukaemia cancers (Jemal *et al.* 2012; Sylla and Wild 2012). With regard to cancer management the focus should be on common cancers because they cause more deaths than others. Also, the range of common cancers in each country suggests that different countries will apply a different priority of cancers in order to control the burden of cancer.

The rise in cancer occurrence rates is associated with diverse factors such as growth and aging of the population (Torre *et al.* 2015; Thun *et al.* 2010), and the adoption of behaviors and lifestyle factors known to cause cancer such as cigarette smoking, lack of physical fitness, intake of high calorie food and reproductive changes (lower parity and later age at first birth) (Vineis and Wild 2014; Torre *et al.* 2015). This suggests that different countries will have different cancers of priority and thus the cancer management plan will not be 'one size fits all', but should be tailor-made to the common cancers in a particular country.

Cancer affects people of all races, ages and genders but is more prevalent in the middle and older age group. The risk of developing cancer increases with age (American Cancer Society 2013: 1). Studies in Great Britain have reported that the life time risk of cancer is greater than 50% for adults less than age 65 years (Ahmad, Ormiston-Smith and Sasieni 2015: 945) and an estimated 70% of the population diagnosed with cancer are adults (American Cancer Society 2011a: 1). It is therefore imperative to prioritise adults with reference to the management of cancer because they contribute to the workforce in the country and the unaffordability of cancer costs in the older group will require more expenditure on cancer care costs by the government.

2.3.2 Impact of cancer in the population

Previous studies reported that cancer is the primary cause of death (WHO 2011b; Bray *et al.* 2012) and one of the leading causes of death globally (WHO 2015; Ferlay *et al.* 2010; Baskar *et al.* 2012; Torre *et al.* 2015). For example, a study by Ferlay *et al.* (2010: 2902) in 2008, reported that in a population of approximately 6.7 billion worldwide (Thun *et al.* 2010: 100), an estimated 12.7 million patients were diagnosed with cancer and 7.6 million died of complications of cancer. Similarly, in 2008, the occurrence of cancer in Africa was approximately 715 000 new cases and 542 000 deaths (Jemal *et al.* 2012: 4373). This indicates that cancer is a national and global issue because of its mortality rate.

In 2012, the number of new patients with cancer and deaths escalated to 14 million and 8.2 million, respectively (Ferlay *et al.* 2015: e363). The occurrence of cancer is expected to rise by 70% in the next two decades (WHO 2015). For example, in a population of 8.3 billion worldwide there will be 26 million new cancer cases and 17 million cancer deaths by 2030 (Thun *et al.* 2010: 100). Global deaths due to cancer in the 20 years old age group escalated by 38% between 2008 and 2010 (Lozano *et al.* 2012: 2096). By 2050, the life time risk of cancer will rise by 50-60% (Parkin *et al.* 2008: 691). The projections on the prevalence of cancer suggest that it is pivotal to control cancer by preventing, curing and alleviating its symptoms.

Approximately 60% of the world's newly diagnosed patients (IARC] 2010; Jemal *et al.* 2010; Ferlay *et al.* 2015; Torre *et al.* 2015) and 70% of cancer deaths annually are from the economically developing countries (Ferlay *et al.* 2010; Varmus and Trimble 2011; Akinde *et al.* 2015; Torre *et al.* 2015). The rationale for devastating prevalence of cancer in economically developing countries is that these countries have a higher population and therefore will contribute a higher percentage of cancer occurrences. For example, economically developing countries such as those in Africa, Asia and Central and South America have 82% of the world's population (Torre *et al.* 2015: 89).

It is vital that the focus on cancer management be placed on economically developing countries because of the high occurrence of cancer deaths.

According to Knaul, Frenk and Shulman (2011: 97), the objective of cancer control is to reduce the occurrence and mortality of cancer, and enhance the wellbeing of cancer patients. The authors further state that this depends on a country's available health resources and infrastructure. Therefore, for effective cancer control, a country should construct its own cancer control programme based on its cancer situation or cancer treatment capabilities (Stefan *et al.* 2013: e189).

2.4 PATIENTS DIAGNOSED WITH CANCER

Individuals diagnosed with cancer experience physical, psychological and social wellbeing problems (Gyasi *et al.* 2011; Cramer *et al.* 2013; Russell *et al.* 2015) as well as financial challenges (Russell *et al.* 2015: 467). Often patients complain of pain and may have depression which impacts negatively on their quality of life, impedes their well-being (Mitchell, Lord and Symonds 2012; Rashid *et al.* 2012; Krebber *et al.* 2014; Mitchell *et al.* 2011) and may ultimately lead to their death. The reason for this is that, as cancer progresses, complications associated with the disease and treatment will deteriorate the patient's quality of life. This suggests that cancer management requires more than medical care and should include other forms of relief for the issues which cannot be cured by medicine such as the social dimensions.

Furthermore, cancer impacts negatively on the caregivers of patients diagnosed with cancer. Caregivers are the people who play an integral role in caring for patients with cancer. For them, caring can become a burden physically, psychosocially, and economically (Girgis *et al.* 2013: 200). Carers have an influence on the health seeking behaviour of a patient so that they (the carers) can ascertain that their patients' have a proper control of the cancer. It is imperative to control cancer in patients in order to enhance their well-being.

Cancer treatment services should be accessible to all the inhabitants of a country, with cost-effective local treatment programmes being accessed by referral pathways (Sankaranarayanan *et al.* 2010: 172). Such services should allow collaboration between those involved in the management of cancer with the objective of building cancer proficiency in the local communities (Kulendran *et al.* 2013; El Saghir *et al.* 2014). This recognises that there are many sources of cancer treatment in each country and that co-operation amongst these is pivotal in order to improve cancer management and treatment.

Although cancer is treatable, it is seldom curable (Senn and Kerr 2011: 248) because of incongruence in prognostic factors such as demographic factors, surgical conditions and tumor characteristics (Ezzati *et al.* 2014: 1). For example, breast cancer with positive tumour margins and high grade is difficult to control in a young patient. This suggests that all avenues of cancer treatment should be used to find a cure for those cancers that are incurable. The professionals in the conventional health system should give health care professionals in traditional health systems an opportunity to demonstrate their ability or skill to cure cancer.

Currently, specialists such as ROs, surgeons, oncologists, immunologists and hormone therapists work together by referring patients between themselves to ensure maximum cure for the cancer patients. However, THPs and these professionals in AMPs do not know each other and do not refer patients to each other. There is a need for these health practitioners in TM and AM to co-operate in the treatment of cancer in order to provide cancer patients with the cure that they deserve.

2.5 TREATMENT OF CANCER

In Sub-Saharan and other economically developed countries radiation therapy is utilised in at least 50% of all cancer patients (Begg *et al.* 2011; Kingham *et al.* 2013), and is commonly used alone or in combination with surgery and chemotherapy to improve survival, depending on the type and stage of cancer

(Begg *et al.* 2011; Price *et al.* 2012; Siegel *et al.* 2012; Powathil, Adamson and Chaplain 2013). For example, surgery and/or radiation are the most important methods of treating early stage (local) cancers, including cancers of the breast, colorectum, cervix, head and neck, esophagus, stomach, and prostate (Sankaranarayanan and Boffetta 2010: 171). The recognised conventional, Western (also referred as allopathic medicine) specialist who utilises radiation therapy to treat patients with cancer is referred to as a RO. This is one of the reasons that the treatment of cancer is resource-demanding and expensive (Kingham *et al.* 2013; Stefan *et al.* 2013).

Disappointingly, the current strategies to control cancer are evidently not working because cancer survival is significantly lower in Africa compared to other lower resource regions (Sankaranarayanan *et al.* 2010: 1937). This could be because patients present with advanced disease and the mortality rates are high in Africa (De Ver Dye *et al.* 2011; Stefan *et al.* 2013). This poor outcome is caused by not prioritising cancer despite its high and growing mortality rate in economically developing countries (American Cancer Society 2011a: 1). This is evidenced by poor organisation of cancer control services preventing accessibility (Sankaranarayanan *et al.* 2010: 172), constrained government budgets preventing prioritising all priority diseases (American Cancer Society 2011a: 1), and limited treatment choices (Kingham *et al.* 2013: e158). Of the 52 African countries there are only 23 countries providing radiotherapy services (Abdel-Wahab *et al.* 2013: e169), with South Africa and Egypt accounting for approximately 60% of all radiation therapy resources. In Ethiopia alone, roughly 74-85 machines are required to provide adequate cancer treatment (Abdel-Wahab *et al.* 2013: e173). Additionally, there are few trained ROs working in the region (Abdel-Wahab *et al.* 2013: 173). For example, in Cameroon there are two ROs serving a population of 18.8 million. Further, it is difficult to retain ROs in government health sector as they opt for better pay in the private sector.

The few radiotherapy clinics and hospitals which are located in urban areas make it difficult for the community in rural areas to access those facilities. What is more, those facilities often have limited radiotherapy equipment

required for cancer treatment and radiation treatment planning (Kingham *et al.* 2013: e163). For example, a study in South Africa reported that an approximate cost for early stage breast cancer management is R15 600 and R108 000 for cancer treatment and radiation treatment planning, respectively (Kingham *et al.* 2013: e163). In the US the overall cost of cancer in 2010 was R3165.6 billion with R1233.6 billion for direct medical costs; R259.8 billion for morbidity costs; and R1681.2 billion for mortality costs (American Cancer Society 2011b: 3). The direct costs of cancer care include diagnostic tests, hospital and physician fees, and the cost of drug therapy (Meropol and Schulman 2007: 184). Although this does not indicate whether this was private or public care, such an expense is exorbitantly high for anyone without medical insurance. There is therefore a need to expand cancer treatment services and improve their accessibility to low and middle-income earners.

Other impediments to treatment are as a result of constrained government budgets for maintenance of radiotherapy machines leading to machine breakdowns (Kivuti-Bitok *et al.* 2013: 6). Furthermore, recent studies have reported that although a cancer treatment regimen may be effective in eradicating cancer or prolonging life, patients do not adhere to treatment resulting in hindrance to recovery and consequently the quality of life for the patient deteriorates (Siegel *et al.* 2012; Shiraz *et al.* 2014). Factors such as the mutilating effects of treatment (Regnier *et al.* 2011; Guth *et al.* 2011; Guth *et al.* 2013; Winterhalder *et al.* 2011); religion; concurrent treatment with THPs (Obrist *et al.* 2014: 827); and concomitant depression and anxiety as a result of cancer diagnosis and treatment (Shiraz *et al.* 2014; Siegel *et al.* 2012) contribute to incomplete treatment. Nonetheless, every effort must be made to expand the capacity of health care delivery systems to provide timely and effective treatment to patients with cancer. It is imperative that patients should complete treatment to eradicate cancer and improve their quality of life.

Cancer should get the priority it deserves as the leading cause of death. The barriers to cancer control need to be understood in the African context in order to develop a new approach to cancer care that is effective and affordable which can be integrated into the public health systems in order to

improve healthcare (Sylla and Wild 2012: 246). Recently many governments in economically developing countries have embarked on improving healthcare service delivery to ensure that low income people have access to quality healthcare services available within a country (Crisp 2010; Gates 2011; Moosa, Luiz and Carmichael 2012; Matsoso and Fryatt 2013). For effective cancer control, a country should construct its own cancer control programme based on its cancer situation or cancer treatment capabilities (Stefan *et al.* 2013: e189). In so doing, a country should devise a cancer control plan based on its available resources to treat cancer including budget, health professionals and treatment equipment. Consequently, it will have a separate policy related to cancer control which can guide its national health care system.

With regard to treatment of cancer or any disease, 80% of the globe's population seek cure from TM before any other available source of healthcare (Campbell-Hall *et al.* 2010; National Aboriginal Health Organization 2012), and all cultures consume certain TMs (WHO 2011a; Alsanad, Williamson and Howard 2014). Keeton (2010: 803) reported that in Africa approximately 80% of the patients are treated with TM for any ailment. This suggests that 20% of patients seek cure from AM. The WHO maintained that 70-95% inhabitants in countries such as Ethiopia, Burundi, South Africa, Mali, Rwanda, Benin and Ghana depend on TM for their first line of care needs (WHO 2011a; Kasilo *et al.* 2013), and that TM dominates systems accessible to TM users in Africa and other economically developing regions (Gyasi, Siaw and Mensah 2015: 1143). This indicates that both AM and TM are the main existing health systems in a country for treatment of diseases.

However, other studies found that TM use varied from 16% to 95% as per different national and sub-national surveys (Faith, Thornburg and Tippers 2013; Gyasi *et al.* 2013; Kretchy, Owusu-daaku and Danquah 2013; Awad and Al-Shaye 2014; Demirci and Altunay 2014; Gyasi *et al.* 2014; Hwang *et al.* 2014; Onyiaapat *et al.* 2011). The incongruities in TM utilisation may result from the variations in research and data collection approaches, response rates, sample selection criteria, the research setting, the operational

explanation of TM, and the period of TM use prior to field work (Gyasi, Siaw and Mensah 2015: 143). This bias may be caused by patients consulting with TM practitioners but being unwilling to disclose this (Price *et al.* 2012: 3633).

The consumption of TM for cancer treatment globally has recently escalated (Pud *et al.* 2005; Scott *et al.* 2005; Tas *et al.* 2005; Elliott, Kealey and Olver 2008; Oh *et al.* 2010). The predominant utilization of TM reflects many needs and concerns that are unmet by conventional medical practices (Muhamad, Merriam and Suhani 2011: 7). For example, in Australia cancer patients utilise TM for psychological complications of cancer to supplement conventional treatment (Furzer *et al.* 2013: 4). Previous studies have reported that patients with cancer utilise AM and TM alone, simultaneously or consecutively (Cassileth and Deng 2004; Gyasi *et al.* 2011; Nxumalo *et al.* 2011). In so doing, they move freely between THPs and ROs.

As stated above, TM dominates the health care systems accessible to TM users in Africa and other economically developing regions (Gyasi, Siaw and Mensah 2015: 1143). This indicates that TM in addition to AM is a key source of cancer treatment and therefore requires to be developed in order to serve the interests of the population including those who use TM alone. TM has been utilised for decades with established efficacy in treating a variety of health problems and was considered a universal approach to spirit, mind and body healing (Gyasi, Siaw and Mensah 2015: 138). A study in Malaysia found that THPs are medicinal healers, emotional comforters, spiritual guides and palliative caregivers (Merriam and Muhamad 2013: 11). However, TM is unrecognised by many governments in economically developing countries. Consequently, its use is prohibited in many countries and therefore TM has been neglected as a source of healthcare. It is for this reason that there is little or no information documented about exclusive use of TM in economically developing countries.

Despite this, patients with cancer utilise TM in addition to AM or as an alternative therapy to manage their disease. The rationale for its utilisation includes: prevention, diagnosis, improvement and or treatment of physical and

psychological disorders (WHO 2008 cited in National Aboriginal Health Organization 2012: 1). The key elements of cancer control are similar all over the world and include prevention, early diagnosis, radical and palliative treatment (Sankaranarayanan *et al.* 2010; Anderson, Ilbawi and El Saghir 2015), education, risk reduction, screening, staging, monitoring, survivorship care, and research (Knaul, Frenk and Shulman 2011: 98). For the purpose of this study, the focus is on treatment of cancer patients because the researcher believes that treatment is the core practice to ensure that patients diagnosed with cancer are free of the disease or survive longer.

Previous studies reported that 80% of the population in the African countries seek help from THPs and consume TM for any disease (Bannerman 1993; WHO 2002). According to Price *et al.* (2012: 3633), cancer patients often consult with THPs first before AMPs. This type of co-use creates problems. The two practitioners are working in parallel and against each other, do not communicate and doubt each other (Peltzer and Khoza 2002: 37). and there is absence of trust and common understanding (Kangwa 2010: 1). A lower status is conferred upon the originality of TM because it is usually associated with a particular ethnic group (Maila and Loubser 2003: 277). Some nurses believe that most THPs offer no benefit while some acknowledge their good work as counsellors for their patients (Mngqundaniso and Peltzer 2008: 382).

Medical doctors are concerned about the danger, usefulness, and quality of THPs' medicines (Calixto 2000: 185; Ekor 2014; Moreira *et al.* 2015). To these concerns, Payyappallimana (2009: 72) added the role of their medicine, accessibility, protection and development of traditional healing. This indicates that traditional healing in South Africa is failing to contribute to the enhancement of the quality of life of patients with cancer. Also, the sour working relationship between the two professions is in conflict with the interests of the South Africans who use both types of practitioners. No study has been conducted in KZN to establish the role and practices of THPs in the treatment of patients with cancer.

Previous studies in economically developing countries reported that patients refer themselves to THPs for various reasons (Truter 2007; Mngqundaniso and Peltzer 2008; Walsh *et al.* 2010; Muhamad, Merriam and Suhami 2012). These include the delays at hospitals, patients' past experience of using TM, recommendations from family or friends, and cultural beliefs. According to Lam (2001: 764), patients perceive that both systems have strengths and weaknesses, therefore can complement each other or can be used as alternatives. Hence, patients refer themselves simultaneously or consecutively between the two approaches despite radiation therapy being the recognised treatment for patients with cancer.

The principle followed in the treatment of cancer patients is to first diagnose a patient, treat the patient based on information about the cancer (type, extent, and site) and the patient (age, preference, general condition) (Symonds and Meredith 2012: 293-294).

The use of TM dates back to many decades before AM, yet it has not been recognised. On the other hand, AM is a new concept but there is a vast amount of research and information on treatment of cancer patients using this approach. In the next section, the researcher will discuss the role and practices of each system in the treatment of patients with cancer.

2.5.1 Treatment of cancer patients by THPs

There are many definitions of traditional healing (WHO 2002: 1). The attributes associated with traditional healing are skill, training, practical experience and knowledge unique to a specific culture (WHO 2002: 7). Traditional healing is utilised to maintain health, prevent illnesses, diagnose illnesses and improve treatment of physical and mental diseases (WHO 2002: 8). This suggests that traditional healing has the same goals as Western medicine. It would seem that with regard to treatment of cancer, traditional healing has a role but cannot be used with intent to cure. It can be used in conjunction with other medicines to advance treatment. Steyn and Muller (2000), O'Brien *et al.* (2012) and Ragosta *et al.* (2015) reported that TM uses

herbs and that it has a role in the treatment of cancer. A study from an economically developed country supported this, and showed that TM manages the complications of cancer, reserves the immune competence of the colon, maximises the tumouricidal effects of radiation and chemotherapy as well as manages the side effects of radiation and chemotherapy (Sagar 2006: 30).

Cassileth and Deng (2004: 80) state that TM is not documented, can be harmful, and some practices and medicines are worthless. Debas, Laxminarayan and Straus (2006: 1283) point out that traditional healing within different countries differs in its use, toxicity and efficacy. This indicates that a particular indigenous community's healing knowledge cannot simply be utilised in another community or country. Research on the practices of traditional healing should be based on their demographic profiles. Previous studies have studied the relationships of patients with each professional to determine the relationship. The findings of such studies will be discussed next.

The WHO defines TM as the sum total of knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures that are used to maintain health, as well as to prevent, diagnose, improve, or treat physical and mental illnesses (WHO 2013: 15). TM practices differ extensively from country to country and even within different communities in the same country (WHO 2013: 22). It follows therefore, that before any collaboration can exist, the role and practices of THPs need to be established. One of the aims of the current study is to establish the role and practices of THPs in the treatment of patients with cancer.

Patients with cancer consult and consume both forms of medicine simultaneously or consecutively in order to cure cancer and to gain emotional relief, spiritual guidance and palliative care (Merriam and Muhamad 2013: 10), and when there is no improvement in their disease (Abubakar 2013: 7). There is no research in KZN regarding the role and practices of THPs in the treatment of cancer. Previous studies indicated that when patients move

freely between the health practitioners, this behavior results in the patient defaulting treatment, delaying diagnosis, presenting with advanced disease (Siegel *et al.* 2012; Ben-Arye *et al.* 2014; Obrist *et al.* 2014). Consequently, there is tension between these health practitioners, they do not communicate, trust and respect each other (Kale 1995; Puckree, *et al.* 2002; Van Niekerk *et al.* 2014). They doubt each other's practices so will not refer patients between them (Mngqundaniso and Peltzer 2008: 7).

2.5.2 Treatment of cancer patients by ROs

Within all economically developing countries, the conventional treatment of cancer which is scientifically proven to be safe and effective is with radiation therapy (Levine 2010; Munshi, Agarwal and Pandey 2013), surgery (Levine 2010; Lezoche *et al.* 2013), chemotherapy (Goffin *et al.* 2010; Levine 2010; Johnson 2012), biological therapy (Balwit *et al.* 2011; Manganoni *et al.* 2011), targeted therapies (Coppin *et al.* 2011; Kudo 2012), and endocrine therapy (Levine 2010: 1979). The most common cancer treatment modalities are radiation, surgery and chemo which are used alone or combined to radically and palliatively treat cancer (Symonds *et al.* 2012; Gospodarowicz 2014).

According to Gospodarowicz (2014: 73), these modalities are effective in relation to only a certain proportion of cancers because of the challenges facing the radiotherapy services. The challenges are associated with access to treatment due to constrained resources such as trained ROs, equipment and facilities, as well as poor referral of patients between professionals (Abdel-Wahab *et al.* 2013: e172), and mutilating effects of treatment (Rödel and Weiss 2014: 3787). This suggests that there is a need to improve access to radiotherapy services, improve the referral between professionals and guide patients in their health seeking behaviour.

Allopathic medicine treatment uses evidence-based and scientific knowledge and adheres to procedures and guidelines (Kangwa 2010: 6). It is for this reason that it is the recognised health system for the treatment of diseases. It uses a variety of treatment modalities in order to manage cancer and improve

the quality of life for patients affected by the disease. The recognised protocol of treatment of patients with cancer includes treatment with radiation, an integral component of the treatment plan. Although there are other modalities, such as surgery and chemotherapy which are used as single modalities or combined, radiation therapy remains the treatment of choice for 60% of cancers (De Santis *et al.* 2014: 254). As a result, radiologists are the main specialists responsible for the treatment of patients with cancer.

Radiation therapy aims to cure the cancer, prevent it from spreading and recurring, as well as treat its complications such as bleeding and spinal cord compression (Baskar *et al.* 2012: 70). However, radiation treatment may cause side effects like diarrhoea, vomiting, and skin reactions. This suggests that patients go to traditional healers because they are afraid of these side effects. Furthermore, previous studies indicated that anxiety and depression are common problems in the patients during their course of treatment with radiation and that concurrent psychological care is essential to alleviate these complications (Guo *et al.* 2013: 8, 10). For this reason, psychological care of patients with cancer during treatment with radiation has become a protocol. Patients are treated for cancer by the ROs and referred further for psychological treatment. This indicates that although Western medicine separates the patient into body and mind when treating patients, the ultimate treatment of patients is holistic.

Despite the ROs being the recognised professionals to treat patients with cancer (Truter 2007:56), an estimated 70-80% of the South African population seek cure for their healthcare needs from THPs (WHO 2002: 2). Additionally, the number of people consulting with traditional healers is increasing. Some patients with cancer consult simultaneously or consecutively with THPs during their course of treatment with radiation. This suggests that THPs have a role to play in the the treatment of cancer. Some THPs claim that their practices do not have side effects. Contrary to this, Gratus *et al.* (2009: 6) allege that although indigenous knowledge practitioners can be successful in the effective management of other diseases, their medicine can be hazardous to

a cancer patient's health when administered with other treatments from Western medicine.

Radiotherapy is an integral constituent of cancer treatment (Abdel-Wahab *et al.* 2013: e168) because approximately 60% of tumors at some point require treatment by radiation (Rosenblatt *et al.* 2013; Gospodarowicz 2014). The specialists in the radiotherapy discipline, referred to as ROs, play a key role in the treatment of cancer. They have the responsibility to refer patients and coordinate the treatment activities of cancer patients between all professionals who have a role in the management of those patients. It is for this reason that the researcher chose ROs to provide information with regard to co-operative practices between them and THPs who treat cancer in order to affect co-operative practice.

The goal of radiotherapy is to “cure” the curable cancers and alleviate symptoms in advanced or incurable cancers in order to prolong survival while preserving the highest possible quality of life in the long and short terms (Siegel *et al.* 2012; Anderson, Ilbawi and El Saghir 2015). Every type of cancer requires a specific treatment regimen in order to cure cancer or considerably prolong life of patients with cancer (Price *et al.* 2012: 3632). This suggests that there should be a variety of modalities to provide efficient treatment for cancer patient. To this end, in addition to the professionals within the existing health system in South Africa, THPs could add to the number of modalities that can treat cancer.

The treatment of cancer by both health systems has both benefits and imperfections. It might be for this reason that patients seek help from both types of health practitioners. Previous authors have studied the THP health-seeking behaviour of patients with cancer and reported diverse factors such as the desire to be cured physically and mentally from the disease, delays at the hospitals, and through their past experience or recommendations from family or friends (Muhamad, Merriam and Suhani 2011: 10). This indicates that TM has various roles in the treatment of patients with cancer and this depends on the skills of the THPs in a particular country or community.

Additionally, the population using TM is increasing (Kangwa 2010: 1) because of dissatisfaction arising from AM utilisation and the persistent side effects of cancer treatment (Gyasi, Siaw and Mensah 2015: 138).

Currently, the risk assessments of TM practices used by cancer (and other) patients are difficult to measure because there is insufficient information available on positive and negative benefits. Further, TM normally involves a complex holistic regime, so it is difficult to attribute specific beneficial or side effects to a particular medicine (Poonthananiwatkul *et al.* 2015: 104). It is impossible to justify the general use of TM in cancer patients, but equally improper to deny the opportunity for late stage patients to try it even though its safety and efficacy has not been scientifically proven. TM users have reported many benefits such as significant reduction in symptoms of the disease with improved quality of life in advanced stage cancer (Poonthananiwatkul *et al.* 2015:105), as well as physical and mental cure from cancer (Muhamad, Merriam and Suhami 2011: 10).

In South Africa health-seeking choices are often rooted within cultural beliefs about the origins of sickness and influenced by previous experience of treatment or reports or information regarding such treatment, as well as financial or material circumstances, and common networks (Nxumalo *et al.* 2011: s133). Urban citizens in economically developing countries use TM because of their familiarity with TM (van Andel and Carvalheiro 2013: 11). This suggests that patients seek cure from many sources because of how they perceive the world.

Integration of cancer management will provide an opportunity to explore the extent of ethnobotanical indigenous knowledge in order to treat a variety of diseases depending on the community's regional profile and could lead to better management of cancers in the liver, lung brain, colon and bones (Cheikhyousssef *et. al.* 2011: 8). THPs have good knowledge about the causes of cancer despite the existence of some misconceptions and therefore could be of assistance in combating cancer (Al-Naggar *et. al.* 2012: 3847). When analysing the major differences between TM and AM with regard to their

usefulness, Fokunang *et al.* (2011) and van Rooyen *et al.* (2015) concluded that synergy between the two forms of medicine is needed in order to improve the quality of health care. It is imperative for THPs to define their role and practices in the management of a particular disease. Richter (2003: 11) suggested that knowledge of THPs' practices will enable AMPs to adapt their practices to the local ones making them relevant to the local peoples' needs. The reality is that TM alone cannot be an effective cure for cancer. Consequently, a decision supporting integration was taken (Kangwa 2010: 15).

In appreciating the significant connection between AM and TM in the treatment of cancer, the WHO officially promoted TM in 1978 (WHO 1978: 3). Following this decision by the WHO, extensive research was done to establish if the two systems should be integrated or segregated. Many countries unanimously agreed to integration and that any tension between the two approaches to cancer care should be resolved (Kangwa 2010: 12). In sub-Saharan Africa the number of THPs exceeds that of AMPs. For example, in South Africa there were 200 000 THPs compared with 25 000 AMPs in 2007 (Kale 1995; Setswe 1999). Therefore, integrating the TM and AM approaches will increase the capacity of treatment care.

In 2002 the WHO devised a strategy for integrating TM into the national health system (WHO 2002: 1). The objectives of the strategy were to develop policies to implement TM; promote safety, efficacy and quality in the use of TM; increase its availability to poor populations; and promote its use in particular diseases (WHO 2002: 5). Three options for integration were proposed, namely: an integrative system where TM is recognised and fully integrated to AM; an inclusive system which recognises TM and partially integrates it to AM; and, a tolerant system where AM is the main health system and a few TM practices are accepted legally (WHO 2002: 8-9). The Council of Yukon suggested that for effective integration, TM must be acknowledged as a significant, respected, and identical component (Friendship and Furgal 2012: 199).

Economically developing countries have lagged behind with regard to integration. For example, South Africa has only been successful in collaboration for the treatment of HIV/AIDS and mental illnesses. However, significant progress has been made in preparation for integration. For example, in support of TM, in 1994 the government in South Africa urged THPs to work with AMPs in order to strengthen the health system of the country by serving the interests of all the inhabitants (Pretorius 1999: 253). Also, the constitution gives people the right to access the health care service of their choice depending on their beliefs (Republic of South Africa 1996: 1249). This suggests that with collaboration, health practitioners should be able to guide patients in selecting their choice of medicine. For example, with the current practice in AM, patients do not refer themselves between radiotherapy, surgery and chemotherapy but are guided by the specialists in these fields.

2.6 CO-OPERATIVE PRACTICE BETWEEN THPS AND ROS IN THE TREATMENT OF PATIENTS WITH CANCER

The exact definition of the co-operative practice required between the two health practitioners to ensure that cancer patients complete the treatment of cancer with each health practitioner, has not been established by previous studies. The literature indicates that co-operative practice can be described by looking at the key elements, that is, the processes needed to work together. These factors are determined by the type of collaboration and partnership, the degree of patient participation, and are influenced by many factors arising from the external environment (D'Amour *et al.* 2005: 127).

In countries like South Africa where there is inadequate access to radiotherapy services, patients rely on THPs for cancer treatment. When exercising this right, cancer patients refer themselves simultaneously and consecutively to THPs and ROs (Kale 1995: 1185). This self-referral has resulted in patients presenting with advanced disease and there are interruptions in treatment of cancer (Merriam and Muhamad 2013: 10). In such cases the two health practitioners are working in parallel and against

each other (Peltzer and Khoza 2002; Mngqundaniso and Peltzer 2008; Kangwa 2010). Therefore, developing a functional relationship between the two groups is a valid concern (Maitai 2013: 1). Co-operation is needed between the two health practitioners in order to refer patients properly without interrupting the treatment of the patients. Additionally, collaboration is needed to capacitate the radiotherapy services in the province because in KZN, there are currently seven ROs in public hospitals which provide cancer treatment compared with 15 000 active THPs (Gqaleni *et al.* 2007: 178).

Despite the integral role of THPs in the treatment of cancer, their practices are unregulated and unaccepted by the ROs. Often the THPs claim that they can cure cancer and that their practices are safe. There is no information available on the role and practices of THPs in the treatment of patients with cancer in KZN. As a result of unsafe practices, the AMPs are refusing to collaborate with THPs in the management of many diseases. No study is available to provide information on the ROs' willingness to co-operate with THPs in the treatment of patients with cancer. The current study will contribute to filling this gap. Solving the problem will allow communication between the two practitioners such that patients with cancer can be referred formally or have some form of guidance in their referral in order to have continuity of treatment. In the following paragraph the treatment of cancer will be discussed in the context of South Africa.

Previous studies have shown that THPs and AMPs in KZN have co-operated in the management of HIV and AIDS and mental illnesses (Mngqundaniso and Peltzer 2008; Gqaleni *et al.* 2011). The same authors maintained that co-operation in the treatment of those illnesses was challenging. They identified many factors impinging on collaboration such as the lack of formal collaborative mechanisms; their own ability to treat; and resistance from the AMPs. Despite these challenges, the study by Gqaleni *et al.* (2011: 7) showed that THPs in KZN are willing to collaborate in the treatment of HIV and AIDS

Most studies on co-operation have been conducted in economically developed countries and focussed on explaining co-operation in general and

partnership leaving a gap in determining the effectiveness of these in practices of service delivery (Sullivan and Skelcher 2002: 6). Williams and Sullivan (2007: 5) conducted a review of literature on the effectiveness of partnership and examined its nature, elements and determinants of success in collaborative arenas. The results of this literature review revealed that collaborative practices are influenced by the policies that had been developed to improve coordination and integration of public services. These authors wrestled with terminology to describe collaboration and what motivates parties in collaborations to work in this way as well as the key costs and benefits thereof (D'Amour *et al.* 2005; Williams and Sullivan 2007). The Policy Framework and Strategy on Cancer in South Africa 2016-2021 advocates for a multidisciplinary approach drawing from multiple disciplines for collaboration and shared decision-making (Department of Health 2016: 10).

Research into collaborative practice is prominent because of the varied disciplines, research paradigms, theoretical standpoints and areas of focus within which it is studied. For example, theories in economy and sociology explain the term “collaboration” (Williams and Sullivan 2007: 6). A broad variety of concepts, notions, models, factors and determinants have been used to explain “collaboration”, including: intensity of partnership behaviour (co-operation, coordination and collaboration), partnerships that move through different phases, effective partnerships with critical successes factors; barriers to, and drivers of effective collaboration (relating to structure, procedure, finance, professionalism and organisational culture); leadership styles that are appropriate to partnership arenas based on facilitation, empowerment and catalytic behaviour; appropriate accountability and performance; and, management frameworks for partnership settings influence collaborative practice (Williams and Sullivan 2007: 6).

Furthermore, D'Amour *et al.* (2005: 121) reviewed seven proposed theoretical frameworks (Gitlin, Lyons and Kolodner 1994; Miller 1997; West, Borrill and Unsworth 1998; Corser 1998; Hawywards, DeMarco and Lynch 2000; Sicotte, D'Amour and Moreault 2002; D'Amour *et al.* 2004) to describe collaboration and identified common concepts namely: sharing, partnership, power,

interdependency and process that can be used to analyse and describe this collaboration. In the review, empirical data, a clear strategy for reviewing the literature and explicit theory were used to evaluate the strength of the frameworks and to analyse the theoretical suggestions to further comprehend collaboration.

Of the seven theoretical frameworks assessed, only three were strong, with two derived from organisational theory (West, Borrill and Unsworth 1998; D'Amour, Sicotte and Levy 1999; Sicotte, D'Amour and Moreault 2002) and one from organisational sociology (D'Amour *et al.* 2004). The framework arising from organisational theory had developed frameworks on group and team effectiveness which were utilised to develop models of interprofessional collaboration in health care (D'Amour *et al.* 2005: 122). West, Borrill and Unsworth's theoretical framework model of team effectiveness was composed of inputs related to tasks, group composition, cultural context and organisational context and also included process variables for effectiveness such as leadership, communication, and decision-making (West, Borrill and Unsworth 1998: 32). The authors are of the view that this model is suitable to study health care teams in primary health, community health, and secondary health as well as the effectiveness of cancer teams.

The seven frameworks provided an understanding of the process of co-operation forming the base for future research and practice. They revealed that the purpose of collaborative process is to satisfy the needs of patients and the professionals on the team; hence each consists of a joint action to address the client needs and a team in which members respect and trust each other. Although those frameworks are strong because of having empirical data and explicit theory, they lack the description of practices. A theoretical framework by Miller, the Certified Nurse-Midwife, Physician and Client Collaborative Cycle, was appropriate in describing the co-operative practices between the team of THPs and ROs (Miller 1997: 302). In Chapter 3, the researcher discusses the seven theoretical frameworks to justify the selection of Miller's theoretical framework as the basis for this study.

D'Amour and team (2005) identified common concepts that defined collaboration and its related practices, namely sharing, partnership, interdependency, power and that collaboration is a changing process (D'Amour *et al.* 2005: 120). For effective practices in health organisations, collaboration requires common qualifiers namely multidisciplinary, interdisciplinary and transdisciplinary that define the type of partnership. Concepts focussed on the patient were client participation in the team and decision making processes. The result of the review on the theoretical frameworks related to collaboration showed that the strong ones comprised empirical data or an explicit strategy of literature review and explicit theory. However, they observed that using these concepts to define collaboration does not distinguish between its determinants, processes and results. They stated that this gap can be filled if future research draws finer dissimilarities between these concepts and provides better description of the nature of collaborative processes (D'Amour *et al.* 2005: 126). The current study is intended to fill this gap as it will draw dissimilarities between these concepts and provide better description of the nature of collaborative processes.

Studies on co-operative practice conducted in the African context have employed varied techniques such mixed methods, qualitative and quantitative to examine the phenomenon of co-operation between TM and AM (Kayombo *et al.* 2007; Campbell-Hall *et al.* 2010; Van Rooyen *et al.* 2015; Boateng *et al.* 2016). For example, a mixed method study on how to initiate collaboration between THPs and AMPs in the treatment of HIV and AIDS in Tanzania had focussed on aspects, namely: entry point to access THPs, knowledge on HIV and AIDS, and handling cultural aspects (Kayombo *et al.* 2007: 4). The weakness of the study was that, the meaningful collaboration between the parties was not planned tactfully. This resulted in the study reporting inappropriate methods of initiating a sustainable collaboration. The methodology employed by the study was weak. In this study, it is unclear what data was collected in the second phase of the study, and how was data analysed using the mixed methodology. Consequently, the study did not have a meaningful contribution to the concepts and description of the nature of collaborative processes.

Also, a qualitative study by Campbell-Hall *et al.* (2010) in KwaZulu-Natal, on collaboration between THPs and AMPs in the treatment of patients with mental illnesses, had a focus on exploring the existing collaboration. Its objectives were establish whether collaboration should take place, and what form of collaboration should exist (Campbell-Hall *et al.* 2010: 616).The study employed a case study design, individual and focus groups interviews to collect data from the participants. The limitation of the study was that the patients who participated in the study were accessed by the Department of Health and primary health care clinics. This could have influenced the participants' responses in that they may have associated the interviews with the Department of Health. Other patients with similar disease who did not utilise the public health facility were not interviewed and therefore their opinions were not obtained.

The study reported that both health practitioners were comfortable with the collaboration. However, they were concerned about treatment adherence and negative interactions between the various drug treatments of THPs and AMPs when they move freely between them (Campbell-Hall *et al.* 2010: 621). The authors suggested that future research on co-operation should learn from previous studies on attempts to establish collaboration between THPs and AMPs. The strength in the methodology of the study was that, it is exploratory and appropriate when the topic has not been addressed properly with a certain group of people, and the prevailing theories are not applicable to the group in the study (Creswell 2009: 19). This methodology will be appropriate to define the concepts in the co-operation and provide a better description of the nature of co-operative practice.

In another study in the Eastern Cape, a qualitative, exploratory and descriptive study by Van Rooyen *et al.* (2015) on collaborative relationship between THPs and AMPs, focussed on the legalisation of traditional healing. The study reported that the THPs highlighted areas of collaboration in the sharing of information and mutual utilisation of resources such as the budget, physical health, and equipment (Van Rooyen *et al.* 2015: 7). It emerged from this study that, in order to facilitate co-operation, the THPs need to be

developed because most of them were illiterate or poorly educated (Steyn and Muller 2000; Van Rooyen *et al.* 2015).

The study recommended that the TH and AM should operate as parallel systems, collaboration can be encouraged through formal policies, the practices of THPs that could be detrimental to patients need to be rectified, and that there should be a representative for THPs in all government structures (Van Rooyen *et al.* 2015: 8). The limitation in the study was the use of only one focus group for the AMPs. The rationale for this was shortage of staff in the health facilities where the study was conducted. Using focus group interview compared with individual interview, yield limited information from some participants who are not confident to express their real opinions (Creswell 2009: 179).

These studies on collaboration were in the realms of biomedicine, anthropology, ethnography, sociology, behavioral sciences, and epidemiology (among others) and took different approaches or had different motivations for examining the topic (Kayombo *et al.* 2007; Campbell-Hall *et al.* 2010; Mwaka, Okello and Orach 2015; Van Rooyen *et al.* 2015). Consequently, many concepts were identified with the objective of understanding collaboration between the healthcare providers.

2.6.1 Concepts to describe co-operation

To draw finer dissimilarities between the concepts that describe collaboration and provide better description of the nature of collaborative processes, the emphasis is on describing collaboration in economically developing countries. In doing so, the researcher described the environment, the nature of relationship, the strength of relationship and the concepts that describe collaboration and from these, constructed a framework for co-operative practice between THPs and ROs in the treatment of patients with cancer.

2.6.2 Barriers to effective co-operation

As previous stated, the impediments to effective collaboration are lack of communication, trust and respect (D'Amour *et al.* 2005: 116-117). The study will explore these based on the responses of the participants in the study.

2.6.3 Enablers for effective collaboration

Enablers are the solutions to issues that hinder collaboration (Williams and Sullivan 2007: 16). Participants provide solutions on how to build a continuous environment conducive for interacting with each other where there is communication, trust and mutual respect. The research question will enable the participants to explore what would affect or improve the collaboration.

2.7 TM INSOUTH AFRICA

In South Africa, TM already existed in the 17th century when the colonial powers arrived but was eventually banned by the Health Act of 1974 (Kale 1995: 1182). TM is defined as indigenous knowledge practice that uses certain techniques and principles (Republic of South Africa 2008: 6). It is a profession dominated by males (Moeng and Potgieter 2011; Semenya and Potgieter 2014). Those in the traditional healing profession, begin their career in their 20s and 30s (Semenya and Potgieter 2014: 5) but the majority are between the ages 41-60 (Ndawonde 2006: 11). They are well known within the municipality in which they live.

THPs in South Africa have different education levels, ranging from no formal education to university degrees and in economically developed countries their education levels range from formal education to university degrees (Semenya 2014: 11). Educational skill is an advantage in ensuring long term sustainability of the profession (Richter 2003: 6). However, traditional healing is acquired through mentoring and from colleagues (Cheikhyyoussef *et al.* 2010: 5) and parents and grandparents (Semenya and Potgieter 2014: 7). TM differs in terms of services offered and practices they use to diagnose and treat their patients.

The THPs Act of 2007 has listed THPs as herbalists, spiritualists, traditional surgeons and traditional birth attendants (Republic of South Africa 2008: 6). They use plants, animals and mineral substances using techniques which rely on their social, cultural and religious background to treat diseases. Their healing is completely natural and tied in with cultural and religious beliefs as well as physical, psychological, spiritual and social aspects of individuals, families and communities (Truter 2007: 57). This suggests patients who are culturally inclined, value and respect THPs.

In treating their patients, THPs do not separate the patient into body and mind but treat the patient holistically (Kale 1995: 1184). They behave like doctors, psychotherapists and ministers in their practices (Truter 2007: 60). THPs treat many diseases including cancer (Peltzer 2009: 85), using plants which they prepare and administer to their patients (Semenya and Potgieter 2014: 7). This means that they provide the same holistic treatment as the radiation oncologists', and their medicine may have side effects like their counterparts' do.

South Africa has lagged behind with regards to the co-operation process of TM and Western medicine since, since 1994 (Truter 2007: 56). There is little information about the roles and practices of THPs in managing patients with cancer. They have a different approach to diagnosing and treating cancer which has not been explored. Also, their scope of practice is undefined. THPs and ROs do not understand each other's practices in the treatment of cancer patients. Consequently, there are many differences between the two professions and there is no proper referral of patients with cancer between the two systems. Thus, more research is needed to establish the role and practices of traditional health professionals, to foster relationships between the two health professions, and to eventually develop a co-operative practice framework between the THPs and ROs in the treatment of patients with cancer. It is imperative for the two systems to co-operate for the benefit of the South African population who use both systems. In the next section previous findings on co-operation will be discussed.

