A MODEL FOR THE INTEGRATION OF HOMOEOPATHY INTO THE PUBLIC HEALTHCARE SYSTEM IN THE PROVINCE OF KWAZULU-NATAL, SOUTH AFRICA

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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is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources).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.

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Signature of student Date

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Abstract

Background

The public healthcare system in South Africa services the majority of its population, as many are unable to afford the services that exist in the private sector. Due to this momentous task of servicing millions of South Africans, the public sector has become overburdened with many issues. Some of the issues that plague this sector include a lack of resources, insufficiency of personnel and financial constraints due to over-usage. Based on this context, the introduction of complementary alternative medicine, such as homoeopathy, into the public healthcare system exists as one of the potential resolutions to this burdened healthcare sector.

Aim

The aim of the study was to gather data, both descriptive and statistical, from healthcare professionals in KZN in order to develop a model for integrating homoeopathy into the public healthcare system.

Methodology

The researcher conducted a mixed methods study using an explanatory sequential design. Thus, the study was conducted in two Phases. Phase 1 employed quantitative measurement tools, where data was collected from medical doctors, nurses and homoeopaths through paper-and-pen/ electronic surveys. This data was analysed using version 25 of the SPSS software. Phase 2 incorporated measurement tools, where data was collected from Chief Operating Officers as well as nursing managers through semi-structured interviews. This data was analysed using Tesch's eight steps of data analysis. The data from both phases was then compared and contrasted to formulate a model for integration.

Findings

Based on the current circumstances that exist in South Africa, it was established from the results of the study that the integration of homoeopathy into the public healthcare system would be complex in nature, due to the changes that would need to be made in both the public and private sectors. Albeit a model of integration was developed, based on the limitations identified in this study, further research needs to be conducted to investigate this phenomenon.

Key words: Allopathy, homoeopathy, integration, perception, public healthcare system.

Dedication

I dedicate this thesis to my brothers and sister, my dad and stepmom, my extended family, my friends and colleagues who were with me along this journey, the homoeopathic and medical fraternity, my companion and his family, my former students, future children and to my mum - Melody Majola. Thank you for your never-failing sympathy and encouragement. My most sincere appreciation goes out to my mum, who raised us single-handedly and has never failed to provide my brothers and I with persistent support in our pursuit of learning.

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Glossary of terms

Acupuncture: A form of traditional Chinese medicine that involves using needles being inserted into the body to manipulate the flow of energy (Nilay *et al.* 2010: 17).

Complementary Alternative Medicine: A group of natural therapies that usually would not form part of orthodox medicine (National Centre of Complementary and Alternative Medicine 2012).

Homoeopathy: A system of complementary alternative medicine that is based on the claim that a substance that can cause a symptom of disease in healthy person can cure a similar symptom in a sick individual (Pillay 2013: xiii).

Homoeopathic mediation: Medication made using very small amounts of natural substances, which in high amounts would cause a disease state (Pillay 2013: 142).

Mainstream medicine: Medicine practiced by medical doctors and by their allied health professionals such as nurses and psychologists (Naicker 2008: 6).

List of acronyms

Acronym	Full word/sentence
AHPCSA	Allied Health Professions Council South Africa
AIDS	Acquired Immune Deficiency Syndrome
AMED	Allied and Complementary Medicine Database
ANOVA	Analysis of Variance
ARF	AIDS Remedy Fund
CAM	Complementary alternative medicine
CHC	Community Health Centre
CEO	Chief Operating Officer
DUT	Durban University of Technology
EMBASE	Excerpta Medica database
U.S. FDA	United States Food and Drug Administration
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HAS	Homoeopathy South Africa
IREC	Institutional Research Ethics Committee
KZN	KwaZulu-Natal
MBChB	Bachelor of Medicine and Bachelor of Surgery
NGO	Non-Governmental Organisation
PATH	Program for Appropriate Technology in Health
SANC	South Africa Nursing Council
SPSS	Statistical Package for the Social Sciences
UJ	University of Johannesburg
WHO	World Health Organisation

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 BACKGROUND TO THE STUDY

South Africa has a three-tier healthcare system that consists of a public sector, private sector as well as a Non-Governmental Organisations (NGOs) sectors (Khulumani 2015: 3). The public healthcare sector caters to the majority of the South African population and is a sector where only allopathic services are provided. It is infiltrated by a variety of issues which can be associated with a lack of resources as it is used by many in South Africa (Van Rensburg 2014: 26). The private and NGOs sectors are said to have a sufficiency of resources (Harris *et al*. 2011: 107). In these sectors, both allopathic and alternative healthcare services rendered, are used by a few that are privileged to have access to these sectors (Khulumani 2015: 4). The abovementioned segregation has conceded for gaps to develop between these three sectors allowing healthcare to become a commodity in South Africa (The South African Civil Society Information Services 2013).