2.8 ANALYSING CO-OPERATIVE PRACTICE IN THE TREATMENT OF PATIENTS WITH CANCER

Research conducted by Kangwa (2010: 16) supports integration stating that it is the best option to manage patients with any disease including cancer. Also, there is a benefit because there is a wide range of ethnobotanical indigenous knowledge available to treat a variety of diseases depending on the community's regional profile (Cheikhoussef *et al.* 2011: 3). Research is recommended to find a common ground between these health practitioners.

A study by Mngqundaniso and Peltzer (2008: 385) reported that there were mixed feelings with regard to collaboration between nurses and traditional healers. In both groups some individuals were unwilling to collaborate. However, the same study showed that the majority of nurses were willing to collaborate with traditional healers for HIV and AIDS management. Another study conducted in North America between medical doctors and traditional healers in the treatment of cancer showed that medical doctors were willing to collaborate on condition that there is one mode of treatment which is scientifically proven to provide all the goals of efficient treatment (Sagar 2006: 35). This suggests that collaboration needs to be based on certain conditions. However, the reality is that traditional healers can work alone to treat patients with cancer.

In South Africa, an evidence-based study on traditional healing for cancer conducted by Struthers and Eschiti (2004: 21) on four patients reported that patients consulted with traditional healers because they were familiar and comfortable with them. In this study, the THPs explained that traditional healing occurs through the interconnection with the spirit world. However, they recommended an integrative approach to provide holistic healing. A study by Steyn and Muller (2000: 8) demonstrated the preventative role of traditional healing and recommended the following for integrated therapy: training and information, infrastructure, equipment and material, co-operation, professionalization (registration and standardisation of training), and an authorised environment for the interaction.

With reference to management of patients with cancer, effective integration requires establishment of the role and practices of traditional health professionals in the management of patients with cancer, collaboration between the two systems, identification of their specific role in cancer management and development of appropriate regulatory systems and institutions (Moshabela 2012: 5). According to Richter (2003: 11), there is a need to learn about traditional health professionals and their practices in order to adapt the Western practitioners' best practices to the local one making it relevant to the local peoples' needs. Medical practitioners and traditional health professionals must communicate with one another and work together in order to treat patients in a way that is both scientifically effective and personally sensitive. It is imperative to adhere to human rights principles and frameworks in aspects of traditional healing. Furthermore, the government, civil society, and the private sector, need to invest in and sustain traditional health professionals and their medicine.

A study by Steyn and Muller (2000: 5-7) explored integration of traditional healing with Western medicine for cancer management and reported that people from all races seek cure from THPs. According to this study, the majority of THPs can treat cancers of breast, cervix, lung, oesophagus, colon and bladder using medicine and herbs. However, they were unsure of its causes, signs and symptoms and cannot prevent cancer though a minority can diagnose it. The study also reported that THPs acknowledged the significant role of Western medicine in managing cancer and agreed on the need for collaboration between the two systems.

The starting point is that THPs should define what they can contribute to the care of the patient and what their practices are in managing and treating cancer. The reality is that TM alone cannot be an effective cure for cancer. Allopathic medicine doctors and THPs must communicate with one another and work together in order to treat patients. Ultimately, there is discrimination and absence of trust and common understanding (Mngqundaniso and Peltzer 2008: 382a), and a lower status conferred to indigenous knowledge in society because it is owned by a particular racial or ethnic group (Kangwa 2010: 13).

The majority of Western health professionals undermine the traditional health professionals because they perceive them not to be of any benefit, while some acknowledge their good counselling skills (Mngqundaniso and Peltzer 2008: 382). Thus, as patients move between THPs and ROs without completing treatments, the cancer continues to grow. Similarly, cancer patients are denied access to a health care practitioner of their choice making it impossible to disclose their association with the other health practitioner. Solving the problem will allow communication between the two practitioners, and cancer patients can be referred properly, resulting in continuity of cancer treatment. The current study is intended to fill this gap.

The researcher has 20 years' experience as a therapeutic radiographer treating patients with cancer using radiation. In this study, she was the principal investigator who designed the study, conducted the literature review, obtained ethical approval for the study, prepared the interview protocol, recruited the participants, collected and analysed data under the guidance of the supervisors and lastly, reported on the findings. Additionally, the researcher conducted bracketing interviews to prepare for the study, scheduled and conducted the interviews with the participants, transcribed the interviews, performed data analysis using descriptive phenomenological analysis procedures, and solely reported the findings.

Also, the researcher's mother tongue is isiZulu. She also studied isiZulu and English as subjects up to matric. In the current study, she was the instrument to collect data. She translated the research questions into isiZulu, and collected data from the THPs. The interview data was translated back to English before transcription. In so doing, the researcher interpreted and reported the findings of the study appropriately.

Previous studies found that collaboration is a multifaceted and changing process because it has changing degrees of collaboration and the process itself is continuously changing (D'amour *et al.* 2005; Williams and Sullivan 2007). The same authors maintained that different people differ in their use and understanding of the term. Consequently, there is no single theory or

theoretical framework that adequately explains it; instead, theoretical paradigms from many disciplines provide a better explanation (Williams and Sullivan 2007: 24).

The rationale for the study is to ensure that there is continuity of treatment in patients with cancer. The study involved health practitioners who are involved in the treatment of patients with cancer. They related their experiences by exploring the challenges encountered in the treatment of patients with cancer. They were required to describe the envisaged co-operative practice between them and identify areas that require intervention in the treatment of patients with cancer in KZN province. A framework for co-operative practice between the THPs and ROs in the treatment of patients with cancer was then developed noting that this should exist in an environment full of harmony, trust and respect. In the next chapter, the researcher will discuss the theoretical framework which guided the study and the methodology by which it was implemented in order to fulfil the requirements of this research.

2.9 SUMMARY OF THE CHAPTER

The chapter covered literature on the topics pertaining to co-operative practice between TM and AM in the treatment of patients with cancer. The gaps identified in literature were that there is no study that has been conducted in South Africa, and KZN in particular, regarding co-operation between THPs and ROs in the treatment of patients with cancer. Although many studies have been undertaken to better understand the impediments to the integration, there has been no conclusion regarding the appropriate description of a framework for co-operative practices in cancer treatment.

CHAPTER 3 : CONCEPTUAL FRAMEWORK

3.1 INTRODUCTION

In this chapter, the researcher develops and discusses the conceptual framework that will be used as a base from which to build or extend the understanding of co-operative practice between the THPs and ROs in the treatment of patients with cancer. In the previous chapter the researcher highlighted that there is no other study available on the co-operative practices in the treatment of cancer patients in South Africa. Therefore, a qualitative approach was used to study the phenomenon. The chapter first explains what a conceptual framework is, its selection, and how to integrate it into the thesis. It also explains and discussed the concepts that are relevant to the topic.

3.2 CONCEPTUAL FRAMEWORK FOR THE CURRENT STUDY

The previous chapter discussed the concepts and theoretical frameworks that were used by previous studies in order to understand collaboration. A conceptual framework forms the foundation and support for the entire thesis from which it is possible to construct the rationale, the problem statement, the purpose, the significance, research questions, literature review, research methodology and analysis and the conclusion for the study (Simon and Goes 2011; Grant and Osanloo 2014). However, the role of theory in the entire thesis is unclear (Kelly 2010: 285), because some authors assert that it is the base from which to construct the aim of the study, the problem statement, the significance of the study, and the research questions (Grant and Osanloo 2014: 12). Contrary to this, Kelly (2010: 285) suggests that theory is introduced when one begins to identify the research questions.

Despite this, it is imperative for a researcher to define the theoretical framework of a thesis (Lysaght 2011: 572) and discuss it in the thesis (Kelly 2010; Grant and Osanloo 2014). To embark on this, the investigator discusses and explains how the theoretical framework for the study was selected in the following section.

3.3 SELECTION OF THE CONCEPTUAL FRAMEWORK FOR THE STUDY

The selection of a framework is based on the problem, purpose, significance and research questions of the study in order for the theoretical framework to guide the option of research design and data analysis (Grant and Osanloo 2014: 17). It should be borne in mind that there is no single theory that is an exact fit of any enquiry, hence the researcher should substantiate the choice of theory that aligns and frames the purpose, research questions, significance and design in the study.

The aim of the study was to understand the treatment of patients by THPs and ROs in order to describe a framework for co-operative practice between them in the treatment of patients with cancer. The previous chapter mentioned the seven theoretical frameworks that previous researchers employed to study co-operative practice. The chapter provides an overview of each framework to show why the researcher selected the Certified Nurse-Midwife, Physician and Client Collaborative Cycle (Miller 1997: 306).

D'Amour and team conducted a literature review and identified seven theoretical frameworks, namely:

- 1) The Model of Team Effectiveness by West, Borrill and Unsworth (West, Borrill and Unsworth 1998: 38) considered inputs such as performance, innovation, well-being and viability which are related to task, group composition, cultural context and organisational context. The model was constructed based on literature on group efficiency. It involves process variables for efficiency such as leadership, communication, and decision-making. This model investigated the functioning of a relationship between groups of cancer teams as well as the wellness of the members (D'Amour *et al.* 2005: 122).
- 2) The Analytical Framework of Interdisciplinary Collaboration by Sicotte, D'Amour and Moreault (2002: 1000) utilised group effectiveness

frameworks to conduct research on community health centres. In their project the contributions were contextual variables. The major findings in their project were that conflicting factors influence interprofessional collaboration and that collaboration occurs as a result of formalisation (D'Amour *et al.* 2005: 122).

- 3) The model of D'Amour, Sicotte and Levy (1999) as well as D'Amour *et al.* (2004) was grounded on the Strategic Analysis and Organisational Approach which conceptualises collaboration according to finalisation, interiorisation, formalisation and governance (D'Amour *et al.* 2005: 123).
- 4) The Five-Stage Model of Collaboration by Gitlin, Lyons and Kolodner (1994: 28) utilised social exchange theory to analyse collaboration. The two significant concepts are exchange and negotiation and the fundamental principle is that one will join a group that has value and in return one should assist the group to obtain its objectives. The negotiation process commences at this stage and the individuals continuously engage in negotiations to maximise benefits, diminish costs and progress under amicable conditions (D'Amour *et al.* 2005: 123).
- 5) The Interdisciplinary Alliance Model of Hayward, DeMarco and Lynch (2000: 224) is a merger of two models (Gitlin, Lyons and Kolodner 1994: 30) that deal with iterative processes and interpersonal issues regarding the concept of alliance. The required environment for alliance was hypothesised to be caring between professionals, mutual reflection and social support. However, such a model has not been tested (D'Amour *et al.* 2005: 123).
- 6) The Conceptual Model of Collaborative Nurse-Physician Interactions proposes a framework for collaboration between physicians and nurses using review of the literature (Corser 1998: 333). According to this framework, personal or interpersonal influences and organisational or professional influences impact on collaboration. The same author

maintained that such collaboration requires mutual respect and maintenance of actual and perceived power balance between the parties in the collaboration. The most significant outcome of collaborative interactions is a more consistent attainment of clinical patient goals. This conceptual framework has not been validated (D'Amour *et al.* 2005: 123).

- 7) The Certified Nurse-Midwife, Physician and Client Collaborative Cycle by Miller (1997: 302) is based on grounded theory and five categories of successful co-operative practices that include descriptions of external conditions, individual attributes, organisational dynamics, trusting attitudes and philosophy of practice. Miller describes a cycle of collaboration which comprises attributes of individuals, patient outcomes and trusting relationships.

D'Amour *et al.* (2005: 126) conducted a review which aimed to identify common concepts relevant to collaboration and to evaluate the strong points in those frameworks. The common concepts that emerged were sharing, partnership, interdependency, and power. The authors described co-operation in terms of the degree of collaboration, and pointed out that it is a changing process. The theoretical framework that the researcher developed to analyse the co-operative practices between the THPs and ROs was based on these concepts. In the following section the researcher links these with the literature review.

According to the WHO, there are three categories of health system which describe the degree to which TM can be incorporated into health systems, namely, integrative, inclusive and tolerant health systems (WHO 2002: 9). In an integrative health system, TM is officially recognised and incorporated into all areas of health care provision; an inclusive system recognises TM but has not yet fully integrated it into all aspects of health care and also the delivery of health care might be unavailable at other health care levels; and in a tolerant system, the conventional health system is based solely on allopathic medicine with TM practices being tolerated by the law. According to Boon *et al.* (2004:

2-3), there are seven models of team oriented health care practice which can provide researchers with a starting point from which to explain research findings. These are explained as follows:

- i. *Parallel practice*: where the health practitioners work independently in a common setting, each working in a defined scope of practice (Ivey *et al.* 1988; Meeker 2002).
- ii. *Consultative*: where expert advice is given from one health practitioner to another via a referral letter (Ivey *et al.* 1988; Meeker 2002).
- iii. *Collaborative*: where independently working health practitioners share information regarding a certain patient who is on treatment or already treated by each of them (Ivey *et al.* 1988: 193).
- iv. *Co-ordinated*: is a formalised administrative structure where the health practitioners communicate and share patient records amongst team members who are treating a particular disease (Ivey *et al.* 1988: 194).
- v. *Multidisciplinary*: where teams are managed by an outsider who plans the patient care, or where one or each member makes their own decisions and recommendations that the team leader integrates (Ivey *et al.* 1988: 193).
- vi. *Interdisciplinary* where the health practitioners from multidisciplinary practice make up the team making decisions about patient care (Ivey *et al.* 1988: 193).
- vii. *Integrative* where the health care practice consists of both AM and TM who provide patient centred care and support in order to treat a patient holistically (WHO 2008: 3).

The concepts associated with co-operative practice are explained next as follows:

Sharing is used in many ways such as shared responsibilities, shared health care philosophy, shared values, shared data, shared planning and intervention (Ivey *et al.* 1988: 192; D'Amour *et al.* 1999: 74).

Partnership suggests that that at least two players interact in a collaborative setting where there is open and honest communication, and mutual trust and

respect (Sullivan and Skelcher 2002: 67-70). The authors maintain that in this partnership each party recognises and values the contributions of others.

Interdependency refers to mutual dependence where the practitioners are dependent on one another for the common objective of meeting the patient's needs (D'Amour *et al.* 2005: 118).

Power is where both parties are empowered while each party's power is acknowledged by the others (Sullivan and Skelcher 2002: 67). The authors state that this power depends on knowledge and experience in one's profession and is associated with relationships and interactions between team members.

Process, associated with collaboration, cautions that it should be acknowledged that collaboration is a developing, changing and interactive process. Hence, the co-operative process follows concrete steps, such as negotiation and compromise in decision-making, shared planning and intervention (D'Amour *et al.* 2005: 120).

There are also concepts related to the team in terms of effective practice in health care organisations (D'Amour *et al.* 2005: 121). These concepts are multidisciplinary, interdisciplinary and transdisciplinary. D'Amour *et al.* (2005: 121) maintain that collaboration within a team can be described on a continuum of professional integration where professionals intervene on an autonomous or parallel basis through means such as co-operation, co-ordination and collaboration.

Focus on the client, in terms of patient participation in a team's collaborative dynamic. The role of patient participation is usually unclear because it is not theoretical but depends on empirical data (D'Amour *et al.* 2005: 121).

With regard to the concepts related to collaboration between the team and the patient, the seven proposed theoretical frameworks addressed the structure of the team rather than the processes involved in improving the effectiveness in

teams (D'Amour *et al.* 2005: 126). Therefore, in the current study, in addition to the above mentioned concepts, the researcher included an existing theoretical framework that would provide the processes necessary for effective practices within the teams.

With regard to studying co-operation between THPs and ROs, there is no literature available that describes co-operation in the treatment of patients with cancer in Africa and any other economically developing countries. The researcher relied on the existing theoretical frameworks and the seven proposed theoretical frameworks described previously. According to Creswell (2009: 64), when no theory exists to study a phenomenon, the researcher depends on the experiences of the participants to understand the phenomenon. Therefore, Miller's theoretical framework, namely, Certified Nurse-Midwife, Physician and Client Collaborative Cycle (D'Amour *et al.* 2005: 121) was selected because it is the only one with no theory but relies on empirical data in order to describe co-operative practice. The same authors assert that this framework describes five classifications of successful practices including external conditions, individual characteristics, organisational dynamics, trusting attitudes and viewpoint of practice.

According to Adams *et al.* (2009: 795), the external environment which influences collaboration includes state regulation, culture, historical context, power and knowledge. In addition to the external environment, in order to study co-operative practice, there is a need to know the reason for the co-operative practice. In the current study the reason for co-operative practice is to initiate collaboration between the THPs and ROs in the treatment of patients with cancer. Van Rooyen *et al.* (2015: 5-8) indicate that the main drivers for collaboration for professionals, who want to initiate collaboration, are the need to deal with the negative attitudes; forging of new relationships to engage in and to provide co-ordinated services; the aspiration to give expression to community leadership; to tender for new resources; to stimulate more creative approaches to problems; to align services with the needs of users; to influence the behaviour of the partners; and, to meet a statutory requirement.

In order to develop a theoretical framework that could be used to assess the co-operative practice between the THPs and ROs, the researcher examined the topic to identify the variables and the relationship between them. In the topic “A practice framework of co-operative practice between the THPs and ROs in the treatment of patients with cancer in KZN province”, the variables are patients with cancer, the THPs who treat patients with cancer, and the ROs who are AMP specialists in the treatment of patients with cancer. The relationship between the variables is that the patients with cancer are the main variable and the centre of the collaboration. The THPs and ROs are the dependent variables where the relationship between them is unknown. Therefore, the study should fill this gap by describing this relationship. To describe the relationship, the investigator asked the following questions of the participants:

The main research question is:

“What would constitute a workable practice between THPs and ROs in the treatment of patients with cancer?” The aim of the study is to describe a framework of co-operative practice between the THPs and ROs in the treatment of patients with cancer, and to develop THPs as a component of the health system in the treatment of cancer patients. The researcher believed that through their experiences in treating patients with cancer, participants would be able to describe the workable practice needed for effective collaboration between them.

The sub-questions are:

- 1) “What is each health practitioner’s experience in the treatment of patients with cancer?”

The aim is to understand how each health practitioner describes their practices, therefore explaining the type of collaboration between the cancer treatment teams.

2) “What is the perception of each health practitioner about the other group with regard to treatment of patients with cancer?”

The aim is to explore and gather information about the pressing issues which impede effective co-operation between the health practitioners.

3) “What is the perception of each health practitioner with regard to co-operative practice in the treatment of patients with cancer?”

The aim is to explore and gather information about the pressing issues which impede effective co-operation between the health practitioners.

4) “What co-operative practice is needed between the two groups of health practitioners in the treatment of patients with cancer?”

The aim is to collect rich information from the participants on how intervene in regard to the pressing issues between the groups.

Rich information was obtained from the THPs and ROs as the main players in the treatment of patients with cancer. In their responses, the THPs and ROs described co-operation in terms of the relationship between them, co-operative practices in the treatment of cancer patients, issues to be addressed, and intervention.

In addition to the previously mentioned questions, the researcher used breaking questions to the THPs in order to establish their knowledge, role and practices in the treatment of patients with cancer, and the following questions were asked:

1. What is cancer?
2. How do you diagnose cancer?
3. What do you do when a patient has been diagnosed with cancer?
4. What type of cancers do you treat?
5. What is your goal in the treatment of patients with cancer?
6. How do you know that you have reached your goal?
7. How long is the survival of patient after treatment?
8. How many patients have you treated successfully?

9. What do you do if your treatment is unsuccessful?

The literature review on the topic provided information about the phenomenon by describing the structure of the relationship and the processes for effective co-operation as well as the proposed theoretical frameworks to study the co-operative practice. The researcher used this information in the literature to develop a conceptual framework because the framework by Miller that suited the study was not based on theory. Creswell asserts that studies which rely on experiences of individuals to explain the phenomenon do not require a theory but are based on phenomenology (Creswell 2009: 64). According to Grant and Osanloo (2014: 16), the conceptual framework is constructed based on the researcher's understanding on how the problem being researched can be explored. The researcher developed the conceptual framework based on the common concepts proposed by D'Amour *et al.* (2005: 119), associated with co-operation, team, and patients. Furthermore, other concepts from the literature that describe the treatment of cancer by THPs were included. Based on these, the conceptual framework has constructs, concepts and ideas as shown in Table 3.1. However, the concepts do not clearly distinguish the concepts related to the co-operation and the team – further research is needed in this area. Creswell (2009: 70) asserted that studies which do not include theory will provide descriptive research.

Table 3.1: Conceptual framework for the study

Construct	Concepts	Category	Ideas
Principles and practices of THPs in the treatment of patients with cancer.	Role and practices of THPs in the treatment of patients with cancer.	Knowledge of cancer. Principles	Description of cancer, its characteristics, causes and effects on patients.
		Diagnosis of cancer.	Methods of diagnosing cancer.
		Treatment of cancer by THPs.	Practices in the treatment of cancer.
		Evaluation of treatment.	Follow up and feedback from patients.
Relationship	Structure	Concepts related to co-operation.	Integrated Inclusive Intolerant Sharing, Partnership, Interdependency, and Power
		Concepts related to the team.	Parallel Integrative Interdisciplinary Multidisciplinary Consultative Coordinated Consultative Power
		Concepts related to the patient.	Communication Participation Decision making
	Processes	Building relationship	Required: Communication. Trust and respect. Negative attitudes and perceptions.
	Co-operative practice	Miller's framework for effective co-operative practice: External environmental factors.	Legislation, institutional, economic, social, political, professional and historical factors.
		Individual attributes.	Personal experiences with each other's professions, levels of skill and competence, and individual self-confidence.
		Organisational or behavioural dynamics.	Procedures necessary to smooth operation of practice and develop trust and respect in the relationship.
		Trusting attitudes.	Ground rules and structured conflict to level the power differences.
		Standpoint of practice.	Philosophical beliefs, dedication and commitment to patient care. and commitment to interdisciplinary co-operative practice.

A conceptual framework is a plane of interlaced concepts, assumptions, expectations, beliefs, and theories that support and inform an understanding of the phenomenon under study (Jabareen 2009: 51). The author asserts that it frames the ontological, epistemological, and methodological assumptions in a study and each concept is an integral part in the research paradigm. The conceptual framework for the current study will be discussed in detail in Chapter 4.

3.4 APPLYING THE CONCEPTUAL FRAMEWORK IN THE STUDY

The conceptual framework provides understanding of the best way of solving the problem, the specific direction to follow, and the relationship between the variables in the study (Grant and Osanloo 2014: 16-17). Miles and Huberman (1994:440) state that it comprises concepts, assumptions and beliefs to guide the research. Those concepts originate from best practices in the research literature related to co-operative practice between practitioners in different disciplines (Grant and Osanloo 2014: 17). The constructed conceptual framework forms the theory of co-operative practice between THPs and ROs in the treatment of patients with cancer. It provides a logical structure of interlinked concepts that depict how ideas relate to each other in a theoretical framework (Grant and Osanloo 2014: 17). The framework applies to the research problem, purpose of the study, significance of the study, research questions, literature review, research methods and data analysis (Grant and Osanloo 2014: 22). The conceptual framework should be aligned to the literature review by concept mapping defined as the process of representing and organizing ideas (Grant and Osanloo 2014: 19). It provides a frame to guide the research methodology, interpretation of the results, and discussion and reporting of the results (Kelly 2010; Grant and Osanloo 2014).

3.5 SUMMARY OF THE CHAPTER

The chapter explained and discussed how a theoretical framework is selected. Based on the literature review and research questions, it showed how the conceptual framework was constructed. Additionally, it explained that the constructed framework will guide the entire study. In the next chapter, the researcher discusses the research paradigm of the study.

CHAPTER 4 : RESEARCH DEIGN AND METHODOLOGY

4.1 INTRODUCTION

Research methodology is a methodical and universal way of searching for appropriate information on a particular topic (Leedy and Ormrod 2010: 2). The purpose of this chapter is to describe the research methodology that underpins the investigation into the problem. In so doing, it explains the methods that will be used to conduct the study, the area where the study will be conducted, the sampling process, the inclusion and exclusion criteria for the sample, the data collection process and its analysis in the study. It will also discuss the ethical considerations as well as the validity and reliability of the research tool. Before discussing the research methodology that will be used in the study, the researcher will briefly discuss the ways in which researchers select how they conduct their investigation into a problem.

Researchers, guided by philosophical assumptions and procedures to be employed in a study, have different ways and beliefs of interacting and viewing their surroundings (Creswell 2009: 5), which is why the conduct of studies differ. However, researchers follow certain rules and standards in their actions and beliefs when searching for information and this are referred to as a research paradigm. In the following section the researcher discusses the research paradigm used in the study in order to get a better understanding of why, and how, the particular research design was selected in relation to the methodology of the current study.

4.2 THE PHILOSOPHICAL VIEWS UNDERPINNING THE STUDY

The philosophical views underpinning the study are described as the experiences, opinions, perceptions and attitudes of people as they view the world (Tong *et al.* 2012). They guide the procedure of investigating a problem (Creswell 2009: 4). Other researchers use the concept 'research paradigm' when referring to worldviews in a study (Creswell and Plano Clark 2011: 169). The research paradigm justifies why researchers employ different strategies

to study the same problem. It is thus important to identify them in a study in order to align the procedures of investigating a problem. In the following section the researcher discusses the philosophical views underpinning the current study.

There are four elements of the research worldview, namely: ontology, which explains the reality as it exists in the world; epistemology, which describes how the truth is extracted from existing knowledge; axiology, which defines ethical requirements and the researcher's standpoint in the study; and, methodology, which explains the field, set of steps or plan of research (Wahyuni 2012: 76). These elements guide the design to be used in a study. In addition to this, investigators specify the philosophical views and make assumptions which will guide them on how they will obtain information to solve a problem. In doing so, they make positivist, constructivism, participatory and pragmatist assumptions in order to search for meaning in the world in which they live or work, and to reform it in order to change the life of the stakeholders and use all available methods to solve the problem (Creswell 2009: 6).

The research paradigm is how researchers view a problem as it exists in society and how to solve it; they take different positions depending on their beliefs and assumptions, and this in turn influences their inquiry into the problem. In the next paragraph the researcher discusses the selected research paradigm in the study.

Ontology: Reality is subjective, can be repeated and may fluctuate, depending on the social actors involved in its construction. It is constructed through group interactions of people with different perceptions, backgrounds, assumptions, and experiences. In the current study the social actors or participants were the THPs and the ROs.

Epistemology: To extract the truth from these individuals, the researcher interacted and had a dialogue with the participants, and used a narrative form

of analysis to uncover their understanding of real meaning of the social phenomenon. In so doing the study achieved the following:

1. Discovered an individual's meanings and group incidences in their natural context.
2. Obtained a deep understanding of the participants' multiple meanings of the occurrence.
3. Understood the social and historical construction of the phenomenon or the reality behind these details; the researcher had subjective meanings and motivated actions.
4. Performed multiple methods in order to analyse and motivate actions based on the wide range of relevant data collected.

Axiology: The researcher was subjective despite being part of what was being researched. To ensure being unbiased, the researcher discussed the trustworthiness or validity and reliability in the study.

Methodology: The steps in the investigation process were the philosophical worldviews, definition of the assumptions, formulation of the research questions, the research design, collection of data and analysis, and interpretation thereof. In the subsequent sections these will be discussed in detail.

The researcher made the following assumptions in the study.

1. The lived experiences, attitudes, perceptions and opinions of an individual from the THPs who treat cancer and ROs could determine an understanding of the co-operation required in the treatment of patients with cancer.
2. The understanding and interpretation of the multiple meanings that the groups attributed to solving the problem could provide the description of the practice necessary for continuity of treatment in cancer patients.

For this reason, a constructivism worldview was utilised because the researcher believed that the participants' experiences of the world would provide meaning in relation to the problem, understanding of the

phenomenon, and that the interpretation of the participants' opinions would provide an explanation of how the problem could be solved (Creswell 2009: 6). In order to obtain multiple views from participants involved in the phenomenon under study, broad, general and semi-structured questions were used in the study. According to Creswell (2009: 8), a constructivist uses broad general semi-structured open-ended questions in in-depth interviews in order to collect information, then interprets this and builds an understanding of the solution to the problem.

The researcher believed that the participants' background would be better understood by visiting the location where they worked to collect information in person. In the next section, the researcher will discuss the research approach appropriate to collect data for the study.

4.3 RESEARCH DESIGN

A qualitative approach was employed to study the co-operative practice between the THPs and ROs in the treatment of patients with cancer. This approach was selected for this study there is no other study available on the co-operative practices between THPs and ROs in the treatment of cancer patients in South Africa. Also, the prevailing theories on collaboration are not applicable to the groups of health practitioners in the study. Qualitative studies are appropriate for collaborative practices in healthcare services to gather contextual information about the viability and suitability of interventions (Gagliardi and Dobrow 2011: 1).

Previous studies which examined the phenomenon of co-operation between TM and AM employed mixed methods, qualitative and quantitative approaches (Kayombo *et al.* 2007; Campbell-Hall *et al.* 2010; Van Rooyen *et al.* 2015; Boateng *et al.* 2016). Studies that utilised the qualitative approach explored collaboration in the treatment of HIV and AIDs (Campbell-Hall *et al.* 2010; Van Rooyen *et al.* 2015; Boateng *et al.* 2016). Thus, they were more appropriate to define the concepts in the co-operation and provide a better description of the nature of co-operative processes.

The qualitative approach was selected because of its ability to explore a topic in-depth (Carlsen and Glenton 2011: 2) in order to produce rich data about the phenomenon under study. Researchers in this approach seek to comprehend how an individual or people have experienced the phenomenon, the meaning they attribute to the phenomenon, or how they make sense of the world (Pietkiewicz and Smith 2014: 7). A qualitative approach can help researchers to access the thoughts and feelings of research participants, which can enable them to develop an in-depth understanding of the meaning that people ascribe to their experiences, attitudes, human behavior and emotions (Tong *et al.* 2012; Sutton and Austin 2015).

A constructivist worldview holds that people comprehend the world in which they live and work through their experiences of the phenomenon under study (Creswell 2009: 8). Therefore, a qualitative research design was appropriate to address the problem in the study. The rationale for using this approach is that there is little information available on the co-operative practices between cancer treatment providers. Also, the researcher sought to explore and understand the meaning that the two groups of health practitioners attribute to the problem.

Qualitative research is a way to discover and comprehend the explanations that an individual or people provide in relation to a problem (Creswell 2009: 4), and allows the topic to be explored in-depth (Carlsen and Glenton 2011: 2). Through an interactive process when collecting data from the participants and interpreting it, a solution to the problem can be found. A qualitative design answers questions such as “what” (Leedy and Ormrod 2010: 141), which are applicable in all the research questions used to obtain information from the informants in this study. Therefore, the design allowed the researcher to obtain rich information about the problem and provided insight into the problem.

Leedy and Ormrod (2010: 94) assert that qualitative design entails looking at qualities of a problem that cannot be expressed in numbers. It was for this reason that the data collected was in text form. Creswell (2009: 175) states

that a qualitative approach is characterised by having a researcher as the key in collecting data in a natural setting and having multiple sources of data so that the researcher can have an understanding of the meaning that the informants attribute to a problem. Creswell (2009: 175) further states that qualitative design is a form of interpretive inquiry where the collected data is built into themes that are interpreted to make a meaningful report of the problem in a study.

Qualitative data is examined inductively to formulate general themes, and explain the understanding of this data (Creswell 2009: 4). Leedy and Ormrod (2010: 136) assert that in qualitative studies, the general research questions about the phenomenon are a guide to initial themes. More themes are formulated as participants provide information in response to more specific questions until no new information is forthcoming (saturation point) (Leedy and Ormrod 2010: 137).

According to Leedy and Ormrod (2010: 136), when asking general questions, the qualitative strategic approach is unknown hence researchers use case study, ethnography or content analysis (strategic approaches used in qualitative studies). As the understanding unfolds with more questions being asked and interpreted, the approaches to qualitative research evolve over the course of the study. The rationale for selecting this design was that it is the best method for exploring the practices and creating an understanding of the meaning that THPs and ROs attribute to the practices necessary for co-operative treatment. In the subsequent section, the researcher discusses the qualitative strategic enquiry that was used in the first interview.

In qualitative studies, according to Creswell (2009: 17), the inquirer selects one of the five most prevalent strategies of inquiry, i.e. phenomenology, narrative, case study, grounded theory, or ethnography, to collect data from the participants. The first two are used to study people while case study and grounded theory explore undertakings, and ethnography studies a group culture. The current study utilised the phenomenological investigation in order to comprehend the THPs and ROs' views about the co-operative practices in

cancer management. The inquiry was appropriate because it assisted the researcher to comprehend people's opinions, and the meaning that the health practitioners attribute to co-operative practices, by capturing information about their lived experiences (Leedy and Ormrod 2010: 141). The phenomenological strategy is discussed in the following section.

4.4 PHENOMENOLOGY

A phenomenological study by Boateng *et al.* (2016) on integration of biomedical and herbal medicines in Ghana, described the experiences of people just as they are, thus reported the responses exactly as provided by the participants. It resulted in varied perceptions on the kind of integration operating in the hospital. The authors recommended that this study could be applied in a mixed sample population (patients, THPs, AMPs and management) and similar findings might be acquired (Boateng *et al.* 2016: 7). It was for this reason that researcher adopted the phenomenological strategy.

The researcher chose a descriptive phenomenological approach to understand the co-operative practice in the treatment of patients with cancer, from the perspective of the ROs and THPs. The researcher believed that, co-operative practice in the treatment of cancer can only be understood and described by the health practitioners who have experienced the phenomenon. Likewise, a phenomenological study by Boateng *et al.* (2016) on collaboration, adopted descriptive phenomenology to describe collaboration exactly as per responses provided by the participants (Boateng *et al.* 2016: 7). It follows that, descriptive phenomenology was appropriate to describe co-operative practice between THPs and ROs in cancer treatment.

Smith, Flowers, and Larkin (2009: 49) assert that, a small sample size is acceptable because, the descriptive phenomenological approach is concerned with understanding a particular phenomenon in a particular context, where few people might have experienced the phenomenon. Englander (2012: 25) argues that, the phenomenon is the object of investigation and not the person who describes his experience. The

same author further stated that, the goal is to identify a person with the experience to provide information about the phenomenon.

According to Starks and Trinidad (2007: 1374), in phenomenology, an analysis of embodied and individual experiences seeks to apprehend the meaning and common features of a phenomenon. It follows that, in phenomenological studies, an in-depth interview of one participant experienced the phenomenon, has the potential provide information and common features of the phenomenon. In the current study, the researcher interviewed 28 THPs and four ROs. In each interview of the participants, data collection and analysis proceeded until there was no new information coming forth.

There are many definitions of phenomenology in literature as a result of many approaches to phenomenology such as descriptive (transcendental constitutive) phenomenology, naturalistic constitutive phenomenology, existential phenomenology, generative historicist phenomenology, genetic phenomenology, hermeneutic (interpretive) phenomenology, and realistic phenomenology (Embree 1997 cited in Chan, Fung and Chien 2013: 1). Despite the variations in the explanation of phenomenology, researchers agree that it is an appropriate approach to understanding and describing participants' experiences.

Phenomenology, which studies experience and ways in which things are understood through experience (Lin 2013: 470), has two objectives. These objectives are: to explore and understand people's everyday experiences (Polit and Beck 2010; Grbich 2012), and to describe the appearance of things in people's minds (Streubert and Carpenter 2011: 28). Murray and Homes (2014: 23) assert that phenomenological studies seek to discover the meanings of lived experiences or explore concepts from new and fresh perspectives. The phenomenon is examined as it is experienced (Lin 2013: 471) in order to demonstrate the actual nature of the phenomenon (Moustakas 1994; Cohen, Kahn and Steeves 2000).

4.5 THE BACKGROUND OF PHENOMENOLOGY

Edmund Husserl, the father of phenomenology, originated the approach as a result of his interests in epistemology and theory of science in the disciplines of philosophy and psychology (Dowling 2007; Polit and Beck 2010; Roberts 2013). In his opinion, a phenomenological researcher rigorously and systematically studies the experiences or explanations that individuals attach to a phenomenon, in order to better understand the essence or structures of a phenomenon (Hein and Austin 2001: 4). The same authors assert that Husserl believed that as people describe their experiences, they provide actual particulars and categories of explanation to which they belong.

Consequently, there are two types of phenomenological studies, the empirical and hermeneutic, where in the former, the methodology uncovers and describes the structure and its vital components (Hein and Austin 2001; Lin 2013). In hermeneutics, also known as interpretive phenomenology, the study describes and interprets the phenomenon from narratives such as texts or oral records (Lin 2013: 471). However, the two are closely related because both are based on the desire to discover the truth from lived experience and utilise thematic analyses to reveal the end product (Hein and Austin 2001: 15). There is confusion amongst different researchers as to which approach of phenomenology to choose, but many researchers use the two interchangeably (Hein and Austin 2001: 5) and reject the dualism in phenomenology (Lin 2013: 471).

Phenomenology existed for approximately 30 years in the psychology discipline (Hein and Austin 2001: 3) and recently is prevalent in education, nursing and information studies (Lin 2013: 469). Phenomenological studies are now most prevalent in human social and health sciences studies (Murray and Homes 2014: 17). Phenomenology continued to develop from descriptive to transcendental, genetic and existential phenomenology, and its development was greatly influenced by ideas of Martin Heidegger, Jean-Paul Satre, Maurice Merleau-Ponty and Alfred Schutz (Denzin and Lincoln 2011; Gallagher 2012).

Matua and Van Der Wal (2015: 23) assert that phenomenology transitioned from pure description to interpretation of experiences. Descriptive phenomenological studies explore, analyse and describe to gain an almost exact picture of the phenomenon of a study (Streubert and Carpenter 2011: 167). IPA is when a researcher attempts to gain a deeper understanding of an experience (Matua and Van Der Wal 2015: 23). Thus, phenomenology is both a methodological and theoretical approach to describing how interviews are conducted and data analysed when doing a study on individuals who have experienced the phenomenon (Murray and Homes 2014: 17). It is for this reason that a small sample size is acceptable (Smith, Flowers, and Larkin 2009: 49), as an interpretive phenomenological approach is concerned with understanding a particular phenomenon in a particular context, where few people might have experienced the phenomenon.

The majority of the researchers employ a purely descriptive approach to discover aspects of experience which were uncovered in previous research (Polit and Beck 2010; Creswell 2014). An interpretive approach helps researchers examine an experience's contextual features like a person's or group's culture or gender and other factors that might affect nursing practice, especially practice addressing the unique care needs of such clients (Polit and Beck 2010; Streubert and Carpenter 2011). Matua and Van Der Wal (2015: 27) advise researchers in nursing to select descriptive and or interpretive methodologies in order to achieve objectives relevant to their field. The phenomenological enquiry responds to questions of meaning to understand the lived experience of people (Robert 2013; Perier *et al.* 2013), with an objective to fully comprehend what is concealed in them (Murray and Homes 2014: 17) and describe their lived experience (Robert 2013: 215).

In the following section the researcher discusses the natural setting where the current study problem is experienced.

4.6 SETTING

According to Creswell (2009: 175), a natural setting is where the participants are experiencing the concern that is being investigated. This allows the researcher to decide on how to collect data from the participants. The researcher provided a map of KZN in order to decide how to accomplish this (Figure 4.1). According to South Africa Info (2012), KZN province, South Africa's third smallest province, covers 96 361 square km area with a population of 10 267 300, whereof this population, 77.8% speak isiZulu, 13.2% English and the rest Afrikaans. It is organised into 11 districts with one metropolitan municipality and 10 district municipalities (Figure 4.1). Its capital and major cities, Pietermaritzburg and Durban are approximately 90 km apart, with an oncology provincial hospital in each city. There are seven ROs in KZN who provide radiotherapy services to all 11 districts.

There are 14 941 active THPs in KZN (Gqaleni *et al.* 2007: 178) distributed across all 11 districts in KZN. Those who were interviewed were located at uThukela, Amajuba, uMkhanyakude, iLembe, uMzinyathi districts and uMgungundlovu districts. They include diviners, herbalists and spiritual or faith healers. The number of THPs who are cancer treatment specialists is unknown in KZN. The study was conducted with 28 such THPs and there were many others available to be interviewed, but the researcher did not do so due to travelling costs and time constraints. However, the researcher attained data saturation with theoretical sampling.

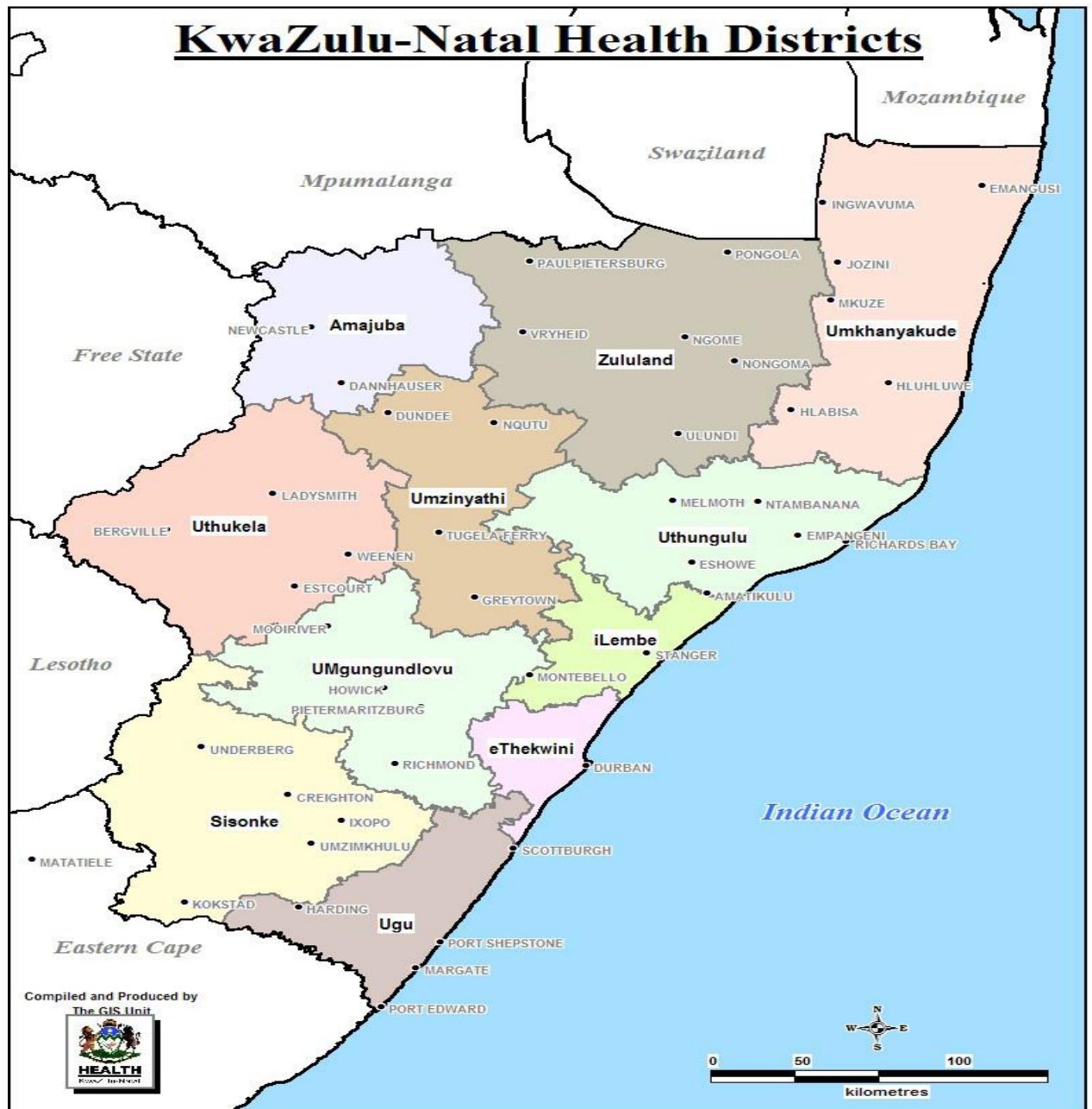


Figure 4.1: The map showing health districts in KZN

Source: KwaZulu-Natal Department of Health 2007

4.7 SAMPLING PROCESS

Selection of participants is critical in qualitative design, and the researcher should document the rationale for the selection of such a study population, and disclose any preferences. Sampling is the process of selecting a portion of the population to represent the entire population (Polit and Beck 2013: 275). Sampling in a qualitative study is achieved by the non-probability sampling technique (Wilmot 2005: 3). In using non-probability sampling in this study, the purposive sampling approach was used where all units in the population were selected to represent the study because the researcher could not distinguish a difference between the study sample and the population.