Many issues plague the healthcare system of South Africa and its current state mirrors major inequalities. Apart from the burden of infectious diseases, a lack of essential medicines and medical equipment, under-qualified management, negligence and mismanagement of funds, there exist a shortage of qualified allopathic practitioners opting to work in the public sector (Van Rensburg 2014: 26; Khulumani 2015: 3). This reality is of major concern as a healthcare system cannot adequately function with such insufficiencies especially when a system presents with a high volume of patients (Kaytzky and Tollmen 2008: 24). Whilst the public health sector has an insufficiency of personnel, the private sector experiences the opposite (Khulumani 2015: 3). The preference to work in the private health sector is not surprising as reportedly, allopathic practitioners in public

facilities earn low wages while working longer hours with few resources (Van Rensburg 2014: 26).

Currently, the South African public healthcare system is not capable of meeting the needs of all its users (Smillie 2010: 6). Albeit some public hospitals offer world class healthcare, accessing these facilities can be traumatic and very time-consuming for patients. In contrast, accessing resources in the private sector is relatively easy, as long as one has the means to pay for them (Harris *et al.* 2011: 107).

Even though allopathic medicine is predominantly used in the public healthcare system in South Africa and the rest of the world, there has been a surge of interest in complementary therapies (Naicker 2012: 3). This is a common trend among certain developed countries and has been well documented in the United Kingdom (UK), Europe, and in the United States (Ullman 1991: 47). This growing interest is directly linked to the benefits that are gained when one makes use of alternative medicine. By definition, Complementary and Alternative Medicine (CAM) is the title used to class a diverse group of therapies and disciplines that are not part of mainstream medicine. South Africa recognises eleven CAM therapies and these are regulated by the Allied Health Professions Council of South Africa (AHPCSA). The following are the eleven CAM therapies (AHPCSA 2018a: para. 2 line 1):

- Homoeopathy,
- Naturopathy,
- Phytotherapy,
- Chiropractic,
- Osteopathy,
- Reflexology,
- Therapeutic Aromatherapy,
- Therapeutic Massage Therapy,
- Chinese Medicine,

- Acupuncture, and
- Unani-Tibb

Homoeopathy, out of the many alternative therapies that exist, is one of the most used types of CAM therapies in the world (Ullman 1991: 1). It is an alternative therapy that was discovered in the 16th century and introduced to South Africa in the 1820s (Gower 2013: 2). Despite its many years of existence in South Africa, it is still unknown to the public at large as it is still mainly available to patients who are able to access facilities based in the private healthcare system (Solomon 2014: 11). Its success in the private healthcare system in South Africa is observed through an increase in the number of qualifying and registered practitioners as well as it's increased usage (Cromarty 2007: 6).

As mentioned previously, people turn to CAM to gain the benefits that are not experienced when orthodox medicine is used. These benefits include receiving holistic treatment, ingesting natural medicine that has minimal side-effects and are inexpensive in nature (Roberts 2008: 49; Spence, Thompson, Barron 2005: 795). Logic suggests that these benefits will be an added advantage to a public healthcare system that presents with high volumes of patients, with little resources (Van Rensburg 2014: 26). Although the efficacy of homoeopathy is widely debated in South Africa, studies done by Erwin, Marks and Couchman (2013: 8) suggest it to offer a variety of benefits to people in South African communities, more especially when access to allopathic healthcare services is poor (Erwin, Marks and Couchman 2013: 8; Khumalo 2015: iii; Love 2016: V; Smillie 2010: VI). Perhaps a direction that CAM therapies can take, more especially homoeopathy, is for it to be integrated into the public healthcare system in South Africa. The integration of alternative therapies into the public healthcare system may offer a possible remedy to the many problems experienced. Such integration should not substitute allopathic practitioners nor to compete with them but should address the multiple issues experienced.

Qualified and registered homoeopathic practitioners in South Africa are recognised as primary contact practitioners that are competent in medical care (Pillay 2013: 21). Since homoeopathic practitioners in South Africa have homoeopathic and medical skills, the building blocks to develop a more plural healthcare system exists but this reality seems to be overlooked. Recent research has revealed that some homoeopathic doctors would welcome the integration of homoeopathy into the public healthcare system in South Africa (Majola, 2015). Therefore, there is a group of medically trained practitioners that are ready and willing to work in the public sector but there are being prevented by outdated regulations (Sweidan 2007:18).

The transfer of efficient and cost-effective healthcare services from private to public sectors lie as a possible solution to remedy some of the problems experienced (Solomon 2014: 4; Smillie 2010: 8). Besides the cost-effectiveness that is found within the different forms of alternative medicine, these therapies also bring along with it curative, preventative and palliative services that are sourced from natural resources.

India, China and North America are areas who have made homoeopathy available to both public and private sectors. These areas should be used as prototypes to achieve successful integration in South Africa (Kotsirilos, Vitetta; Sali 2011: 3). Though these countries may vary geographically, socially and economically, studies that reported on integration in these countries have concluded that this system of medicine is cost-effective and brings about best clinical results while preserving the patients' choices (Roberts 2008: 49; Nayeri and Lopez-Pardo 2005: 797; Rossi *et al.* 2010: 280; Spence, Thompson, Barron 2005: 795). Therefore, this is what the healthcare systems in South Africa should be striving for. This should be further motivation for integrating homoeopathy into the public healthcare system in South Africa. Developing a model for integration will add to the panel of discussions around this phenomenon as this particular component is under-researched locally.

1.2 PROBLEM STATEMENT

There is a need for an integrated healthcare system in South Africa, one that will aid in dispelling the disparities that exist in it (Erwin, Marks and Couchman 2013: 8; Ndzimande, Sibiya and Gqaleni 2014: 509; Smillie 2010: 8). These disparities particularly exist in the public healthcare system, as mentioned previously (Kautzky and Tollmen 2008: 24). These range from a lack of resources to the constant battle against communicable and non-communicable diseases (Van Rensburg 2014: 26). The introduction of CAM, more especially homoeopathy lies as a possible solution (Solomon 2014: 4; Smillie 2010: 8). This potential solution brings along the possibilities of more practitioners moving into the public healthcare system and as well as the introduction of a more cost-effective medicine to treat communicable and non-communicable diseases (Solomon 2014; Rossi *et al*. 2010 and Roberts 2008: 49). This solution is also in keeping with what is recommended by the WHO (2002: para. 12 line 5). In addition to this, developed countries such as France, Germany and the UK are also starting to depict a trend of more patients turning to CAM for preventative and palliative care (WHO 2002: para. 4 line 1). It is also interesting to note that CAM has played a major role in many African countries, in the delivery of primary health care (PHC) (Muweh 2011: 1). Therefore, allowing for its integration in public facilities should not be seen as a foreign step. In South Africa, a recent study suggested that some homoeopaths would welcome the integration of homoeopathy into the public healthcare system (Majola 2015: VI). Previous studies also put forward that a fair number of the public and allopathic practitioners would welcome this integration (de Villiers 2006: ii; Harripershad 2009: v; Macquet 2007: iii; Allopi 2008: ii and Naicker 2008: iii).

While authors such as Louw and Duvenhage (2016: 489) and Chitindingu, George and Gow (2014: 40) have published literature on the introduction of traditional healers into the South African healthcare system and medical school curricula, there is still little to define a feasible model of the

integration of homoeopathy into the healthcare system of South Africa. This has prompted the aim of this study, as outlined next.

1.3 AIM OF THE STUDY

The aim of this study was to gather data, both descriptive and statistical from healthcare professionals in KZN in order to develop a model for integrating homoeopathy into the public healthcare system.

1.4 OBJECTIVES OF THE STUDY

The objectives of the study were to:

- Determine what the enablers are, for integrating homoeopathy into the public healthcare system in South Africa.
- Determine what the barriers are, for integrating homoeopathy into the public healthcare system in South Africa.
- Identify how to overcome possible barriers to integrating homoeopathy into the public healthcare system in South Africa.
- Explore the perceptions of healthcare professionals in KZN, with regards to homoeopathy being integrated into the public healthcare system in South Africa.
- Develop a model for integrating homoeopathy into the public healthcare system in South Africa.