Qualitative research seldom agrees on the exact sample size required for a qualitative study, but agrees that certain factors influence the number of interviews required to attain saturation. A research study should estimate and qualify the sample size; hence, estimating a satisfactory sample size is associated with the theory of saturation (Marshall *et al.* 2013: 12). The theory necessitates increasing the study sample repetitively until there is redundancy, implying that the researcher gathers data to the point when nothing new is being added (Bowen 2008: 150). Leedy and Ormrod (2010: 137) maintain that in qualitative research 1-25 individuals can be studied. In the following section, the researcher discusses the choice of purposive sampling for the hospitals, ROs and THPs.

4.7.1 Sampling of hospitals

Stakeholder purposive sampling was used to select both public oncology hospitals where the ROs are placed in KZN. The researcher did not choose private hospitals because they accommodate patients with medical aids and those who can afford the high medical fees (Gouws *et al.* 2012: 447). The focus of the current study is to improve the accessibility to radiotherapy services by the poor communities who are not accommodated in private hospitals because they cannot afford the high medical fees. Palys (2008 cited in Given 2008: 697) describes stakeholder purposive sampling as a selection

method for choosing the sample because they are the major stakeholders involved in the phenomenon under study. This type of purposive sampling was based on the needs of the study to interview oncologists placed at these hospitals. It was appropriate in this study to select oncology hospitals because they are the provincial hospitals providing oncology services in KZN. Of the three provincial oncology hospitals in KZN, one was a tertiary hospital and the other two were regional hospitals. The ROs placed at the tertiary hospital were rotating to one of the regional hospitals. Hence the hospitals selected for the study were the tertiary (Hospital A) and one district (Hospital B) where ROs were placed permanently.

4.7.2 Sampling of ROs

There was an estimated population of seven ROs placed at the two public oncology hospitals in KZN. Purposive sampling was used to select the study population. According to Pietkiewicz and Smith (2014: 10), this sampling allows the researcher to select a group of people based on preselected relevance to a particular study. With regard to the sampling of ROs in the study, the sampling was employed to choose all ROs from the two public oncology hospitals because they are the ROs treating patients with cancer in KZN.

The sample comprised ROs who were registered with the HPCSA, willing to co-operate with THPs in the treatment of cancer patients, willing to respond to the questions, and who had given consent for the study. Excluded were the registrars (not yet qualified as an RO) in the Radiation Oncology Department and the ROs unwilling to participate in the study. Four of the seven ROs gave their consent to participate. The other three ROs were followed up every two weeks for five months to remind them to respond to the questions in the interview guide. The following section discusses the selection of the THPs in KZN.

4.7.3 Sampling of THPs

The study population comprised THPs who treated patients with cancer in KZN, were registered as traditional healers with a traditional healer's organisation, were willing to respond to questions and had signed consent. Excluded were those who did not treat patients with cancer, were not registered with a traditional healer's organisation, were unwilling to participate in the study and did not give consent to conduct the study.

Snowball sampling, also referred to as chain referral sampling, was employed in the study. In this form of sampling, one participant is identified and then used to refer others in his or her social network (Tongco 2007; Patton 2015: 180). The rationale for using this method is to increase the number of participants and build networks. However, such techniques may be biased in that potential participants from socially impaired networks, who might have rich information, may be neglected. In the current study, this selection bias was addressed by having many referral points and increasing the sample size of the THP participants.

Utilising snowball sampling to identify THPs who treat cancer, the researcher attended a meeting of THPs convened by the Department of Health in Pietermaritzburg on the 18th March 2015. The researcher was introduced to the THPs by Professor Gqaleni who works with THPs who are collaborating on HIV and AIDS. In this meeting, there was a representative from all districts in KZN (as per the attendance register, Appendix 11). The attendance register had names and contact details of the attendees, as well as the district from which they were residing. The researcher used the contact details from the register, to call a THPs' chairperson of a particular district to ask if he was involved in the treatment of patients with cancer. If they were involved, the researcher made an appointment to interview them. The interviewed THP identified other THPs who treat cancer within the same district.

In the districts where the THPs' chairpersons were not involved in the treatment of patients with cancer, they were asked to identify THPs who treat cancer within their district. Also, in districts where the chairperson did not attend the meeting, the researcher called any attendee from a particular district, and requested the contact details of the THPs' chairperson of that district. The same procedure was then followed to identify THPs who were involved in the treatment of patients with cancer. With regard to the selection of a district, the researcher interviewed THPs based on their earliest availability.

As identified by the chairperson of each district, the researcher interviewed all THPs who treat cancer in a particular district. The selection of the THPs from districts stopped at the point of theoretical saturation, when no new concepts emerged from the data collected from THPs (Bradley, Curry and Devers 2007: 1764). The researcher was able to easily access 28 THPs from six districts, as identified by the chairpersons of those districts. All the THPs identified, were willing participate in the study and gave permission to be audio-recorded.

The way in which the THPs were identified, influenced how the interviews were conducted. For example, if the chairperson was involved in the treatment of patients with cancer, they were interviewed first, followed by other THPs identified. As a result, the researcher conducted individual interviews and focus group. Nine THPs were interviewed individually, and the other 19 in five groups of three, four, five, and seven THPs. According to Creswell (2009: 181), the maximum number of interviewees in focus group interviews is six to eight. The researcher interviewed the participants individually and in groups depending on how they could avail themselves for the interview. However, the researcher informed the first person interviewed that the next group identified should have a maximum of six to eight THPs.

Jamshed (2014: 88) asserts that in individual interviews, the participants express their personal views freely. Contrary to this, in focus groups the participants influence each others ideas, in that some participants who are not

confident may not freely express their own opinions but agree with the others in their ideas and opinions. As a result, the researchers collect rich information from interviews conducted individually compared to focus groups. In the current study the researcher collected rich information from the individual participants and also from the several groups of THPs in the different districts. Therefore, the inherent limitation of interview in focus group was not a drawback in the current study.

The 28 THPs interviewed were from uThukela, Amajuba, uMkhanyakude, iLembe, uMzinyathi districts and uMgungundlovu districts. They were located in various towns and the surrounding rural and informal settlement areas in the district. Smith, Flowers, and Larkin (2009: 49) declare that a small sample size is adequate in qualitative research because the researcher is concerned with understanding a particular phenomenon in particular contexts. The rationale for choosing this sample size was to ensure that there is no bias. The researcher assessed that saturation was reached at 28 and that no new information was going to emerge from more interviews.

The four ROs interviewed were from two public oncology hospitals in KZN. The most appropriate data collection technique used in this group, was face-to-face interviews. Two interviews were audi-recorded. However, other ROs responded in writing to the questions, and sent their responses to the researcher via email.

In the current study, all 28 THPs participants identified, gave permission to be audio-recorded. Of the four ROs participants, two refused to be audio-recorded and opted to respond to the research questions in writing. The researcher collected rich information from interviews which were audio-recorded. However, it was time-consuming to transcribe data because the interviews lasted for 45 minutes to one and half hours. Contrary to this, the written responses did not require transcribing, but the answers were brief and therefore not providing enough information on the questions asked.

4.8 DATA COLLECTION PROCESS

After obtaining ethical clearance (REC 1/15) from DUT (Appendix 1), KZN Department of Health (Appendices 3a and 3b), and eThekweni Municipality District of Health (Appendices 2a and 2b), the researcher requested permission from the Chief Executive Officers at the two hospitals selected for the study (Appendices 4a and 5a). After obtaining support letters from the Clinical Managers at the hospitals, the researcher phoned the Heads of Department of Radiation Oncology to make appointments to discuss the purpose of the study, and obtain email addresses of the ROs for further communication regarding the interviews.

The Heads of Departments invited the researcher to explain the aim of the study to a group of ROs in their departments. It was made clear to them that the purpose of the study was to assess the practices of THPs in the treatment of patients with cancer, in order to describe the viable co-operative practice framework between THPs and ROs in the treatment of patients with cancer, and contribute to the development of TM as a component of the health system in KZN Province. Once the participants expressed an interest in the study, he or she reviewed and signed the consent form to participate, which included his or her willingness to provide information required in the study. The researcher contacted the participant by e-mail to arrange a time and date for the interview with those who preferred face-to-face interview. Other ROs opted to respond in writing, and send their written responses to the researcher via email. The researcher obtained rich information from the interviews conducted face-to-face compared with written responses sent via email.

In-depth semi-structured and face-to-face as well as focus group interviews were utilised to collect data from the THPs. All ROs were interviewed individually. After identifying the THPs informants who constituted the samples in the study, nine interviews were conducted on individual THPs, and others in four groups comprising three, four, five and seven THPs. Face-to-face interviews were preferred for interviewing the ROs. Other ROs responded in writing to the research questions. The researcher first made an

appointment to meet with the potential participants in order to do a proper introduction and obtain consent (Appendix 6a and 6b). The interviews for the THPs were held at their homes and work places. The two ROs were interviewed face-to-face at their workplace. The other two ROs sent their written responses to the researcher via email. The interviews were conducted in isiZulu and English for the THPs and ROs, respectively. They lasted between 45 minutes to one and half hours. The data collection process was executed between June 2015 and December 2015.

4.8.1 Phase 1

The first phase of data collection was in-depth interviews with THPs from the six districts mentioned earlier, in KZN. An in-depth interview is a one-to-one method of data collection that involves an interviewer and an interviewee discussing specific topics in-depth. In-depth interviews are used when seeking information on individual, personal experiences from people about a specific issue (Hennink, Hutter, Bailey 2011: 109). The in-depth interviews were informed by the emerging concepts, categories and propositional statements.

The protocols utilised during the in-depth interviews with THPs included demographic information, research questions and breaking questions such as: (1) What is cancer?, (2) How do you know that a patient has cancer?, (3) What do you do when a patient has cancer?, (4) Which types of cancers do you treat?, (5) What is your goal in the treatment of cancer?, (6) How do you know that you have achieved your goal?, (7) How long do cancer patients survive after you have treated them? (Appendices 8a and 8b).

In this phase, the researcher collected information from the THPs using in-depth interview with semi-structured questions. The information was collected in isiZulu. In each session of the interview, data was collected from the interviewee or interviewees and analysed until data saturation. The interviews of THPs from the various selected districts, continued in this manner for all THPs interviewed until there was no new information coming forth. After interviewing 25 THPs, three THPs following those did not provide any new

experience, ideas, opinions, and attitudes about co-operative practice between THPs and ROs in the treatment of patients with cancer. All interviews were conducted in isiZulu and audio-recorded.

Data analysis began at this stage after the first and second interviews of an individual THP and focus group, respectively. The researcher first transcribed the interviews in isiZulu then translated them into English. The collected data were then reviewed without coding. The reason for this was to understand the scope and context of the experiences that the interviewees attached to cooperative practice. Once data had been reviewed, the researcher identified emergent themes without losing the connections between the concepts and their context. There was no coding at this stage of data analysis. The data analysis procedure would be discussed in the section of data analysis.

4.8.2 Phase 2

The second phase was directed towards collecting data from the ROs. They received a protocol with only demographic information and the research questions (Appendix 7). Data were collected through in-depth, audio-recorded interviews with four ROs, from two public oncology hospitals in KZN. The most appropriate data collection technique used in this group was face-to-face interviews. With regard to interviews for ROs, two participants were audio-recorded and the other two participants provided written responses to the questions in the study.

With regard to the information obtained from the ROs, the first interview was conducted face-to-face with RO, in English and using in-depth semi-structured questions. The researcher collected information from each participant, about the phenomenon under study, until there was no new information coming forth. Data analysis began after the first interview. The researcher transcribed the interviews and then reviewed the information to understand the scope and key context of the key experiences and opinions of the RO in the co-operative treatment of patients with cancer. After reviewing data, the researcher

identified emergent themes without losing the connections between the concepts and their context.

Data analysis began at this stage after the first interview of an individual RO. The collected data were first transcribed then reviewed. The reason for this was to understand the scope and context of the experiences that the interviewee attached to co-operative practice (Englander 2012: 34). Once data had been reviewed, the researcher identified emergent themes without losing the connections between the concepts and their context. There was no coding at this stage of data analysis. The data analysis procedure would be discussed in the section of data analysis. In the following sections, the researcher explains the interviews briefly.

1. **In-depth interviews** which are like informal discussions were employed for the THPs. The researcher used face-to-face interviews for the THPs and interviewed them at their homes or workplace or a hall in town. The interviews lasted for 1-2 hours. Using interviews is advantageous because it permits control over the direction of questions.

It was appropriate to use this method of data collection because the researcher wanted the THPs to freely provide their opinions and experiences regarding the treatment of cancer patients. As the interviews were time consuming, the researcher did not intend taking THPs away from their work and workplace, so the interview was in a comfortable environment for them.

The research questions in the study were included in the interview. The interview guide comprised the demographic information of the THPs and information about the treatment of patients with cancer. The demographic information included questions about their level of education, type of traditional health professional and whether they were registered with any THP organisations. They were asked for their description of cancer and how they diagnose and treat it; the types of cancers they have treated including the aim of treatment; what they had done when the treatment was unsuccessful; the

duration of the patients' survival after treatment; the number of patients with cancer they have treated.

Additionally, they had to describe their experiences and opinions in treating cancer patients who consulted with both health practitioners, their perceptions of ROs in the treatment of cancer, co-operation and co-operative practices required between the two healthcare practitioners in cancer treatment. The questions were translated and asked in isiZulu for all the THPs (Appendix 8b) so they could express themselves freely in their mother tongue.

The interview guide for ROs comprised the demographic information of the ROs and the treatment of patients (Appendix 7). Their questions included detailed description of their experiences and opinions in treating patients diagnosed with cancer who consult with THPs and their perceptions of co-operative treatment and co-operative practices required between the two healthcare practitioners in cancer treatment. Furthermore, the ROs provided information regarding their position and employment status as a specialist. The questions were asked in English. Email interviews were appropriate because ROs are always occupied by their work and do not have time to engage in a face-to-face interview. With email they were able to respond at their own time when they were not busy. The researcher gave them two weeks in which to respond to the questions. If there were no responses received after a week, the researcher reminded and requested them to respond.

The interviews were audiotaped (with the permission of the interviewee). The researcher first asked permission to record the interview before recording them. If not allowed, the respondents asked to send written responses to the researcher via email. The participants' real names were not utilized but were assigned "Participant Number". The rationale for this was to remain unanimous. Also, interview data collected from the participants were stored in the iPad, where only the researcher has the password. After transcribing the interview data, the researcher stored data in the computer. Only the researcher has the password. The research data was stored in the computer

and disposed off after the completion of the study. The objective is to preserve confidentiality of information.

The secondary research questions were asked first then the main research question. With regard to ROs, the researcher first visited them to identify those who were willing to co-operate with THPs in the treatment of cancer patients.

2. **Semi structured interviews** were employed as the interviews progressed. The questions for the interview were set before the interviews in order to guide the interview but without interfering with the participants' opinions during the interview. Hence, the sub-questions in the study were asked from all participants. The questions were based on the conceptual framework in the study. The researcher used bracketing theory when analyzing the data. This is described as the researcher being objective when analyzing data (Leedy and Ormrod 2010: 147).

Bracketing in descriptive phenomenology is when researchers set aside their presumptions that may flaw the research process (Tufford and Newman 2010; Sorsa *et al.* 2015). These presumptions arise across all the phases in the study (Starks and Trinidad 2007: 1376). The reason for this, is that the researchers as the instruments in data analysis (Starks and Trinidad 2007: 1376), turn to be subjective when conducting the research (Tufford and Newman 2010: 81). The same authors maintain that, this influences the collection, interpretation and presentation of data. Bracketing prevents these influences when the researchers are being objective in the research process (Sorsa, Kiikkala and Astedt-Kurki 2015: 9). In doing so, the researcher focused fully on the viewpoints of the participants to describe the co-operative practice in the treatment of patients with cancer.

Table 4.1: Summary of data collection methods, data sources – management and operational levels

Objectives	Data source	Methods	Research sub-questions
To understand the treatment of cancer patients by THPs.	THPs that treat patients with cancer	In-depth Interviews and focus groups	Breaking questions
To understand the co-operative practice between the THPs and ROs in the treatment of patients with cancer.	THPs that treat patients with cancer and ROs in the public hospitals within the province.	In-depth Interviews and focus groups for THPs. In-depth interviews for ROs.	What are the practices in the treatment of patients with cancer by both health practitioners?
To understand the attitudes and opinions of each health practitioner in the treatment of patients with cancer.	THPs that treat patients with cancer and ROs in the public hospitals within the province.	In-depth Interviews and focus groups for THPs. In-depth interviews for ROs.	What are the perceptions of each health practitioner about the other in terms of treatment of patients with cancer?
To understand the attitudes and opinions of THPs and ROs with regard to co-operative practice.	THPs that treat patients with cancer and ROs in the public hospitals within the province.	In-depth Interviews and focus groups for THPs. In-depth interviews for ROs.	What are the perceptions of THPs and ROs in terms of co-operative practice?
To understand the co-operative practice needed for continuity of treatment	THPs that treat patients with cancer and ROs in the public hospitals within the province.	In-depth interviews and focus groups interviews for THPs. In-depth interviews for ROs.	What co-operation is required between the two healthcare practitioners in cancer treatment?

4.9 DATA ANALYSIS

In phenomenological studies, data analysis decreases, organises, and gives meaning to data (Creswell 2009: 183). Data analysis has numerous constituents as the researcher tries to make sense of the data. Creswell (2009: 183) claims that data collection and analysis consists of preparation of data for analysis, conducting a variety of analyses, developing an understanding of the data, representing the data and interpretation of the larger meaning of the data. According to Appelbaum (2014 16), the interview data demonstrates the description and interpretation of the phenomenon, and these coexist and are complementary to each other in the process of data analysis. The interpretation of the phenomenon from the participants and the researcher's perspective is taken into consideration in the data analysis process (Pietkiewicz and Smith 2014: 7). As a result, data analysis should match the type of phenomenological study chosen for the study.

The researcher chose Hurssel's descriptive phenomenology to describe the co-operative practice needed between the THPs and ROs in the treatment of patients with cancer. The rationale for this was that, the researcher believes that the health practitioners, who provide cancer treatment service, have experienced the phenomenon under study. Thus they have the potential to provide rich information about the phenomenon, through in-depth interviewing (Wills *et al.* 2016: 1194). Padilla-Diaz (2015: 103) asserts that, in a descriptive study, the researcher studies the personal experience of the participant or participants with regard to the phenomenon under study, thereafter describes the meaning they attribute to the phenomenon. To achieve this, both data collection and data analysis shadow descriptive phenomenology in order to achieve rigour (Englander 2012: 15). In the data analysis of the study, the researcher therefore described the phenomenon as described and interpreted by the participants. In so doing, the focus was on the subjectivity of the participants, and the researcher described that subjectivity (Englander 2012: 15).

In the current study, the data were analysed using Tesch's method to identify themes and subthemes using the conceptual framework analysis (Bradley, Curry and Devers 2007; Jabareen 2009). The following are the guidelines by the researchers, to develop an organising system for qualitative data, as described in Tesch (1992: 142-145).

- Read through all data to obtain the required background, and get the essence of the whole data.
- Begin with one document, and ask themselves a question "What is this about", with regard to the topic.
- Complete this procedure for several documents, and make a list of all topics. Compare all the topics and group the same topics together. Write those groups in columns with headings that represent the main topics, unique topics and remnants.
- Abbreviate the topics as codes so that the researcher could write next to the appropriate segments of the text. Anticipate the emergence of new codes, and write them down if there are any.
- Identify the descriptive words for the topics that have started to form categories. Reduce the categories by grouping together those that are related. Identify any subcategories.
- Finalise the abbreviations of each category and arrange them alphabetically to ensure that there are no duplications.
- Insert the data belonging to each category together, and conduct preliminary analysis. Focus on the content of each category, while keeping the research questions in mind in order to discard irrelevant data.
- Record the existing data where necessary.

The adapted version of Tesch's method utilised in the study is depicted below in Figure 4.2.

The data analysis process was managed by a framework, which provides theory and guidelines for data collection and analysis (Pietkiewicz and Smith 2014: 8). The framework method for data analysis is being popularised in medical and health, nursing, psychology and sociology research (Gale *et al.* 2013: 1), to be able to manage massive textual data from studies in the fields. It allows the interview data to be matched and distinguished using themes across many cases while locating each standpoint in context by keeping the connection to other aspects of each character's version (Gale *et al.* 2013: 5).

The researcher used an integrated approach to data analysis which utilises the principles of inductive reasoning and the constant comparison method (Glaser and Strauss 1967: 129), while employing predetermined code types (codes) to analyse data (Bradley, Curry and Devers 2007: 1768). The rationale for this is that at the end of the analysis, the researcher will develop a framework. In so doing, the integrated approach achieved the objective of phenomenology to diagnose phenomenon, explain the behavioural factors and the cure (Parnas, Sass and Zahavi 2013: 271).

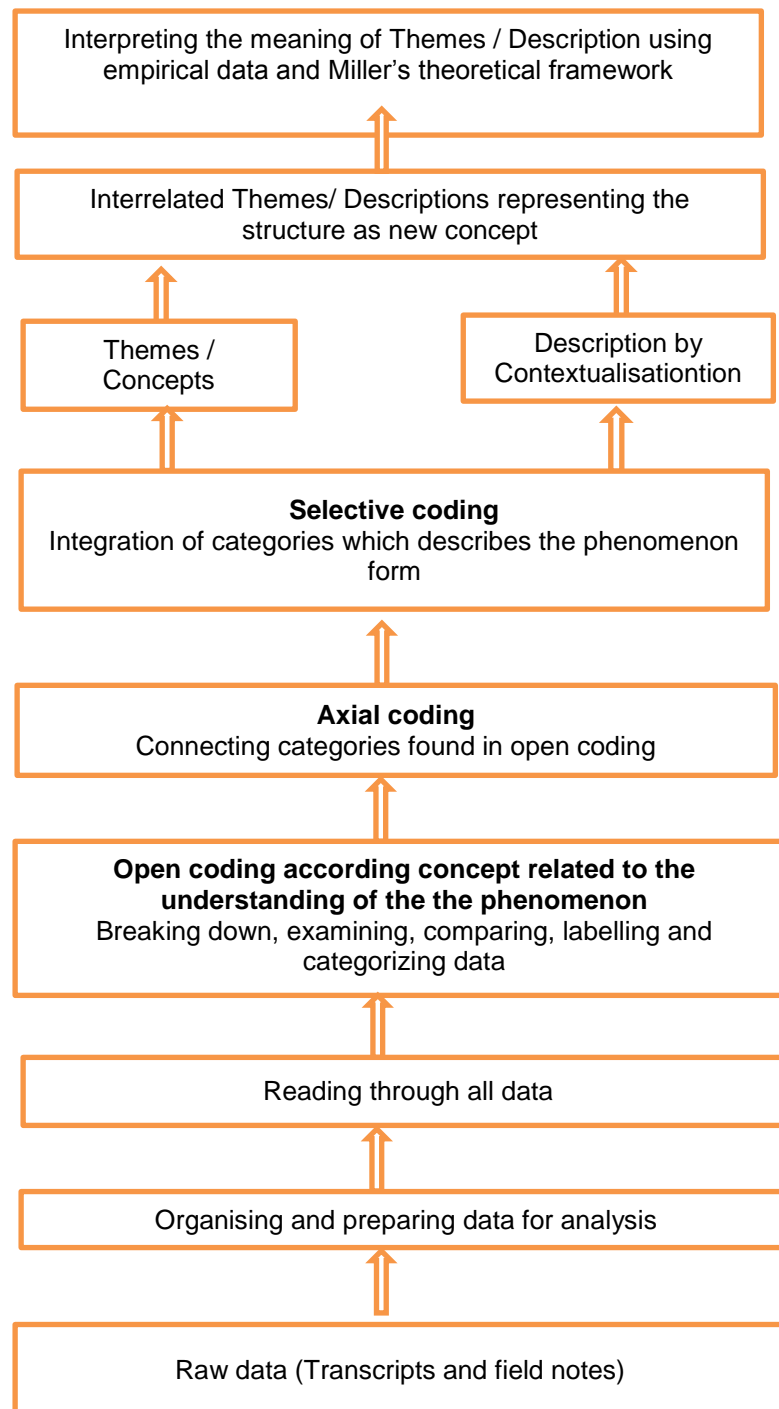


Figure 4.2: Data analysis using the conceptual framework analysis (Adapted from Creswell 2009: 185)

An integrated approach resulted in the data being analysed deductively and inductively using the conceptual framework developed in Chapter 3, as well as grounded theory, to develop new insight into the existing knowledge of the relationship between THPs and ROs in the treatment of patients with cancer. When analysing data deductively, researchers use a framework analysis to manage the massive data in health science research (Smith and Firth 2011: 53) in the fields of nursing, psychology and sociology. Teams often include epidemiologists, health economists, management scientists and others (Gale *et al.* 2013: 1). The framework analysis was developed in 1980 and since then has been used by applied science researchers (Ritchie and Lewis 2003; Smith and Firth 2011). The analysis in the current study was in three phases as explained below.

The data collected from the participants were in text form, and needed to be conceptualised, analysed and interpreted into larger meaning (Creswell 2009: 183). The interview data from four ROs and 28 THPs were transcribed verbatim (excerpts of RO and THP transcripts are in the Appendices 9 and 10a). Those for THPs were first transcribed verbatim in isiZulu before being translated into English (Appendix 10b).

4.9.1 Transcription

The interviews from the informants were transcribed verbatim into different types of sources of information in a Microsoft Word document in order to convert the spoken words into data that could be analysed. The interviews collected in IsiZulu were first translated into English before they were transcribed. The researcher checked all transcripts for accuracy and completeness against the audio-recording. Large margins and adequate line spacing were made in the transcripts for later coding and making notes. During the transcription, the researcher became immersed in the data to ensure that the phenomenon was as explained by the participants (Pope, Ziebland, and Mays 2000: 114). In this way, the researcher reviewed data without coding and identified developing themes aligned with concepts and their context.

4.9.2 Familiarisation with the interview

The investigator read and re-read the data to acquire a variety of meanings. A standard general inductive approach was used to identify initial themes. Once the data had been reviewed and there was a general understanding of the scope and contexts of the key experiences under study, coding commenced. Coding provides the analyst with a formal system to organise the data, uncovering and documenting additional links within, and between, concepts and experiences described in the data. Codes are tags (Bradley, Curry and Devers 2007: 1767) or labels, which are assigned to whole documents or segments of documents (that is paragraphs, sentences, or words) to help catalogue key concepts, while preserving the context in which these concepts occur.

Phenomenological analysis attempts to find meaning of how individuals and society in a given context make sense of the given phenomenon (Sanders 1982; Moustakas 1994), and is informed by insight and consideration based on exhaustive and tedious reading of the composed stories (Lin 2013: 473). Data analysis is a continuing, iterative process that begins with the interview data of the first participant during data collection, and continues throughout the study. In the following paragraph the researcher discusses the data analysis in the study.

The researcher utilised a deductive approach in the current study because the researcher intended to have a prior understanding of the phenomenon being studied in order to construct the internal structure of the framework (Ryan and Bernard 2003: 9). With such an approach, *a priori* of themes are derived from the core concepts of the phenomenon from the conceptual framework developed in Chapter 3 (Strauss and Corbin 1990; Ryan and Bernard 2003). In the current study, the researcher used the concepts in the conceptual framework constructed in Chapter 3 as the themes of the study.

Using the phenomenological approach, the responses to the interview questions provided the meaning of co-operative practice as experienced by

the ROs and THPs involved in the treatment of cancer patients (Englander 2012: 13). The participants' description of the phenomenon only provides the general structure of the phenomenon. In order to describe the essential structure of the phenomenon, the philosophical phenomenological method comprised four linking steps: 1) the epoche or bracketing, 2) phenomenological reduction or eidetic reduction, 3) imaginative variation (Moustakas 1994; Lin 2013), and 4) synthesis (Moustakas 1994: 153).

In the epoche step, the researcher wrote down predispositions and biases in an attempt to stay away from the familiarity of everyday happenings, events and people in order to see things for what they were. The phenomenological reduction step had numerous phases. At first, all predetermined notions were set aside, an equal value was given to each statement, and irrelevant statements were deleted. After this, the statements were grouped into themes. Finally, a textural description was developed by repeating a pattern of looking and describing. In the imaginative variation step, the researcher sought the fundamental meaning of the phenomenon by constructing structural themes. All of the textural and structural descriptions were synthesised into a combined statement of the essences.

The data were analysed using Tesch's method as described by Creswell (2009: 186) to identify themes and subthemes using conceptual framework analysis (Bradley, Curry and Devers 2007; Jabareen 2009). The themes ensured a better understanding of the phenomenon under study, presentation of the results and their interpretation.

Data analysis employs eidetic reduction with exhaustive reading of each interview script (Lin 2013: 473) using open coding with the Straus and Corbin technique (1990: 57). Strauss and Corbin (1990: 57) define coding as the actual process through which the data are broken down, conceptualised, and put back together in new ways into some form of theoretically meaningful structure.

Open coding allows for the identification of concepts and categories because it fragments the interview transcriptions into smaller units, and categorises and explains their conceptual characteristics. The open coding process results in the reduction of data using descriptive codes to depict the spoken word as well as detect and distinguish various aspects of the meaning (Lin 2013: 475). However, in Chapter 3 the researcher had already identified the concepts to understand the phenomenon under study. Therefore, the open coding helped identify the category codes.

As mentioned before, the researcher used an integrated approach of framework analysis and grounded theory; the process of data collection and analysis is an integrated process. Therefore, the researcher analysed the data as she continued with data collection. The combined coding for the two included matching data to the prior concepts by first coding the categories, as illustrated in Figure 4.3.

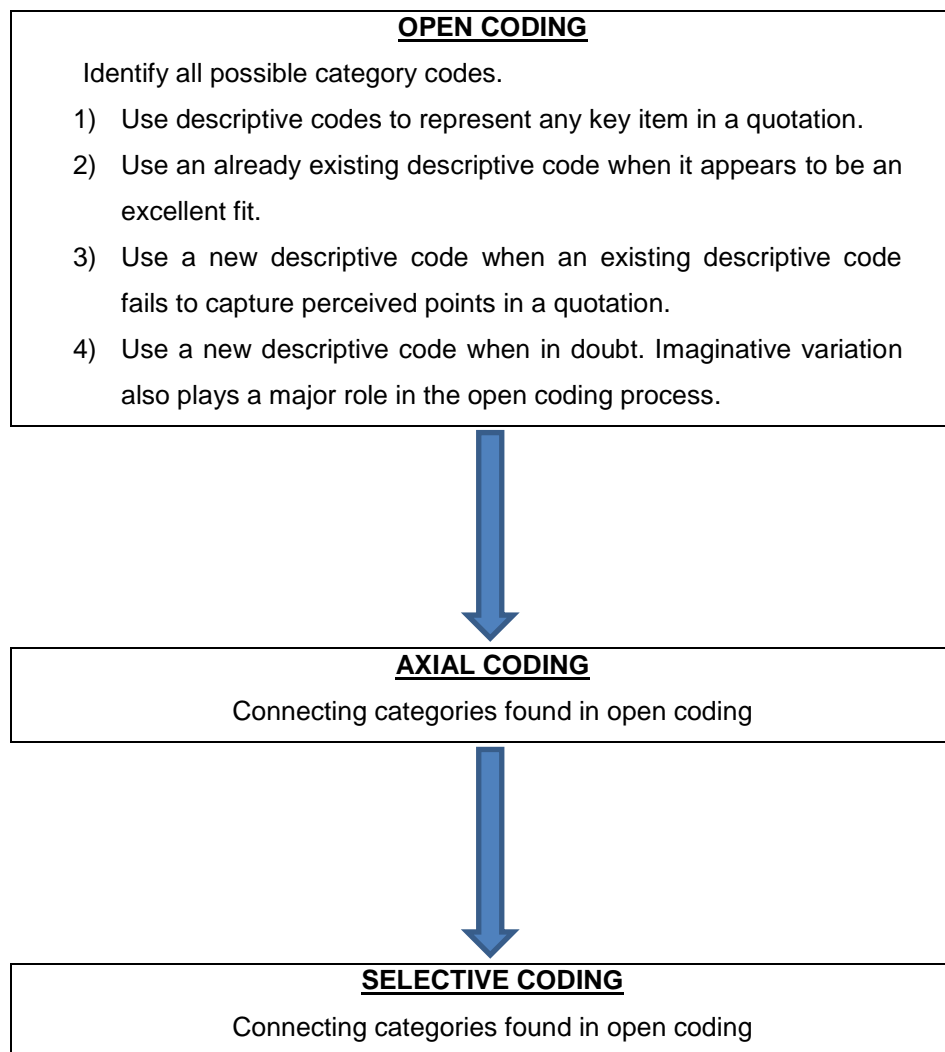


Figure 4.3: Strauss and Corbin's process of data analysis using Lin's technique in open coding (Lin 2013: 475)

4.9.3 Coding

The researcher initiated a detailed analysis by establishing the segments of text data, segmenting these into sentences or paragraphs, and classifying those into predetermined codes based on theory. Thereafter, the investigator coded anything that might be relevant from as many different perspectives as possible. By coding the researcher classified all of the data so that it could be compared and contrasted systematically with other parts of the data set.

4.9.4 Developing the analytical framework

In Chapter 3, a conceptual framework was developed which served as a base for an initial organizing framework for the codes. The framework method is amongst the methods of data analysis termed thematic analysis or qualitative content analysis and is a flexible tool that can be adapted for use with many qualitative approaches that aim to generate themes (Gate *et al.* 2013: 2). Consequently, it is not aligned with a particular epistemological, philosophical, or theoretical approach. Gate *et al.* (2013: 2) maintain that this approach identifies commonalities and differences in qualitative data before focusing on relationships between different parts of the data, thereby seeking to draw descriptive and/or explanatory conclusions clustered around themes.

Utilising the framework, the data that did not belong to the predetermined codes were used to form a start list. After coding the first few transcripts, the researcher met with the main supervisor and cosupervisor to ensure that the labels agree on a set of codes to apply to all subsequent transcripts. Codes were grouped together into categories which were then clearly defined. In this way, the coding made meaning of the setting or themes for analysis.

4.9.5 Applying the analytical framework

In applying the analytic framework, the researcher formulated the themes so that they could be presented in a narrative form. Using framework method analysis, only the content and not the conventions of dialogue transcripts is transcribed. During the analysis process when a conceptual gap was identified, the researcher expanded the sample to continue data collection to clarify and refine emerging concepts and codes. Such use of the codes to guide data collection is known as theoretical sampling and continued until 28 THPs were interviewed.

4.9.6 Charting data into the framework matrix

The researcher summarised the data by category from each transcript in order to make meaning of it.

4.9.7 Interpreting data

The researcher explored an interesting idea, concept or potential theme by writing an analytic memo. The entire analysis moved through different interpretative levels, from more descriptive stages to more interpretative ones. All concepts not supported by data, were eliminated. The data was organised into themes and analysed manually until data saturation was reached. Data saturation is achieved when no new information is coming forth. The data was stored electronically on a computer where only the researcher knew the password.

An example of a theme from raw data to conclusion, from a THP participant, is depicted in the appendix (Appendix 13).

4.10 ETHICAL CONSIDERATIONS

According to Lawson (2011: 4), ethics originated in the prehistoric Greek philosophy of Aristotle who believed that rightness and wrongness rooted from the personality of an individual. The same author maintains that ethics is guided by the four principles of autonomy, beneficence, non-maleficence and justice. These are discussed as follows:

- 1) Autonomy is the principle of respect for decision-making in that the participants are allowed to make informed choices. The researcher should disclose all information relevant to the decisionmaking process and ensure that the participants have comprehended it. For this reason, sick people are assumed to have a certain level of deficiency of autonomy thus should not participate in a study unless a prior arrangement with a doctor has been made to ensure proper treatment of the individual should a need arise.
- 2) Beneficence is where the researcher is obliged to act morally in order to benefit the participants. Participation is voluntary in that each participant has a right to decline participating in the research.
- 3) Non-maleficence is a principle of not having the participant subjected to any harm, pain, complication or discomfort as a result of the study.

- 4) Justice is a principle concerned with the fair distribution of health resources. The researcher should treat all participants the same; if any resources were to be distributed amongst the participants, for example if there was any payment to be paid in respect of transport for the participants, they would all receive the same amount.

These principles are intended for research with human participants and the researcher is obliged to consider the ethical implications for the participants in the research. The fulfillment of these principles in the course for this study is discussed below.

Firstly, the study was approved by the university's Ethics Committee on the 6th February 2015 and the reference number was REC 1/15 (Appendix 1). The researcher sought and received permission to conduct the study from KZN Department of Health (Appendices 3a and 3b) and the District Manager of eThekweni District (Appendices 2a and 2b). Permissions were obtained from the Oncology Departments and the Chief Executive Officers at the public oncology hospitals (Appendices 4a and 4b) and (Appendices 5a and 5b).

Secondly, the researcher gave the letter of information about the study and consent form to sign (Appendix 6a and Appendix 6b) before the interview. For THPs' data collection tools, the letter of information, consent and interview guide were translated into isiZulu. All the participants' participation was voluntary and they were told that they could withdraw at any time from the study if they so wished. They were informed that their confidential information would be used solely for the purpose of the study and would be disposed of once it had been processed for research purposes. Signed consent forms were obtained before conducting the interviews.

Thirdly, all personal information obtained from this study was kept strictly confidential and presented as anonymous. In so doing, all the participants were assigned "Participant Number" in the respective category of THPs or ROs. This ensured that they remain anonymous. Also, information obtained from the participants known to the researcher only. The audio-recorded information from the interviews was stored on the iPad, where the password is

only known to the researcher. It was disposed after it was processed for research purpose. The transcribed information was stored on the computer, where only the researcher had the password. This information was utilised solely for the purpose of the study.

Fourthly, the inquirer requested permission to audio-record the interviews. For the ROs who refused, they sent their responses via email. The researcher transferred the information to other information for research on the computer, and then deleted those emails.

Fifthly, the participants were interviewed at settings where they were free to express their opinions about the phenomenon. The ROs were interviewed face-to-face at their place of work, and at their time convenient time. Those who sent written responses did so at their convenient time. Also, the THPs were interviewed at their homes and workplaces.

Sixthly, the researcher analysed data and reported the findings objectively. Those who participated in the study did not get any form of remuneration.

4.11 TRUSTWORTHINESS

Qualitative research due to its nature of exploring individual experiences, describing a phenomenon, and developing theory to generate large quantities of detailed information about a single unique phenomenon, is subjective, prone to researcher bias, and lacking generalisability. Consequently, researchers are compelled to discuss quality issues in the entire study to enable evidence-based professionals to assess the strengths, limitations or scientific merit of a study when reviewing the literature (Anyan 2013; Cope 2014).

To critique quality in qualitative research, researchers use many terms such as credibility and trustworthiness (Cope 2014: 89), or validity and reliability (Creswell 2009; Creswell and Plano Clark 2011). Creswell (2009: 191) associates trustworthiness, authenticity and credibility with validity. Validity is

attained when a researcher assesses the accuracy of information from the participants during the analysis procedures, while reliability relates to whether the multiple coders on a team can reach agreement on codes for passages in text (Creswell and Plano Clark 2011: 211). Qualitative researchers attend to three major categories of trustworthiness namely: integrity of the data, balance between reflexivity and subjectivity, and clear communication of findings (Williams and Morrow 2009: 578).

Trustworthiness is explained from data collection to analysis in qualitative research (Elo *et al.* 2014: 1) using four criteria, namely, credibility, dependability, confirmability, transferability, and authenticity (Polit and Beck 2013: 178).

- a) **Credibility** is confidence in the truth and in interpreting data and is confirmed through data triangulation, which is achieved by interpreting and integrating quantitative and qualitative findings. To ensure credibility in the current study, the data triangulation method was used. In data triangulation many sources of information are used in order to increase validity in the study. To increase internal validity further, the researcher distinguished clearly between statements by the interviewees and interpretations or accounts of those statements by the researcher (Polit and Beck 2013: 179).
- b) **Dependability:** refers to the replicability of the results, which is, will the same results be obtained if research was to be repeated in a similar sample and context (Lincoln and Guba 1985: 129). Semi-structured interviews were conducted to further clarify findings from the qualitative phase. In addressing dependability, the research design of this study might be viewed as a 'prototype model' to enable readers to develop a thorough understanding of the methods and their effectiveness.
- c) **Confirmability:** is concerned with whether the data presented represents what the participants said and are without the biases of the researcher (Lincoln and Guba 1985: 129). To achieve confirmability, the researcher ensured that the study findings were the results of the lived experiences that emerged from the THPs and ROs who treat cancer by conducting in-depth interviews and generating thick descriptions. All

responses were recorded, categorised, and compared with items in the refined coding system. Excerpts and direct quotes from the data were used to support the themes that emerged from the data. The supervisors were invited to review the data scripts. The researcher and the supervisors concurred on the identified categories and themes.

- d) **Transferability:** Tracy (2010: 845) states that transferability is achieved when readers feel as though the story of the researcher overlaps with their own situation and they intuitively transfer the research to their own action. For transferability, the researcher established the context of the study and gave a detailed description of the phenomenon by interviewing 28 THPs and 4 ROs with various experiences to allow comparisons to be made.

In the current study, the researcher utilised a framework of rigour for interpretive phenomenological studies (Lincoln and Guba 1985: 130), to assure the quality.

4.12 SUMMARY OF THE CHAPTER

Despite many approaches to data analysis in phenomenological studies, it is imperative to select an analysis based on the rationale for the study. The current chapter has discussed the analytical procedures of the study.

CHAPTER 5 : PRESENTATION OF THE RESULTS

5.1 INTRODUCTION

This chapter presents the results of interview data obtained from four ROs and 28 THPs who treat patients with cancer in KZN. The interview data were analysed for their relevance to the research questions of the study. Firstly, the chapter describes the interviewees briefly and presents the results of the study as themes. The chapter concludes with a summary.

The study was intended to understand the co-operative practice, if any, between THPs and ROs in the treatment of patients with cancer in order to describe a framework of co-operative practice between them, and to contribute to the development of TM as a health system in KZN Province. According to Morse *et al.* (2002: 1), a framework is formed when a researcher fleshes out the internal structure built from the responses of participants, and establishes how all other structures fit together. It follows that the findings presented in this chapter form the internal structure which the researcher will interpret and will flesh out in relation to literature in the field in order to build a framework.