1.5 SIGNIFICANCE OF THE STUDY

To date, some literature has been published on the topic of integration of homoeopathic doctors into South African public healthcare system. While some research has considered the advantages and disadvantages of integration of homoeopaths into South African public healthcare, there is still no complete model of integrating homoeopathy into the public healthcare system of the country. By gathering all the information on untested and tested models of integration and the perceptions of those affected by homoeopathic integration, the study developed a model of

integrating homoeopathy into the public healthcare system of South Africa. With this model of integration, the study hopes to contribute to the panel of discussion that is continually happening around homoeopathy; and provide knowledge on the means of integrating homoeopathy into the public healthcare system of South Africa or any other country that may be attempting to integrate homoeopathy into its public healthcare system. Conducting this research brought about a clearer picture on how the skills of homoeopaths can be added into the public healthcare system, thus allowing the skills of homoeopaths to be more widely felt across South Africa. In addition, formulating this model of integration can potentially allow a more sustainable healthcare system to be developed, which will ultimately benefit the country as a whole

1.6 STRUCTURE OF THE DISSERTATION

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

Table 1.1: Structure of the thesis

Chapter	Title	Content description
1	Overview of the study	Chapter one has a brief discussion of the problem that has motivated for the conduction of the study. The aims, objectives and research questions were covered in this chapter.
2	Literature review	Chapter two, by means of a literature review has highlighted the definition of homoeopathy, its development, global, continental, national and local current state of homoeopathy. In this Chapter, there was also a discussion of the current state of the public healthcare system in South Africa and mainstream medicine.
3	Conceptual framework	Chapter three highlights the conceptual framework and the worldview of the researcher.
4	Research methodology	Chapter four went into details on how the study was conducted using the mixed method approach- highlighting the research design; setting; populating; and sampling process; data collection process and data analysis process.
5	Presentation of results: Phase 1	Chapter five presents the data collected in Phase 1 of the study.
6	Presentation of results: Phase 2	Chapter six presents the data collected in Phase 2 of the study.
7	Integration of findings from Phase 1 and Phase 2	Chapter seven presents the triangulation of results.
8	Discussion of results	Chapter eight contains the analysis and discussion of the data.
9	A model for the integration of homoeopathy into the public healthcare system in the province of KZN, South Africa	Chapter nine presents a model for integrating homoeopathy into the public healthcare system.
10	Limitations, conclusion and recommendation	Chapter ten contains the conclusion of the study and recommendations.

1.7 SUMMARY OF THE CHAPTER

This chapter has highlighted the background of the study. The sources used in this chapter hint at the potential role that homoeopathy has in the public healthcare system. The main purpose of this study is to develop a model for the integration of homoeopathy into the public healthcare system. The next chapter will review literature relating to the topic at hand and highlight the gap this study intends to fill.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter discussed literature relating to the study. The review of related literature pointed out the gaps that were filled through the conduction of the study- in this case, developing a model for integration. The literature review also expanded on the objectives and problems of the study. Before doing so, the researcher starts of by highlighting the background of homoeopathy, how it was developed and why it was developed. Such points are vital to know before exploring the possibilities of integration.

2.2 LITERATURE SEARCH

The main focus for this chapter was to review literature relevant to the study and literature that assisted in model development. Albeit the challenges experienced in locating reliable literature on the study phenomenon, to avoid potential bias, the researcher conducted a search in both specialized CAM databases as well as mainstream medicine databases. These databases include AMED, Science Direct, CINAHL, EMBASE; MEDLINE; Pubmed; MedlinePlus EMBASE, Web of science; HOMIN-FORMBritish and HOMEOIN-DEX, MEDLINE. The keywords used in these search engines included words such as homoeopathy, integration, public healthcare system/ national healthcare system as well as phrases such as "*integration of homoeopathy in the public healthcare/ national healthcare system"* and "*integration of CAM into the public healthcare system/national healthcare system*". The same keywords and phrases were used to search for articles in google scholar. The same keywords were also used when video conferences relevant to the study were searched for.

2.3 BACKGROUND OF HOMOEOPATHY

Many definitions exist to define what homoeopathy is (Prinsloo 2000 para. 2 line 1). In keeping with its true definition and the context of the study, the word homoeopathy is a derivative from the Greek words '*homoios*', meaning like and "pathos", meaning suffering (Homoeopathy South Africa 2016). Its etymology is directly linked to how the system of medicine works. Therefore, homoeopathy is described as "a therapeutic medical system, which is based on the observation that substances that are capable of causing diseases of the mind or body in healthy people can be used in their diluted form as remedies to treat the similar disorder in someone who is ill" (Homoeopathy South Africa 2016: para. 1 line 1). This system of medicine, allows for a person to be treated holistically with medicament that respects the body's healing powers by stimulating its energy or vital force (Bloch and Lewis 2003: 24). This, in turn, treats the whole person with less emphasis on drugs through non-invasive approach and minimal side-effects (Kayne 2008: 226).