The conceptual framework constructed in Chapter 3 depicted that the responses to the above questions would provide an understanding of the structure and processes in the relationship between THPs and ROs. The table developed in Chapter 4 (Table 4.1) indicated that these objectives with these questions were to understand the treatment of cancer patients by THPs, co-operative practice between THPs and ROs in the treatment of patients, barriers to co-operative practice between THPs and Ros, and enablers for effective co-operative practice. The same chapter showed how the information was obtained from the participants in the study. Using the conceptual framework developed in Chapter 3, the result of the data analysis is discussed in this chapter. The *a priori* (previously developed) concepts in the conceptual framework developed in Chapter 3 are the key findings of the study and are denoted by themes. The results of the study first describe each

group of the participants of the study, and then present the key findings as themes which are discussed in terms of their subthemes.

5.2 DESCRIPTION OF THE PARTICIPANTS IN THE STUDY

The participants of the study comprised 28 THPs who treat patients with cancer and four ROs who were willing to work with THPs in the treatment of patients diagnosed with cancer. Based on the information collected from the participants, the researcher describes the demographics of the participants by first describing the demographics of the THPs followed by ROs.

5.2.1 Demographics of the THPs

The researcher employed snowball sampling utilising different referral points to identify 28 THPs who treat patients diagnosed with cancer. All the participants were registered with the various traditional healers' organisations. Additionally, they were willing to participate in the study. The demographic profile of an individual THP is depicted in Table 5.1 below. Most participants were males; there were 19 males and 9 females. Their age ranged from 20-80 years where the majority was at age 40-60 years. Three had no formal education, 12 had primary school education (Grade 1-7), 12 had high school education and one had a diploma. They indicated that they had prior training in the treatment of HIV and AIDS. The majority was traditional herbalists (18), followed by seven diviners and one spiritual healer. Two THPs were both a traditional herbalist and a diviner or a traditional herbalist and a spiritual healer. The THPs' work experience as traditional healers ranged from 1-60 years with the majority being between 1-40 and a minority above 40 years.

Table 5.1: Demographics of THPs

Participant No.	Gender		Age (years)			Education level				Type of THP			Work experience (years)		
	M	F	20-40	41-60	61-80	No	Gr 1-7	Gr 8-12	Grad	Traditional herbalist	Diviner	Spiritual Healer	1-20	21-40	41-50
1	M			x				x		x				x	
2	M				x		x			x					x
3	M			x			x			x					x
4		F		x			x			x				x	
5	M			x			x			x					x
6	M			x			x			x			x		
7	M			x		x				x				x	
8	M			x		x				x				x	
9	M			x				x		x			x		
10	M			x			x			x				x	
11		F		x				x			x		x		
12	M			x			x				x		x		
13		F	x					x				x	x		
14		F			x		x				x			x	
15	M		x					x			x		x		
16	M			x		x				x				x	
17	M		x						x	x			x		
18	M			x				x		x					x
19		F		x				x			x			x	
20		F		x			x				x			x	
21		F		x				x			x		x		
22		F			x		x				x	x			x
23		F			x			x		x				x	

24	M		x				x			x	x		x		
25	M			x			x			x			x		
26	M			x				x		x			x		
27	M			x				x		x				x	
28	M			x				x		x				x	
Total	19	9	4	20	4	3	12	12	1	19	8	1	11	12	5

Gr = grade

Grad = graduate

THP = Traditional health practitioner

5.2.2 Demographics of the ROs

The four ROs were all of different races with English as their first language and were employed full time in different positions at two public hospitals. For reasons of confidentiality, the researcher has chosen not to disclose their race group and positions as this could lead to them being identified. Of the four ROs, three were males and one was female. Participant 1 was a 45-year old with more than 10 years of work experience as an RO. Participant 2 was a 38-year old working as an RO for six years. Participant 3 was a 46-year old employed for 15 years as an RO. Participant 4 was a 36-year old and had 5 years' work experience as an RO.

Using the matrix developed in Chapter 4, the results of the interview data from the THPs and ROs were outlined as follows: (a) the conceptualisation of cancer treatment by the THPs, (b) conceptualisation of co-operative practice between THPs and ROs, (c) barriers to co-operative practice between the THPs and ROs in the treatment of patients with cancer and (d) enablers to co-operative practice between the THPs and ROs in treatment of patients with cancer. These formed the main themes of the study (Table 5.2) and each is discussed in detail.

5.3 CONCEPTUALISATION OF THE TREATMENT OF CANCER PATIENTS BY THPs

From the outline of the results stated above, five subthemes emerged, namely: knowledge of cancer, diagnosis of cancer, treatment of patients with cancer, follow up of patients after treatment, and health-seeking behavior. In the following section, the researcher discusses each theme and its related subthemes. To highlight a point, the quotations derived from the transcribed focus group and face-to-face interviews are used.

Table 5.2: Main themes and subthemes from interviews with THPs and ROs

Theme	Subtheme	Category
1. The principles and practices in the treatment of patients with cancer by the THPs.	1.1 Knowledge of cancer	<p>1.1.1 Cancer is a sore which does not heal.</p> <p>1.1.2 The common cancers that are treated are of cervix, breast, prostate, bladder, lungs, kidneys, mouth, colon and vagina. The most common types are cancers of the breast and cervix.</p> <p>1.1.3 Cancer can spread to the lungs, liver and brain.</p> <p>1.1.4 Signs and symptoms of different cancers are bleeding for more than the menstrual days for the cancer of the cervix, painful breast oozing pus, breast oozing pus, patient loses weight and looks tired.</p> <p>1.1.5 Cancer is caused by the chemicals from the food we consume.</p> <p>1.1.6 Recurrence due to non-compliance with treatment.</p>
	1.2 Diagnosis of cancer	Use ancestral powers to diagnose patients, signs and symptoms and fully dependent on hospital to diagnose and confirm diagnosis, provide general condition of the patient before treatment, transfuse patient if there is low blood.
	1.3 Treatment of cancer	<p>1.2.1 Treat to cure the disease and alleviate pain.</p> <p>1.2.2 Treatment duration for early and late stages of cancer.</p> <p>1.2.3 Refer patient to hospital to confirm diagnosis before commencing treatment, to check general condition of patient before treatment, to transfuse patients if they have low blood.</p> <p>1.2.4 Patients not to consume both treatments from THPs and ROs simultaneously but consecutively. Also, to complete course of treatment before consuming any other medication.</p>
	1.4 Evaluation of treatment	<p>1.4.1 Patients referred back to check response to cancer treatment.</p> <p>Patient to be evaluated and monitored to check the outcome of treatment by the ROs.</p> <p>Follow up problems and remedy.</p> <p>-Some patients do not give feedback due to various reasons. In future they will keep records of patients in order to follow them up after treatment.</p> <p>-Some return to give feedback such as were cured or not cured. If they were not cured they will be referred to other THPs or hospital for treatment and those who were cured will be referred to the hospital to check if there is any persisting disease.</p>
2. Co-operative practice between THPs and ROs in the treatment of cancer.	2.1 Collaboration	<p>2.1.1 There is no relationship between them.</p> <p>2.1.2 One-way referral from the THPs.</p> <p>2.1.3 Both teams did not have power because the patients exercise their rights by referring themselves to any health practitioner.</p>
	2.2. Team	<p>2.2.1 Parallel working team.</p> <p>2.2.2 Respect and trust.</p> <p>2.2.3 Communication.</p>
	2.3 Patient participation	<p>2.3.1 Communication between patients and health practitioners.</p> <p>2.3.2 Involved in decision making for treatment.</p> <p>2.3.3 Not to consume both TM and AM during treatment.</p> <p>2.3.4 Coordinate THPs and ROs' activities.</p>
3. Barriers to co-operative practice	3.1 External conditions	<p>3.1.1 National health insurance.</p> <p>3.1.2 Government's mandate.</p> <p>3.1.3 Patients' rights charter.</p> <p>3.1.4 Culture.</p>
	3.2 Individual attributes	<p>3.2.1 THPs are uneducated.</p> <p>3.2.2 Training to be an RO takes more than 10 years.</p>
	3.3 Organisational dynamics	3.3.1 No communication and transfer of information between all parties

		involved. 3.3.2 Only patients make can make decisions with regard to choice of health practitioner.
	3.4 Trusting attitudes	3.4.1 No respect and trust. 3.4.2 Sharing of resources.
	3.5 Attitudes on practice	3.5.1 ROs do not acknowledge failure in their treatment.. 3.5.2 Role clarity. 3.5.3 Evidence based practice. 3.5.4 Delays in referral. 3.5.5 No recognition of their treatment.
4. Enablers for effective co-operation	Enormous effort Training Co-operation	4.1 Capacity building for THPs. 4.2 Proper referral system. 4.3 Communication, trust and respect.

All participants who were interviewed claimed to have experience in the treatment of patients with cancer. They understood treatment of cancer as a provision of treatment to patients using different forms of treatment. In doing so, they claimed to know what cancer is, how it can be diagnosed and each described their practices in the treatment of cancer. These concepts in cancer treatment formed the subthemes against which to map data from the interviews.

5.3.1 Knowledge of cancer by the THPs

The THPs who were interviewed are those who have had experience in the treatment of patients with cancer in KZN. They appeared to have a variety of information about cancer. When providing this information, they defined cancer, stated the different types, named the organs of cancer spread, explained its presenting features, stated the causes of cancer, and mentioned cancer recurrence.

5.3.1.1 Definition of cancer

In explaining what cancer is, most THPs stated that it is a sore which does not heal and explained the various ways they believe it grows. The following extracts illustrate this:

“.... Cancer is a sore that doesn’t heal but continues to grow and invade surrounding tissue.” (THP 1)

“... My understanding of cancer is that cancer is an open sore inside the womb that continues to bleed internally and patient will have bad odour.”
(THP 2)

“... Cancer is a sore that doesn't heal. It invades the surrounding tissue and ends up affecting the blood such that the blood cannot flow properly and end up making a clot of blood. The cancer will then grow from this clot inside and becomes visible as cancer ... (THP 3)

Some THPs interviewed believed that cancer is any disease or sore that cannot be treated successfully by the hospital doctors. The following quotes affirm this.

“... They have a sore that continues to grow and will tell you that the hospital has tested their sugar level and it was normal yet the sore continues to grow.” (THP 13)

“... Without any diagnosis by the clinic or hospital, every patient that has a continuous sickness that the hospital cannot cure, I think it is cancer.”
(THP 16)

5.3.1.2 Types of cancer

In terms of types of cancer, the THPs interviewed stated that cancer grows anywhere in the body and affects both males and females. The different THPs mentioned various sites from which cancer can grow and those included cervix, breast, prostate, bladder, lungs, kidneys, mouth, colon and vulva. The following extracts illustrate this.

“... The cancer will then grow from this clot inside and becomes visible as cancer like for example cancer in the colon, throat, prostate or cervix.”
(THP 3)

“... It affects the breast in females and in males it grows anywhere in the body.” (THP 6)

“.... It is a sore that can grow mostly in the cervix and breast in females. It can also grow in the bladder, lungs, kidneys, mouth and colon in other patients. From these organs the cancer grows continuously into a growth. Such growths develop in cows and goats as well.” (THP 7)

“There are many types of cancers. I will talk about one patient who had cancer that appeared like cauliflower in the vulva.” (THP 13)

The majority of THPs mentioned that in their experience as THPs treating cancer patients, the most common cancers were in the breast and cervix.

5.3.1.3 Spread of cancer

With reference to the spread of cancer, while most did not mention it, a few THP participants mentioned that cancer can spread to other organs such as lungs, liver, and brain in the body. The following excerpts confirmed this.

“... Cancer is a disease that results in many other diseases and affects the body in many ways like affecting the patient’s brain or bones such that a patient gets crazy, or in the bones of the arm as if they have arthritis.” (THP 3)

“... Patients have reported to me that the hospital has told them that cancer can spread to lungs and liver.” (THP 16)

“...Cancer grows inside the body and once it has progressed to the outside then it means the cancer has advanced. Sometimes patients develop jaundice. Some patients with cancer will bleed through their nose and others may not be able to walk.” (THP 25)

5.3.1.4 Signs and symptoms

Most THPs mentioned various signs and symptoms of different cancers in the body, for example they stated that some patients with breast cancer ooze pus, those with throat cancer cough continuously, and that other patients lose weight, are fatigued, unable to swallow food and develop pimples on the face. In some instances, they mentioned signs and symptoms of cancer but were not specific of where that cancer was. The following excerpts illustrate this.

“...When the sore is in the breast there will be round dark patches, ooze pus, a painful breast and in most cases one breast is affected. A patient with throat cancer coughs continuously as a result of a sore in the throat. Sometimes a patient has a rash in the vagina if they have cancer of the cervix.” (THP 2)

“... Some patients with cancer lose weight, look tired, unable to swallow food or develop pimples on the face. Patients will tell you that they cannot control their urine. Some will have hoarseness of the voice and a tracheostomy. They also develop an oozing wound on the neck. Sometimes pus comes out of the sore.” (THP 3)

“Breast cancer has round dark patches, oozing pus, painful breast and mostly one breast is affected.” (THP 12)

“This lesion was hard and whitish in colour. There were sores in the vagina “ugqunsula”. The patient had lost weight, had shortness of breath and was coughing with nothing coming out from the cough.” (THP 13)

“.... Throat cancer patient coughs continuously as a result of a sore in the throat. Cervical cancer patients have bad odour, sores and bleeding.” (THP 14)

With regards to sign and symptoms of cancer, most THPs mentioned signs and symptoms that patients with advanced cancer present with. The following quotes illustrate this.

“When the sore is in the breast there will be round dark patches, ooze pus, painful breast” (THP 2)

“.... Patients will tell you that they cannot control their urine They also develop an oozing wound on the neck. Sometimes pus comes out of the sore.” (THP 3)

“This lesion was hard and whitish in colour. There were sores in the vagina The patient had lost weight, had shortness of breath and was coughing with nothing coming out from the cough.” (THP 13)

“.... Patients will tell you that they cannot control urine.” (THP 21)

Furthermore, the THPs participants indicated that some of the patients with advanced stage had referred themselves to them after the conventional cancer treatment had failed. The following quotes illustrate this.

“.... I would indicate the problems that I encounter when a patient consults us after having treatment at the hospital. The patients present with an advanced stage and the radiation had damaged other veins in the body making it difficult for our medication to work on damaged veins and the cancer does not respond to our treatment.” (THP 10)

“They have a sore that continues to grow and will tell you that the hospital has tested their sugar level and it was normal yet the sore continues to grow.” (THP 13)

5.3.1.5 Causes of cancer

With reference to the causes of cancer, most THPs mentioned that cancer can be caused by a virus, certain foods, abortion and smoking. The following excerpts affirm this.

“It results from a virus which makes it to grow nonstop and kills you.” (THP 1)

“Cancer is caused by the food we eat because other foods have chemicals which cause cancer. The chemicals circulate in the body and can lodge anywhere in the body resulting in cancer.” (THP 2)

“I believe that cancer of the cervix develops as a result of abortion. Sometimes when the mother has a calling to be a traditional healer, the ancestral spirit causes all the symptoms of cancer.” (THP 3)

“.....throat cancer as a result of smoking and the patient ends up having a difficulty to swallow.” (THP 15)

5.3.1.6 Cancer recurrence

Two THPs mentioned that cancer can recur. One said that a patient said that the doctors told the patient that the cancer had recurred, and the other said the cause of recurrence is when a patient does not complete treatment. The following extracts confirm this.

“One patient who came to me for treatment told me that she was previously treated for breast cancer by the hospital but the cancer had returned.” (THP 3)

“Their ROs’ medicine only works at the top and leaves the roots of cancer, hence after some time the cancer recurs.” (THP 15)

“Cancer comes back if a patient does not follow instructions when taking medication. Patients need to be told to complete treatment.” (THP 20)

5.3.2 Diagnosis of a patient

With regard to diagnosis, they had to respond to how they know if a patient has cancer and what do they do if a patient has cancer. Amongst the different types of THPs, most herbalists indicated that they cannot diagnose patients with cancer but rely on observation of the patient, patients give the symptoms of the disease, or some patients come with the diagnosis of cancer from the hospital. A few herbalists said that they use the ancestral spirits to diagnose patients with cancer. The herbalist asserted that patients with a possible diagnosis of cancer were referred to diviners to diagnose cancer before they started treatment. The following extracts support these statements.

“I cannot diagnose a patient but am told by the patient that they have cancer and that they have been bleeding. Some patients with cancer of the cervix may get their menstruation for more than 3-5 days. Other patients may give all the symptoms of the cancer or others take a photo of their private parts to show the cancer. In some instances, patients tell me that the hospital has already diagnosed them with cancer.” (THP 1)

“... I throw bones to diagnose a patient and also listen from the patient of what the symptoms.” (THP 3)

“... The patient tells me about the symptoms of cancer, also my ancestors tell me through a dream about the cancer and what cause it. I also learn from other THPs on how to diagnose cancer.” (THP 18)

Despite the various means of diagnosing cancer, almost all THPs stated that they do not commence treatment of cancer until the diagnosis has been confirmed by the hospital. The following extracts confirms this:

“.... I use ancestral spirits to diagnose a patient. I also refer the patient to the clinic in order to confirm the patient’s diagnosis because I do not want to rely on my diagnosis to give the correct treatment. Like I have said that cancer is many diseases therefore I would not like to conclude on the diagnosis and treat the disease according to my diagnosis. It is for that reason that I refer the patient to the hospital because they have the right equipment to diagnose the diseases in patients.” (THP 3)

“The disease should be confirmed by the hospital before I can give cancer treatment. Patients tell about the symptoms of cancer but I prefer not to rely on their story that they have cancer I have noticed that some come with low blood. In that case I refer them back to the hospital to have transfusion before commencing treatment.” (THP 4)

5.3.3 Treatment of cancer by THPs

Only a few THPs stated that they would start their treatment after having confirmed the disease with another THP. Almost all THPs mentioned they commence treatment once cancer has been confirmed by the hospital. They were all not asked the type of medicine or the mixture they use to treat cancer. Instead they responded to a question of what will they do when a patient has been diagnosed with cancer. Almost all stated that they would inform the patient of the final diagnosis then involve the patient in the choice of treatment. If the patient opts for TM, they advise the patient not to consume any other medicine once they have started consuming theirs. Also if patients were already on medication, they tell patients to discontinue such medicines and commence their medicine and complete it before consulting with any other medicine practitioner. The following extracts illustrate this:

“I ask the patient if he or she would prefer to be treated by the hospital or myself. When a patient has chosen TM, I ask them if there is any difference between the treatment from the hospital and the one given by me. I then give them medication prepared from medicinal plants and tell them to report after some days if the disease is still persisting, and if yes I

tell the patient that I was unable to help and refer them to other THPs or the hospital. I prefer to see the results within few days and if not I refer the patient.” THP 1)

“I treat patients that have not started treatment with ROs. It is not proper for a patient to receive treatment from both healers simultaneously. (THP 3)

“Training by Prof Qgaleni taught us to refer patients if we unable to treat the diseases. Now the problem is we don’t know who to refer to at the hospitals. I think they also don’t know who to refer to. We have realised that the referral is a one-way system from THPs only and not from the hospitals.” (THP 2)

When patients choose treatment by the THPs, they are given instructions not to use any other medicine while having treatment with TM, complete treatment with TM before consuming any other medicine, and never use both medicines simultaneously. The following statement supports this:

“Once I start my treatment, I tell my patients not consult or take any other medicine until they have completed my medicine.” (THP 2)

All THPs interviewed in the study indicated that they started treatment only after the diagnosis of the patient has been confirmed by the hospital, and use plant medicine, but they did not disclose the types of plants. Most indicated that their treatment of cancer patients aims to cure cancer, and others said that they cure and alleviate the pain. However, if the cancer cannot be cured, they refer the patient to other THPs or the hospital. The following statements affirm this subtheme:

“The goal of my treatment is to cure the disease and I then advise the patient to go back to the hospital to be checked if the cancer is still in existence.” (THP 1)

“The aim is to cure the cancer or make it feel better from the disease. It is difficult to cure the disease because as it grows it already has many roots that when you try to cure the disease it is like cutting a tree but not its roots. When you have a disease, it shows itself after a while.” (THP 2)

“The training by Prof Gqaleni taught us to refer patients to other THPs or the hospital if we unable to treat patients successfully.” (THP 2)

“When I treat cancer patients, I treat to cure the disease and to alleviate the pain. I have successfully cured patients with cancer of the breast and advanced cervix.” (THP 3)

Most THPs mentioned that the duration of treatment or the time at which to observe results is from a few days to months. However, some mentioned that it takes longer if the disease is advanced. The following statements affirm this.

“The duration of treatment depends on the stage of cancer. Early stage takes 3 days to three weeks, but the advanced cancer takes almost a month to observe the results.” (THP 1)

“I give them (cancer patients) our medication from plants and tell them to report back after 3-5 days because I prefer to see the result within few days.” (THP 2)

“.....They (ROs) should then give us approximately 3 months to treat the cancer and see the results of treatment.” (THP 15)

5.3.4 Evaluation of treatment

Most THPs participants in the study indicated that once treatment has started, the patient should be checked for response to treatment. If the response is good, they continue with the treatment. However, if the response is negative, they refer the patient to other THPs or the hospital. During treatment they are told not to consume both TM and AM simultaneously and to complete

treatment before consuming any other medicine. After completing treatment, they said that they tell their patients to go to the hospital to check if the disease still persists and ask the patient to report back to them. The following statements affirm this.

“I give them medication and tell them to report after some days if the disease is still persisting, and if yes I tell the patient that I was unable to help and refer them to other THPs or the hospital. I prefer to see the results within few days” (THP 1).

“Though patients have right to access a health practitioner of their choice they still need to be educated that they should not take both medicines simultaneously. They should be told to finish treatment before going to any other health practitioner.” (THP 2)

“Another patient was with cervical cancer was given medication and after 3 weeks I told her go to the hospital to check if the disease is still there” (THP 1)

From the above quotes, the enquirer noted that those practices were not sequential. Also noted, some THPs said that they tell the patients to stop treatment if the treatment is from the hospital. The following excerpt supports this.

“I tell the patient to stop whatever medication that the hospital has given them then give my own medicine.” (THP 1)

According to the THPs interviewed, not all patients referred to the hospital to check if the disease still persists would provide feedback. Some patients reported positive treatment outcome and others did not. They suggested that there was a need to follow up patients. The following excerpt supports this subtheme.

“.....and it is important to follow up patients so that we can prove to the doctors that we can treat patients. This can be done by keeping record of patients, their names, address and contact numbers.” (THP 8)

Most THPs interviewed claimed to cure all patients that have consulted with them while others acknowledged a failure due to reasons such as patients presenting with advanced cancer, not completing treatment, the ancestral spirits wanting them to be traditional healers, or patients having been previously treated by radiation. The following excerpts affirm this.

“When a patient has not yet had any treatment from the doctors, I treat them in order to cure this disease. ... I have never had a patient that I could not treat successfully. ... I only treat successfully patients who have not been to the hospital and those cancers that are not very old. Cancer of six years is not the same as the one of 6 months with regard to treatment.” (THP 1)

“I have treated cancer in the kidneys. Cancer is curable. Our medication can cure any sore whether inside or outside.” (THP 3)

“I treat successfully any type of cancer which is at any stage even advanced stage.” (THP 28)

The researcher noted that other THPs claimed that they could cure all cancers. The following statements support this.

“However, it is difficult to cure the disease because as it grows, it already has many roots that when you try to cure the disease it is like cutting a tree but not its roots. Also, when the patient has the disease, it manifests itself after some time.” (THP 7)

“Some patients do not complete treatment because our medicine is too bitter. This makes it difficult to cure cancer ... some patients though with medical aids, are required to pay from their own pockets ... patients do not

complete treatment because they can't afford to pay the accumulating fees of the THPs during their treatment.” (THP 2)

“Cancer of six years is not the same as the one of six months with regard to treatment. ... Some patients are not cured of their cancer because their ancestors want them to be traditional healers.” (THP 3)

“The problem with radiation is that the cancer is treated superficially and its roots remain. Now when I treat the patient with my medication, I can't reach the roots of cancer which had started cancer. If the patient hasn't had radiation treatment I will go directly to cancer and its roots.” (THP 14)

The THP participants in the study asserted that if cancer is not cured after completing the course of treatment, they were trained to refer the patient to other THPs or the hospital. The following excerpts affirm this.

“If the disease is still persisting then it means that I was unable to help the patients, and then I refer them to other THPs or the hospital. The training by Prof. Gqaleni taught us to refer patients if we unable to successfully treat the diseases.” (THP 2)

Most of the THPs stated that post treatment they ascertain if there is cure in cancer patients by asking the patients if there are still any symptoms of the disease, checking for any sign of the disease or referring the patient to the hospital to be assessed for persistent cancer. The following quotes support this:

“After treating a patient (with cancer of the bladder) you can check if cancer is still there by checking the urine. If it (cancer) is still there the urine will be dirty and will be clear if the patient has been cured of the disease. However, if the patient still has cancer, the urine will show dirt and looks greyish. I would then refer the patient to the hospital and ask them to check his or her blood to see if there is any other disease in the blood causing the cancer not to respond to treatment or maybe there is raised sugar level or whether cancer has spread to the brain.” (THP 12)

“After treatment I refer patient to the hospital to check the response of cancer to my treatment.” (THP 27)

However, some of their patients do not return to give feedback after treatment. The following extract affirms this.

“I wouldn’t know if the patient was cured or not because only a few patients had returned to inform me about the outcome of treatment.” (THP 2).

The THPs believed that reasons such as patients not having money to pay them, the disease not being cured etc. could be the cause for not coming back to give feedback about the outcome of treatment. The following extracts affirm this.

“If patients are given medication which is not working they will not come back for more of your medicine but will refer themselves to other healers.” (THP 1)

“Also, some patients have medical aids but have to pay for our costs out of pockets ... they do not return to pay the accumulated costs for our medicine.” (THP 2)

According to the THPs interviewed those patients who gave feedback after treatment reported that they were cured of cancer. The following quotes confirm this.

“I do recall a number of patients telling me that I have cured them.” (THP 1)

“....and some do report back to report that they have been cured of the disease.” (THP 17)

Other THPs interviewed acknowledged that not all patients report positive results post cancer treatment. The following quote supports this.

“I give them medication and tell them to report after some days if the disease is still persisting. If it still does, I tell the patient that I was unable to help and then refer them to other THPs or the hospital.” (THP 1)

“If I could not cure the patient, I refer to the clinic or sometimes to other THPs.” (THP 12)

Most THP participants affirmed that they were unsure of the total number of patients they have cured with traditional healing because they do not keep records and do not follow up their patients. They indicated that in future they will keep records with patients' contact detail in order to facilitate the follow up. The following excerpts support this.

“I do not know the number of patients that were cured after treatment because patients do not return to inform us and also I have never kept any records.” (THP 2)

“I have never done any follow up on patients. I will start doing that from now and onwards. I will record the type of cancer too as well as the contact details of patients and do a follow up on patients to find out about the progress.” (THP 16)

Most THPs interviewed in the study mentioned that they had successfully treated patients with cancers of the breast and cervix. The following extract illustrates this.

“I can remember only one patient that survived for 13 years after treatment of the cervix. Another one patient had survived for more than 5 years following treatment of breast cancer.” (THP 16)

5.4 CONCEPTUALISATION OF CO-OPERATIVE PRACTICE

Most THPs and ROs participants who were interviewed in the study did not have an understanding of co-operative practice. They highlighted that there were problems in the treatment of patients with cancer. They described their current practice in the treatment of cancer in terms of the relationship between them. The conceptualisation of the co-operative practice between all those involved in the collaboration will be discussed next. The individuals involved in the co-operation include the health practitioners and the patient hence they play a significant role in this relationship. The subthemes which emerged are elaborated upon below.

5.4.1 Collaboration

Almost all THPs who participated in the study said that they did not have any experience of treating a patient referred to them by ROs because there is no relationship. However, a few mentioned that they had an experience where a patient had referred themselves to them, or they have referred the patient to the hospital, but the problem was they did not know who to refer to because as cancer treatment specialist they don't know each other. The following excerpts confirm this.

"I do not have any experience of treating a patient who was being treated by the doctors. However, patients come to me after they were not cured at the hospital." (THP 1)

".... now the problem is we don't know who to refer to at the hospitals. I think they also don't know us. We have realised that the referral is a one-way system from THPs only and not the hospitals." (THP 2)

"I have not seen too many patients that were referred by THPs. Some patients have told us that they have had TM treatment before coming to us but we don't know any details of this treatment like how long it was given." (RO 1)

"I do not have any experience of treating a patient that was being treated by a THP and they have not referred any patient to me." (RO 2)

5.4.2 Team

With regard to perception of treatment by ROs and co-operative treatment, the THPs interviewed said they give patients advice to not use both TM and AM treatment simultaneously. The quotes in the following text confirm the findings.

"I tell patient to use a healer that they prefer but not to allow simultaneous treatment from both health practitioners. However, sometimes I refer patients to the hospital if they have low blood because I cannot transfuse patients." (THP 1)

With regard to co-operative practice, the ROs are doing a good job and they have a lot to do for patients than us. However, they undermine us in the treatment of cancer patients. Also, if they cannot cure cancer, they do surgery and do radiation treatment." (THP 1)

"Patients have a right to access a health practitioner of their choice Patients consult simultaneously with both health practitioners if there is no control for the pain during treatment of their cancer." (THP 2)

"They perceive us as uneducated people who have demons, yet we do believe in the bible." (THP 2)

"Doctors don't want work with us because they say we are uneducated." (THP 4)

"We first need to establish what needs to be done in order to know that we should be accepted." (THP 4)

“We need to work together however the government should first have evidenced based role of our treatment for cancer patients then use the law for us to work together.” (THP 5)

To the same questions, the ROs responded by also indicating that there was no interaction between them and the THPs. The statements quoted next affirm that subtheme.

“There is no proof that TM or their practices can be used in cancer patients. What we practice is evidence based. I have never seen any evidence or research about THPs practices or TM for cancer treatment. I cannot recommend this for now because of there is no evidence that it can be used. Some patients choose to take that route but it is their choice.” (RO 1)

“Working in co-operation will be a new collaborative work and a new task for us. If the THPs want to collaborate with us we don’t have a problem, we can talk, understand and learn from each but to use this treatment is still difficult for now.” (RO 1)

“I do not think that THPs have any role in the treatment of patients with cancer though some of our patients consult with them. The problem is that after being diagnosed with the disease they disappear and return when the disease has advanced. This makes it difficult for us to manage the disease.” (RO 2)

“With regard to co-operative practice, we do want to work with them as mandated by the government however, it is difficult because we don’t know what they can do and believe that they can cure cancer as they claim.” (RO 2)

The researcher noted that both groups of health practitioners mentioned that the patient has a right to consult with a health practitioner of their choice and that they are mandated by the government to work together and that they

were willing to work together in the treatment of patients with cancer. When they were asked what co-operation was needed between them regarding co-operative practice, they indicated that some issues that needed to be addressed including agreeing on which issues to address, how to treat patients in a partnership, knowledge of the role and practices of each in co-operative practice, etc. before they can work together. The following quotes support this.

“We need to agree together with ROs on the viable practice on co-operative treatment.” (THP 1)

“We need to get together with ROs to discuss how we can treat cancer patients successfully. The cancer patients should be workshopped on how they will be referred between the two health practitioners. We need to educate each other about cancer and that some cancers cannot be cured because of the ancestors’ spirit. Having this shared knowledge we can approach cancer successfully.” (THP 3)

“They need to tell us how they treat cancer and tell us their role. We can then discuss the way forward together.” (RO 1)

However, one RO did not predict any possibility of a workable practice, as illustrated by the following excerpt.

“I am not sure there can be any viable co-operative practice, the divide between the two is far too vast.” (RO 4)

5.4.3 Patient participation

All the participants indicated that the patient was in the centre of the collaboration and was the main actor in the collaboration between the THPs and ROs. The following extracts illustrate this.

Patients have a right to access a health practitioner of their choice.” (THP 3)

“Some patients refuse to have chemo and say that they want to go back to THPs ... to take that route but it is their choice.” (RO 1)

They also mentioned that the patient is the main actor and should be involved in the activities described below.

5.4.3.1 Communication

All THPs interviewed believed that there should be reasonable communication and respect amongst all involved in the collaboration in order to achieve the common goal. The following excerpts support this.

“We need to work together with the doctors so that we can conquer cancer. In so doing we need to discuss how to refer patients, share responsibility and share information as to whom amongst us are the cancer treatment specialists and the type of cancers we can treat successfully.” (THP 2)

“However some patients indicated that they have been to THP but we don’t know what form of medication or treatment they have received as well as the duration of the treatment and the role of treatment in cancer.” (RO 1)

5.4.3.2 Decision making

Both the RO and THP participants in the study understood that in a co-operative practice, the patient has a right to make a decision on which health practitioner should treat them. They said the patient should therefore be involved and given power on matters related to their treatment. This was confirmed in the following excerpts.

“Involve the patient in decision making and this should involve the patient and the two health practitioners. We need to explain to the patient how the patient should be treated. Once the diagnosis of the patient is confirmed, the patient should be told about the role of THPs and ROs in the treatment of cancer then the patient should make an informed decision with regard to a health practitioner of their choice then sign documents to that effect. (THP 5)

“Some patients refuse to have chemo and say that they want to go back to THPs.” (RO 1)

All THPs interviewed believed that there should be reasonable communication and respect amongst all involved in the collaboration in order to achieve the common goal. The following excerpts support this.

“.... We need to work together with the doctors so that we can conquer cancer. In so doing we need to discuss how to refer patients, share responsibility and share information as to whom amongst us are the cancer treatment specialists and the type of cancers we can treat successfully.” (THP 2)

“.... However, some patients indicated that they have been to THP but we don't know what form of medication or treatment they have received as well as the duration of the treatment and the role of treatment in cancer.” (RO 1)

The researcher noticed that even though they did not have any relationship, they all mentioned that referral by each was necessary in a co-operative practice. The THPs also mentioned that they have already been referring patients to the hospital for the diagnosis and confirmation of cancer in their patients, transfusion, checking the general condition of the patient before starting treatment, and to check if the disease has been cured following treatment. The excerpts from the THPs in the following statements support this subtheme.

“... I do not like to start treatment without having confirmed the cancer with the doctors at the hospital because I avoid treating patients incorrectly as some patients can present with cancer symptoms when in actual fact they have ancestral spirits.” (THP 3)

“... Let the patient be diagnosed first before coming to us or referred to us if they so prefer.” (THP 5)

“... After giving treatment, I wanted to see the progress but I don't have the equipment used by the hospital to check the response of cancer to treatment.” (THP 6)

“... Once you have given medication and the patient alludes that they are now feeling better and you should also observe this, then refer the patient back to the hospital so that they should confirm that the cancer is now cured.” (THP 7)

The researcher assessed that the patient plays a pivotal role in the referral system because of their rights as patients, which gives them power in the collaboration. Those included the coordination of treatment activities between the health practitioners, and responsibilities to ensure that they inform the health practitioners about any other treatment. The following concepts from the participants that were interviewed in the study support this subtheme:

“In working together we need to discuss how we should refer patients to each other, we need a list of all ROs and they should also have a list of THPs who treat cancer as well as the type of cancers that we can treat successfully. We should be allowed to walk up and down with our ‘ishoba’ (traditional healers’ attire) when we have to in the hospital, same way that the doctors walk up and down with their stethoscope. The doctors should allow other TM to be used when the patient is being hospitalised. Or they should tell us what guidelines we need to follow in order to use our medication in the hospital. They should also learn what our medication can do. The hospitals’ chemist should have our medicine. When our patient is

in the hospital I will come personally to administer the medicine as the doctors use nurses to administer the medicine.” (THP 3)

“The cancer patients should be workshopped on how they will be referred between the two health practitioners.” (THP 10)

“If the patient is already being treated at the hospital and decides to go to THP, the patient has a responsibility to ask his or her family to inform the hospital of this decision. The patient will then sign a form in this regard. When the RO refers this patient to me, they must inform me of the patient’s diagnosis, also the THP in question should know about this, the patient should agree to be referred and the RO should be aware of this arrangement. I will then use my medicine on the patient and once I have confirmed with the patient that cancer has been cured, I will refer the patient back to hospital.” (THP 16)

“When a decision has been made to refer a patient, the people that should be involved are the patient’s family, the doctor and the THP.” (THP 9)

“When the RO refers this patient to me, they must inform me of the patient’s diagnosis, also the THP in question should know about this, the patient should agree to be referred and the RO should be aware of this arrangement.” (THP 15)

“If a patient first consults with me as a THP and I diagnose the patient with cancer, I will refer the patient to the ROs so that they can confirm my diagnoses and we should be on the same page that we would be treating cancer. This would make it easy for us to refer patients to each should a need arise.” (THP 23)

5.5 NEGATIVE ATTITUDES ON TREATMENT OF PATIENTS WITH CANCER AND CO-OPERATIVE PRACTICE

Barriers are the issues that lead to the development of a particular phenomenon (Strauss and Corbin 1990: 96). It follows that these are the factors that caused non-referral or later referral by THPs and ROs of cancer patients for treatment. The participants in the study were of the opinion that there were many factors related to treatment all of which constituted barriers to co-operative practice.

Both groups of participants mentioned a range of factors for effective co-operative practice. They highlighted that co-operative practice is a process that would require the management of the issues that impede co-operative practice. They indicated that as this would be a new venture for them, first they would want to know each other to discuss the issues that may facilitate co-operative practice. They also indicated issues that were concerns for them and making it difficult to work together or interact with each other. These issues are discussed next.

5.5.1 ROs undermine THPs' practices

The ROs were concerned with the unscientific practices of THPs. The following excerpts illustrate this.

"I do not think that THPs have any role in the treatment of patients with cancer though some of our patients consult with them. The problem is that after being diagnosed with the disease they disappear and return when the disease has advanced. This makes it difficult for us to manage the disease." (RO1).

"I did not have any interaction with a THP before. However, some patients indicated that they have been to THP but we don't know what form of medication or treatment they have received as well as the duration of the treatment and the role of treatment in cancer." (RO2)

“Traditional healers should realise that management of cancer is evidence based treatment. There is no science to support TM. They should not delay referral of patients to an oncologist.” (RO 3)

“We do want to work with them as mandated by the government however, it is difficult because we don’t know what they can do and believe that they can cure cancer as they claim.” (RO 2)

“It is ill-advised that TM be used to treat cancer until there is level 1 evidence.” (RO 3)

5.5.2 ROs undermine THPs because they are uneducated

The ROs believed that the THPs do not have the appropriate level of education to treat patients with cancer. The following statement illustrates this.

“We have been to school for many years to treat cancer and the THPs do not have that kind of education. How possible is it that they can treat and cure cancer?” (RO 1)

5.5.3 Delay in the referrals of patients

The ROs are of the opinion that the THPs were the cause of the delay in the starting of treatment and patients presented to the hospital when the disease was already advanced. The following statements support this.

“The problem is that after being diagnosed with the disease they disappear and return when the disease has advanced. This makes it difficult for us to manage the disease.” (RO 2)

“I don’t think a collaboration is possible because management needs to be based on evidence also patients may attend traditional healers then present to hospital when things go wrong and expect the complications to now be managed by Western medicine.” (RO 4)

5.5.4 No communication about treatment details

The ROs felt that there was no communication about treatment details for their patients who were on treatment. The following extracts illustrate this.

“I don’t think a collaboration is possible because management needs to be based on evidence also patients may attend traditional healers then present to hospital when things go wrong and expect the complications to now be managed by Western medicine This is often very difficult as there is no knowledge provided about what's been used or done.” (RO 4)

5.6 ENABLERS FOR CO-OPERATIVE PRACTICE

To correct the negative attitudes both parties agreed that they needed to get together in order to know each other and set a platform for discussion. There were many issues that needed attention. The following statements illustrate this.

“Before we start co-operating we need to talk and know each other and what they do in the treatment of cancer and once we understand that we can think of a framework or standard approach to what they can offer to cancer patients.” (RO 1)

“We need to agree together with ROs on the viable practice on co-operative treatment.” (THP 2)

Most THPs interviewed highlighted many other issues to be involved in the discussion to facilitate co-operative practice. The following statements support this.

“If the THPs want to collaborate with us we don’t have a problem, we can talk, but they must understand that evidence based practice should be the priority in our discussions.” (RO 1)

“We need to share knowledge then work together to treat the patients successfully. We need to get together with ROs to discuss how we can treat cancer patients successfully. The cancer patients should be workshopped on how they will be referred between the two health practitioners. We need to educate each other about cancer and that some cancers cannot be cured because of the ancestors’ spirit. Having this shared knowledge we can approach cancer successfully. ... ROs and nurses should be educated that black people will always use TM because of their culture, whether from the chemist or THPs. We need to get together with ROs to discuss that some patients will not be cured because of their ancestors.” (THP 2)

“The patients need to be told that only one medicine can be used at a time. Once you have given medication and the patient alludes that they are now feeling better and you should also observe this then refer the patient back to the hospital so that they should confirm that the cancer is now cured. To achieve this, we need to work together with ROs because amongst them there are those who cannot cure the disease and the same applies to us THPs and find common grounds. We need to discuss this together.” (THP 8)

“If a patient wants to access both practitioners at the same time we know that the hospital would not like it when we burn our medication at the hospital. Hence we want our own hospital so that we can burn our medicine when a need arises. Where a patient is getting treatment from THPs and ROs, it would be better to have the patient admitted at our hospital so that we can burn our stuff at our hospital. ROs access our hospital if there is something they need to do on their patient.” (THP 6)

“We should be allowed to walk up and down with our “ishoba” (traditional healers’ attire) when we have to be at the hospital, same way that the doctors walk up and down with their stethoscope. The doctors should allow other TM to be used when the patient is being hospitalised. Or they should tell us what guidelines we need to follow in order to use our

medication in the hospital. The hospitals' chemist should have our medicine. When our patient is in the hospital I will come personally to administer the medicine as the doctors use nurses to administer the medicine.” (THP 9)

“The patient should be counselled and told that we are working together. In that way they will be able to tell them about their visit to us.” (THP 3)

“...to achieve this, we need to work together with ROs because amongst them there are those who cannot cure the disease and the same applies to us THPs and find common grounds. We need to discuss this together.” (THP 7)

5.7 CONTEXT OF CO-OPERATIVE PRACTICE

Context refers to the particular set of conditions under which the phenomenon is managed such as the locations of events or incidents affecting a phenomenon along a dimensional array (Strauss and Corbin 1990: 96). From the data sources, the need for co-operative practice between the THPs and ROs in the treatment of patients with cancer in South Africa arose as a response to: (a) patients' using their rights to hop between health practitioners, (b) the mandate from the government, (c) the NHI and (d) culture. In the next section these will be discussed to show how they influence co-operative practice.

5.7.1 Patients' rights

The THPs and ROs highlighted that co-operative practice was put in place because of the patients' rights to access a health practitioner of their choice, as indicated in the following quotes from the interviewees' statements.

“Patients have a right to access a health practitioner of their choice. Patients consult simultaneously with both health practitioners if there is no control for the pain during treatment of their cancer. When I treat cancer

patients, I treat to cure the disease and to alleviate the pain whereas the ROs give panado and antibiotics which sometimes do not alleviate the pain.” (THP 2)

“I have never seen any evidence or research about THPs practices or TM for cancer treatment. I cannot recommend this for now because of there is no evidence that it can be used. Some patients choose to take that route but it is their choice.” (RO 2)

To ensure that patients make a decision on which health practitioner treats their cancer, they need to be taught to stop this. Patients should be taught that they cannot use the both medicines simultaneously.” (THP 2)

5.7.2 Mandate from the government

The ROs indicated that co-operative practice should be put in place because it is the government’s mandate. The THPs stated that they would like the government to facilitate the collection of TM evidence based treatment for cancer which is an issue with regard to co-operation between the health practitioners, provide guidelines and avail research on integration. The following extracts support this.

“The government in 1994 gave THPs permission to work with us, however, we don’t know the limits of that permission we would like to know what their vision is about that and what THPs’ perception in treating cancer. We don’t know how this treatment is applied, there is no guideline or recommendations we can study or learn from research about this.” (RO 1)

“We need to work together however the government should first have evidenced based role of our treatment for cancer patients then use the law for us to work together. The law is there already but the government has to do more like getting us to know each other and discuss what each can offer to the cure of cancer.” (THP 4)

“... However the government should first allow us to prove our role in the treatment of cancer or facilitate our evidenced based treatment for cancer patients then use the law for us to work together.” (THP 12)

5.7.3 The NHI

Some THPs indicated that co-operation is needed so that the NHI should not discriminate against patients who consult with both AM and TM for their treatment. The following excerpt supports this statement:

“Some patients do not come to give report following treatment because they know that they must pay us when the disease has been cured. ... therefore following them up will cause a problem because as they do the follow up there will be costs of treatment and they do not have that money because the medical aid does not cover patients who are treated by us.” (THP 2)

5.7.4 Culture

Some THPs highlighted that it is imperative to co-operate with ROs because in black people's culture some diseases are caused by ancestors and cannot be cured by allopathic medicine. The excerpts in the following statements illustrate this.

“ROs and nurses should be educated that black people will always use TM because of their culture, whether from the chemist or THPs. We need to get together with ROs to discuss that some patients will not be cured because of their ancestors.” (THP 2)

“However, I realised that the patient had refused the amputation because she had trust in me. I therefore told my ancestors about this. I then gave her my own medicine. The patient was cured of the disease in the feet and the cervix.” (THP 16)

As mentioned earlier, any data that did not fit into the framework was not forced by the researcher into the framework for analysis, therefore all the data that remained was analysed thematically as in grounded theory. Analysis began with open coding where transcribed interviews were read and coded line by line to identify descriptions of thoughts and actions. Substantive codes were developed and formulated in the words used by the participants themselves.

As co-operative practice was the phenomenon of interest in this study, it remained the core concept in the framework analysis around which all other concepts revolved. Through constant comparison of substantive codes, similar codes were uncovered and labelled. Substantive codes with the same meaning were grouped into descriptive categories and subcategories. Axial coding revealed one concept that was linked to the concepts in the conceptual framework. Constant comparison between the categories continued until they were theoretically saturated with data that had already been collected. The concept referral emerged and the related subthemes were the description for referral. Reasons for referral were unsatisfied needs, cultural beliefs, word of mouth by patients, the health practitioners refer when a need arises. Non-referral by the health practitioners was a barrier to co-operative practice. This is discussed in the following section.

5.8 OTHER THEMES THAT EMERGED FROM THE THEMATIC ANALYSIS: PATIENT REFERRAL

As mentioned earlier, interview data that could not fit into the conceptual framework was analysed thematically and the theme that emerged was patient referral.

Most participants from the ROs and THPs interviews claimed that there was no collaboration between them because neither group referred patients for treatment. In their understanding, referral of patients leads to a successful co-operative practice between the parties involved. However, they stated that self-referral by a patient could be a barrier to co-operative practice, because it

creates problems between the groups of health practitioners. The following statements illustrate this theme:

“I have not seen too many patients that were referred by THPs. Some patients have told us that they have had treatment before coming to us but we don’t know any details of this treatment like how long it was given. Some patients refuse to have chemo and say that they want to go back to THPs.” (RO 1)

“I do not have any experience of treating a patient that was being treated by a THP and they have not referred any patient to me. ... The problem is that after being diagnosed with the disease they disappear and return when the disease has advanced. This makes it difficult for us to manage the disease.” (RO 2)

“Patients come to me after they were not cured at the hospital. I have noticed that some come with low blood. In that case I refer them back to the hospital to have transfusion.” (THP 1)

“..... I will indicate the problems that I encounter when a patient consults us after having treatment at the hospital. The patients present with an advanced stage and the radiation damages other veins in the body making it difficult for our medication to work on damaged veins and the cancer does not respond to our treatment.” (THP 10)

The THPs participants stated that to remedy the problems with self-referral patients should be guided on how to access both groups of health practitioners if they so prefer, as indicated in the excerpts below.

“To ensure that patients make a decision on which health practitioner treats their cancer, they need to be taught to stop this. Patients should be taught that they cannot use the medicines simultaneously.” (THP 2)

“There is no way that the medication from both health practitioners should be taken simultaneously. It becomes a problem when a patient gets simultaneous treatment. Though patients have the right to access a health practitioner of their choice they still need to be educated that they should not take both medicines simultaneously.” (TPH 6)

According to Carroll, Booth and Cooper (2011: 4), after the themes have been identified and discussed, the researcher interprets the findings by finding a relationship between the themes as they were generated in the conceptual framework developed in Chapter 3. Therefore, in the next chapter the researcher will interpret and discuss the key finding as themes.

5.9 REFLEXIVITY

There are many definitions of reflexivity, depending on the objectives and functions of its application, and the theoretical or methodological traditions encompassed (Finlay 2002: 224). Reflexivity is an integral part of qualitative research (Flood 1999: 35) and is a process where researchers check on their actions and interactions in the entire research project to ensure that the findings are produced with accuracy (Kitto, Chesters and Grbich 2008: 245). Researchers should acknowledge and address the influence of the relationship between the researcher, the research topic and the findings in the research (Malterud 2001; Finlay 2002), recognising that their sociocultural stance and values may influence the choice of research problem, research design, data collection and analysis (Grbich 1999; Finlay 2002). They need to be aware of the social context of the project (Finlay 2002: 221 and Green and Thorogood 2004), ensure proper ethics approval from the relevant committees (Kitto, Chesters and Grbich 2008: 245), and ensure that the relevant community leaders have been consulted to obtain approval for the research (Finlay 2002; Green and Thorogood 2004). Kitto, Chesters and Grbich (2008: 245) encourage researchers to engage in introspection on their actions and interactions in the research process, to ensure that the results are as accurate as possible without any bias.

With regard to reflexivity in the current study, the researcher now discusses the relationship between the researcher, research topic and the participants, to demonstrate how these influenced the results of the study. With 20 years' work experience treating patients with cancer in Radiotherapy and Oncology Department, for her PhD research, the investigator had an interest to explore the area of treatment of patients with cancer. In her work experience, the researcher noticed that patients were defaulting or did not complete treatment. Hence the current topic was selected with the aim of finding a solution to this problem. The researcher was of the opinion that the health practitioners responsible for cancer care, namely, the ROs and THPs who treat patients with cancer, could provide the solution to the problem.

The researcher could access the ROs at ease because of the previous working relationship with them in the Radiotherapy and Oncology Department. With regard to the THPs who treat cancer, access was facilitated by one of the student's supervisors who is running a project involving collaboration between the THPs and AMPs in the treatment of HIV and AIDS. The researcher was invited and introduced to the THPs during the traditional healers' meeting held on 18th of March 2015 in Peitermaritzburg. Through the leaders of THPs in a district, the researcher had several reference points for THPs who treat cancer in several districts within KZN.

The inquirer interviewed the participants in English and isiZulu for the ROs and THPs, respectively. There was no translator required when conducting the interviews because the researcher is fluent in English and isiZulu is her mother tongue. The researcher utilised a phenomenological approach to qualitative research though having no previous experience regarding this approach to qualitative research. The rationale for selecting this method was that Pascal *et al.* (2011) recommended this approach when one requires to understand a phenomenon from lived experiences of people (Pascal *et al.* 2011: 175). The researcher relied on literature and supervisors to ensure that the results were produced with accuracy. Both the supervisors have extensive experience of supervision of masters and and doctoral students in qualitative research and therefore could help by advising the researcher appropriately.

How the researcher ensures rigour in the analysis, the researcher utilised the method of Gale *et al.* (2013: 5-6) and summarised the data during charting, so that the supervisors could verify if data analysis was done appropriately. In the charting, the researcher described the data using each participant's quotes, prior to interpreting the data. The matrix structure was simply structured so that it could simplify the recognition of patterns in the data by the supervisors. It was also not rigid and could be used for both the deductive and inductive analyses, using pre-existing theoretical constructs deductively, then revising the theory inductively to find themes in the data. The framework allowed for an audit trail from original raw data to the final themes by including the clarifying excerpts.

In order to guarantee trustworthiness of the study, the researcher sent raw data for analysis to the supervisors as they are familiar with qualitative research (Creswell 2009: 192). They were provided with a clean set of the transcripts and a copy of the research question, aim and objectives and a guideline of how the researcher analysed the data. The researcher gave them the conceptual framework developed in Chapter 3 and the raw data in order to confirm if the researcher had captured all the relevant information for the themes. Both the supervisors and the researcher reached a consensus through discussion on the themes and subthemes derived by the researcher. Additionally, the researcher obtained clearance from the ethics committee at the university as well as KZN Department of Health to conduct the study at the public hospitals. The eThekweni District of Health gave permission with regard to the interview of the THPs in KZN.

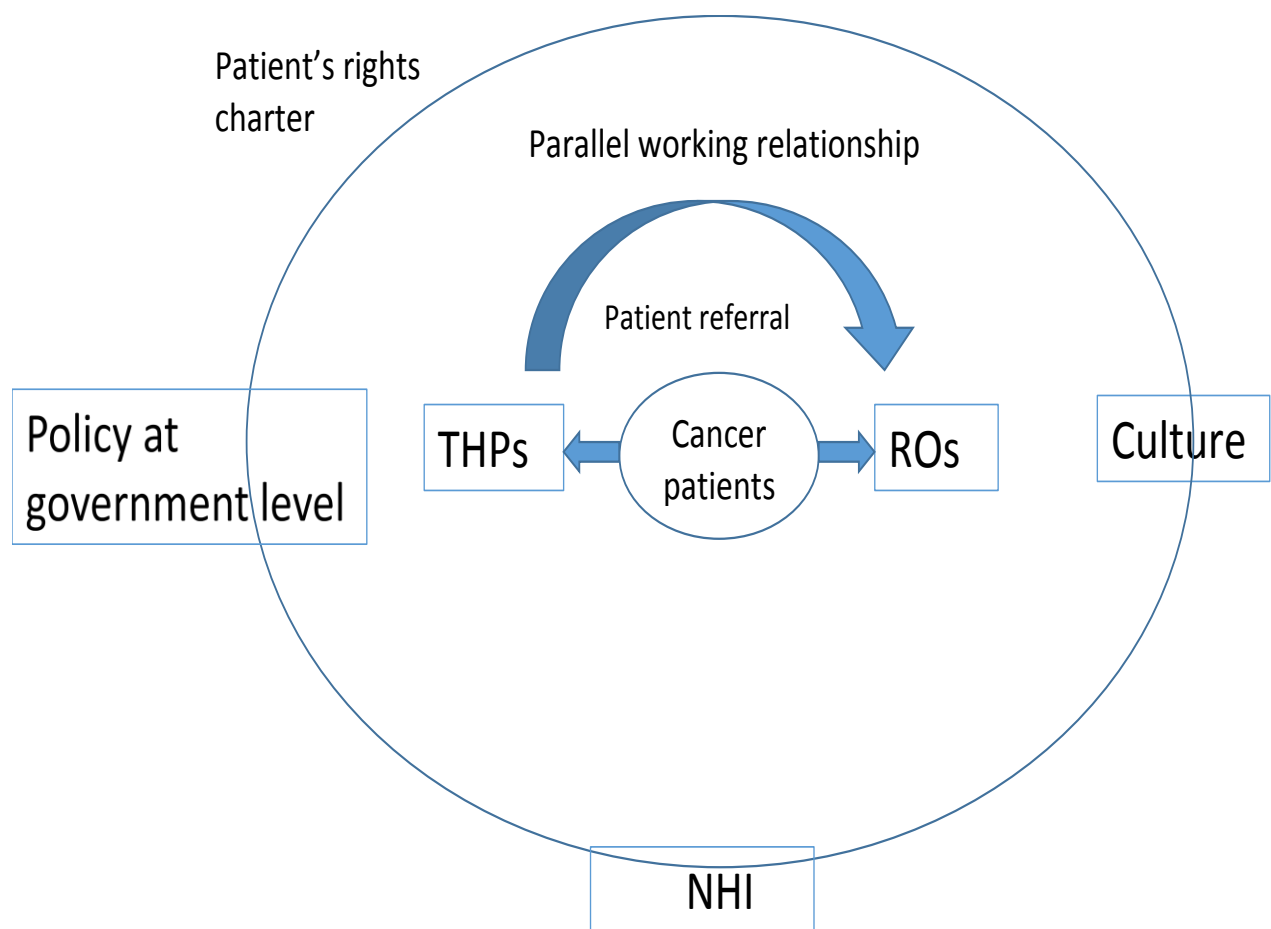


Figure 5.1: Schematic representation of the current co-operative practice between THPs and ROs in the treatment of patients with cancer in KZN, South Africa

5.10 SUMMARY OF THE CHAPTER

This chapter presented the key findings and presented them as main themes and subthemes that emerged in the study. In the next chapter, the investigator will interpret and discuss them. The diagrammatic representation of the co-operative practice between the THPs and ROs in KZN in the treatment of patients with cancer as described by them is outlined in Figure 5.1.

CHAPTER 6 : DISCUSSION OF RESULTS

6.1 INTRODUCTION

In this chapter, the enquirer discusses and interprets the results presented in the preceding chapter. The results are discussed as findings and interpreted in order to develop categories from the data (Creswell 2009: 193). According to Carroll, Booth and Cooper (2011: 4), in the interpretation stage a framework synthesis is utilised to find the relationship between the subthemes that emerged in the data analysis. The framework synthesis approach is used on data which were analysed with framework analysis (Barnett-Page and Thomas 2009; Smith and Firth 2011; Gale *et al.* 2013). This involves primary identification of *a priori* themes against which to chart the data and represent the platform whereupon the findings may be brought together and organised (Carroll, Booth and Cooper 2011: 1).

The discussion is in three sections. Firstly, presentation of the demographic profiles of the participants and the strategy to develop THPs in the treatment of patients with cancer. Secondly, discussion of the results or subthemes as themes and findings based on Table 5.1, as follows: (a) the principles and practices of THPs in the treatment of patients with cancer, (b) co-operative practice between THPs and ROs in the treatment of patients with cancer, (c) barriers to co-operative practice and (d) enablers for effective co-operation. Thirdly, discussion of the results in relation to the objectives of the study, the discussion of reference literature that was used to build the conceptual framework (Roberts 2013: 218), and the new literature found as a result of the themes that emerged through thematic analysis.

6.2 DEMOGRAPHIC PROFILE OF THPS WHO TREAT PATIENTS WITH CANCER

The THPs and ROs are the health practitioners involved in the treatment of patients with cancer in KZN. The 28 THPs who treat patients with cancer and four ROs participants placed at the public oncology hospitals in the province interviewed were all willing to co-operate with each other in the treatment of patients with cancer. Additionally, all were registered with their official statutory body that monitors their professional practices in order to be eligible to practice as THPs and ROs. For example, the THPs affiliated in one of the traditional healers' organisations while the ROs were registered with the Health Profession Council of SA. The demographic profile of each group is discussed below.

6.2.1 THPs

Some THPs indicated that they had workshops on how, and when, to refer patients to the hospitals in the treatment of patients with HIV and AIDS. The researcher noticed that the THPs were categorised into traditional herbalists, diviners and spiritual healers, with the traditional herbalists being in the majority of the traditional healing profession. Though divided into categories, only some of them diagnosed patients, while all of them treated patients with cancer. Truter argued that THPs have unique features, and differ in their functions, and therefore do not fall in the same category although their roles may overlap (Truter 2007: 57). This explains why there were two THPs who overlapped in their functions such as traditional herbalist and diviner or diviner and spiritual healer.

Males were the majority of the THPs and there were 68% males and 32% females in the traditional herbalist and diviner categories, respectively. The findings in the study are in line with findings in the study by Semenya and Potgieter (2014: 8) describing the socio-cultural profile of THPs among Bapedi involved in TM in the Limpopo Province. In their study, there were nearly two-thirds of male participants (Semenya and Potgieter 2014: 6). Similar findings

were reported in previous studies conducted in VhaVhenda in the same province (Bereda 2002; Peltzer 2009; Moeng and Potgieter 2011; Van Rooyen *et al.* 2015). Inconsistent with this are the findings by De Wet, Nzama and Van Vuuren (2012) in Maputaland KZN where females dominated the TM profession (De Wet, Nzama and Van Vuuren 2013: 3). In their study they found that the ratio of females to males was high because most men were employed somewhere else and not living in that area. It would seem that in the current study males outnumbered females because most participants were traditional herbalists who significantly exceeded the female diviners. Also, traditional herbalist as a profession is believed to be a calling for men.

Most THPs were at age 41-60 years (71%), with 14.5% each in the younger and older groups. This finding is consistent with a previous study in KZN where the majority of THPs were in this age group (Ndawonde 2006; De Wet, Nzama and Van Vuuren 2012). There were similar findings in other studies in Limpopo and Western Cape provinces by Semanya and Potgieter (2014: 9), and Mintsu Mi Nzue (2009: 145), respectively. It appears as if this group looks upon traditional healing as a source of income to support their families.

Also observed in this group, most had grade 1-12, with 15% having no formal education. Most of the younger group aged 20-40 years had education grade 7-12 and a diploma while those older than 60 years had 1-7 grade education. It would seem that the younger generation of THPs has better education compared to their older counterparts. The study found that there was a very small percentage of THPs with no formal education. This finding is in line with previous studies in KZN, though much higher percentages were reported, such as 40% (Mthembu 1990: 92) and 64% (Mathibela *et al.* 2015: 5). However, the study is inconsistent with a study by Steyn and Muller (2000: 7) in Atteridgeville, a suburb in Pretoria, Gauteng Province, on THPs who treat patients with cancer. They had slightly different findings in that the bulk of THPs' studied had no formal education, and only a few went up to grade 12 (Steyn and Muller 2000: 5). Mathibela *et al.* (2015: 5) and Semanya and Potgieter (2014: 7) recommended Adult Basic Education and Training (ABET) for THPs to empower them with basic educational skills such as reading,

writing and arithmetic. Mathibela *et al.* (2015: 7) further recommended communication skills for communication with other health practitioners to facilitate collaboration.

The years of experience in practice of THPs participants did not reflect the age structure. Thirty nine percent of the THPs in the age category 20-40 years had 1-20 years of work experience, 42% in the 41-60 years category had between 21 and 40 years of work experience, and 18% of those above 60 years of age had 41–50 years of traditional healing experience. The researcher noticed that work experience was independent of age, as some older THPs had fewer years of experience and vice versa. This finding is inconsistent with findings of the study by Mathibela *et al.* (2015) in Blouberg Village, Limpopo Province. In their study the years of experience that THPs had revealed the age structure in that 29% of THPs had less than 10 years of experience, while 21% had between 11-20 years as THPs and 7% had between 21 and 30 years of work experience. Forty-three percent of participants had above 30 years of traditional healing experience (Mathibela *et al.* 2015: 6).

6.2.2 ROs

The four ROs were of different races with English as their first language and were employed full time in different positions at the public oncology hospitals. The fact that all ROs speak English signifies that patients with no formal education cannot effectively communicate issues of cancer to ROs, thus rendering the THPs as the most appropriate health practitioners to deal with the psychosocial effects of cancer in patients diagnosed with the disease.

In their specific description, the researcher did not disclose the ROs races and positions as this could lead to them being identified. Of the four ROs, three were males and one was female. Their ages ranged from 36 years to 46 years and their work experience in years as ROs was from 5 years to 15 years. The researcher noted that work experience in years is dependent on their age structure.

The researcher observed that there are more THPs (28) compared with ROs (seven) involved in the treatment of patients with cancer in the province. This observation agrees with previous findings that there are more THPs than medical doctors providing health care services in Sub-Saharan countries (Kale 1995; Setswe 1999; Liddell, Barrett and Bydawell 2005; Gqaleni *et al.* 2007). Further, only four of the ROs worked at both public oncology hospitals in KZN, providing oncology services to a population of over 10 million (South Africa Info 2012), In South Africa the ratio of doctors per population is 50:100,000 whereas the minimum requirement is 180:100,000 (WHO 2012: 5) Other studies in economically developing countries with constrained resources (Kingham *et al.* 2013; Morhason-Bello *et al.* 2013) confirm that specialists alone (Oosthuizen and Ehlers 2007; Mokoka, Ehlers and Oosthuizen 2011) manage the burden of cancer. Yang *et al.* (2014: 44) conducted a study in the US to assess the demand for radiation therapy services and the capacity for ROs. They found that there was a severe shortage of ROs. The situation is worse in economically developing countries where there are fewer ROs and a larger population to manage compared with the population in economically developed countries. This is evident from the current study.

6.3 PRINCIPLES AND PRACTICES OF THPs IN THE TREATMENT OF PATIENTS WITH CANCER

How the THPs practice in the treatment of patients with cancer seemed to be influenced by several factors. The themes which emerged from the study with regard to the principles and practices of THPs and ROs in the treatment of patients with cancer are discussed next.

6.3.1 The knowledge of cancer

When the THPs were asked about their knowledge of cancer, they defined and explained how they recognise cancer. Almost all THPs defined cancer as a sore which does not heal but continues to grow and invade surrounding tissue. Some further indicated that it continues to bleed, and the patient may

have a bad odour, while others mentioned that the bleeding may result in a clot which manifests itself as cancer. Others defined cancer as any sore that does not heal and cannot be treated successfully by the hospital. A few stated that cancer is a virus. The researcher noticed that THPs use many terms such as a sore and virus when referring to cancer. Consistent with this observation, the theory of cancer describes cancer as a virus, fungus, mould, acid-fast bacteria or amoeba (Kehr, n.d: 20). Goepel (2012: 269) defines cancer as an abnormal growth of cells which continue to grow if not removed.

According to Ragosta *et al.* (2015: 70), a herbalist in Ghana describes cancer as a sore that does not heal and grows outside when in an advanced stage, but grows inside in an early stage. Additionally, a study by Steyn and Muller (2000) in Atteridgeville, Gauteng Province found that THPs utilise terms such as “*sefolo, sesepidi, umdlavuza, le thala, thosola, seso, nyamakazi, fokozani, emfokozane, umhlavosi, imvelase* and *thlagala*” meaning growth, lump or a sore which does not heal (Steyn and Muller 2000: 2).

THPs indicated that patients with various cancers present with menstrual bleeding for more than five days, painful breasts with oozing pus, fatigue and loss of weight. According to Kunkler (2012: 435), some patients with advanced breast cancer present with a painful breast, weight loss and tiredness. This indicates that THPs are consulted by patients with advanced stage cancers. This finding is consistent with the study by O’Brien *et al.* (2012), where they found that the majority of cancers seen by THPs are visible, bleeding and in an advanced stage (O’Brien *et al.* 2012: 6). Seemingly, THPs are able to notice the signs of cancer which can be seen when the disease has advanced.

Most THPs stated that cancer grows anywhere in the body and may grow in the breast, cervix, prostate, bladder, lungs, kidneys, mouth, colon, throat and vagina. The most common cancers that they are consulted about are those of the breast and cervix. This finding indicates the different types of cancers that are prevalent in KZN. According to the Cancer Association of South Africa (2015: 2-3), these are among the top ten cancers in black males and females

in the country, with breast and cervical cancers being the top two in the list. This indicates that THPs have the potential of alleviating the burden of cancer treatment in patients diagnosed with cancer of the breast or cervix.

Furthermore, some THP participants held the view that cancer may spread to other organs such as brain, bones and spine. One mentioned that a patient told them that it often recurs following incomplete treatment. According to Goepel (2012: 273), cancer at an advanced stage may spread to organs such as brain, liver, lungs and bones. Also, previous studies found that some cancers may recur after treatment (Anders and Carey 2010; Moreno-Smith, Lutgendorf and Sood 2011), therefore impacting negatively on the quality of life of the individual affected by the disease. The findings in this study support these facts and are similar to those in a study conducted by Berger-González, Renner and Gharzouzi (2016: 3) in Guatemala amongst Maya THPs, which explored their conception of cancer. The study found that some characteristics of cancer as described by the THPs resemble those in AM oncology, in that they believed that cancer is caused by a human papillomavirus and is hereditary. According to Berger-González, Renner and Gharzouzi (2016: 9), these cross-cultural definitions emerged as a result of the healers' association with cancer patients who have not completed their treatment in the public hospitals. The finding in this study supports this opinion, in that some THPs indicated that patients told them that cancer can recur after treatment. It would seem that all the information about cancer is from the patients because the THPs cannot diagnose patients with cancer.

With regard to the cause of cancer, THPs stated that cancer is caused by some types of foods that the population consumes which includes chemicals, and viruses. A few mentioned that some cancers are as a result of ancestors. These findings are consistent with the facts that diet and chemicals such as asbestos and the HIV virus influence formation of cancer (Hole and Symonds 2012: 139). Also, according to Peltzer (2009: 956), TM practice is about determining the cause and ascertaining who would have caused an illness. This supports the belief of THPs that some cancers are caused by ancestors.

6.3.2 The diagnosis of cancer

THPs diagnose cancer by various means, including: using ancestral power; depending on the signs and symptoms of cancer; having the patients tell them that they have already been diagnosed with cancer. However, they do not commence treatment until the diagnosis of the patient has been confirmed by the hospital. They also indicated that they rely on the hospital to transfuse patients or stabilise patients who are pale or weak. The study found that the THPs cannot diagnose cancer, especially early stage cancer, but rely on hospitals for this. This finding is in line with the study by Ragosta *et al.* (2015: 10) who found that cancer diagnoses were based on patient observations and sometimes confirmed by physicians. Findings of the study by Berger-González, Gharzouzi and Renner (2016: 7) are different to this study in that those researchers found that healers did diagnose cancer, employing various traditional methods to diagnose their patients, but they warned that this approach led to the possibility of misdiagnosing patients.

The THPs indicated that once the diagnosis of the patient has been confirmed, they involve the patient in the decision making process regarding their treatment of choice. They inform the patients not to consume treatment from TM and AM simultaneously until after the completion of the initial treatment. If the patient is already on hospital medication, they tell the patient to stop the medication before they can start treatment with the TM. The researcher found that the THPs are against simultaneous consumption of the TM and the AM treatment. This practice has the potential to facilitate effective collaboration between the THPs and ROs because one health practitioner is responsible and accountable for a patient at a particular time. Previous studies reported that medical doctors are not willing to co-operate with the THPs in the treatment of patients, because with the implementation of NHI the doctor can be sued as an individual when the treatment has gone wrong (Rowe and Moodley 2013: 7).

6.3.3 The treatment of patients with cancer

With regard to treatment, all THPs asserted that they treat their patients utilising TM prepared from medicinal plants which is administered orally. None of them mentioned any adverse side effects as a result of their treatments. The study observed that many THPs from African countries, of which South Africa is one, use TM prepared from medicinal plants, and often their medicines do not have side effects. This finding confirms findings from previous studies from economically developing countries in Africa (Kamatenesi-Mugisha *et al.* 2008; Cheikhyyoussef *et al.* 2011; Semanya and Potgieter 2014: 9) and Malaysia. In Malaysia, a study found that TM is prepared from medicinal plants which are easily available to the community and most patients prefer herbal medicine (Mahomoodally 2013: 9). Often there are no antagonistic side effects of treatment when using herbal medicine in the treatment of cancer (Oyedemi, Bradley and Afolayan 2009; Ragosta *et al.* 2015). In order to protect the intellectual property of participating THPs, the researcher did not ask them about the type of plants used in the treatment of cancer.

TM treatment lasts for 3-5 days for early stage cancers and up to 3 months for advanced cancers after which the patient is referred to the hospital to check the response of the cancer to the treatment. The researcher also noted that THPs claim that their role is to cure cancer and alleviate pain associated with cancer. However, they do not follow up their patients after treatment and they could not produce any patients that they have treated successfully. They stated that they have difficulty following up patients because some patients do not return to give feedback for unknown reasons. They said that to improve the situation they would keep records of their patients' details so that they could contact those who do not come back for follow up after having received treatment. The patients' details they would record would be name, age, contact details, next of kin, diagnosis and the treatment given to the patient.

The THPs indicated that they consider their treatment to have failed if the symptoms of the cancer persists after completion of three to five days and up to three months of treatment for early and late stage cancers, respectively. They attributed failure in their treatment to ancestral spirits wanting the patient to be a traditional healer, previous treatment with radiation, patients presenting with an advanced cancer, or not completing treatment.

The researcher noted that THPs use different treatments for early stage and advanced cancers, yet they cannot describe or diagnose early stage cancer. Furthermore, they claim to cure cancers which are in an early stage. This finding is inconsistent with the findings in the study by Steyn and Muller (2000) which aimed to explore the possibility of collaboration between THPs and medical doctors in Atteridgeville, Gauteng Province. They found that THPs could be involved in cancer management as complementary medicine practitioners by diagnosing early stage breast cancer and preventing cancers by educating the public on diet (Steyn and Muller 2000: 6). The current study found that THPs claim to use alternative (not complimentary) treatment in cancer management.

Some THPs indicated that not all patients can be treated successfully. They asserted that they were previously trained to refer the patients to other THPs or the hospital if they could not cure them. They judge the success of treatment if the patient informs them that the symptoms of cancer have disappeared. They claim that they successfully treat cancers of the cervix and breast. However, advanced stage cancers and those with prior treatment by radiation therapy, are incurable. Following this, they prefer that if patients present with with early stage cancer and opt for combined treatment by THPs and ROs, THPs should be the first to provide treatment. A further study is needed to get the opinion from cancer survivors in KZN about the role of THPs in the treatment of cancer patients.

According to Kunkler (2012: 435), a lump in the breast can be detected at an early stage by an individual patient if they have properly trained themselves to do breast self-examination. Therefore, THPs should not be involved in

detecting breast cancer at an early stage because the researcher believes that only the patients themselves with proper training in breast self-examination, are able to find a lump in their breasts. This misconception reflects the desperation of THPs to participate in the treatment of patients with cancers.

6.3.4 The evaluation of treatment

The evaluation of treatment once treatment has been completed is weak. The researcher noted that THPs faced a challenge of losing some patients on follow up. According to the THPs, causes included patients avoiding payment of THPs' medicinal fees, failure of the treatment, or no valid reason. The researcher noted that these are speculated reasons because the reality is that they do not have a method for follow up on their patients. This is confirmed by their suggestion that they need to keep records of personal details for all patients who consulted with them to enable them to contact all patients after the completion of treatment. Therefore, a study is needed to establish the reasons for patients not reporting back after treatment by THPs.

With regard to the principles and practices of THPs in the treatment of patients with cancer in KZN, the study included registered THPs who treated patients with cancer only from KZN, and generalisation to other provinces in SA should be considered cautiously. The following observations were noted in the study:

- 1) THPs have a good knowledge of cancer. They have described cancer, its behaviour and presenting features as described by AM, but lack knowledge of the early stages of cancer. Instead they identify cancer by its visible signs and still require confirmation of the diagnosis by the hospital. Despite this shortcoming, patients with both advanced and late stage cancers continue to seek cure from THPs, indicating their trust and belief that the patients have in THPs. It may prove useful for THPs in KZN to be made more aware of the early signs and symptoms of locally predominant cancers in order to improve the early detection of cancer.

- 2) Although some THPs can diagnose cancer, they do not rely on their diagnosis but require the hospital to confirm the diagnosis before commencement of treatment.
- 3) The THPs claim that their role is to cure and alleviate pain in patients diagnosed with cancer. However, this claim will remain controversial until there is evidence based practice. Of significance, THPs have a reasonable duration of treatment in which to see results of treatment on the cancer patients; hence the referral of these patients to hospital will not delay the commencement of treatment by the ROs. They represent an available and accessible cancer treatment resource in the province, and with education and training, they can alleviate the burden of cancer. THPs are aware of some of the factors for cancer. Therefore, with education on more risk factors, their role could be extended in cancer prevention by advising patients on the types of foods the community can consume or avoid in order to reduce the incidence of cancer.

The WHO describes TM as a means to ensure holistic health care for patients (WHO 2002: 13). THPs offer information, counselling and treatment to patients and their families in a personal manner as well as having an understanding of their patient's environment (Gurib-Fakim 2006; Gurib-Fakim and Mahomoodally 2013). A study by Campbell and Amin (2014) observed that THPs have deep, inside knowledge of the spiritual needs of their patients, and awareness of cultural practices relating to illness, death, dying and bereavement, therefore they could enrich palliative care (Campbell and Amin 2014: 8). Further research is needed to confirm this potential role of THPs in patients with cancer in KZN.

However, it is not known to what extent this role can form part of the national health system. Consequently, the health practitioners in the national health system have wrestled with the issues of the role and practices of THPs in the treatment of cancer. It is imperative to note that TM's belief systems of sickness and health vary from region to region, and even within the same communities of different languages (Richter 2003: 13). Consequently, the role

and practices of THPs vary in the same country in the different communities. For example, TM practice of THPs in KZN is dissimilar to that in Limpopo. Therefore, THPs' practices and roles in the treatment of cancer will vary and therefore cannot be generalised. In KZN rural areas, palliative care is frequently provided by volunteer caregivers with basic training in palliative care due to shortage of professionally trained healthcare workers (Campbell and Amin 2014: 2).

The current study has provided a step forward with regard to the accreditation of THPs as it has provided the relevant information. According to Peltzer (2009: 957), the establishment of Traditional Healers Act was intended to provide accreditation to THPs, however there is a delay in this process due to diverse diagnostic classifications, therapeutic methods, or curriculum to qualify THPs. The current study found that THPs rely on the hospital to diagnose patients, and that they use medicine prepared from plants in order to treat patients with cancer. Seemingly, THPs are experienced in treating patients with breast and cervical cancers.

4) THPs identified a need to follow up their patients post treatment in order to evaluate their treatment. The response of cancer to treatment depends on the feedback provided by the patients. It is therefore imperative to have this feedback in order to decide whether the patients require referral for further treatment or if the cancer has been cured. Nonetheless, most patients are lost on follow up due to reasons such as outstanding fees for THPs, and the cancer not being cured. This may be the reason why THPs could not showcase the patients that they have treated successfully. To remedy this, they should take initiative in following up patients if they don't show up to provide feedback on treatment. It is thus vital to keep records of patients containing patients' diagnosis and contact details in order to facilitate the follow up.

6.4 DEVELOPMENT OF THPs IN THE TREATMENT OF PATIENTS WITH CANCER

The THPs already seem to be a fundamental constituent of the health care system in SA and other resource-constrained countries in Africa. It is necessary to develop them in order to benefit the community whose beliefs of healing are embedded in TM or trust TM to have the potential to cure cancer. The following skill developments are crucial to develop THPs in the treatment of patients with cancer.

- Basic educational skills such as writing and reading in order to broaden their knowledge regarding conservation issues related to protected and threatened species, and medically-related issues such as diagnoses and treatment of ailments. Furthermore, writing will help equip THPs with the skill to document and safeguard their own knowledge thus help prevent erosion of medicinal plants and support conservation of natural resources in their areas. Greater levels of education and consequently awareness could contribute to the long term sustainability of this important profession (Mathibela *et al.* 2015: 6). It is crucial that they learn arithmetic as people who are in business. A study by Steyn and Muller (2000: 8) which explored the possibility of integrating THPs into the modern in an endeavor to combat cancer highlighted the need for using pictures, illustrated pamphlets, magazines, and other material that was simple to understand so as to suit the level of education of a THP.
- Communication skills for when they interact with ROs or their patients and other stakeholders, including how to communicate via cell phones. This should include English because this is the communication medium with ROs. However, the ROs should also learn isiZulu so that the two groups can understand each other when communicating while collaborating, as well as so that ROs can communicate better with their patients. They also need training on how to correctly publish their traditional healing knowledge in order to safeguard their intellectual knowledge.

- Knowledge of diet and other chemicals that have the potential to cause cancer. As THPs are easily accessible and readily available for the communities in rural areas, this knowledge can be imparted to the population thus help to reduce the incidence of cancer.
- Knowledge of signs and symptoms of advanced cancers. A few THP participants in the study indicated that they check the response of patients to treatment by asking them about the symptoms of cancer. This is done in the second day or at the end of treatment. If the response is good, they continue with the treatment until its completion. Others complete the treatment first before checking the response to treatment. If the response is good they consider their treatment to be successful, and vice versa. However, if there is no response to treatment, they refer the patient to other THPs or the hospital for further treatment. The study observed that THPs do not follow up patients after completion of treatment. This finding is not supported by the study by Weaver *et al.* (2014) on follow up care experiences in patients with cancer. Steyn and Muller (2000: 8) highlighted the need for using pictures, illustrated pamphlets, magazines, and other material that was simple to understand and which would suit the level of education of a traditional healer.
- The study found that continuous follow up after cancer treatment is a fundamental part of cancer care in early and advanced stage cancers in order to prevent, detect and manage cancer recurrence, second cancers, late and long-term effects of treatment and psychosocial impact (Weaver *et al.* 2014: e235). The rationale for THPs not to follow up their patient, could be attributed to their belief that they have cured the patient, or do not have anything to do with the patient because the patient is in the care of another health practitioner.
- Other THPs refer the patient to the hospital post treatment to check if the patient has been cured of the disease, despite having been assured by the patient that the symptoms of cancer have disappeared. Some

highlighted that some patients do provide feedback after confirming that the disease has been cured, while others do not. They indicated that this is caused by many reasons such as ignorance, patients not having money to pay for the services rendered, or not having been treated successfully by the THPs. Most THPs highlighted the importance of keeping records of patients with patient information such as the name, age of the patient, gender, diagnosis, both physical and postal addresses, as well as cell and telephone numbers. Information of the next of kin such as the name, relationship with the patient, contact details should also be kept in order to facilitate follow up in case the patient is not available upon follow up.

According to Beach and Oates (2014: 45), patients' records provide evidence regarding the care and treatment patients receive, progress notes, assessments and care plans, letters written to and about patients, and written communication between health practitioners about patients. The authors further maintain that they are also clinical tools, enabling continuity of care and appropriate decision making about future care and treatment. The HPCSA requires all health practitioners to keep patient records as a means to show life-long commitment and dedication to sound professional and ethical practices in the interest of the patients (HPCSA 2008: 1). The majority of THP participants expressed a desire to receive training on record keeping.

6.5 CO-OPERATIVE PRACTICE BETWEEN THPs AND ROs IN THE TREATMENT OF PATIENTS WITH CANCER

Williams and Sullivan (2007: 15) assert that the need for co-operative practice and integration of health systems of different disciplines arises from challenges facing the public policy system which include fragmentation of public services, limited financial resources, decentralisation, and globalisation of policy issues. The results of the study showed that interpreting and or operationalizing co-operative practice in cancer treatment depends on a number of factors including:

- Relationship between the health practitioners;
- Collaboration;
- Communication;
- Trust;
- Respect;
- Team;
- Patient participation;
- Government's mandate;
- Patients' rights charter;
- Referral;
- NHI; and
- Culture.

The THPs and ROs interviewed, indicated that the government mandated them to work together, and patients' rights provided them with the right to access a health practitioner of their choice, according to their culture. They indicated that when patients exercise their rights they move freely between health care providers. Some patients refuse treatment with chemotherapy and seek further treatment from the THPs. In so doing, they interrupt treatment. Ng *et al.* (2012: 14), in their study on defaulters among lung cancer patients in a suburban district in an economically developing country, found that some patients with lung cancers had interruptions in their treatment. The reason for this, is that they refused further treatment as a result of side-effects from chemotherapy, and sought treatment with traditional healers. The interruption of treatment was a concern for the ROs.

The THPs indicated that patients referred themselves to them because they trust that THPs could cure their disease. However, when they do not find cure or relief from the treatment, they refer themselves to any health practitioner. They indicated that not all patients who have referred themselves to THPs could be treated successfully and that they would like to refer such patients to the ROs. However, patients refer themselves to the ROs while on TM and consume both medicines simultaneously. As indicated earlier, THPs believe

that consumption of both TM and AM during treatment, affects the outcome of their treatments.

Following these concerns from both THPs and ROs interviewed in the study, there is a need for them to work together in order to improve the outcome of their treatment and enhance survival of patients with cancer. However, they operate in an environment where they do not interact with each other. They indicated that they have not interacted with each other because they do not refer patients to each other. The researcher observed that the rationale for not referring patients to each other, is that they do not trust and respect each other. The ROs believe that THPs' medicine cannot be used in the treatment of patients with cancer because their practices are not evidence based and do not have a role in cancer treatment. Similar findings were reported in Van Rooyen *et al.*'s (2015) study on AMPs and THPs' collaboration regarding the legalisation of traditional healing in South Africa. They found that both sets of health practitioners experienced negative attitudes towards each other. The unscientific methods used by THPs in treating patients, and THPs' postponements in referring patients to the hospital, were some of the reasons mentioned by AMPs for their negative attitudes (Van Rooyen *et al.* 2015: 7).

The THPs in the current study voiced concerns regarding the ROs non-referral of patients to them. Some THPs acknowledge the practices of the ROs in the treatment of cancer while others are of the opinion that the ROs are unable to treat patients with cancer successfully. The findings in this study are similar to those of a study by Mngqundaniso and Peltzer (2008), who investigated collaboration between traditional health and biomedical healthcare systems, as viewed by the nurses and THPs in KZN. The study found that the two health professions had mixed attitudes towards each other, mostly negative (Mngqundaniso and Peltzer 2008: 386). Nurses were of the opinion that THPs lack training, use expired medicines, administer incorrect dosages, and have improper records of patients. On a positive note, they believed that THPs contribute to the management of infections associated with HIV and AIDS. The THPs assumed that nurses undermined their work

and subsequently did not refer patients (Mngqundaniso and Peltzer 2008: 385).

As a result of this antagonistic relationship between the THPs and ROs, the two are operating in parallel and do not communicate. The researcher observed that patients with cancer move freely between health practitioners by referring themselves to a health practitioner during or after treatment with the other group, and therefore consume both TM and AM. This observation is supported by a study by Appelbaum *et al.* (2015) on concurrent use of TM and anti-retrovirals (ART) in KZN. The study found that AMPs felt that patients who used TM to treat or 'cure' HIV did so out of desperation, or due to lack of knowledge about the efficacy of this medicine. Many of them were of the opinion that patients utilised TM in the treatment of HIV because they do not understand the disease and how TM works in the treatment of HIV and AIDS (Appelbaum *et al.* 2015: 7). Contrary to this, they believed that the use of TM is cultural and an African identity, hence some patients believed that it is acceptable to consume both medicines simultaneously.

When the patients refer themselves between the health practitioners, they sometimes inform the health practitioners, but do not provide full details of their treatment from the other party, while some do not communicate any information about treatment from the other health practitioner. The two groups of health practitioners provide their services in parallel and rigidly subscribe to their practices only.

The THPs highlighted that patients consult with them when they do not want additional treatment with chemotherapy, fear the mutilating effects of surgery, experience a delay in commencing allopathic medicine treatment, treatment by ROs is unsuccessful, and when there is no pain relief from the treatment. Both the THPs and ROs believe that patients seek cure from them when treatment by the other party has failed. The study found that patients refer themselves to either THPs or ROs while being managed by the other. This finding is supported by the study by Abubakar *et al.* (2013) who explored the socio-cultural determinants of health-seeking behaviour on the Kenyan coast.