Homoeopathy is system of medicine that was founded by Samuel Hahnemann in the early 19th century (Solomon 2014: 1). However, prior to the development of homoeopathy, many 'schools of thought' existed in the world of medicine (Eizayaga 1991: 11). Two of the main schools of thought that stood out were those that were derived by Hippocrates (c460-c370 BCE) (Eizayaga 1991: 11). Hippocrates believed these two main schools of thought were possible ways to cure a disease (Ross 2011: 36). These two ways were through the application of contraries (Law of Contraries) or through the application of similitudes (Law of Similar) (Eizayaga cited in Ross 2011: 36 and Prinsloo 2000: para. 2 line 1). In the world of medicine, the Law of Contraries ended up outshining the law of similitudes as it was used more frequently by medical practitioners from the second century until today (Ross 2011: 36). The law of contraries, currently used by allopathic practitioners, was translated as the law that involved in treating an individual with a substance that will go against the natural flow of the body by suppressing the

symptomatology and if was not applied correctly, it would result in death e.g. anti-biotics, anti-hypertensive, anti-depressant medication (Eizayaga 1991: 11 and Swayne, 2000: 16). The law of similitudes, currently used by homoeopathic practitioners, was translated as the law that involved treating an individual with a substance that will not go against the natural flow of the body (Lilley 2008 cited in Smillie 2010: 11). Though the law of contraries surpassed that of similitudes, Hahnemann, did further investigations on the latter (Ross 2011: 36). Hahnemann's investigations, along with collaborating literature from existing philosophers led to him developing the fundamental principles of homoeopathy that are currently used throughout the world (Dooley 2001: 37).

2.4 HOMOEOPATHIC MEDICATION

Homoeopathic medication can be made from any substance including plant, animal, energy sources, vegetable or mineral sources (Getoff 2013: 84). When a homoeopathic remedy is being produced, a crude substance is highly diluted and energized according to pharmaceutical methods and standards stipulated in the homoeopathic pharmacopoeia (Bloch and Lewis 2003: 28). In order to test the effects of new homoeopathic medicaments, whose therapeutic effects is unknown, a proving can be conducted (Ross 2011: xxxii). Hahnemann, the founder of homoeopathy, conducted his first proving on himself (Botha 2010:8). He ingested a substance, observed and noted symptoms he experienced and this allowed him to gain more knowledge on the potential of a substance or what it can be used for (Lilley 2008 cited in Smillie 2010: 11). Later on, Hahnemann conducted further provings on healthy individuals using various substance from zoological, botanical and mineral kingdoms during which he would take note of the participants' holistic experiences (Smillie 2010: 11). The data obtained from these experiments would provide Hahnemann with enough information to publish a Materia Medica Pura- a book which contains systemic reviews, description and collective therapeutic repertoire of homoeopathic medicines (Swayne 2000: 132-133). Provings, since Hahnemann's time, are the main ways that

homoeopathic philosophers use to gain more knowledge on a substance and have evolved and are being done in a different way. The method in which a proving is done has not been altered, but slightly modernized and improved. The original Materia Medica's and Repertories which are an essential tool to homoeopathic practitioners daily practice can be now accessed even electronically allowing for a quick effective guideline to prescribing (Lilley 2008 cited in Smillie 2010: 10).

2.5 THE USE OF HOMOEPATHY WORLDWIDE

The usage of homoeopathy throughout the world varies (Love 2016: 13). Internationally, homoeopathy is currently used by 450 million patients worldwide (Malik 2011: para. 1 line 5). It is legally recognised as an individual system of medicine in 42 countries and as part of complementary medicine in 28 countries (Malik 2011: para. 1 line 1). According to Globimed (2015: para. 2 line 1), homoeopathy is included in the public healthcare system in areas such as Brazil, Tuscany, Mexico, India and UK. In these countries, it exists in various clinical settings such as hospitals and clinics within surgical and non-surgical settings (Roddis 2007: 23 and Roberts 2008: 48). Out of these areas mentioned, homoeopathy is most popular in India, UK and Europe with a combination of over 206 million users (Prasad 2007: 1679). Integration of homoeopathy into the public health care facilities in these countries has occurred in the following manner:

- In the UK, partial integration of homoeopathy into its public healthcare system has occurred through government creating facilities that provide strictly homoeopathic medicine to the public through the national health insurance (Roberts 2008: 48).
- European countries have attempted a similar integration and have even created homoeopathic dispensaries within public facilities where allopathic medicine is rendered (Spence, Thompson and Barron 2005: 797). Medication from these dispensaries is prescribed by qualified and registered homoeopaths as well as allopathic practitioners that are

skilled on homoeopathy (Roberts 2008: 49; Spence, Thompson and Barron 2005: 797).

- In Bangladesh, just like in the UK, facilities that cater only homoeopathic medicine have been created and the government has a made it a point to increase these facilities over the years (Rahman 2013: 3).

In India, homoeopathy was introduced in 1810 by German homoeopaths. Two of the reasons why it is said to have remained popular include it resonating with the country's culture and belief system as well as its usage by Mahatma Ghandi (Raman and Manchanda 2011: 356; Ullman 1991: 3). In India, homoeopathy is available in public and private hospitals and clinics, surgical and non-surgical settings. In adding to this, some of these facilities have even gone a step further and introduced the use of homoeopathy in pre and post-surgical procedures as well as during surgical procedures (The Kerala University of Health Sciences Handbook 2010: 3). A study conducted by Roddis (2007: iii) focused on an established homoeopathic medical hospital in India. This hospital was situated in an area where the researcher felt had similar health needs as South Africa. The study established homoeopathy to be of great benefit to the public health healthcare system in India, as it was very effective in treating both acute and chronic diseases. In India, homoeopathy is tasked with the same responsibilities as conventional medicine and is said to be cost effective as well as highly suited for a country with poor agriculture (Roddis, 2007:23-27).

2.6 THE USAGE OF HOMOEOPATHY IN AFRICA

The usage of homoeopathy amongst African countries varies according to that countries governing legislation. The extent to which people use homoeopathy for health problems is also unknown (Ullman 1991: 47). There is paucity of literature to validate that homoeopathy has been added to the public healthcare system of any African country (Love 2016: 16). Instead, various sources of literature were found on initiatives that have been started by

various homoeopaths to make this system of medicine available to a larger group of people (Majola 2015: 13 and Bingley *et al*. 2014: 34). The main illnesses treated in these initiatives are malaria, non-communicable diseases and AIDS related symptoms (Grimes 2009: para. 1 line 5 and Smillie 2010: 8). These illnesses are some of the leading causes of mortality worldwide and exist in the majority of people that use the public healthcare system in South Africa (WHO 2017: 50-60 and Van Rensburg 2014: 26). Some of the countries that have these initiatives include South Africa, Senegal, Ivory Coast, Nigeria, Kenya, Tanzania, Botswana, Ethiopia and Ghana (Grimes 2009: para. 1 line 5 and Smillie 2010:42).

According to Erwin, Marks and Couchman (2014: 7-14), the Maun Homoeopathy Project works hand-in-hand with the local community organisations and is said to provide health care services to over 1500 people. The Maun Homoeopathy project was specifically developed to assist those who have been diagnosed HIV as well as women who have suffered abuse and rape (Bingley *et al*. 2014: 34). A lot of positive feedback has been received from the beneficiaries of the project (Bingley *et al.* 2014: 36). Some even say that this project should be advertised more to people in order to manage their side-effects from HIV medication (Bingley *et al* 2014: 36). The majority of patients preferred being treated homoeopathically at this project as they particularly appreciate the holistic approach. One user even expressed: "*The hospital helps me, really, yes, but not as homoeopath clinic can help me. Yes, because the homoeopath clinic, you know, they go deeper into my life"* (Bingley *et al*. 2014: 36).

The AIDS Remedy Fund (ARF) initiative has assisted many people in Tanzania and Kenya living with AIDS and more than 90% of the patients have been reported to react positively (ARF 2008: 6). The aim of the ARF foundation is to study the effectiveness of homoeopathic therapy for HIV/AIDS and make the remedy available at low cost to large populations suffering from this disease. The foundation is non-profit and the specific homoeopathic

remedy that is being used in this project is the "*iqilai"* (ARF 2008: 5). The homoeopathic medication used in this initiative has assisted many patients in recovering from opportunistic infections, disappearance of diarrhoea, respiratory infections and skin problems. The most significant result of this pilot is that more than 90% of the patients showed improvement in their health. The overall benefits of the homoeopathic therapy provided in this initiative were said to be low cost, easy administration, no resistance, no side-effects, rapid effect, and restoration of independence (ARF 2008: 7).