The study found that a sick person may consult a THP or AMP while on treatment if there is no improvement (Abubakar *et al.* 2013: 2). Another study conducted to contextualise integration of TM and AM health systems found that patients move between TM and AM health systems, using both systems simultaneously to search for a diagnosis, healing or other services (Adams *et al.* 2009: 793).

The THPs claim to have been referring patients to the hospital to confirm the diagnosis of the patient and for further treatment when their treatment is unsuccessful. The researcher observed that they were in fact not referring these patients to the ROs because the THPs and ROs at the hospitals do not know each other. This observation is not supported by the study of Peltzer, Mngqundaniso and Petros (2006) on HIV, AIDS, sexually transmitted infections and tuberculosis knowledge, beliefs and practices of THPs in KZN. Their study found that more than 50% of THPs were already involved in the referral of patients to the hospital for HIV testing and management (Peltzer, Mngqundaniso and Petros 2006).

The team of health practitioners does not have control over the self-referral of patients between the THPs and ROs, because the patients' rights charter provides for patients to consult a health practitioner of their choice for healing. The study found that when patients refer themselves between the THPs and ROs, they interrupt treatment, delay the start of treatment, and do not complete treatment leading to poor treatment outcome and diminished survival. This finding is consistent with findings in the study by Campbell-Hall *et al.* (2010) conducted with main health care providers and service users in one typical rural South African health sub-district. The study found that patients who consume both TM and AM by moving freely between these treatment modalities, do not adhere to treatment (Campbell-Hall *et al.* 2010: 622).

This is a concern for both sets of health practitioners because they are aware that patients have rights to consult with a health practitioner of their choice. They are mandated by the government to work together, and they are

determined to cure patients with cancer. The study found that they were willing to discuss how to co-operate in the treatment of patients with cancer. This finding is consistent with the finding of a study by Campbell-Hall *et al.* (2010: 623), who explored the ways in which collaboration could be improved in the provision of community mental health services in South Africa. Their study found that the THPs were open to training in AM methods and to form collaborative relationship in order to improve the care of patients, whereas the AMPs showed no interest in collaboration (Campbell-Hall *et al.* 2010: 623). Consistent with the findings in the current study, is the study conducted in Ghana on the role of THPs in cancer management by O'Brien *et al.* (2012: 7). These researchers found that the majority of THPs showed interest in training and willingness to collaborate with AMPs to share knowledge and integrate medical practices in the treatment of patients with cancer. Furthermore, a study by Steyn and Muller (2000) conducted in Atteridgeville, Gauteng Province, to explore the opportunity of integrating TM into AM in order to fight cancer, found that the majority of THPs favoured co-operation while a minority opposed it (Steyn and Muller 2000: 8). The THPs in favour of co-operation, recommended that the TM and AM health practitioners should share information and the AMPs should teach the THPs their practices in cancer treatment.

All the THPs in the current study are willing to work together with ROs and share knowledge in order to enhance the treatment of patients with cancer. These health practitioners could therefore be seen as an important service delivery resource in the health care system, and certain tasks such as prevention of cancer, early detection tasks and treatment of cancers could be shifted to them thus maximizing the utilisation of ROs in the treatment of patients with cancer in KZN. Also, they showed willingness to receive continuous education to expand their medical knowledge.

The current study is the first of its kind in Africa where the AMP specialists, the ROs, were interviewed to provide their opinion regarding co-operation in cancer management and to explore the opportunity of integrating TM and AM in the treatment of patients with cancer. This study will therefore describe the

co-operative practice as understood by the THPs and ROs in the treatment of patients with cancer in KZN. In the following section, the researcher discusses the concepts that describe co-operative practice between the THPs and ROs.

6.6 CONCEPTUALISATION OF CO-OPERATIVE PRACTICE

Effective co-operative practice is organised according to the needs of the population it serves, considers how local health care is delivered, and depends on the readiness of the parties involved in the co-operation, institutional support, working culture and environment (WHO 2010b: 28). Inter-organisational relationships between parties have become popular internationally in the health sector, with the objective of providing continuity of care to patients. There are many terms such as collaboration, co-operation, co-ordination, partnership, alliance, and joint working that are used to define the relationship (Williams and Sullivan 2007: 16), but there is no universally acceptable word. Different people often use these words interchangeably when they mean different things. Williams and Sullivan (2007: 16) assert that the definition of these terms often reveal conceptions of collaboration as an organisational form. The most common word to define the relationship of professionals in different disciplines is 'collaboration'.

D'Amour *et al.* (2005: 116) point out that the word 'collaboration' in the context of health practitioners expresses the notion of sharing and denotes collective action aimed at a common goal, in harmony and trust. The same authors maintain that collaboration denotes a type of interaction which has partial understanding of the complication of relationships between health practitioners. The concepts associated with collaboration denote collaboration as a multifaceted and vigorous process encompassing numerous skills. Lawrence, Phillips and Hardy (1999: 481) explain that collaboration is a co-operative and interorganisational relationship that is negotiated through continuous communication. This term is thus used in numerous ways and has different meanings but can be understood by analysing its related concepts (D'Amour *et al.* 2005: 126).

Authors differ regarding what they regard as the main concepts and processes involved in collaboration. Additionally, the definitions of collaboration do not distinguish between its determinants, processes and its results. Ultimately, frameworks of collaboration are used to address matters related to the structure of the team and the settings of collaborative activities, instead of addressing the processes involved in collaboration (D' Amour *et al.* 2005: 126).

To understand co-operative practice in the current study, the researcher reviewed several concepts from the conceptual framework developed in Chapter 3, in order to determine the elements of collaboration and the relationship between them. The theoretical framework of Certified Nurse-Midwife, Physician and Client Collaborative Cycle (Miller 1997) was used to understand the co-operative practices between the THPs and ROs in the treatment of patients with cancer. This framework describes the external conditions, individual attributes, organisational dynamics, trusting attitudes and philosophy of practice; hence, it is suitable to describe the environment in which collaboration exists, identify the barriers and enablers for effective collaboration and build an environment conducive for collaboration. The five conceptual categories for understanding co-operative practice that emerged from the data analysis process, were relationship, collaboration, team, patient participation, and referral of patients. These are discussed later in this chapter.

The findings in the current study reveal that the THP and RO participants understood co-operative practice differently. They expressed different views regarding the process of integrating their practices. The researcher noted that the participants used the terms “work together”, “get together” and “interact” interchangeably, yet their understanding of these terms had different meanings for different participants.

They described their current practice in the treatment of cancer in terms of the interaction and referral of patients between them and identified the need for co-operation between their practices. Both groups indicated that their patients

consume both TM and AM thus interrupting treatment as they move freely between the health practitioners. However, they recognized that patients have a right to consult a health practitioner of their choice. There is therefore a need to collaborate in order to provide continuity of care for patients. As mentioned previously, in 1994 the SA government mandated the two health practitioner groups to work together in order to strengthen the national health system.

The THP and RO interviewees indicated that continuity of care for a patient requires co-operation between the THPs, ROs and the patient. In the next section the researcher discusses the following concepts: relationships, collaboration, team, and patient participation in co-operative practice between the THPs and ROs in the treatment of patients diagnosed with cancer. The researcher also discussed the five conceptual categories for understanding co-operative practice that emerged from the data analysis.

6.6.1 Relationship

The THP and RO interviewees indicated that they do not know each other, and have not interacted or referred patients to each other. The researcher noted that for effective co-operative practice the parties should know each other, communicate, interact, refer patients to each other, and work together. In this way, patients would complete treatment before referral to the other health practitioner. The THPs indicated that they needed a relationship with the ROs so that they could know them and be able to refer their patients to them to confirm the diagnosis of a patient before commencing treatment, evaluate their treatments of patients, and for further treatment if their treatment is unsuccessful.

On the other hand, the ROs did not indicate a need to refer their patients to the THPs but did want to provide continuity of care to patients. According to WHO (2002: 9), a country's healthcare system which recognises TM but is not yet fully integrated into all aspects of healthcare, is an inclusive one. This is the case now in South Africa in that TM is unavailable at hospitals and is not

covered by the NHI. Nonetheless, the parties in the relationship are expected to reach full integration in future. Both the THP and RO participants highlighted that the relationship involves both parties, with the patient playing a major role in the relationship. In the following section the subthemes in the relationship are discussed.

6.6.2 Collaboration

Collaboration is a systematic effort to produce effective results in patient care, hence it consists of inputs, processes and outputs. The inputs are the organisational, professional and structural factors that affect the process. The outputs are the team's efficiency (Miller 1997; Corser 1998; West, Borrill and Unsworth 1998; Sicotte, D'Amour and Moreault 2002).

In order to conceptualise collaboration, one needs to take into account the environment of collaboration, the processes in terms of human interactions, and the outcomes (D'Amout *et al.* 2005: 125). D'Amout *et al.* (2005: 116) maintain that collaboration as a form of an interaction which refers to collective action oriented toward a common goal in a harmonised and trustworthy environment for the health practitioners. Collaboration is a strategy to ensure that there are no interruptions in the treatment of a disease; continuity was acknowledged as a common theme among the THPs and ROs participants. They understood collaboration as the combined practices offering diagnosis and treatment to patients through interaction and referral of patients.

For effective collaboration, the parties acknowledged that the relationship amongst the parties in the collaboration should be healthy. This will facilitate communication and referral of patients between the health practitioners. In so doing, patients will not refer themselves between the health practitioners, though they have right to do so. The THPs indicate that the patients should follow proper channels of communication if they want to be referred to another health practitioner. They indicated that the patient should inform the doctor concerned and his/her family as well and sign documents to that effect, before

any referral can be affected. They should inform the health practitioners of their treatment with other practitioners. In so doing, the patient is required to provide detailed information about treatment such as type of medicine and duration of treatment. Patients play an integral role in decision making with regard to the choice of treatment and therefore their decisions should be respected.

The THPs indicated that such collaboration can occur in an environment where there is harmony, trust and respect amongst the parties in the co-operative practices, despite the different levels of education. The ROs and THPs need to recognise each other's skill and acknowledge failure in treatment in that they cannot always treat all patients with cancer successfully.

6.6.3 Team

The THPs and ROs envisaged being a team working in harmony and in a coordinated manner though working in parallel with each utilising their competencies in the treatment of patients. This should function in an environment where each health practitioner and team member respects and trusts each other.

6.6.4 Patient participation

Patients are at the centre of, and the main actors in, the collaboration between the THPs and Ros, and should be assigned the following responsibilities:

- Decision making regarding the choice of treatment, the type of health practitioner to treat them and referrals, based on training on the roles of THPs and ROs and how they will be referred between them.
- Coordinate the activities of the health practitioners in referrals.
- Update the THP or RO and family regarding any changes in treatment.

6.6.5 Referral of patients

The principle of referral requires health practitioners to develop on an individual practitioner and unit basis, and on an organised basis between representative societies, a system for referral of patients (Janse van Rensburg *et al.* 2014: 43). The term 'proper referral' in this study means intervention strategies that focus mainly on setting up a communication channel that will ensure proper referral of patients, whether they access both health professionals simultaneously or consecutively.

The findings in the current study showed that co-operation between THPs and ROs demands cross referral of patients with cancer for effective joint care. A study by Devenish (2005: 250) reported that the Department of Health supports co-operation but condemns referral from AM to TM essentially due to lack of research and regulation of dosage and efficacy of traditional treatment. As a result, AMPs are reluctant to recommend THPs to patients (George, Chitindingu and Gow 2013: 5).

According to Peltzer (2009: 957), the AM health practitioners do not refer patients to THPs despite the general policy in place to affect collaboration between the two health practitioners, because the Department of Health does not approve of referrals due to concerns of safety and efficacy of TM. A study by Gqaleni *et al.* (2011) on the referral system between THPs and local clinics in KZN, found that collaboration between THPs and the staff at clinics and hospitals was difficult in the beginning because the two systems were suspicious of each other (Gqaleni *et al.* 2011: 7). However, after learning about each other's practices, mutual understanding was established. The findings in the current study confirmed that AMPs do not refer patients to the THPs and they indicated that they would not refer patients to the THPs.

Evidence-based practice is a priority to effect referral between the two groups of health practitioners. The findings in the current study supported this, as both the THPs and ROs unanimously suggest that evidence-based practices of THPs should be established in order to ensure the safety and efficiency of

their medicine in the treatment of patients with cancer. This should be a priority before any referral of patients.

The participants listed the following strategies as a means of ensuring proper referral of patients between the health practitioners: (a) involve the patient in decision making regarding the choice of treatment, (b) a list of health practitioners involved in cancer treatment should be available, (c) knowledge and role of THPs in the treatment of patients with cancer should be available, (d) both parties should be transparent with regard to their practices in the treatment of patients with cancer, (e) trust among all parties, (f) sharing of information and knowledge in order to develop trust, (g) sharing of responsibility, (h) mutual respect for the expertise of all members of the team and this respect is communicated to the patients, (i) two-way communication to facilitate sharing of patient information and knowledge, and (j) co-operation and coordination to promote the use of the skills.

6.7 BARRIERS TO CO-OPERATIVE PRACTICE

These are the factors that caused non-referral or late referral of cancer patients for treatment by THPs and ROs.

6.7.1 No communication between the parties

THPs and ROs interviewed in the study were of the opinion that there is no communication between them because they do not know each other. Patients do not provide details of treatment with the other health practitioner.

6.7.2 Individual attributes

The differences in education level make a significant difference in their practices. The THPs are of the opinion that the ROs do not want to work with them because they are uneducated.

6.7.3 Trusting attitudes

Both groups of health practitioners lack trust regarding each other's treatment. The ROs wrestled with the unscientific methods of treatment, improper qualifications as healthcare providers in cancer treatment, and no communication about details of TM treatment when patients refer themselves to them. Similar findings were noted in a study by Van Rooyen *et al.* (2015), who explored and described the collaborative relationship between AMPs and THPs regarding the legalisation of traditional healing. Van Rooyen *et al.* (2015: 9) found that AMPs had negative attitudes towards THPs and these stemmed from the unscientific methods used by the THPs in treating patients, interference of THPs with the effectiveness of AMPs' treatment, and delays in referrals of patients by THPs. It recommended change of attitude, improvement of communication and capacity building (Van Rooyen *et al.* 2015: 9).

6.7.4 Unscientific methods of treatment

The ROs are concerned about evidence based treatment to ensure safety of patients. They would not work together with THPs until such concerns have been addressed. There is currently no evidence-based treatment by THPs for patients with cancer.

6.7.5 Delays in referral

The ROs are of the opinion that THPs keep patients and only refer them to the hospital when the cancer has advanced.

6.8 ENABLERS FOR CO-OPERATIVE PRACTICE

The THPs and ROs interviewed in the study had an interest in working together in the treatment of patients with cancer. The implications for harmonising the roles of traditional healers and health professionals would be vital for the success of collaborations (Campbell and Amin 2014: 8). In the light of this, the following strategies were suggested by the participants. All

participants expressed willingness to initiate the process of collaboration through discussions of the following agenda items:

- i. What needs to be done in order to know that we would be accepted;
- ii. Approach to co-operation;
- iii. Provide proof of scientific evidence basis;
- iv. Overcome differences in backgrounds and approaches;
- v. Build environment of trust and respect;
- vi. There is a need for training, building each other's capacity to operate effectively in this organisation;
- vii. Each group needs to provide their role and practices in the treatment of cancer;
- viii. Sharing of resources, ROs to tell patients that they are working together;
- ix. A mechanism for communication amongst the THPs, ROs and patients with cancer;
- x. Mechanism for monitoring patient outcome; and
- xi. Patients require workshopping on how they will be referred between the THPs and ROs.

6.9 RESULTS IN RELATION TO THE OBJECTIVES OF THE STUDY

The aim of the study was to understand the co-operative practice between THPs and ROs in the treatment of patients with cancer in order to describe a viable practice between them. The current study achieved these objectives by describing the role and practices of THPs in the treatment of patients with cancer; describing the knowledge of THPs in the treatment of patients with cancer and the development needed; describing the perceptions of each health practitioner about the other in terms of treatment of patients with cancer and co-operative practice; describing co-operation required between the two healthcare practitioners in cancer treatment. Ultimately, the study described a workable practice between the THPs and ROs in the treatment of patients with cancer using the five concepts in Miller's framework, and the concepts of collaboration involved in the treatment of patients with cancer.

The results in relation to the research questions asked in the study are discussed next. The participants responded to the following questions:

- 1) What are practices in the treatment of patients with cancer by both health practitioners? Each group of health practitioners in the treatment of the patients with cancer described how they treat the patients with cancer. The results showed that the patients move between the health practitioners, and do not complete treatment. There is no communication between the health practitioners.
- 2) What is the knowledge of THPs with regard to the treatment of patients with cancer? Each participant described their knowledge. The study found that the knowledge of THPs in the treatment of patients with cancer is reasonable and they need to be developed. The study found that most THPs have formal education; however they require ABET for basic educational skills such as writing and reading so that they can broaden their knowledge regarding conservation issues related to protected and threatened species, and clinically-related issues such as diagnoses and treatment of ailments. They also require communication skills for when they interact with ROs, patients and other stakeholder in the collaboration, including how to communicate via cell phones. They need training on how to correctly publish their traditional healing knowledge in order to safeguard their intellectual property. They also need knowledge of diet and other chemicals that have the potential to cause cancer.

This knowledge can be imparted to the population, thus help to reduce the incidence of cancer. They need to keep records of patients with patient information such as the name, age of the patient, gender, diagnosis, both physical and postal addresses as well as both the cell and telephone numbers, in order to be able to follow up patients.

3. What are the perceptions of each health practitioner about the other in terms of treatment of patients with cancer and co-operative practice?

Each group of health practitioners described the perceptions of each health practitioner about the other in terms of treatment of patients with cancer. The two groups of health practitioners do not trust each other in the treatment of cancer and are of the opinion that there is late referral of patients. The THPs are of the opinion that the ROs undermine them because they are uneducated. The ROs are of the opinion that THPs do not have a role in the treatment of patients with cancer. Also, the results showed that both THPs and ROs participants are willing to co-operate in the treatment of cancer. They saw the need to co-operate for continuity of care.

4. What co-operation is required between the two healthcare practitioners in the treatment of patients with cancer? The results showed that THPs and ROs interviewed operate in an environment where they have no relationship, and there is no trust and respect for each other. The parties work in parallel with no communication between them and the patients. The patients move freely between the two health practitioners and consume both medicines consecutively and continuously. Consequently, there are interruptions in the treatment as patients refer themselves to the other practitioner when there is no improvement or relief of pain from the disease.

The study found that the two groups are willing to have a meeting in which to discuss how the THPs can be accepted by the ROs. The ROs are opposed to referring patients to THPs because they are concerned about the safety of patients when using TM. The first requirement for co-operation is for the THPs to provide evidence based treatment for cancer management.

6.10 SUMMARY OF THE CHAPTER

This chapter discussed the demographic profiles of the THPs and ROs interviewed for the study. It also discussed and interpreted the results regarding the role and practices of THPs in the treatment of patients with

cancer, the co-operative practice between THPs and ROs in cancer treatment, as well as the barriers to, and enablers of, co-operative practice. It further discussed the findings in relation to the objectives of the study.

Despite other studies speculating on the difficulty of co-operation between THPs and AMPs, the findings in the current study have shown that both THPs and ROs are willing to co-operate in the treatment of cancer due to common problems such as delay in starting treatment, and patients not completing treatment. Facilitating collaboration between THPs and ROs is imperative considering the realities of the constrained oncology services and the burden of cancer treatment in the AM system that is a challenge in South Africa. Suggestions were made regarding co-operation in terms of changing attitudes of each party, improving communication between the health practitioners and the patient, and building an environment of harmony and trust.

The findings supported and contributed to new aspects of understanding the co-operative practice between the THPs and ROs in treatment of patients with cancer. They contributed to the researcher being able to describe a viable co-operative practice framework between the THPs and ROs in the treatment of patients with cancer in KZN. However, these findings cannot be generalised to other communities in South Africa or to other forms of TM that exist in South Africa, as the study was conducted only in KZN Province.

The THPs could play an integral role in radical treatment and palliative care of patients with cancer as well as prevention of cancer in the Zulu community because they are easily accessible to all communities, especially in rural areas. With appropriate training and development they can sustain their care in cancer and many other diseases because SA has an array of medicinal plants used in TM. THPs in the health system could also alleviate the burden of care on the conventional healthcare system.

CHAPTER 7 : FRAMEWORK FOR CO-OPERATIVE PRACTICE BETWEEN THPS AND ROS IN THE TREATMENT OF PATIENTS WITH CANCER

7.1 INTRODUCTION

The purpose of the study was to understand the co-operative practice between THPs and ROs in order to describe a workable practice between them in the treatment of patients with cancer, and develop THPs in cancer treatment in KZN Province. This chapter discusses the final step of the qualitative research analysis. In so doing, the researcher coordinates and structures the categories identified from the conceptual framework developed in Chapter 3, by identifying any relationship or linkage between them (Nieuwenhuis 2008: 110). Utilising the framework synthesis, the data on the discussion of the themes that emanated from the study was reduced and a framework was developed. The framework depicts the identified determinants of collaboration, the existing relationship between them, and the types of co-operation and intervention needed for effective co-operative practices.

7.2 A WORKABLE PRACTICE BETWEEN THPs AND ROs

In the previous chapter the results of the current study were discussed. The focus of the study in all the information presented so far has been on the first three objectives of the study which were to:

- Explore and describe the role and practices of THPs in the treatment of patients with cancer.
- Explore and describe the knowledge of THPs in the treatment of patients with cancer then the development needed.
- Explore and describe the perception of each health practitioner about the other with regard to treatment of cancer and co-operative practice.
- Explore and describe co-operative practice required between the two healthcare practitioners in cancer treatment.

This section focused on the last objective of the study which is the description of workable co-operative practice between the THPs and ROs in the treatment of patients with cancer. Effective co-operative practice is organised to provide a patient centred approach to the care of patient in order to ensure that there is continuity of care in patients with cancer. Co-operative practice in the treatment of patients with cancer requires co-operation from all those involved in the care of patents with cancer. These include patients and their relatives, professionals and everyone involved in the care of patients with cancer (Nelson *et al.* 2011: 4). In this study, the co-operation was between ROs and THPs who were interviewed in this study.

The conceptual framework developed in Chapter 3 used concepts for understanding co-operative practice, and was based on, the theoretical framework by Miller (1997: 302) on individual practice of midwives, nurses and physicians working together. The results of the study indicated areas that are barriers to co-operative practice as well as areas that require improvement. The goal of co-operative practice would be to ensure that patients with cancer are provided with continuity of care without any interruptions in treatment.

7.3 FRAMEWORK FOR CO-OPERATIVE PRACTICE BETWEEN THPs AND ROs IN THE TREATMENT OF PATIENTS WITH CANCER

The framework depicted in Figure 7.1 is intended to provide strategies and ideas that would assist health policy-makers to adopt the elements of interprofessional education and co-operative practice that they deem would be beneficial (WHO 2010b: 10). It also highlights the current status of collaboration, identifies the enablers of successful collaborative teamwork, and outlines several action items that policy-makers can apply within their local health system. It further depicts the existing relationship between the THPs and ROs, and the types of co-operation and intervention needed for effective co-operative practice.

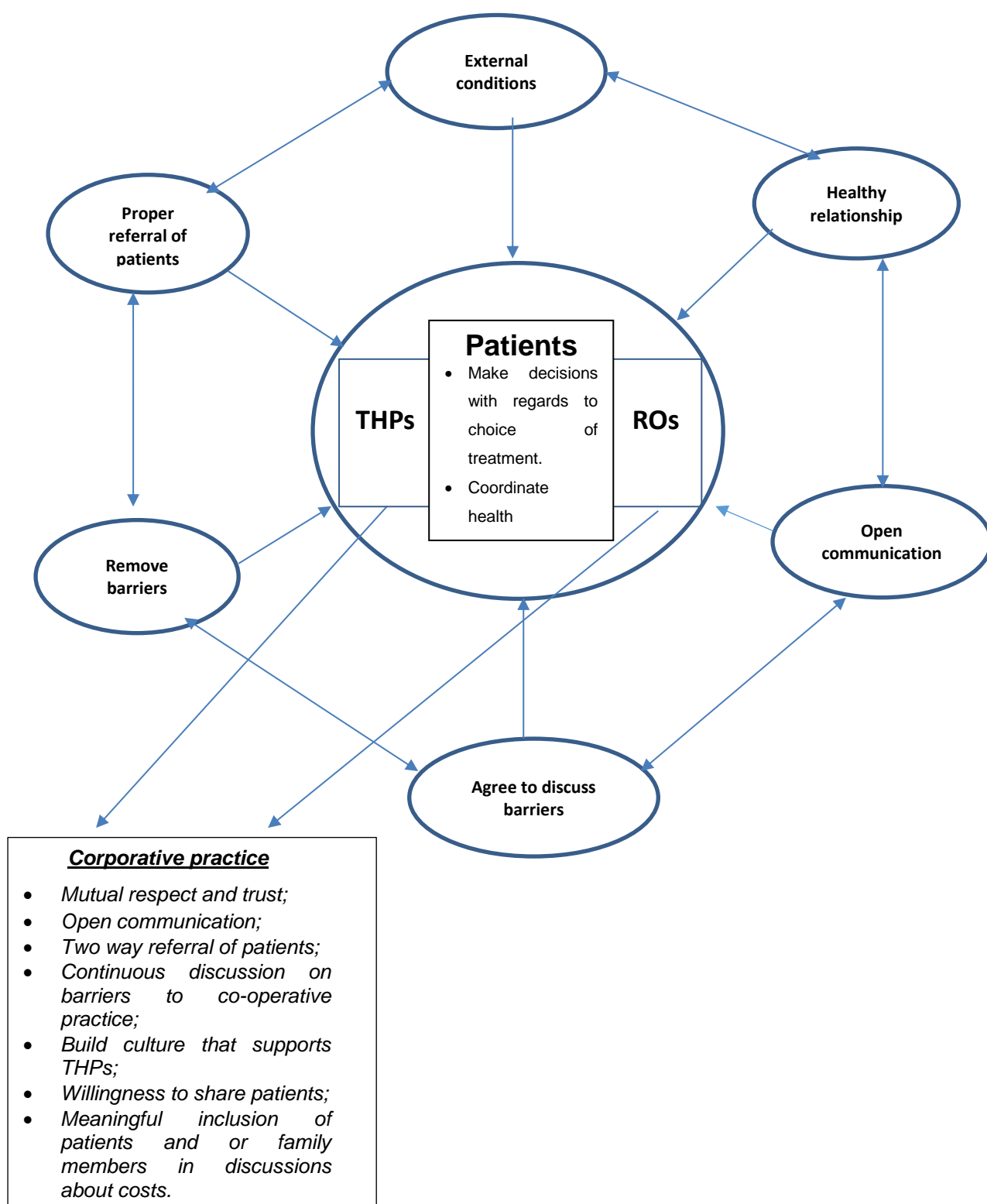


Figure 7.1: Framework for co-operative practice between THPs and ROs in the treatment of patients with cancer in KZN

With regard to development of the framework, the different categories of co-operative practice, namely: external conditions, individual attributes, organisational dynamics, trusting attitudes, attitudes on practice, and referral system (arising from the material in Chapter 6), are connected together to develop a rational explanation for the phenomenon studied, and it is associated with the existing literature (Isaacs 2014: 321). In the next section the framework is described.

7.3.1 Elements of the collaboration

- The patients and their families

The patient is central to the co-operative practice. Patients have the right to access a health practitioner of their choice to get the quality care they deserve. Collaboration allows patients and the health care providers to interact. The patient has the responsibility to make decisions regarding the choice of treatment, coordinate the treatment activities, inform the health practitioner of any change in the choice of treatment, and provide detailed information of treatment when they are referred.

- The health practitioners

It is crucial for the THPs and ROs to know the needs of the patients so that care is planned around their individual needs. The health practitioners should empower the patients with information so that they or their relatives know what to expect from the health care provider, and can make informed choices while taking responsibility for their health. They should provide patients with information with regard to the types of treatment modalities available as well as the relief they offer. They should involve the patient in the decision making regarding treatment. They should respect the choice of the patient on issues of the care that they choose. They need to avail themselves when the patient is in need of their services. They should be willing to refer patients to each other in reasonable time when they themselves cannot treat the patient successfully.

7.3.2 Structure of the team

To develop THPs as a component of the health system, the THPs and ROs involved in the treatment of patients with cancer should co-operate. It is imperative to develop traditional healing for the benefit of those patients whose cultural beliefs lead them to opt for traditional healing alone or with AM. The patients are at the centre and need to be guided with regard to their referrals to either health practitioner.

7.3.3 Current status of collaboration: Existing relationship between THPs and ROs

Currently there is no relationship between the health practitioners and they do not work together or interact. They do not refer patients to each other. Patients refer themselves between the health practitioners, and do not provide details of treatment with the other health practitioner. Both teams do not have power because the patients exercise their rights by referring themselves to any health practitioner.

The THPs and ROs are in an antagonistic relationship where they blame each other for the poor outcome of treatment of patients with cancer. They do not trust and respect each other's practices in the treatment of cancer because of the different levels of education in matters relating to cancer treatment.

The parties work in parallel, do not know each other and there is no communication between them. In exercising their rights, the patients with cancer move freely between the health practitioners and consume both medicines. They refer themselves to one health practitioner while still on treatment with the other. Consequently, there are interruptions in the treatment and some patients refuse treatment with chemotherapy. This impacts negatively on treatment outcome and reduces survival in patients.

There is a one-way referral from the THPs to the hospitals to confirm the diagnosis of the patient before they commence treatment and to evaluate treatment at the end of treatment. However, they do not refer to the ROs directly because they do not know each other.

7.3.4 Co-operation required for effective practice

A change is needed in the relationship where the parties co-operate with each other, interact, and work together in harmony. There should be mutual trust and respect to effect referral of patients between the health practitioners. There should be open communication on matters related to treatment, and treatment activities should be coordinated to ensure continuity of care for patients.

There should be a two-way referral of patients between the health practitioners in order to refer a patient when the treatment is unsuccessful, hence reducing the delays in referral of patients between the health practitioners.

There should be continuous discussions on barriers to collaboration related to negative attitudes toward treatment and co-operative practice. The parties should have trust and respect for each other's practices in the treatment of patients with cancer.

Health practitioners should build a culture that supports trust, a willingness to share in patient care decision making, and meaningful inclusion of patients and/or family members in discussions about their care.

The coordination of health practitioners' activities regarding treatment is paramount to ensure continuity of care.

7.3.5 Enablers of successful co-operative practice

- i. Healthy relationship.
- ii. Environment conducive for co-operative practice.
- iii. Proper referral of patients between health practitioners.
- iv. Removal of barriers to co-operative practice
- v. No delay in referral of patients.
- vi. Both parties should agree to discuss issues that are barriers to co-operative practice.

7.3.6 Intervention needed for effective co-operative practice

The results of the study have indicated areas which are lacking in the rendering of integrated care for patients with cancer and have highlighted areas where improvements are required. The goal of integrated care would be to ensure that there is continuity of care while the patients exercise their rights to access the health practitioner of their choice. This co-operation will ensure strengthening of the national health system where the users have accessibility to care of their choice. The identified areas are discussed below.

7.3.6.1 Relationship

- Healthy relationship.
- Mutual respect and trust.
- Parties work in harmony.

7.3.6.2 Communication

- Open and frequent communication amongst all parties in collaboration.
- Workshop for patients on how they will be referred between the THPs and ROs.
- ABET to improve communication skills of THPs.

7.3.6.3 External conditions

- Policy on referral of patients to include referral to THPs.
- NHI to involve THPs.

7.3.6.4 Referral of patients

- Patient involvement in decision making regarding the choice of treatment.
- List of health practitioners involved in cancer treatment should be available.
- Both parties should be transparent with regard to their practices in the treatment of patients with cancer.
- Trust among all parties.
- Sharing of information.
- Sharing of knowledge.
- Sharing of responsibility.
- Mutual respect for the expertise of all members in the team.
- Open communication among all parties.
- Co-operation.
- Co-ordination of treatment activities.

7.4 SUMMARY OF THE CHAPTER

Effective collaboration and a healthy relationship between the health practitioners are fundamental to continuity of care. Co-operative practice between health practitioners in the treatment of patients with cancer ensures that they work together in harmony and with trust in an environment which is conducive for co-operation. The patient, as the main actor in the collaboration, has the responsibility to co-ordinate all the health practitioners' activities that impact on continuity of care. A two-way referral of patient between the health practitioners should be established so that the patient should not move between the health care providers without both knowing about it. The

framework could be adapted and utilised by health care providers to improve on referrals by the ROs who were found to be lacking in in this regard.

CHAPTER 8 : SUMMARY OF THE FINDINGS, LIMITATIONS OF THE STUDY, CONCLUSION AND RECOMMENDATIONS

8.1 INTRODUCTION

This chapter summarises the findings, discusses the limitations and the recommendations of the study, and concludes with a summary. The current study has contributed towards documenting and describing the diverse demographic information of THPs who treat cancer among the Zulus in KZN Province of South Africa. It is envisaged that this information will provide a clearer picture of the socio-cultural profile and traditional healing practice of isiZulu health practitioners, who play a crucial role in the treatment of patients with cancer in both the rural and urban areas.

The study was aimed to understand and describe the practices between THPs and ROs in the treatment of patients with cancer, in order to describe a viable practice between them and develop the THPs as a health system in KZN. The focus of the study that has been presented thus far has been based on the research questions. In their response, the participants responded as follows:

- Explore and describe the practice of THPs and ROs in the treatment of patients with cancer.
- Describe the knowledge of THPs in the treatment of patients with cancer co-operative practice in the treatment of cancer as explained by the THPs and ROs.
- Explore and describe the perception of each health practitioner about the other with regard to treatment of patients with cancer.
- Explore and describe the negative perception of THPs and ROs with regard to co-operative practice in the treatment of patients with cancer.

8.2 DISCUSSION OF FINDINGS

The findings in relation to these objectives guided the description of a workable practice between the THPs and ROs in the treatment of patients with cancer. A more detailed summary is presented in Table 5.1. The findings for each objective are summarised below.

8.2.1 Principles of treatment of patients with cancer by THPs

The role of THPs in cancer is to cure the disease and alleviate pain. However, they rely on AMPs to diagnose or confirm the diagnoses of the patient before commencing treatment. Their treatment lasts for almost three days and up to a month in early and advanced stages, respectively. At the end of treatment, they refer the patient to the clinic to evaluate the treatment.

8.2.2 Co-operative practice between the THPs and ROs in the treatment of patients with cancer

The THPs could be integrated inclusively into the national health system where the parties work in collaboration sharing resources. A healthy relationship and an environment where there is mutual trust and respect, and free communication between all the parties in the collaboration, is paramount in co-operative practice in order to facilitate referral of patients between the health practitioners. Co-operative practice and inter-referral would provide patients with continuity of care. It is imperative that the patient should not consume both TM and AM simultaneously.

The patient is the main actor in the collaboration and has the responsibility to coordinate the treatment activities of the health practitioners, and make decisions with regard to the choice of a health practitioner. The patient's decisions should be respected.

8.2.3 The barriers to co-operative practice between THPs and ROs in the treatment of patients with cancer

The barriers to effective co-operative practice emanate from unhealthy relationships, no communication, negative attitudes as a result of unscientific practices of THPs in treating patients, and delay in the referral of patients. All parties should clarify their roles, acknowledge failure in their treatment, and recognize each other's treatment.

8.2.4 The enablers for effective co-operation between the THPs and ROs in the treatment of patients with cancer

Both parties need to make an enormous effort to change the barriers to co-operative practice such as in communication, trust and respect. Effective communication and co-operation among the parties in the collaboration, as well as proper referral systems, are key to continuity of care for patients.

8.2.5 The development of THPs as a health system in the management of patients with cancer

The THPs require development in the following aspects:

- ABET for basic educational skills such as writing and reading to equip them with the skill to document and safeguard their own knowledge
- Communication skills are needed to interact with ROs in the collaboration.
- Knowledge of diet and other chemicals that have the potential to cause cancer so they can impart this knowledge to the population and thereby help to reduce the incidence of cancer.
- The majority of THP participants expressed a desire to receive training in respect of record keeping. This will enable them to follow up their patients after treatment in order to evaluate their treatment.

- They need a workshop to teach them how they will be referred between the THPs and ROs.

8.3 A FRAMEWORK FOR CO-OPERATIVE PRACTICE BETWEEN THPs AND ROs IN THE TREATMENT OF PATIENTS WITH CANCER

A framework is required to describe the co-operative practice between THPs and ROs in the treatment of patients with cancer. Co-operative practice is fundamental to the provision of continuity of care for patients. The framework describes the co-operative practice between the THP and RO interviewees. In the current study, the parties involved in the collaboration are the THPs, ROs and the patients. The THPs and ROs work in collaboration while the patient is in the centre playing a major role in the collaboration. The collaboration exists in an environment with harmony, trust and respect.

The framework identified barriers such as unhealthy relationships, an environment full of mistrust and disrespect. There is therefore currently no communication and referral of patients between two groups of health practitioners.

The study found that the enablers of effective co-operation are effective communication, and trust and respect amongst those involved in the co-operation. Effective communication and co-operation among the parties in the collaboration as well as a proper referral system are key to the provision of continuity of care for patients.

The study found that the intervention needed is a proper referral system and capacity building for THPs.

8.4 SUMMARY OF THE STUDY

The study found that both THPs and the ROs in KZN are willing to co-operate in the treatment of patients with cancer. The THPs' description of cancer is similar to the clinical definition of cancer, but they cannot diagnose cancer

because they do not have the necessary skill and equipment to aid in diagnosis. However, some TMPs detect cancer by visualising the signs of cancer and use TM diagnostic techniques such as ancestral powers. With regard to co-operation between the THPs and ROs in the treatment of patients with cancer, both parties agreed that they require an initial meeting to introduce themselves to each other and to discuss priority issues that are the main barriers to co-operation. Barriers include evidence-based practice in the treatment of patients with cancer, and lack of understanding each other's role in the treatment of patients with cancer. Subsequent meetings will ensure the discussion of other factors which would further improve the relationship between the health practitioners.

The topic of co-operation between THPs and ROs in the treatment of patients with cancer is still in its infancy in KZN. Extensive research is needed in this field to improve the co-operation between THPs and ROs in the treatment of cancer.

Given the prevalent usage of TM, THPs could alleviate the burden of cancer treatment on the national health system. The WHO has long advocated collaboration between TM and AM. The government and community bodies understand the need for more human resources for health to assist in scaling up effective services in the treatment of patients with cancer. It is therefore essential to move from rhetoric to actual implementation. THPs are already engaged in treating patients with cancer. Oncology services are always constrained by lack of resources and are less available in the rural areas where the large population of the country resides.

The next step should be facilitating a meeting between the THPs and ROs to discuss the way forward in regard to effective co-operative practices including initiation of proper referral of patients between them. Implementing the training programmes for THPs in the treatment of patients with cancer, will also be a scrutiny. A meeting between the THPs and ROs is necessary to commence the discussion on effective co-operative practice and the clinical evidence of THPs' role and practices in the treatment of patients with cancer.

With regard to the government not allowing referral of patients due to paucity of evidence based practice of THPs, the THPs have shown willingness and have provided suggestions on how to approach this. The government should support THPs so that ROs can also refer patients to the THPs when the need arises.

8.5 MAXIMISATION OF TRUSTWORTHINESS IN THE STUDY

The researcher utilised qualitative research in the current study. This design allows the exploration of the participants' experiences in order to describe the phenomenon of a study. In doing so, it generates large quantities of detailed information about a single unique phenomenon. As a result, it is subjective, prone to researcher bias and lacking generalizability (Anyan 2013; Cope 2014). To reduce bias and improve trustworthiness in the data collection and analysis, the researcher utilised the four criteria, namely, credibility, dependability, confirmability, and transferability (Polit and Beck 2013: 178).

a) Credibility deals with the focus of the study and shows how well data and processes address the anticipated focus. The focus of the study is to describe the co-operative practice between the THPs and ROs in the treatment of patients with cancer. The researcher believed that, the THPs and ROs who provide cancer treatment, have experienced the phenomenon. Thus they have the potential to provide information required to describe the phenomenon. Traditional health practitioners and ROs with various experiences were chosen to answer the research questions, and provide rich information about the phenomenon under study.

Also, in-depth interviews using semi structured questions were used to collect data from the participants. The interviews were appropriate in the study because they allow exploration of the topic in the study. The interviews with individual participant and focus group continued until data saturation. This increases credibility and quality of information collected.

Credibility of research findings focuses on how the categories and themes shield data. To accomplish this, the researcher used quotations from the transcriptions of the interview data, to show how themes and categories were developed.

- b) Dependability** takes into account the degree to which data change as time progresses, and the changes made in the researcher's decisions during the analysis of data (Lincoln and Guba 1985: 299). To address dependability, the research design of this study might be viewed as a 'prototype model' to enable readers to develop a thorough understanding of the methods and their effectiveness.
- c) Confirmability** is concerned with whether the data presented represents what the participants said and are without the biases of the researcher (Lincoln and Guba 1985: 129). This was addressed when the researcher ensured that the study findings were the results of the lived experiences of the THPs and ROs who provide cancer treatment. Thick descriptions from the in-depth interviews were recorded, categorised, and compared with items in the refined coding system. The researcher used excerpts and direct quotes from the data to support the themes and categories that emerged from the data. Also, the supervisors were invited to review the data scripts. The researcher and the supervisors concurred on the identified categories and themes.
- d) Transferability** is when is achieved when readers feel as though the story of the researcher overlaps with their own situation and they intuitively transfer the research to their own action. For transferability, the researcher established the context of the study and gave a detailed description of the phenomenon by interviewing 28 THPs and 4 ROs with various experiences to allow comparisons to be made. Also, a framework was utilised to assure quality of data collected and analysed.

8.6 LIMITATIONS OF THE STUDY

Limitations are barriers or constraints that weaken or decrease the credibility of the study results. These could be the research design, sample of the study or research methods (Botma *et al.* 2010; Burns and Grove 2011). According to de Vos *et al.* (2011: 288), limitations of the study are to be explicit so that precautionary measures may be applied to reduce any possible negative impact that the study could have. In this regard, Grove, Burns and Gray (2013: 598) state that limitations can be identified before conducting a research study. In this study the researcher used a limited sample size and provided a detailed description of the methodology of the study.

Data collection documented and sent via email from some of the ROs due to their time constraints, was a limitation. The data derived from these individuals, was very brief and written in only a few sentences compared to the volume of data collected in face-to-face interviews from other ROs. Furthermore, only four of seven ROs, responded to the study despite many reminders. The researcher is of the opinion that the poor response was as a result of them not being ready to collaborate with THPs in the treatment of patients with cancer. Another factor was that during the time of the interviews one provincial oncology hospital was non-operational leaving the other hospitals with an exorbitant workload thus limiting their time to engage in one-to-one interviews.

The current study did not investigate how THPs qualify to be an expert in the treatment of patients with cancer, or how to identify qualifying THPs and their practices in the treatment of patients diagnosed with cancer.

The THPs did not mention the type of medicinal plants they use to prepare their medicine for use in the treatment of patients with cancer, due to fear that the researcher might tamper with their intellectual property.

The findings of a qualitative study cannot be generalised to other settings. The study was designed to be representative of the THPs and ROs who participated in this study only.

The use of deductive approaches using a structured or predetermined framework to analyse data was a limitation. Such approaches are useful in studies where researchers are already aware of probable participant responses. However, while it is relatively quick and easy, it is rigid and can potentially be biased because the coding framework has been decided in advance, which can severely limit theme and theory development. Studies that use both deductive and inductive approaches, though time-consuming, are more appropriate in the development of theme and theory for phenomenological studies in this field.