2.7 THE USAGE OF HOMOEOPATHY IN SOUTH AFRICA

According to Gower (2013: 1), homoeopathy was introduced to South Africa in the 1820s by missionaries from Europe. Though homoeopathy has been around in South Africa for several years, studies conducted by Lamula (2010: iii) and de Villiers (2006: ii) and Majola (2015: V) concluded that homoeopathy is still unknown to the public at large. Two of the main reasons linked to this include inhibitory laws that regulate homoeopathy in South Africa and it being only made available in the private sector (Majola 2015: 8; Babletakis 2006: 175). Although it is not currently available in the public healthcare system, theoretically its addition could serve to enhance this health sector and thus improve access to healthcare.

In contrast to the above stated, Prinsloo (2011: para. 3 line 1) has seen a steady growth of homoeopathy in South Africa. More growth could possibly afford the homoeopathic profession a unique chance to become an integral part of health care in South Africa, and to clear up misconceptions that may exist regarding this form of medicine (Pillay 2013: 148). Most misconceptions about homoeopathy speak to the credibility issues surrounding the profession (Solomon 2014: 10). Some believe it is yet to prove itself scientifically, although there is an existence of many studies suggesting it has a scientific base. Some question the principles of the profession and others, the medication. However, it is interesting to note that when a study conducted on allopathic medicine fails, it is not publicized as much (Ottermann 2010: para.1

line 1). It is also interesting to note that some methods of treatment in the allopathy profession are congruent with that of homoeopathy. An example of such treatment includes faecal transplantation, a procedure that corresponds with the law of similimum.

The public healthcare system in South Africa services the bulk of the population and the majority of the population rely on this system as they have no means to reach services provided in the private sector (Kautzky and Tollmen 2008: 24). Without neglecting the burden of various disease previously stated, other things that plague this system include issues of negligence and mismanagement of funds; a shortage of medication and treatment; a lack of funding of some public facilities; staff shortages; burdens of infectious and lifestyle diseases; double burden of communicable and non-communicable diseases relating to poverty, as well as emerging chronic diseases (Van Rensburg 2014: 26). Of major concern to the researcher are the issues of personnel insufficiency, communicable and non-communicable diseases as well as shortage of medication- as the addition of homoeopathy into the public sector has a potential to alleviate these burdens. Ultimately, no discipline should exist in silo, to attend to vast array of problems experienced in the public healthcare system (Smilie 2010: 8). The aim of employing homoeopathy in the public healthcare system would be to complement allopathic medicine in addressing problematic issues experienced, in order to create sustainable healthcare services (Erwin, Marks and Couchman 2013: 8).

2.8 HOMOEOPATHIC PRACTITIONER

In South Africa, a homoeopathic practitioner is a primary contact practitioner, recognised as a doctor (Solomon 2014: 8). In order for a homoeopathic practitioner to legally practice in South Africa, one must be registered with the Board of Healthcare of Funders of Southern Africa (BHF), an organisation that will allocate a practice number and the AHPCSA, an organisation that regulates the professions and allocates a practitioner number (Majola 2015:

8). In order to register with these statutory bodies, one must be in possession of a master's degree obtained from either the Durban University of Technology (DUT) or University of Johannesburg (UJ) (Majola 2015: 9). In South Africa, once registered, homoeopathic practitioners are exclusively available to those who are able to use facilities that exist in the private healthcare system and those who have access to free homoeopathic community clinics provided through various initiatives.

2.9 HOMOEOPATHIC EDUCATION

In South Africa, UJ and DUT are the two institutions that offer a full-time, five-year, state subsidized Master's Degree programme in homoeopathic medicine (Prinsloo 2000 para. 4 line 1). The five-year full-time master's degree was introduced to Technikon Natal (now DUT) in 1987 and later in 1992 to Technikon Witswaterand (Now UJ) (Solomon 2014: 7-8). The homoeopathic programme offers medico-scientific training and is based on the Bachelor of Medicine and Bachelor of Surgery (MBChB) programme available to medical students in South Africa (Majola 2015: 9 and Solomon 2014: 7). Because the homoeopathic programme at these institutions models the Bachelor of Medicine and Bachelor of Surgery (MBChB) programme available to medical students in South Africa, it allows all registered homoeopaths to have both medical and homoeopathic skills, which should be useful in practice (Ross cited in Majola 2015: 10). There seems to be a disconnection between the Department of Education (that sets the criteria for how homoeopathic students should be trained, which includes three years of traditional medical training) and the Department of Health (that prevents homoeopathic practitioners from working in the over-stretched public healthcare system that requires assistance).