8.7 STRENGTHS OF THE STUDY

The researcher was introduced to THPs in their meeting, prior to the collection of data. The researcher built a relationship with the THPs which resulted in most THPs will to participate in the study. Consequently, there were many referral points to identify THPs who provide cancer treatment. This resulted in reduced bias because THPs were identified in several districts.

Individual and focus group interviews were utilised to collect data from nine individual THPs and four groups of THPs. The researcher was able to collect rich information from individual THPs because in individual interviews, the participants freely express their opinions. Furthermore, the focus group interviews created triangulation of data in that the participants verified the information collected from the other participants in the same group.

8.8 RECOMMENDATIONS

In terms of the findings in this study, it is recommended that although the TM healing system operates in parallel to the AM system, there can still be areas of collaboration, namely, sharing resources such as equipment, facilities, and patient information. The sharing of facilities does not suggest that THPs are

permitted to treat their patients, whilst they are being hospitalised as THPs indicated that consumption of both medicines impairs healing. The THPs need to have their own health facilities to admit very ill patients who are on treatment.

It is also suggested that there should be a representative for THPs in all authority structures in the province, to facilitate co-operation between the health practitioners (Van Rooyen *et al.* 2015: 8).

Some THPs have already initiated the process of acquiring their own training and health facilities but are struggling to progress due to unavailable funding. It is recommended that the government make funding in order for TM to be developed as a health system which operates in co-operation with the AM health system.

THPs have been mandated to work together with AMPs in order to strengthen the national health system. Therefore, referral policy should include THPs because without this policy, AMPs will not refer patients to THPs in fear of litigation in case treatment goes wrong. Another problem is that the NHI excludes THPs leaving patients with the burden of having to pay out of pocket for their treatment with THPs.

Enough budget should be allocated to fund projects aimed at developing THPs and the collaboration of THPs and ROs in the treatment of cancer. The current study is the first of its kind regarding collaboration in the treatment of patients with cancer, but extensive research is needed in the effort to improve co-operation between THPs and ROs. The following recommendations regarding further research are based on the findings of this study:

- 1) A study is needed to establish why patients treated by THPs do not return to give feedback after treatment with TM.
- 2) The study showed that patients have power in the relationship between health practitioners and therefore have a great influence on the co-operative practices between the health practitioners. Further research is needed to establish the perception of patients with cancer with regard to

effective co-operative practices in order to determine how they can influence such practices.

- 3) If the NHI is to be successful, then TM should be included as a component of the health system which provides a treatment service to that population of the country, whose beliefs are rooted in TM. The strengthening of health systems is central to implementing a successful cancer prevention and control programme. Primary health care (PHC) re-engineering of services and the introduction of NHI are essential to the implementation and operation of this strategy (Department of Health 2016: 10). Research is needed on how to include TM in the NHI.
- 4) The current study only showed the profile of THPs who were interviewed which is inadequate to generalise to the entire population of THPs who treat patients with cancer in the province. Therefore, a study should be undertaken to profile the THPs who treat cancer in KZN in order to create training programmes that will be appropriate for their education level.
- 5) A survey to profile the THPs who treat cancer in KZN in order to design training programmes that will be appropriate for their education level.
- 6) In the current study, the researcher noted that the THPs who treat cancer, seemed to have a reasonable knowledge of signs and symptoms of cancer as well as the causes of cancer. With further development of these skills in the THPs, their role can be extended to prevention of some cancers as well as screening. Further research is required to establish the types of cancer in which those roles can be applicable. In so doing, the cancer management service can be further capacitated.
- 7) Some cancer patients will require hospitalisation while being treated by the THPs. Current facilities for admitting cancer patients are in the public hospitals. Therefore, further research is needed to establish the possibility of admitting TM patients to those hospitals without them being stigmatised by staff and other patients because of their beliefs.
- 8) Further research is needed to identify cancers for which conventional treatment protocols are unable to manage effectively, causing patients to refer themselves to THPs for relief or cure.

- 9) The current study did not investigate how the THPs qualify to be experts in the treatment of patients with cancer. Future research should be directed at distinguishing qualified practitioners and practices for treating cancer.
- 10) Research is greatly needed to document the nature, value and effectiveness of TM practices in the treatment of patients with cancer.
- 11) Research is needed regarding the attitudes of communities in different cultures on the integration of TM into the national health system.

8.9 SUMMARY OF THE CHAPTER

The current study contributed towards a better understanding of the role and practices of THPs in the treatment of patients with cancer, THPs' knowledge of cancer and their diagnosis and treatment of patients affected by the disease. It also provided the analysis of co-operative practice between THPs and ROs and described the attitudes of health practitioners that impede co-operation as well as those that enable co-operation, as described by these practitioners. Ultimately, the study provided an understanding of co-operative practices by contributing referral to the concepts in Miller's theoretical framework (Miller's 1997: 302).

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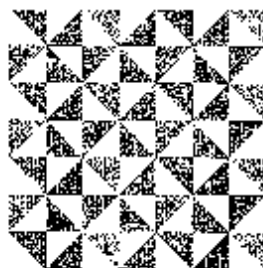
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APPENDICES

APPENDIX 1: DUT ethics clearance



Institutional Research Ethics Committee
Faculty of Health Sciences
Room 115 42, Mainlink School St.,
Glen 5, Ridge Campus
Durban University of Technology

P.O. Box 3524, Durban 6001, Africa 4001

Telephone: 323 1940
Fax: 031 721 3400
Email: research@rec.dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

6 February 2015

IREC Reference Number: **REC 1/15**

Ms P B Nomnga
1 Ellington Gardens
35 Riff Road
Manor Gardens
4001

Dear Ms Nomnga

A practice framework of African Traditional Health Professionals in the management of patients with cancer in the KwaZulu-Natal Province

I am pleased to inform you that Full Approval has been granted to your proposal REC 1/15.

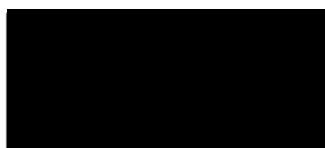
The Proposal has been allocated the following Ethical Clearance number **REC 013/15**. Please use this number in all communication with this office.

Approval has been granted for a period of one year, before the expiry of which you are required to apply for safety monitoring and annual recertification. Please use the Safety Monitoring and Annual Recertification Report form which can be found in the Standard Operating Procedures (SOP's) of the IREC. This form must be submitted to the IREC at least 3 months before the ethics approval for the study expires.

Any adverse events (serious or minor) which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's. In addition, you will be responsible to ensure gatekeeper permission.

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely



Professor J K Adam
Chairperson: IREC

APPENDIX 2a: Letter of permission to the District Manager of eThekweni District

Mrs P Dladla
EThekweni District Manager
Mayville

Dear Mrs Dladla

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am currently registered as a doctoral student at the Durban University of Technology in the Department of Health Sciences within the Faculty of Health Sciences. I would like to embark on a research project towards a Doctor of Philosophy degree in Health Sciences.

The proposed title of my study is '*A practice framework of traditional health practitioners in the treatment of patients with cancer in KwaZulu-Natal, South Africa*'. This is a qualitative descriptive study using open ended unstructured interviews to collect data from traditional health practitioners on how to work in cooperation with radiation oncologists in the treatment of patients with cancer. Following the analysis of data, there will be guidelines on how to collaborate the two health practitioners in order to improve the treatment outcome of patients with cancer in KwaZulu-Natal.

The study will be conducted at the three government oncology hospitals in KZN, namely Greys Hospital, Inkosi Albert Luthuli Central Hospital and Addington Hospital. In-depth interviews will be conducted with the Radiation Oncologists who are willing to cooperate with Traditional Health Practitioners in the treatment of cancer patients.

My proposal has been reviewed by the Faculty of Health Sciences Research Committee and approved by the Institutional Research Ethics Committee at the Durban University of Technology. Copies of my research proposal and data collection tools are attached for your perusal. Your support to perform this study will be greatly appreciated.

Should you have any queries please do not hesitate to contact my supervisors
Prof MN Sibiya at 031-373 2606 or e-mail her at nokuthulas@dut.ac.za and
Prof N Gqaleni at 031-764 2970 or e-mail ncebag@dut.ac.za.

Your consideration in this matter is highly appreciated.

Sincerely,

Nkosi Pauline Busisiwe (Ms)
PhD Student at DUT
Email: nomngabusi@yahoo.com
Phone: 031 373 2509
Cell: 082 943 8688

APPENDIX 2b: Approval letter from the District Manager of eThekweni District



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Postal Address: Private Bag X54318 Durban 4000
Box 83 Jan Smuts Highway, Mayville, Durban 4031
Tel: 031 2405308 Fax: 031 2405509
Email: nenny.nadla@kzn-health.gov.za
www.kznhealth.gov.za

Enquiries: Ms Nombuthi Mthethwa

Tel: 031 240 5342

Date: 20 February 2015

Attention: Nominga Busisiwe
Email: nomingabusisi@yahoo.co.za

REQUEST TO CONDUCT RESEARCH:

A practice framework of traditional health practitioners in the treatment of patients with cancer in KwaZulu-Natal.

Support is hereby granted to conduct research on the above topic.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regard to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Ms. N.B. Mthethwa

For The District Manager
Elmekwini Health District
Telephonat: 031 2405342
Fax: 031 2405501
Email: nombuthi.mthethwa@kznhealth.gov.za

uMnyango Wozempilo : Departemen van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX 3a: Letter of permission to the KZN Department of Health

Health Research and Knowledge Management Component
Department of Health
Natalia Building
Room 102, South Tower
Pietermaritzburg
3200

Dear Dr Lutge

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am currently registered as a doctoral student at the Durban University of Technology in the Department of Health Sciences within the Faculty of Health Sciences. I would like to embark on a research project towards a Doctor of Philosophy degree in Health Sciences.

The proposed title of my study is '*A practice framework of Traditional Health Practitioners in the treatment of patients with cancer at KwaZulu-Natal, South Africa*'.

This is a qualitative descriptive study using open ended unstructured interviews to collect data on cooperation needed for traditional health practitioners to work in cooperation with radiation oncologists in the treatment of patients with cancer. The participation of radiation oncologists is important because the information on collaboration is obtainable from them. Following the analysis of data, there will be guidelines on how to collaborate the two health practitioners in order to improve the treatment outcome of patients with cancer in KwaZulu-Natal.

The study will not affect the normal work routine as radiation oncologists will be interviewed using email and they can respond to those emails when they are not busy. The interview consists of a questionnaire and letter of information and consent. I am planning to commence data collection in January 2015 and complete the entire research process by August 2015.

The Head of Department of Nursing, Professor M.N. Sibiya and Honorary Professor N. Gqaleni are supervising the study. The direct benefit from the study is that a summary of the research findings will be made available to the traditional health practitioners, the radiation oncologists, the Department of Health and eThekweni Municipality. The long term benefits are that the research findings will benefit patients to improve their cancer treatment outcome.

The sample will be drawn from the public oncology hospitals in KwaZulu-Natal which are situated, two in Durban and one in Pietermaritzburg. All information will be treated in confidence and no reference will be made to a specific authority.

My proposal has been reviewed by the Faculty of Health Sciences Research Committee and approved by the Institutional Research Ethics Committee at the Durban University of Technology. Copies of my research proposal and support letters from KwaZulu-Natal Department of Health and Institutional Research Ethics Committee of the Durban University of Technology have been attached for your perusal.

Your support to perform this study will be greatly appreciated. Should you have any queries please do not hesitate to contact my supervisors Professor M.N. Sibiya at 031-373 2606 or e-mail her at nokuthulas@dut.ac.za and Professor N. Gqaleni at 031 764 2970 or e-mail ncebaga@dut.ac.za.

Your consideration in this matter is highly appreciated.

Yours Sincerely

Nkosi Pauline Busisiwe (Ms)
PhD Student at DUT
E-mail: paulinen1@dut.ac.za
Phone: 031-373 2509
Cell: 082 943 8688

APPENDIX 3b: Approval letter from the KZN Department of Health



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
1C – 103 Natalla Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 42/15
NHRD: KZ_2015RP38_418
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Ms B. Nomnga

Subject: Approval of a Research Proposal

1. The research proposal titled '**A practice framework of African Traditional Health Professionals in the management of patients with cancer in the KwaZulu-Natal Province**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Greys, Addington and IALCH.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805

Yours Sincerely

Dr E Lutge

Chairperson, Health Research Committee

Date: 28/07/15

uMnyango Wezemphilo : Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX 4a: Letter of permission to the CEO of the selected tertiary hospital

The Chief Executive Officer
XXX Hospital
Cator Manor
Durban
4041

Dear Sir / Madam

**REQUEST FOR PERMISSION TO CONDUCT A STUDY IN
RADIOTHERAPY DEPARTMENT**

I am currently registered as a doctoral student at the Durban University of Technology in the Department of Health Sciences within the Faculty of Health Sciences. I would like to embark on a research project towards a Doctor of Philosophy degree in Health Sciences.

The proposed title of my study is '*A practice framework of Traditional Health Practitioners in the treatment of patients with cancer at KwaZulu-Natal, South Africa*'. This is a qualitative descriptive study using open ended unstructured interviews to collect data from traditional health practitioners and radiation oncologists with regard to the cooperation required in the treatment of patients with cancer. Following this, the analysis of data, there will be guidelines on how to collaborate the two health practitioners in order to improve the outcome of patients with cancer in KwaZulu-Natal.

Your assistance in allowing me to conduct the study and Human Resource Department to identify the radiation oncologists in the Radiotherapy Department at your hospital will be appreciated. The names of the radiation oncologists will solely be used for the purpose of the study and confidentiality will be maintained all the time.

The direct benefit from the study is that a summary of the research findings will be made available to the traditional health practitioners, the radiation oncologists, the Department of Health and eThekweni Municipality. The long

term benefits are that the research findings will benefit patients in that their treatment outcome could improve.

Copies of my research proposal, support letter from KwaZulu-Natal Department of Health and a letter of permission from the Institutional Research Ethics Committee of the Durban University of Technology have been attached for your perusal.

Your support to perform this study will be greatly appreciated. Should you have any queries please do not hesitate to contact my supervisors Professor Sibiya at 031-373 2606 or e-mail her at nokuthulas@dut.ac.za and Professor N. Gqaleni at 031 764 2970 or e-mail ncebaga@dut.ac.za.

Many thanks for considering my request.

Yours Sincerely

Nkosi Pauline Busisiwe (Ms)
PhD Student at DUT
E-mail: paulinen1@dut.ac.za
Phone: 031-373 2509
Cell: 082 943 8688

**APPENDIX 4b: Approval letter from the
CEO of the selected tertiary hospital**



health

Department of
Health
PROVINCE OF KWAZULU-NATAL

Inkos. Albert Luthuli Centre Hospital
Ehlekweni Health District
Office of the Medical Manager
Private Bag X 03, Mayville, 4058
600 Bellair Road, Mayville, 4058
Tel: 031 240 1059,
Fax: 031 240 1050
Email: ursulanun@iolch.co.za
www.kznhealth.gov.za

23 JUNE 2015

Ms P B Nomnga
DUT

Dear Ms Nomnga

Re: Approved Research: Ref No: REC 1/15: A practice framework of African Traditional Health Professionals in the management of patients with cancer in the KwaZulu-Natal Province

As per the policy of the Provincial Health Research Committee (PHRC), you are hereby granted permission to conduct the above mentioned research once all relevant documentation has been submitted to PHRC inclusive of Full Ethical Approval.

Kindly note the following:

1. The research should adhere to all policies, procedures, protocols and guidelines of the KwaZulu Natal Department of Health.
2. Research will only commence once the PHRC has granted approval to the researcher.
3. The researcher must ensure that the Medical Manager is informed before the commencement of the research by means of the approval letter by the chairperson of the PHRC.
4. The Medical Manager expects to be provided feedback on the findings of the research.
5. Kindly submit your research to:

The Secretariat
Health Research & Knowledge Management
330 Langalibale Street, Pietermaritzburg, 3200
Private Bag X9501, Pietermaritzburg, 3201
Tel: 033395-3123, Fax 033394-3782
Email: hrkm@kznhealth.gov.za

Yours faithfully

Dr M Letebele
Medical Manager

LMnyarango Wezemple, Department van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX 5a: Letter of permission to the CEO of the selected district hospital

The Chief Executive Officer
XXXX Hospital
Town Bush Road
Pietermaritzburg
3201

Dear Sir / Madam

**REQUEST FOR PERMISSION TO CONDUCT A STUDY IN
RADIOTHERAPY DEPARTMENT**

I am currently registered as a doctoral student at the Durban University of Technology in the Department of Health Sciences within the Faculty of Health Sciences. I would like to embark on a research project towards a Doctor of Philosophy degree in Health Sciences.

The proposed title of my study is '*A practice framework of Traditional Health Practitioners in the treatment of patients with cancer at KwaZulu-Natal, South Africa*'. This is a qualitative descriptive study using open ended unstructured interviews to collect data from traditional health practitioners radiation oncologists with regard to the cooperation required in the treatment of patients with cancer. Following this, the analysis of data, there will be guidelines on how to collaborate the two health practitioners in order to improve the outcome of patients with cancer in KwaZulu-Natal.

Your assistance in allowing me to conduct the study and Human Resource Department to identify the radiation oncologists in the Radiotherapy Department at your hospital will be appreciated. The names of the radiations oncologists will solely be used for the purpose of the study and confidentiality will be maintained all the time.

The direct benefit from the study is that a summary of the research findings will be made available to the traditional health practitioners, the radiation oncologists, the Department of Health and EThekweni Municipality. The long

term benefits are that the research findings will benefit patients in that their treatment outcome could improve.

Copies of my research proposal, support letter from eThekweni district and a letter of permission from the Institutional Research Ethics Committee of the Durban University of Technology have been attached for your perusal.

Your support to perform this study will be greatly appreciated. Should you have any queries please do not hesitate to contact my supervisors Professor Sibiya at 031-373 2606 or e-mail her at nokuthulas@dut.ac.za and Professor N. Gqaleni at 031-764 2970 or e-mail ncebaga@dut.ac.za.

Many thanks for considering my request.

Yours Sincerely,

Nkosi Pauline Busisiwe (Ms)

PhD Student at DUT

E-mail: paulinen1@dut.ac.za

Phone: 031-373 2509

Cell: 082 943 8688

**APPENDIX 5b: Approval letter from the
CEO of the selected district hospital**



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

GREYS HOSPITAL

OFFICE OF THE CEO

Private Bag X 9001 Pietermaritzburg, 3200
Town Bush Road, Chase Valley, Pietermaritzburg, 3201
Tel. 033 – 897 3521 Fax: 033 – 8973399
www.kznhealth.gov.za

To:	Ms. Pauline Busisiwe Nomnga 1 Ellington Gardens 35 Rif Road, Manor Gardens, 4001
From:	Dr. K. B. Bilege CEO - Greys Hospital
Date:	22 May 2015
Re:	Request for permission to conduct research at Grey's Hospital: <i>A practice framework of Traditional Health Practitioners in the treatment of patients with cancer at KwaZulu-Natal, South Africa</i>

Dear Ms. Nomnga

Your request to conduct research at Grey's Hospital refers.

Permission to conduct the above study is hereby granted under the following conditions:

- Your ethics approval and research protocol is assumed to be valid;
- You are also required to obtain approval from the Provincial Department of Health KZN Health Research Unit prior to commencing your study at Grey's Hospital. You will find more information on their website: <http://www.kznhealth.gov.za/hrkm.htm>
- Confidentiality of hospital information, including staff and patient medical and/or contact information, must be kept at all times;
- You are to ensure that your data collection process will not interfere with the routine services at the hospital;
- You are to ensure that hospital resources are not used to manage your data collection, e.g. hospital staff collating data; photocopying; telephone; facsimile, etc.;
- Informed consent is to be obtained from all participants in your study, if applicable;
- Policies, guidelines and protocols of the Department of Health and Grey's Hospital must be adhered to at all times;
- Professional attitude and behaviour whilst dealing with research participants must be exhibited;
- The Department of Health, hospital and its staff will not be held responsible for any negative incidents and/or consequences, including injuries and illnesses that may be contracted on site, litigation matters, etc. that may arise as a result of your study or your presence on site;
- You are required to submit to this office a summary of study findings upon completion of your research.
- You are requested to make contact with the Head of Clinical Unit – Oncology & Radiotherapy, **Dr. O. M-Koha**, at Grey's Hospital once you are ready to commence data collection.

Recommended by:

Dr. L. Naidoo
Senior Manager: Medical Services

Dr. K. B. Bilege
Hospital CEO

uMnyango Woxempilo : Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX 6a: Letter of information and consent in English



Dear Participant

INFORMATION

Thank you for agreeing to participate in the study. The information about the study is as follows:

Title of the Research Study: A framework of co-operative practice between radiation oncologists and traditional health practitioners in the management of patients with cancer in KwaZulu-Natal Province.

Principal Investigator/s/researcher: Ms Pauline Busisiwe Nomnga, MBL and M.Tech: Radiography (Therapy)

Co-Investigator/s/supervisor/s: Professor M.N. Sibiya, D.Tech: Nursing and Professor N. Gqaleni, PhD.

Brief Introduction and Purpose of the Study: Cancer is a health concern because of its mortality and morbidity in the population. Its incidence is escalating and could rise by 78% in 2030. Patients with cancer refer themselves between traditional healers and cancer treatment specialists, yet there is no cooperation between the two. The purpose of the study is to describe a viable practice framework by the two cancer service providers in the co-operative treatment of cancer patients and contribute to the development of traditional healing as a health system in KZN. Therefore I need your assistance to participate in this study. The study is a requirement for completion of my philosophy degree in Health Sciences.

Outline of the Procedures: If you agree to participate in this study, you will be required to sign the consent page and answer the questions That will be sent to you immediately after you have responded. After receiving the questions, you have 2 weeks in which to return the responses. You will be reminded every first week to return your responses. The questionnaire comprises of semi-structured questions interviewed by the researcher. The interview will take an hour and half. The interview consists of two demographic information and treatment of cancer. It is important that you answer the questions as openly and honestly as possible. Your responses will provide information on the questions the asked by the researcher. It is therefore vital to answer the questions.

At the end of the interview, we will schedule another interview at the time agreed upon by you. The questionnaire and the signed consent page must be handed to the researcher. Should you wish to be informed of what your information provide and or / the results of this study, note that this will be provided at the end of the last interview.

There are no foreseeable risks or harm to you that can be imposed by the research study to you. Also, you will not incur any research related injury or adverse reaction in this study. The study involves completing the questionnaire about a feasible practice framework by traditional health practitioners who treat cancer and radiation oncologists and demographic information. Participation in the study is voluntary. Should you decide not to be in the study any more, you can withdraw at any time.

Reason/s why the Participant May Be Withdrawn from the Study: You will not be advantaged or disadvantaged in any way should you choose to participate or not to in this study. A participant can withdraw from the study if they feel that they no longer wish to continue with the study. If you decide to do so, kindly inform the researcher. There is no obligation to complete the study. Should you decide to withdraw from the study after information was collected from you, please inform the researcher and your data will be returned to you or it will be destroyed at your request.

Benefits: The results of this study will improve the treatment outcome of patients with cancer. The researcher will benefit by obtaining a doctor of philosophy qualification and publishing in peer reviewed journals. The results will also be presented in conferences within South Africa and abroad.

Remuneration: You will not receive any monetary gift or remuneration of any kind for participation in this research study.

Costs of the Study: You do not pay anything to participate in the study. The only cost for participating in this study is the time it will take you to complete the questionnaire.

Confidentiality: All information and data will be kept strictly confidential. All questionnaires are coded to facilitate recording but no names will be written on the questionnaires. The list of participant's names and their corresponding research number will be kept on the computer which only the researcher has the password to access the information. The supervisor will only have access to the anonymous individual data on the researcher's computer and not the questionnaires and therefore will not be able to link the participant to this data. The research data, questionnaires and any other confidential information will be kept for five years thereafter it will be deleted by the researcher.

Persons to Contact in the Event of Any Problems or Queries: If you have any questions, concerns or problems at any time about the study or the procedures feel free to contact the researcher, Busisiwe Nomnga at 082 943 8688, 031-373 2509 (W) or via email at paulinenl@dut.ac.za or my supervisor Prof M.N. at 031-373 2606 and Prof N. Gqaleni at 084 727 0119. If you have any questions or concerns about ethical issues or your rights, or feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this study, please feel free to contact the Institutional Research Ethics administrator on 031-373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031-373 2382 or dvctip@dut.ac.za.



Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, P.B. Nomnga, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant

Date

Time

Signature / Right Thumbprint

I, P.B. Nkosi (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

P.B. Nomnga

Full Name of Researcher

Date

Signature

Full Name of Witness (If applicable) Date Signature

Full Name of Legal Guardian (If applicable) Date Signature

Full Name of Witness (If applicable) Date Signature

APPENDIX 6b: Letter of information and consent in isiZulu



Ngiyakubingelela mhlanganyeli

Siyabonga ukuba uvume ukuba yingxenywe yalolucwaningo. Imininingwane mayelana nocwaningo ingenzansi.

Isihloko socwaningo: Indlela abelaphi bendabuko abangasebenzisana ngayo nodokotela abajwayelekile ekwelapheni umdlavuza Kwazulu-Natal, eSouth Afrika.

Uncwaningi omkhulu: Ms P.B Nomnga, umfundi weziqu zobuDokotela.

Abambhekile: USolwazi M.N. Sibiya, D Tech: Nursing kanye noSolwazi N. Gqaleni, PhD.

Isingeniso esifishane kanye nenhloso yocwaningo: Ngizobe ngenza ucwaningo ngendlela izigulane ezinomdlavuza ezathola ngayo ukwelashwa ngenkathi zelashwa odokotela abajwayelekile.

Isifo somdlavuza siyinkinga kakhule emphakathini wonke ngenxa yokuthi uyabulala futhi ugulise. Ukudlondlobala kwalesisifo kungase kufike kumaphesenti angu 78 ngo 2030. Izigulane ezinalesisifo ziya kubelaphi bendabuko abelapha umdlavuza kanye nodokotela abajwayelekile abangochwepheshe ekwelapheni lesisifo, ukuze zithole ukwelashwa, kodwa akukho ukubambisana kulabelaphi bobabili. Lokhu kuye kwabangela ukuphazamiseka ekwelashweni kwaleziziguli.

Inhloso yalolucwaningo ukuba sithole futhi sichaze indlela lababelaphi abangasebenzisana ngayo ekwelapheni izigulane ezinomdlavuza. Lokhu sikwenza ukuze sithole esivivaneni ekuthuthukiseni abelaphi bomdabu njengohlelo lwezempilo Kwa Zulu-Natal. Ngakhoke ngicela usizo lwakho ukuba uhlanganyele ekupheni izimpendulo kulolucwaningo.

Ngifisa ukwazi ngento eyodwa. Ingabe ungazithumela izigulane ezinomdlavuza kodokothela abawayelekile ukuze zithole ukwelashwa. Uma uvuma sizokhubeka nalolucwaningo kodwa uma umgavumi angeke sisokhubeka. Ulwazi engizoluthola ngizolusebenzisa ukwenza ukuba kubengcono ukwelashwa kweziziguli ezinomdlavuza futhi ngikwazi ukuphetha iziqu zami zobudokotela kwezeMpilo.

Inqubo yohlelo: Uma uvuma ukuhlanganyela kulolucwaningo, kuzodingeka usayine ifomu lokuvuma elingezansi bese uphendula imibuzo embadlwana. Lemibuzo

imayelana nendlela ongasebenzisana ngayo nodokotela abajwayelekile ekwelapheni iziguli ezinomdlavuza kwaZulu-Natal. Kule interview kuzothatha esikhathi esingu 1-2 amahora. Kulokhu uzophendula imibuzo embadlwana emide nemifushane ngendlela ekungasetshenziswa ngayo ekwelapheni izigulane ezinomdlavuza, kwaZulu-Natal.

Kubalulekile ukuphendula imibuzo ngokucophelela. Izimpendulo zakho zingezwakala kahle uma uphendule imibuzo yonke. Ngakho kubalulekile ukuphendula yonke imibuzo ebuziwe. Uma sesiqedile nge interview, sizohlela enye ezayo ngesikhathi nosuku esizovumelana ngaso thina sobabili. Uma ufisa ukwazi ngemiphumela yalolucwaningo, ungachazelwa ngayo ekupheleni kwama interviews.

Ukungaphatheki kahle kwabangenele ucwaningo: Abukho ubungozi nokungaphatheki kahle kwabangenele lolucwaningo.

Inzuzo: Lolucwaningo luzosiza ekutheni kwenziwe wena nezinye iziguli ezinomdlavuza zikwazi ukuya kunoma yimuphi udokotela ezimkhethayo kodwa kungabi nazinkinga.

Izizathu ezingenza labo abayinxenye yocwaningo bengabe besaqhubeka nocwaningo: Uvumelekile noma yinini ukuphuma ungabi yingxenye yocwaningo uma ufisa ukwenza njalo.

Inkokhelo: Ayikho inkokhelo etholakalayo ngokuba yingxenye yocwaningo, kanjalo nalabo abayinxenye yocwaningo akulindelekile ukuthi bakhokhe ukuze babe yingxenye.

Ukugcinwa kwemfihlo: Yonke imininingwane iyogcinwa iyimfihlo, Igama lakho angeke libhalwe ezimpendulweni ozinikile, lezimpendulo ziyosetshenziselwa lolucwaningo kuphela. Wonke amaphepha aqukethe imininingwano ngocwaningo ayogcinwa ebhokisaneni elikhiyiwe bese kuthi konke okuwuhlelo lwamakhomputha kuvikelwe ngekhodi eyimfihlo eyokwaziwa kuphela ngumcwaningi.

Ukulimala okungenzeka ngenxa yocwaningo: Akukho ukulimala okungenzeka kuloluhlobo locwaningo.

Ongabathinta uma unemibuzo noma ofuna ukuchazelwa ngakho mayelana nalolucwaningo:

Thinta umcwaningi, PB Nkosi (Tel no 082 943 8688), umbhekeleli Solwazi. M.N. Sibiya (Tel no 031-373 2606), osizana naye, usoLwazi N. Gqaleni (Tel no 031-764 2970), or the Institutional Research Ethics administrator on 031-373 2900. Izikhalazo zingabikwa ku DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.



ISIVUMELWANO

Isivumelwano sokuhlanganyela kucwaningo:

- Ngiaqinisekisa ukuthi ngithintwe umcwaningi, u B.P. Nomnga, ngemvela phi inzuzo, (nobunzima) bocwaningo. Inombolo yemigomo yocwaningo:_____.
- Ngitholile, ngafunda ngazengaqondisa ngokumbandakanyeka kwalo locwaningo.
- Kusobala kimi ukuthi imiphumela yalolu cwaningo ihlangene nezimfihlo zami maqondana nobulili, iminyaka, usuku lokuzalwa. Amagama ami kumbe ibizo lami kuzoba imfihlo kulolucwaningo.
- Umangibheka izidingo zocwaningo ngiya vuma ukuthi yonke imininingwane eqoqekengesikhathi kucwaningwa, kungenzeka igcinwe kwisi khahlamezi umcwaningi.
- Kungenzeka noma kunini nga phandle kwesivumelwano ngihoxe ekuzibandakanyeni kocwaningo.
- Sengibenesikhathi esanele ukubuza (nginga phoqiwe) ukuzilungiselela ngizabandakanye nocwaningo.
- Ngiaqonda ukuthi lonke ulwazi olwanele olutholakale ngokuzimba ndakanya kwami kulolucwaningo ngiyokwaziswa ngalo.

Igama eliphelele

Usuku

Isikhathi Soyina/kwesokudla

Isithupha isigxivizo

Mina mcwaningi B.P. Nkosi (igama lomcwaningi) ngiaqinisekisa ukuthi lombandakanyi ongenhla uchazelwe ngokuphelele ngemvelaphi, izimiso, zocwaningo.

Igama eliphelele lomcwaningi

Usuku

Isikhathi

Igama eliphelele lofakazi

Usuku

Sayina

Igama eliphelele lomgcini osemthethweni Usuku

Sayina

APPENDIX 7: Interview guide for the Radiation Oncologists

Section A: Demographic information

1. Age: _____
2. Gender: _____
3. Race: _____
4. Years in practice as oncologist _____
5. Position:
Please tick (X) where appropriate.

Oncologist	Senior specialist	Head of Department
------------	-------------------	-----------------------

6. Employment status

Full time	Part time	Contract
-----------	-----------	----------

7. Are you willing to work to cooperate with traditional health practitioners in the treatment of patients with cancer?

Yes	No
-----	----

Section B: Co-operative practices in the treatment of cancer with patients

1. What is your experience in treating a cancer patient who is consulting or has consulted a traditional healer?
2. What is your opinion with regard to combined allopathic and traditional medicines treatment medicines?
3. What are your perceptions about a traditional health practitioner in treating patients with cancer?
4. What are your perceptions with regard to co-operative practice between you and the traditional health practitioners in the treatment of patients with cancer?

5. What are the common grounds for co-operative between the health practitioners in the treatment of patients with cancer?

APPENDIX 8a: Interview guide for the Taditional Health Practitioners in English

Section A: Demographic information

1. Age: _____
2. Gender: _____
3. Race: _____
4. Home language: _____
5. Place of residence: _____
6. Level of education: _____

Please tick where applicable (X)

iDiploma	Level of education	No schooling	Grade 1-7.	Grade 8-12	Graduate
----------	--------------------	--------------	------------	------------	----------

7. Type of THP. Please tick where applicable (X)

Diviner	Traditional herbalist	Spiritual healer
---------	-----------------------	------------------

8. Work Experience

9. Registered with THP organisation

Yes	No
-----	----

Section B: Role and practices in the treatment of patients with cancer

10. What is cancer?
11. How do you diagnose cancer?
12. What do you do when a patient has been diagnosed with cancer?
13. What type of cancers do you treat?
14. What is your goal in the treatment of patients with cancer?
15. How do you know that you have reached your goal?
16. How long is the survival of patient after treatment?
17. How many patients have you treated successfully?
18. What do you do if your treatment is unsuccessful?

Section C: Co-operative practices in the treatment of cancer with patients

1. What is your experience in treating a cancer patient who is consulting or has consulted a traditional healer?
2. What is your opinion with regard to combined allopathic and traditional medicines treatment medicines?
3. What are your perceptions about a traditional health practitioner in treating patients with cancer?
4. What are your perceptions with regard to co-operative practice between you and the traditional health practitioners in the treatment of patients with cancer?

5. What are the common grounds for co-operative between the health practitioners in the treatment of patients with cancer?

APPENDIX 8b: Interview guide for the Traditional Health Practitioners in isiZulu

Ingxenye A: Imininingwane

1. Iminyaka yobudala: _____
2. Ubulili: _____
3. Ubuhlanga: _____
4. Ulwimi lwasekhaya: _____
5. Ikhaya endaweni yokuhlala: _____
6. Izinga lemfundo: _____

Ngicela uphawule lapho kufanele (X)

Imfundo yasesikoleni	Ibanga A kuya kubanga 1	Ibanga 1-6.	iSecondary School	Umatiku-letsheni	iDiploma	iDegree	iPost-graduate
----------------------	-------------------------	-------------	-------------------	------------------	----------	---------	----------------

7. Uhlu lodokotela womdabu:

Ngicela uphawule lapho kufanele (X)

Isangoma	Inyanga	Umthandazi
----------	---------	------------

8. Iminyaka oprakthise ngayo njengodokotela womdabu:

9. Ukubhalisa ne organisation yodokotela bomdabu:

Yebo	Cha
------	-----

Ingxenye B: Ulwazi nenhloso ekwelapheni izigulane ezinomdlavuza

1. Uyini umdlavuza?
2. Wazi kanjani ukuthi isiguli sinomdlavuza?
3. Wenzanjani uma isiguli sinomdlavuza?
4. Yizigulane ezinamuphi umdlavuza ozelaphayo?
5. Uma uzelapha ingabe yimuphi umphumela owuhlosile?
6. Wazi kanjani ukuthi uwufinyelele lowomphumela?
7. Izigulane ziphila isikhathi esingakanani ngemva kokuba usuzilaphile?
8. Zingakhi izigulane osuke wazelapha?
9. Wenzanjani uma ungakwazi ukuwelapha umdlavuza?

Ingxenye C: Ukwelashwa kwezigulane ezinomdlavuza ngokuhlanganyela ngabelaphi bendabuko nabasentshonalanga.

1. Ngicela uke ungixoxele kabanzi ngesipiliyoni sakho ngokwelapha isigulane esinomdlavuza esiya noma esiye kudokotela wasentshonalanga nakuwena.
2. Uyini umbono wakho ngesigulane esilashwa ngokuhlanganyela abelaphi bendabuko nabasentshonalanga?
3. Uyini umbono wakho ngodokotela ekwelapheni isigulane esinomdlavuza?
4. Uyini imbono wakho ekuhlanganyeleni nabelaphi basentshonalanga ekwelapheni umdlavuza?
5. Yimiphi imigomo engalandelwa ukwenza lokhukubambisana kube yimpumelelo ekwelapheni izigulane ezinomdlavuza?

APPENDIX 9: A sample of the transcript of the Radiation Oncologists

Participant 1

SECTION A: DEMOGRAPHIC INFORMATION

Age 45 years old, years of experience as radiation oncologists more than 10 years, Head of Department, employed full time and is willing to cooperate with THPs in the treatment of patients with cancer. His mother tongue is English.

SECTION B: CO-OPERATIVE PRACTICE IN THE TREATMENT OF PATIENTS WITH CANCER.

1. What is your experience in treating a cancer patient who uses a combination of THPs and ROs treatment for cancer treatment?

I have not seen too many patients that were referred by THPs. Some patients have told us that they have had treatment before coming to us but we don't know any details of this treatment like how long it was given. Some patients refuse to have chemo and say that they want to go back to THPs. I did not have any interaction with a THP before. However some patients indicated that they have been to THP but we don't know what form of medication or treatment they have received as well as the duration of the treatment and the role of treatment in cancer.

2. What are your perceptions about a patient who uses combined treatment of THPs and ROs in the treatment of cancer?

There is no proof that TM or practices can be used in cancer patients. What we practice is evidence based. I have never seen any evidence or research about THPs practices or TM for cancer treatment. I cannot recommend this for now because of there is no evidence that it can be used. Some patients choose to take that route but it is their choice. We don't know how this treatment is applied, there is no guideline or recommendations we can study or learn from research about this.

3. What are your perceptions about the THPs in treating patients with cancer?

It will be a new collaborative work and a new task for us. If the THPs want to collaborate with us we don't have a problem, we can talk, understand and learn from each but to use this treatment is still difficult for now. I want to know

their knowledge of cancer, what is cancer, different types of cancer, how to diagnose cancer, how do they treat different cancers, do they use the same type of treatment for all cancer. I know that they will not be able use the same treatment as ours but we need to understand how they apply their knowledge and treatment in cancer.

4. What are your perceptions regarding co-operative practice between the THPs and ROs in the treatment of patients with cancer?

Before we start cooperating we need to talk and know each other and what they do and once we understand that we can think of a framework or standard approach to what they can offer to cancer patients. It is difficult for now to define any viable practice because I don't know what exactly they do then we can decide what is possible that can be done between us and them.

We only hear about THPs treating cancer patients but we have never seen them, hear from them and don't know what they do. In my opinion that is usually not a safe approach for the patient. Usually patients go to THPs and later to us presenting with disseminated and advanced disease making it difficult for us control cancer.

5. What cooperation is required between the two health care practitioners in cancer treatment?

I am keen to know how we can help each other, help patients by talking together, guidelines or recommendations when to see patients and when they can be treated by THPs because eventually they will come to us. It is an important subject to talk about.

You have mentioned that the government in 1994 gave THPs permission to work with us, however, we don't know the limits of that permission we would like to know what their vision is about that and what THPs' perception in treating cancer. It is difficult to understand and treat. We need to know what they do. How they gained it and how they apply it. If we find that it is safe and possible we will cooperate with them from the diagnosis of patient to completion of treatment or till they cannot be treated anymore. If we can know their role in cancer treatment we will cooperate with them.

**APPENDIX 10a: A sample of the transcript
of the Traditional Health Practitioners in
English**

Participant 3

SECTION A: DEMOGRAPHIC INFORMATION

A 60-year old male with standard six level of education and has 47 years practicing as a traditional herbalist.

SECTION B: TREATMENT OF CANCER

1. What is cancer?

Cancer is a sore that doesn't heal. It invades the surrounding tissue and ends up affecting the blood in that the blood cannot flow properly and end up making a clot of blood. The cancer will then grow from this clot inside and becomes visible as cancer like for example cancer in the rectum, throat, prostate or cervix. As it continues to grow in these organs, eventually it affects the brain and the patient is affected psychologically, or the bones can be affected and the patient concludes that she or he has arthritis.

I can also say that cancer is a disease that results in many other diseases, which affect the body in many ways like having infectious disease like a drop, affecting your brain or bones. Patients often are affected psychologically, or may have pain when passing stools, or if in the throat and private parts having signs of a drop. It ends up in the brain such that a patient gets crazy, or in the bones of the arm (as if you have arthritis) and other parts of the body.

Some patients with cancer lose weight, look tired, unable to swallow food, develop pimples on the face. Patients will tell you that they cannot control their urine. I tell the patient to stop whatever medication that the hospital has given them and give them my own medicine.

Some will have hoarseness of the voice and a tracheostomy. They have a sore that continues to grow and they will tell you that the hospital has tested their sugar level and it was normal yet the sore continues to grow. They also develop an oozing wound on the neck. Sometimes pus comes out of the sore. I tell the patient to stop whatever medication that the hospital has given them and give them my own medicine.

Ancestors will tell you what's wrong with the patient and also on discussion the patient will tell you the symptoms of cancer. Others are coming with the diagnosis from the hospital. We give them medicine to drink and something to apply on the wound. If you can't treat the patient then you should refer the patient.

Cancer is a sore that does not heal but continues to grow and develop pus and eventually bleeds.

Cancer results from the type of food we eat. Sometimes it is caused by putting snuff in the vagina or results from abortion. Sometimes it is in the family as *umkhokha* (meaning family disease). In this way we will give an appropriate treatment.

2. How do you know a patient has cancer?

I use ancestral spirits to diagnose a patient. I also refer the patient to the clinic in order to confirm the patient's diagnosis because I do not want to rely on my diagnosis to give the correct treatment. Like I have said that cancer is many diseases therefore I would not like to conclude on the diagnosis and treat the disease according to my diagnosis. It is for that reason that I refer the patient to the hospital because they have the right equipment to diagnose the diseases in patients.

However, when I refer a patient to the hospital, they don't come back if they were diagnosed with cancer because the doctors tell them not to come to us. We are being undermined and I think this is the reason why we are not known as cancer specialists. This is a problem that needs to be resolved and I am sure the hospital and the THPs can resolve this matter. If a patient can come back, I can discuss with the patient the diagnosis and agree that I can give treatment.

I throw bones and confirm that the patient has cancer but I do not start treating the patient instead I refer them to the hospital to confirm the diagnosis

at the hospital. I do not like to start treatment without having confirmed the cancer because I avoid treating patients incorrectly as some patients can present with cancer symptoms when in actual fact they have ancestral spirits. After cancer has been confirmed, if the patient can come back, I will involve the patient in decision making with regard to treatment. However, patients do not come back after their referral to the hospital because they are told not to come to us.

3. What do you do when a patient has cancer?

Most of the time patients do not come back to us after referral. They only come back when the hospital has failed them.

I treat patients that have not started treatment with ROs. It is not proper for a patient to receive treatment from both healers simultaneously.

I have successfully cured patients with cancer of the breast and advanced cervix. The duration of treatment depends on the stage of cancer. Early stage take 3 days to three weeks, but the advanced cancer takes almost a month.

Patients with cancer end up having backache. Cancer of 6 years is not the same as the one of 6 months with regard to treatment.

I only treat successfully patients who have not been to the hospital and those are cancers of the cervix.

4. What type of cancers do you treat?

I treat patients with cancer of the breast, bladder, kidneys and oesophagus.

5. What do you want to achieve?

When a patient has not yet had any treatment from the doctors, I treat them in order to cure this disease.

6. How do you know that you have achieved your goal?

The cancer will not show on the breast and the patient will tell me that they do not have pain any more. Some go to the hospital and ask to be checked for cancer and doctors tell them that they don't have cancer anymore.

7. How long do your patients survive?

I have treated patients in 2003, 2006, 2010 and 2011 and they are still alive except for those who were killed by other diseases other than cancer

8. How many patients have you treated successfully?

I know of patients who are disease free about ten but the 11th one died in hospital of another disease other than cancer.

9. What do you do if you cannot treat a patient successfully?

I have never had a patient that I could not treat successfully.

SECTION C. CO-OPERATIVE PRACTICE IN THE TREATMENT OF CANCER

1. What is your experience in treating a cancer patient who uses a combination of THPs and ROs treatment for cancer treatment?

There are many but I will quote one. The patient was at that stage that he could not control his urine. I started treating this patient but he absconded before completing his treatment. He did not inform me that he was getting treatment simultaneously from the ROs until someone warned me about this conduct. I discussed with the patient that it is not advisable to take treatment simultaneously from both health practitioners. I then asked the patient to complete treatment with ROs before coming to me. He refused to take my medicine insisted to be treated by doctors.

2. What are your perceptions about a patient who uses combined treatment of THPs and ROs in the treatment of cancer?

The patients should be told how each treatment each health practitioner works. They should be told that the two treatments should not be used simultaneously, they should then make a decision of which treatment they want.

We as health practitioners should learn to respect each other. We should also guide our patients in their referral to the health practitioners. We need to know that we cannot do everything on our own but need each other in order to fight cancer.

We as THPs need to teach each other that a patient should be asked if they have already visited the ROs to confirm their diagnosis, if not then refer the patient to the hospital for diagnosis. We should agree on the procedure to treat cancer patients and how to follow it during management of cancer patients.

Patients consult with both health practitioners because they are in pain and seek cure. Their choice of treatment is influenced by the pain and they will take any advice from the people with regards to the choice of treatment.

Patients should be told to complete their treatment before visiting the other health practitioner without fighting over patients.

We need to work together in researching what can be done about cancer.

3. What are your perceptions about the ROs in treating patients with cancer?

They rush to operate on patients to treat cancer yet black people do not need operations. Yet we as THPs, give medicine to cure cancer anywhere in the body.

However, doctors would not refer patients to us because they undermine and tell patients not to consult with us.

Doctors need to fix this because we need to work together.

4. What are your perceptions regarding co-operative practice between the THPs and ROs in the treatment of patients with cancer?

As we are being undermined in treating patients with cancer, currently we are not yet free to discuss any treatments with them because they tell patients not to consult us yet; we have capabilities in the cure of many diseases. We use traditional medicine which doesn't have any harm because it is natural.

5. What cooperation is required between the two healthcare practitioners in cancer treatment?

We need to be recognised that we can treat cancer.

We need to discuss each other's role in the treatment of cancer and the health practitioners should not interfere on how the other group treats cancer patients.

Refer patients between each other.

Guide patients they refer themselves between us.

Work together in researching the cure of cancer.

Where possible we need to be taught how to diagnose cancer so that we can also be able to diagnose some patients. In that way we can also discuss the same treatment options with the patient and guide the patient in their choice of treatment.

We already have a clinic where all THPs can be taught how to diagnose patients. Amongst THPs, the diviners are able to diagnose a disease and refer patients to the herbalists

Some THPs should be trained to use the doctors' instruments of diagnosing cancer. We aspire to increase our knowledge with regard to the treatment of

cancer. We would like to share knowledge with the world and compete globally.

**APPENDIX 10b: A sample of the transcript
of the Traditional Health Practitioners in
isiZulu**

UMHLANGANYELI 3

INGXENYE A: IMINININGWANE

Uyindoda eneminyaka engu 60 ofunde wafinyelela ebangeni lesithupha futhi usesebenze njengenyanja iminyaka engu-47.

INGXENYE B: UKWELASHWA KOMDLAVUZA

1. Uyini imdlavuza

Umdlavuza uyisilonda esingapholi esiqhubeka sidlavuza inyama yomuntu size sifinyelele egazini bese senza igazi lingahambi kahle. Bese kuthi lapho igazi lime khona kwakheka isilonda esizobese sikhula ngaphakathi. Lessilonda sizoqhubeka sikhula size sidale umdlavuza. Lomdlavuza uzoqala ukhule ngaphakathi uze uphumele ngaphandle. Njengoba ukhula njena uze ufinyelele ekhanda ubone umuntu esenekhanda elingathathi kahle. Ngesinye isikhathi umuntu uzozizwa eqaqanjelwa amthambo aze acabange ukuthi unesifo samathambo kanti yiso lesisifo sesiza safinyelela emathanjeni.

Ngingathi futhi umdlavuza uyisifo esigcina sibangela ezinye izifo eziningi ezingaba khona emzimbeni njegezifo ezithathelanayo zangokocansi. Isiguli sigcine singasakwazi ngisho nokuya endle kahle.

Ezinye iziguli ezinomdlavuza ziyonda , zibukeke zikhathele, zingakwazi nokugwinya zivele nezinduna ebusweni. Njengoba besengishilo ngaphambili zigcina zibe naso lesisifo ekhanda nasemathanjeni, zingakwazi nokulawula umchamo. Abanye baba namaphimbo ahosholezayo noma bagcine sebabafake lento yodokotela yokuvula umphimbo. Bazokutshela ukuthi sebenesikhathi belashwa esibhedlela kodwa kungabi nomehluko. Isigulani sichaza nokuthi odokotela sebebheke nesifo sikashukela kodwa kwangatholakala lutho. Ziphinde futhi zibe nesilonda esihlala sigxza igazi lapha entanyeni. Kokunye kuphuma nobovu kuso lesilonda.

Uma isigulane siza kimi ngalesisikhathi ngisitshela ukuthi sishiye yonke imithi esiyiphuzayo bese ngisipha owami umuthi. Abaphansi baye babonise ukuthi isigulane siphethwe yini. Kanti futhi ungake uxoxisane naso belu isigulane bese sichaza izimpawu zomdlavuza. Kodwake um ngingakwazi ukxelapha isigulane ngiyaye ngisithumele kwabanye abelaphi.

Umdlavuza udalwa okunye ukudla esikudlayo, ukufakwa kwesinefu esithweni sesifazane noma ukukhishwa kwezisu omama. Ngesinye isikhathi kungenxa yabaphansi noma kumane nje kungumkhokha okhona emndenini. Thina njengabelaphi bendabuko siyakhona ukunika izigulane umuthi okwaziyo ukuzelapha lezizifo.

2. Wazi kanjani ukuthi isigulane sinomdlavuza

Ngiyabhula abaphansi bese bengitshela noma mhlawumbe ngithumela isigulane esibhedlela ukuze baqiniseke ukuthi ngempela isigulane sinomdlavuzo. Angiyaye ngithande ukuthi ngelaphe isigulani ngokwencika kokwami ukuqonda. Ngipha izigulane umuthi uma nje esibhedlela lesiqinisekisile ukuthi isigulane sinomdlavuza. Isizathu salokhu wukuba esibhedlela banayo imshini yokupopola iziguli ukuze bazu ukuthi imgabe ziphethwe yisiphi isifo.

Kanti futhi njengoba sengishilo ukuthi umdlavuzwa uyizifo eziningi yingakho kungekho kuhle ukumane welaphe isiguli ungakaqinisekisi ukuthi ingabe ngempela isigulane sigula kangakanani.

Ngeshwa uma sithumela iziguli esibhedlela azingabe zisabuya ngoba uma abalaphi abajwayelekile bazitshela ukuthi zingezi kubelaphi bendabuko. Lokhu kungenxa yokuthi lababelambi basibhekela phansi abathembi ukuthi siyakwazi ukwelapha. Futhi abasinaki nokuthi nathi sinobuchwepheshe ekwelapheni lesisifo.

Lento iyinkinga ngempela ngoba kufanele sisebenzisane ekufuneni ikhambi lalesisifo. Ngakhoke abelaphi abajwayelekile kuyodingeka baxoxisane nezigulane bazazise ukuthi nathi siyakwazi ukwelapha lesisifo.

Kodwa uma isigulane singabuya uma sesazi ukuthi siphethwe umdlavuzwa kungadingeka sizikhethela ukuthi singathanda ukuba selashwe ngubani, Okwamanje sisathembele kwizangoma ekucwaningeni izigulani ezinomdlavuzo. Futhi naso isibhedlela kudingeka siphe izigulane ithuba lokuthi zikhetha ukuthi zingathanda ukwelashwa yimuphi umelaphi.

3.Wazi kanjani ukuthi isigulane sinomndlavuzwa?

Njalo nje iziguli azizi kithi uma sekutholakele ukuthi ziphethwe umdlavuzwa. Kodwa esezike zeza kimi ngiye ngaphumelela ukwelapha iziguli ebeziphethwe umdlavuzo wesibeletso kanye nowebele. Kuye kutha izinsuku ezintathu kuya emavikini amathathu noma ukuya enyangeni ekwelapheni isigulani esinomdlavuzwa osunesikhathi esincane nomaosunesikhathi eside. Uma kuza ekwelapheni umdlavuzwa osnesikhathi awelapheki kalula uma uqhahanisa nalowo osunesikhathi esincane. Futhi ngelapho ngokuphumelelayo uma isiguli singakaze silshwe esibhedlela.

4 Yiziphi izigulane osuke wazelapha?

Izigulane ezinomdlavuzwa wezinso, ibele, isibeletso Kanye nesinye.

5 Ume welapha isigulane esinomdlavuzwa usuke uhloseni?

Ngihlose ukuthi ngelaphe umdlavuzwa ukuthi ungsaphindi ube khona.

6 Wazi kanjani ukuthi uwufinyelele umgomo ekwelapheni?

Ngizobona ngokuthi umdlavuzwa ungasabikho nomaisigulane singitshela ukuthi asisezwa buhlungu ngemva kokuba seselashiwe.

7 Ziphila isikhathi esingakanani izigulani osuke wazelapha.

Izigulane engizelaphe ngo 2003, 2006, 2010 and 2011 zisaphila nakuba kunesisodwa esiye sadlula emhlabeni kodwa bekungengenxa yomdlavuzwa ngoba siye sashona engozini yemoto.

8 Zingakhi izigulane osuke wazelapha?

Zingase zibe yishumi ngaphandle kwales ebesingike ngakhuluma ngaso.

9 Wenzanjani uma ingakwazi ukuselapha isigulane.

Kuzo zonke izigulane esengike ngazelapha asikho nesisodwa engake ngahluleka ukuseplapha. Kodwa uma kwenzeka ngehlulela ukuselapha ngingasithumela kwabanye abelaphi.

INGXENYE C: UKUSEBENZISANA KWABELAPHI BOMDABU NABAJWAYELEKILE EKWELAPHENI ISIFO SOMDLAVUZA

1. Siyini isipiliyoni ekwelapheni izigulane eziya kubelaphi bendabuko nabajwayelekile?

Lesigulane besesinmdlavuza obusunesikhathi ngoba besingasakwazi ngisho nokulawula ukukhishwa kwamanzi. Ngemva kokuba sengiqale ukwelashwa lesisigulane siye sanyamalala ngaphambi kokuba siqede ukwelashwa. Lesisigulane besingazange sichaze ukuthi silashwa abelaphi ababili.

2. Uyini umbono wakho ngabelaphi abajwayelekile ekwelapheni izigulane ezinomdlavuza?

Iziguli kudingeka zichazelwe ukuthi akumelwe zelashwe abelaphi ababili ngesikhathi esisodwa. Iziguli kumelwe zichazelwe ukuthi ngamunye umelaphi usebeza kanjani ekwelapheni. Njengabelaphi kumelwe sihloniphane futhi sibonise iziguli ukuthi zingalashwa kanjani una zidinga ukwelashwa ngabalaphi bobabili kodwa akufanele balashwe ngesikhathi esisodwa, Asikwazi ukusebenza ngamunye ekwelapheni izigulane zomdlavuza kunalokho siyadingana ukuze silwisane nalesisifo. Njengabelaphi bomdabu siding ukufundisa futhi sikwazi nokubuza iziguli ukuthi ingae ziye zaya kwabanye abelaphi.

Izigulane ziya kubelaphi bobabili ngesikhathi esisodwa uma zisezinhlungwini bese zithatha noma iziphi iziluleko. Kumelwe sizifundise ukuthi ziqede ukwelashwa wumelaphi ngaphambi kokuba zidlulele phambili. Kumelwe sisebenze ndawonye ukuze sikwazi ukuthola ikhambi lalesisifo.

3. Uyini umbono wakho ngabelaphi abajwayelekile ekwelapheni umdlavuza?

Baje basheshe ukusika iziguli bakhohlwe ukuthi abantu abansundu abadinge kusikwa. Kanti thina belaphi bendabuko sinawo umuthi wokwelapha umdlavuza ongaba noma kuphi emzimbeni ngaphandle kokuhlizwa. Nakuba kunjalo abelaphi abajwayelekile abake bathumele izigulane kthi ngoba besebhekela phansi baze batshele izigulane ukuthi zingazi kithi. Kuzodingeka ukuthi bayilungise lendaba ngoba kudingeke sisebenze ndawonye.

4. Uyini umbono ngokusebenza ndawonye nabelaphi abajwayelekile ekwelapheni isifo somdlavuza?

Okwamanje asikwazi ukukhululeka ukuthi sixoxe ngokusebenza ndawonye ekwelapheni izigulane ezinomdlavuza ngoba batshele izigulane ukuthi zingezi kithi lokhu thina sikwazi ukwelapha izigulane ezinomdlavuza kant fithi nemithi yethu ayilimazi ngoba eyemvelo.

5. Ningasebenzisana kanjani nabelaphi abajwayelekile ekwelapheni isifo somdlavuzo?

Kuzodingeka bakunake ukuthi siyakwazi ukwelapha isifo somdlavuzo, nokuthi sixoxisane ngokuthi yini esikwaziyo ngamunye kubelaphi bendabuko nabajwayelekile ekwelapheni izigulane ezinomdlavuzo. Akumelwe omunye nomunye angenele ekutheni isiguli selashwa kanjani. Kumelwe sithumele iziguli komunye nomunye futhi neziguli zifundiswe ukuthi sisebenza ndawonye.

Kokunye bangase basifundise ukuthi singazicilonga kanjani izigulane eziomdlavuzo. ukuze athi sikwazi ukukhulumisana neziguli mayelana nokuthi zikhetha ukwelashwa yimuphi umelaphi.

Sesinawo kakade umtholampilo lapho abelaphi beqeqeshwa khona ukucilonga iziguli. Phakathi kwethu belaphi bomdabu, izangoma kuphela ezikwaziyo ukucilonga izigulane bese zithumela izigulane kubelaphi abayizinyanga.

Singajabula uma abanye babelaphi bangaqeqeshwa ukuze bakwazi ukusebenzisa amathulusi asetshenziwa odokotela abajwayelekile ekucilongeni izigulane. Nathi singakujabulela ukukhulisa ulwazi lwethu kwezokwelapha umdlavuzo ukuze sikwazi ukuqophisana nomhlaba wonke jikelel,

**APPENDIX 11: Register of the attendees of
the Traditional Health Practitioners meeting
on 18 March 2015 at the Provincial
Department of Health**

REGISTER

MEETING: TJP
18 MARCH 2015
CAPITAL TOWERS, 3RD FLOOR, ROOM 307

NAME/SURNAME	DISTRICT	DESIGNATION	TEL. NO.	E-MAIL
Renele Makenani	ETHEKWINI	<i>(Signature)</i>	0791153314	-
Thomson Mlambo	ETHEKWINI		0824050519	-
Alfred Kwayile	ETHEKWINI	<i>(Signature)</i>	0837887864	-
Celine Mhlongo	AMATJUBA	<i>(Signature)</i>	0737744980	-
Busi Nondoo	ETHEKWINI	DUT	0809438088	nondoo@yohani.com
Rose Potade	ETHEKWINI	TAPC	0815603180	-
NOBONGI KAKA	ETHEKWINI	FHO	073539986	-
ZANELE SITHOLE	ETHEKWINI	T.H.O.	0732506307	zanele.sithole@gmail.com
THERESA and LOU	ETHEKWINI	T.H.O.	0823619902	-
Wendy Saramba	"	<i>(Signature)</i>	0823785137	-
STZIG. MHLONGO	ETHEKWINI		08236281425	-
Nomvulano P. Mero	HARLEY GAWA	DISTRICT CHIEF	0792895844	N/A
Thandiswa Mlambo	Hlangwani District	CLERK	0824050819	TA

REGISTER

MEETING: TUP
18 MARCH 2015
CAPITAL TOWERS, 3RD FLOOR, ROOM 307

NAME/SURNAME	DISTRICT	DESIGNATION	TEL. NO.	E-MAIL
Ntshona Khathele	Amathole	Chairperson	0825550666	
Nceba Gqaleni	eThekweni		0847270119	nceb5850@gmail.co
Shanele Mkhala	D.O.H	Chairperson	0121338692	shanele.mkhala@capetown.gov.za
Lessee Mupeni	Ilembe DOH	olm	0725388280	lessee.mupeni@capetown.gov.za
Musube Hamity	uThungulu	IHP	08346030898	
Sibusiso Gumede	ILembe	TUP	0835022529	
Shanele Mkhala	Ilembe	IHP	0730531288	shanele.mkhala@capetown.gov.za
R. Mqwenya	uThungulu	" "	0733498155	
Md. P. Mkhathini	uThungulu	Chairperson	0764645247	
S. Mkhathini	uThungulu	Secretary	0789631631	smkhathini@gmail.com
Thabani Dlamini	uThungulu	Chairperson	0833741670	
Mkhathini Nkomo	uThungulu	Secretary	0783101211	
Phumzile Mkhize	uThungulu	Secretary	0781319994	

REGISTER

MEETING: TUP
18 MARCH 2013
CAPITAL TOWERS, 3RD FLOOR, ROOM 307

NAME/SURNAME	DISTRICT	DESIGNATION	TEL. NO.	E-MAIL
Melrose, M. M. M.	W. H. H. H.	-	0717728820 0716491884	-
M. S. S. S. S.	W. H. H. H.	-	08366419077	-
B. P. S. S. S.	W. H. H. H.	-	0828396822	-
P. C. K. H. H.	W. H. H. H.	-	0726193504	-
C. R. N. H. H.	W. H. H. H.	-	042512110	-
B. V. M. H. H.	W. H. H. H.	-	0735609525	-
A. V. M. H. H.	W. H. H. H.	-	0820570120	-
C. J. H. H. H.	W. H. H. H.	-	0837884408	-
L. F. S. H. H.	W. H. H. H.	-	0716330001	-
M. F. H. H. H.	W. H. H. H.	-	0834899880	-
M. R. S. H. H.	W. H. H. H.	-	0730618946	-
M. S. N. H. H.	W. H. H. H.	-	0842795458	-
M. M. H. H. H.	W. H. H. H.	-	083467217	-

MEETING: TEP
18 MARCH 2015
CAPITAL TOWERS, 3RD FLOOR, ROOM 307

022857

APPENDIX 12: Certificate of editing from the professional editor

DR RICHARD STEELE

BA, HDE, MTech(Hom)

HOMEOPATH and EDUCATOR

Registration No. A07309 HM

Practice No. 0807524

Freelance academic editor

110 Cato Road

Glenwood, Durban 4001

031-201-6508/082-928-6208

Fax 031-201-4989

Postal: P.O. Box 30043, Mayville 4058

Email: rsteele@telkomsa.net

EDITING CERTIFICATE

Re: Pauline Busisiwe Nkosi

**Master's dissertation: A FRAMEWORK OF CO-OPERATIVE PRACTICE BETWEEN
RADIATION ONCOLOGISTS AND TRADITIONAL HEALTH PRACTITIONERS
IN THE MANAGEMENT OF PATIENTS WITH CANCER IN KWAZULU-NATAL
PROVINCE**

I confirm that I have edited this dissertation and the references for clarity, language and layout. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at UCT was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University of Technology). During my 13 years as a part-time lecturer in the Department of Homoeopathy I supervised numerous Master's degree dissertations.

Dr Richard Steele
25 September 2016
electronic

DR RICHARD STEELE

BA, HDE, MTech(Hom)

HOMEOPATH and EDUCATOR

Registration No. A07309 HM

Practice No. 0807524

Freelance academic editor

110 Cato Road

Glenwood, Durban 4001

031-201-6508/082-928-6208

Fax 031-201-4989

Postal: P.O. Box 30043, Mayville 4058

Email: rsteele@telkomsa.net

EDITING CERTIFICATE

Re: Pauline Busisiwe Nkosi

**Doctoral thesis: A FRAMEWORK OF CO-OPERATIVE PRACTICE BETWEEN
RADIATION ONCOLOGISTS AND TRADITIONAL HEALTH PRACTITIONERS
IN THE MANAGEMENT OF PATIENTS WITH CANCER IN KWAZULU-NATAL
PROVINCE**

I confirm that I originally edited this thesis, and have now re-edited it in accordance with the typographical requirements of the Examiners.

Dr Richard Steele
26 December 2016
electronic

APPENDIX 13: An example of theme from raw data to conclusions

EXAMPLE OF THEME FROM RAW DATA TO CONCLUSIONS

A. DATA COLLECTION AND ANALYSIS

In this section, the researcher provides an example of a theme from raw data, collected from THP. The theme selected is, the treatment of cancer patients by a THP.

Interviews were used to collect data, and the responses were audio-recorded. The responses were then transcribed verbatim.

The questions utilised to collect data were in isiZulu, and were as follows:

1. *Uyini umdlavuza?*
2. *Wazi kanjani ukuthi isiguli sinomdlavuza?*
3. *Wenzanjani uma isiguli sinomdlavuza?*
4. *Yizigulane ezinamuphi umdlavuza ozelaphayo?*
5. *Uma uzelapha ingabe yimuphi umphumela owuhlosile?*
6. *Wazi kanjani ukuthi uwufinyelele lowomphumela?*
7. *Izigulane ziphila isikhathi esingakanani ngemva kokuba usuzilaphile?*
8. *Zingakhi izigulane osuke wazelapha?*
9. *Wenzanjani uma ungakwazi ukuwelapha umdlavuza?*

Translating these into English, the following questions were asked from the THP:

19. What is cancer?
20. How do you diagnose cancer?
21. What do you do when a patient has been diagnosed with cancer?
22. What type of cancers do you treat?
23. What is your goal in the treatment of patients with cancer?
24. How do you know that you have reached your goal?
25. How long is the survival of patient after treatment?
26. How many patients have you treated successfully?
27. What do you do if your treatment is unsuccessful?

The interview data or raw data collected in isiZulu, and audio-recorded, was as follows:

1. Uyini imdlavuza

Umdlavuza uyisilonda esingapholi esiqhubeka sidlavuza inyama yomuntu size sifinyelele egazini bese senza igazi lingahambi kahle. Bese kuthi lapho igazi lime khona kwakheka isilonda esizobese sikhula ngaphakathi. Lessilonda sizokhubeka sikhula size sidale umdlavuza. Lomdlavuza uzoqala ukhule ngaphakathi uze uphumele ngaphandle. Njengoba ukhula njena uze ufinyelele ekhanda ubone umuntu esenekhanda elingathathi kahle. Ngesinye isikhathi umuntu uzozizwa eqaqanmjelwa amthambo aze acabange ukuthi unesifo samathambo kanti yiso lesisifo sesiza safinyelele emathanjeni.

Ngingathi futhi umdlavuza uyisifo esigcina sibangela ezinye izifo eziningi ezingaba khona emzimbeni njegezifo ezithathelanayo zangokocansi. Isiguli sigcine singasakwazi ngisho nokuya endle kahle.

Ezinye iziguli ezinomdlavuza ziyonda, zibukeke zikhathale, zingakwazi nokugwinya zivele nezinduna ebusweni. Njengoba besengishilo ngaphambili zigcina zibe naso lesisifo ekhanda nasemathanjeni, zingakwazi nokulawula umchamo. Abanye baba namaphimbo ahosholezayo noma bagcine sebakufake lento yodokotela yokuvula umphimbo. Bazokutshela ukuthi sebenesikhathi belashwa esibhedlela kodwa kungabi nomehluko. Isigulani sichaza nokuthi odokotela sebebheke nesifo sikashukela kodwa kwangatholakala lutho. Ziphinde futhi zibe nesilonda esihlala sigxaza igazi lapha entanyeni. Kokunye kuphuma nobovu kuso lesilonda.

Uma isigulane siza kimi ngalesisikhathi ngisithela ukuthi sishiye yonke imithi esiyiphuzayo bese ngisipha owami umuthi. Abaphansi baye babonise ukuthi isigulane siphethwe yini. Kanti futhi ungake uxoxisane naso belu isigulane bese sichaza izimpawu zomdlavuza. Kodwake um ngingakwazi ukxelapha isigulane ngiyaye ngisithumele kwabanye abelaphi.

Umdlavuzwa udalwa okunye ukudla esikudlayo, ukufakwa kwesinefu esithweni sesifazane noma ukukhishwa kwezisu omama. Ngesinye isikhathi kungenxa yabaphansi noma kumane nje kungumkhokha okhona emndenini. Thina njengabelaphi bendabuko siyakhona ukunika izigulane umuthi okwaziyo ukuzelapha lezizifo.

2. Wazi kanjani ukuthi isigulane sinomdlavuzwa

Ngiyabhula abaphansi bese bengitshela noma mhlawumbe ngithumela isigulane esibhedlela ukuze baqiniseke ukuthi ngempela isigulane sinomdlavuzo. Angiyaye ngithande ukuthi ngelaphe isigulani ngokwencika kokwami ukuqonda. Ngipha izigulane umuthi uma nje esibhedlelal sesiqinisekisile ukuthi isigulane sinomdlavuzwa. Isizathu salokhu wukuba esibhedlela banayo imshini yokupopola iziguli ukuze bazu ukuthi ingabe ziphethwe yisiphi isifo.

Kanti futhi njengoba sengishilo ukuthi umdlavuzwa uyizifo eziningi yingakho kungekho kuhle ukumane welaphe isiguli ungakaqinisekisi ukuthi ingabe ngempela isigulane sigula kangakanani.

Ngeshwa uma sithumela iziguli esibhedlela azingabe zisabuya ngoba uma abalaphi abajwayelekile bazitshela ukuthi zingezi kubelaphi bendabuko. Lokhu kungenxa yokuthi lababelambi basibhekela phansi abathembi ukuthi siyakhwazi ukwelapha. Futhi abasinaki nokuthi nathi sinobuchwepheshe ekwelapheni lezisifo.

Lento iyinkinga ngempela ngoba kufanele sisebenzisane ekufuneni ikhambi lalesisifo. Ngakhoke abelaphi abajwayelekile kuyodingeka baxoxisane nezigulane bazazise ukuthi nathi siyakhwazi ukwelapha lezisifo.

Kodwa uma isigulane singabuya uma sesazi ukuthi siphethwe umdlavuzwa kungadingeka sizikhethela ukuthi singathanda ukuba selashwe ngubani, Okwamanje sisathembele kwizangoma ekucwaningeni izigulani

ezinomdlavuzo. Futhi naso isibhedlela kudingeka siphe izigulane ithuba lokuthi zikhethe ukuthi zingathanda ukwelashwa yimuphi umelaphi.

5. Wazi kanjani ukuthi isigulane sinomndlavuza?

Njalo nje iziguli azizi kithi uma sekutholakele ukuthi ziphethwe umdlavuza. Kodwa esezike zeza kimi ngiye ngaphumelela ukwelapha iziguli ebeziphethwe umdlavuzo wesibeletho kanye nowebele. Kuye kutha izinsuku ezintathu kuya emavikini amathathu noma ukuya enyangeni ekwelapheni isigulani esinomdlavuza osunesikhathi esincane nomaosunesikhathi eside. Uma kuza ekwelapheni umdlaviza onesikhathi awelapheki kalula uma uqhathanisa nalowo osunesikhathi esincane. Futhi ngelapho ngokuphumelelayo uma isiguli singakaze silshwe esibhedlela.

4 Yiziphi izigulane osuke wazelapha?

Izigulane ezinomdlavuza wezinso, ibele, isibeletho Kanye nesinye.

5 Ume welapha isigulane esinomdlavuza usuke uhloseni?

Ngihlose ukuthi ngelaphe umdlavuza ukuthi ungsaphindi ube khona.

6 Wazi kanjani ukuthi uwufinyelele umgomo ekwelapheni?

Ngizobona ngokuthi umdlavuza ungasabikho nomaisigulane singitshele ukuthi asisezwa buhlungu ngemva kokuba seselashiwe.

7 Ziphila isikhathi esingakanani izigulani osuke wazelapha.

Izigulane engizelaphe ngo 2003, 2006, 2010 and 2011 zisaphila nakuba kunesisodwa esiye sadlula emhlabeni kodwa bekungengenxa yomdlavuza ngoba siye sashona engozini yemoto.

8 Zingakhi izigulane osuke wazelapha?

Zingase zibe yishumi ngaphandle kwales ebesingike ngakhuluma ngaso.

9 Wenzanjani uma ingakwazi ukuselapha isigulane.

Kuzo zonke izigulane esengike ngazelapha asikho nesisodwa engake ngahluleka ukuseplapha. Kodwa uma kwenzeka ngehlulela ukuselapha ngingasithumela kwabanye abelaphi.

Translated into English, the interview data was as follows:

1. What is cancer?

Cancer is a sore that doesn't heal. It invades the surrounding tissue and ends up affecting the blood in that the blood cannot flow properly and end up making a clot of blood. The cancer will then grow from this clot inside and becomes visible as cancer like for example cancer in the rectum, throat, prostate or cervix. As it continues to grow in these organs, eventually it affects the brain and the patient is affected psychologically, or the bones can be affected and the patient concludes that she or he has arthritis.

I can also say that cancer is a disease that results in many other diseases, which affect the body in many ways like having infectious disease like a drop, affecting your brain or bones. Patients often are affected psychologically, or may have pain when passing stools, or if in the throat and private parts having signs of a drop. It ends up in the brain such that a patient gets crazy, or in the bones of the arm (as if you have arthritis) and other parts of the body.

Some patients with cancer lose weight, look tired, unable to swallow food, develop pimples on the face. Patients will tell you that they cannot control their urine. I tell the patient to stop whatever medication that the hospital has given them and give them my own medicine.

Some will have hoarseness of the voice and a tracheostomy. They have a sore that continues to grow and they will tell you that the hospital has tested their sugar level and it was normal yet the sore continues to grow. They also develop an oozing wound on the neck. Sometimes pus comes out of the sore.

I tell the patient to stop whatever medication that the hospital has given them and give them my own medicine.

Ancestors will tell you what's wrong with the patient and also on discussion the patient will tell you the symptoms of cancer. Others are coming with the diagnosis from the hospital. We give them medicine to drink and something to apply on the wound. If you can't treat the patient then you should refer the patient.

Cancer is a sore that does not heal but continues to grow and develop pus and eventually bleeds.

Cancer results from the type of food we eat. Sometimes it is caused by putting snuff in the vagina or results from abortion. Sometimes it is in the family as *umkhokha* (meaning family disease). In this way we will give an appropriate treatment.

2. How do you know a patient has cancer?

I use ancestral spirits to diagnose a patient. I also refer the patient to the clinic in order to confirm the patient's diagnosis because I do not want to rely on my diagnosis to give the correct treatment. Like I have said that cancer is many diseases therefore I would not like to conclude on the diagnosis and treat the disease according to my diagnosis. It is for that reason that I refer the patient to the hospital because they have the right equipment to diagnose the diseases in patients.

However, when I refer a patient to the hospital, they don't come back if they were diagnosed with cancer because the doctors tell them not to come to us. We are being undermined and I think this is the reason why we are not known as cancer specialists. This is a problem that needs to be resolved and I am sure the hospital and the THPs can resolve this matter. If a patient can come back, I can discuss with the patient the diagnosis and agree that I can give treatment.

I throw bones and confirm that the patient has cancer but I do not start treating the patient instead I refer them to the hospital to confirm the diagnosis at the hospital. I do not like to start treatment without having confirmed the cancer because I avoid treating patients incorrectly as some patients can present with cancer symptoms when in actual fact they have ancestral spirits. After cancer has been confirmed, if the patient can come back, I will involve the patient in decision making with regard to treatment. However, patients do not come back after their referral to the hospital because they are told not to come to us.

3. What do you do when a patient has cancer?

Most of the time patients do not come back to us after referral. They only come back when the hospital has failed them.

I treat patients that have not started treatment with ROs. It is not proper for a patient to receive treatment from both healers simultaneously.

I have successfully cured patients with cancer of the breast and advanced cervix. The duration of treatment depends on the stage of cancer. Early stage takes 3 days to three weeks, but the advanced cancer takes almost a month. Patients with cancer end up having backache. Cancer of 6 years is not the same as the one of 6 months with regard to treatment.

I only treat successfully patients who have not been to the hospital and those are cancers of the cervix.

4. What type of cancers do you treat?

I treat patients with cancer of the breast, bladder, kidneys and oesophagus.

5. What do you want to achieve?

When a patient has not yet had any treatment from the doctors, I treat them in order to cure this disease.

6. How do you know that you have achieved your goal?

The cancer will not show on the breast and the patient will tell me that they do not have pain any more. Some go to the hospital and ask to be checked for cancer and doctors tell them that they don't have cancer anymore.

7. How long do your patients survive?

I have treated patients in 2003, 2006, 2010 and 2011 and they are still alive except for those who were killed by other diseases other than cancer

8. How many patients have you treated successfully?

I know of patients who are disease free about ten but the 11th one died in hospital of another disease other than cancer.

9. What do you do if you cannot treat a patient successfully?

I have never had a patient that I could not treat successfully.

This massive textual data demonstrate the description and interpretation of the phenomenon "treatment of cancer patients by a THP". The description and interpretation of the phenomenon coexist, and are complementary to each other in the process of data analysis.

Data analysis decreases, organises and provides meaning to the data. It consists of preparation of data for analysis, conducting a variety of analyses, developing an understanding of the data, representing the data and interpretation of the larger meaning of the data. Tesch's method was used to analyse data. The data analysis process was managed by the framework method. The framework method allows the interview data to be matched and distinguished using themes across many cases, while locating each standpoint in context. This is achieved by keeping the connecting the themes to other aspects of each character's version (Gale *et al.* 2013: 5).

The data was reviewed. The researcher read and re-read through the entire data to obtain general understanding of the information regarding the phenomenon. The researcher utilized Tesch's method to identify themes and sub-themes, using the conceptual framework. Coding began when the researcher began establishing segments of data, segmenting them into sentences, and classifying those into predetermined codes based on the conceptual framework (Table below), developed in Chapter 3.

Table: Conceptual framework for the study

Construct	Concept	Category	Ideas
Principles and practices of THP in the treatment of cancer.	Role and practices of the THP in the treatment with cancer	Knowledge	Description of cancer, its characteristics, causes and effects on patients.
		Diagnosis	Methods of diagnosing cancer.
		Treatment treatment of cancer patients	Practices in the treatment of cancer.

Open coding continued until anything that might be relevant from as many different perspectives as possible, was coded. With coding, the researcher classified all of the data, so that it could be compared and contrasted systematically with other parts of the data set.

Axial coding was performed to connect codes obtained in open coding. Codes were grouped together into clearly defined categories, and these formed the sub-themes of the study (Table below). The researcher integrated the categories by utilising selective coding. This resulted in a main theme or concept describing the phenomenon by contextualisation.

Table: Main theme, sub-themes, and categories from interview data

Main theme	Sub-theme	Category
The principles and practices in the treatment of patients with cancer by the THPs.	a) Knowledge of cancer	<p>1. Cancer is a sore, which does not heal.</p> <p>2 The common cancers that are treated are cancers in the rectum, throat, prostate and cervix, <i>breast, bladder, kidneys and oesophagus</i></p> <p>3 Cancer can spread brain.</p> <p>4 Signs and symptoms of different cancers such as may have pain, are affected psychologically, lose weight, have fatigue, difficult to swallow, can not control urine, hoarseness of the voice, and oozing wound.with pus.</p> <p>.5 Cancer is caused by some types of foods, abortion, putting snuff in the vagina, and is a family disease.</p>
	b) Diagnosis of cancer	Use ancestral powers to diagnose patients and refers patient to the hospital, to confirm the diagnosis, before commencing treatment.
	c) Treatment of cancer	<p>1 Refer patient to hospital to confirm diagnosis before commencing treatment,</p> <p>2 Patient is involved in decision making regarding treatment,</p> <p>3. Treats successfully patients who have not had prior treatment by the RO.</p> <p>4. Patient should not have both THP's and RO's treatments simultaneously.</p>

A. CONCEPTUALISATION OF THE TREATMENT OF CANCER PATIENTS BY THP

From the results stated above, five subthemes emerged, namely: knowledge of cancer, diagnosis of cancer, and treatment of patients with cancer. The researcher discusses each theme and its related subthemes. To highlight a point, the quotations derived from the transcribed individual face-to-face interview are used

The participant interviewed, claimed to have experience in the treatment of patients with cancer. He understood treatment of cancer as a provision of treatment to cancer patients using different forms of treatment. In doing so, he claimed to know what cancer is, and how it can be diagnosed. He described how he treats a patient diagnosed with cancer, and how he knows if the patient has been cured. These concepts formed the subthemes against which to map data from the interviews, and are discussed as follows:

a) Knowledge of cancer

When providing this information, he defined cancer, stated the different types, named the organs of cancer spread, explained signs and symptoms, stated the causes of cancer, and mentioned cancer recurrence.

a) 1. Definition of cancer

In explaining what cancer is, the THP stated that it is a sore which does not heal, and explained the various ways he believes it grows. The following extracts illustrated this:

“Cancer is a sore that doesn’t heal. It invades the surrounding tissue and ends up affecting the blood in that the blood cannot flow properly and end up making a clot of blood.”

a) 2. Types of cancer

The THP mentioned various sites from which cancer can grow and those included rectum, throat, prostate and cervix. The following excerpt confirmed this:

“The cancer will then grow from this clot inside and becomes visible as cancer like for example cancer in the rectum, throat, prostate or cervix. breast, bladder, kidneys and oesophagus”.

a) 3. Spread of cancer

The participant mentioned that, cancer can spread to the brain and bones. The following excerpt confirmed this:

“Cancer is a disease that results in many other diseases and affects the body in many ways like, affecting the patient’s brain or bones such that a patient gets crazy, or in the bones of the arm as if they have arthritis.”

a) 4. Signs and symptoms of cancer

The THP cited various signs and symptoms of different cancers in the body. For example, he mentioned that some patients diagnosed with cancer may have pain, are affected psychologically, lose weight, have fatigue, difficult to swallow, can not control urine, hoarseness of the voice, and oozing wound with pus. The following excerpts illustrated this:

“Patients often are affected psychologically, or may have pain when passing stool, or if in the throat. Some patients with cancer lose weight, look tired, unable to swallow food. Patients will tell you that they cannot control their urine. Some will have hoarseness of the voice.... They also develop an oozing wound on the neck. Sometimes pus comes out of the sore”

a) 5. Causes of cancer

The participant stated that cancer can be caused by some types of foods, abortion, putting snuff in the vagina, and is a family disease. The following excerpts affirmed this.

“Cancer results from the type of food we eat that has chemicals. Sometimes it is caused by putting snuff in the vagina or results from abortion. Sometimes it is in the family as umkhokha (meaning family disease)”.

b) Diagnosis of cancer

With regard to diagnosis, the THP participant had to respond to, how he knows if a patient has cancer and what do they do if a patient has cancer. The participant, as a herbalist, said that he uses the ancestral spirits to diagnose patients with cancer. He also mentioned that he refers this patient to the hospital so that the diagnosis of the patient can be confirmed, before commencing treatment. The following excerpts illustrated this

“I use ancestral spirits to diagnose a patient. I also refer the patient to the clinic in order to confirm the patient’s diagnosis because I do not want to rely on my diagnosis to give the correct treatment. Like I have said that cancer is many diseases therefore I would not like to conclude on the diagnosis and treat the disease according to my diagnosis. It is for that reason that I refer the patient to the hospital because they have the right equipment to diagnose the diseases in patients.”

c) Treatment of cancer

The THP interviewed stated that does not commence treatment until the diagnosis of the patient has been confirmed by the hospital. The rationale for this is that, he is avoiding treating the patient incorrectly. He further mentioned that, he involves the patient in decision making with regard to the treatment. He also mentioned that he treats successfully a patient who did not have prior

treatment with the ROs. He also mentioned that all his patients were treated successfully. The following extracts illustrated this

“I do not like to start treatment without having confirmed the cancer because I avoid treating patients incorrectly as some patients can present with cancer symptoms when in actual fact they have ancestral spirits. After cancer has been confirmed, if the patient can come back, I will involve the patient in decision making with regard to treatment. I treat patients that have not started treatment with ROs. It is not proper for a patient to receive treatment from both healers simultaneously.

“I have treated patients in 2003, 2006, 2010 and 2011 and they are still alive except for those who were killed by other diseases other than cancer I have never had a patient that I could not treat successfully”.

After the themes have been identified and discussed, the researcher interprets the findings by finding a relationship between the themes as they were generated in the conceptual framework developed. In the next section, the researcher interprets and discusses the key finding of this interview.

PRINCIPLES AND PRACTICES OF THE THP IN THE TREATMENT OF PATIENTS WITH CANCER

How the THP practices in the treatment of patients with cancer seemed to be influenced by several factors. The interpretations and discussion of the findings are compared with the existing literature relevant to the topic the topic. The themes that emerged from the study, with regard to the principles and practices of the THP in the treatment of patients with cancer, were as follows:

a) Knowledge of cancer

When the THP was asked about their knowledge of cancer, he defined and explained how he recognises cancer. In this section, the researcher discusses the knowledge of cancer and compares it with literature. The study found that the THP has a reasonable knowledge of cancer.

b) The diagnosis of cancer

The THP diagnoses cancer by using ancestral power. In addition, the patient explains the symptoms of cancer. However, treatment commences after the diagnosis of the patient has been confirmed by the hospital. The finding in this study is that, the THP cannot diagnose a patient with cancer, but relies on the hospital.

c) Treatment of patients with cancer

This THP asserted that all the cancer patients he has treated are still alive. To this he claimed that he has treated them successfully. Nonetheless, he has not indicated that those patients are free of the disease. The study found that, the issue of treating patients successfully is a claim. Only evidence-based practice in cancer treatment would justify this claim.

In conclusion, the THP could be developed further with regard to signs and symptoms of the relevant cancer diagnosis. Therefore, he can be able to diagnose the different types of cancers. The THPs are contacted first for any ailment, Thus with appropriate knowledge of cancer, they can diagnose patients and alleviate the burden of cancer on the already constrained radiotherapy services.

The claim of treating cancer patients successfully is controversial until there is evidence-based treatment. Despite this, some cancer patients will always seek treatment from THPs because of their cultural beliefs.