2.10 SCOPE OF PRACTICE

In South Africa, a homoeopathic practitioner is considered as a primary contact practitioner. According to the AHPCSA, the scope of practice for a homoeopathic practitioner is as follows: "*diagnose, and treat or prevent physical and mental disease, illness or deficiencies in humans; prescribe or dispense medicine; or provide or prescribe treatment for such disease, in illness or deficiencies in humans*" (Republic of South Africa 1982: 28).

2.11 ALLIED HEALTH PROFESSION COUNCIL SOUTH AFRICA

The AHPCSA is a statutory health body that regulates all allied health professions. As aforementioned, the AHPCSA regulates eleven allied health professions (AHPCSA 2018a: para. 2 line 1). This statutory body was established in terms of the allied health professions act, 63 of 1982 and has the equivalent status as the Health professional council South Africa (HPCSA) (Majola 2015: 8). This statutory body was set to not only regulate alternative medicine practitioners but it is mandated to also "*promote and protect the health of the public; manage, administer and set policies relating to the professions registered with the AHPCSA; investigate complaints relating to the professional conduct of practitioners, interns and students; set guidelines for the education and training of prospective practitioners, be accountable to the Minister of Health and the National Department of Health; advise the Minister on matters relating to the allied health professions as well as matters of public importance known to the AHPCSA as a result of its activities*" (AHPCSA 2018b: para. 2 line 1).

2.12 HOMOEOPATHY SOUTH AFRICA

Homoeopathy South Africa (HSA) is a voluntary supportive body for homoeopathic practitioners (HSA 2019a: para. 1 line 1). This supportive body represents qualified homoeopathic practitioners, homoeopathic students as well as educators. The role of HSA is to support and promote the homoeopathic profession with relevant stakeholders (Majola 2015: 10).

2.13 HOMOEOPATHY COMMUNITY CLINICS

Homoeopathy is not formally included in the public healthcare in South Africa (Majola 2015: 13). This is in keeping with what is done in other African countries mentioned previously, such as Nigeria and Kenya and Tanzania. In these African countries, homoeopathy is mainly available in the private sector and initiatives have been developed to make it available to certain areas (Majola 2015: 13 and Bingley *et al* 2014: 36). An example of such initiatives in South Africa include community outreach programmes such as Redhill (Durban North), Ukuba Nesibindi (Warrick Triangle community), Kenneth Gardens (Umbilo), Marburg Haven (Marburg / Port Shepstone), Narian Jeawon Vedic Centre Clinic (Avoca Hills) (Clinics DUT 2015: para 3 line 1). Some of these clinics have been evaluated by previous students and their conclusions are similar in nature, indicating positive results and motivating for the integration of homoeopathy into the public healthcare system in South Africa (Khumalo 2015: iii; Love 2016: V).

A pilot study that was conducted by Botha, in the Redhill Homoeopathic Clinic, was able to establish that homoeopathy was well received by both patients and allopathic practitioners in the facility (Botha 2010 cited in Pramlall 2016: 12). According to Botha 2010 cited in Pramlall (2016: 13), this was also confirmed by some patients and allopathic practitioners verbally. In addition to this, the high rate of return visits and constant referral of patients to the initiative by the allopathic practitioners supported Botha's conclusions (Botha 2010 cited in Pramlall 2016: 12). Such findings also indicate the potential role homoeopathy could play in alleviating human resource insufficiency within

public health facilities and in return improve service delivery. A study conducted by Watson (2015: IV) on patients who attended the Ukuba Nesibindi clinic was also able to conclude that certain patients would support the inclusion of homoeopathy in the public healthcare system in South Africa.

The Department of Homoeopathy at UJ has also established homoeopathic community clinics. These clinics are located in primary schools that are in Ennerdale and Soweto. Both DUT and UJ initiatives, provide free consultations to the community it serves as well as free homoeopathic medication (Mazibuko, pers. comm. 15 September 2013). The positive results seen in these initiatives can only suggest that there would be similar effects if homoeopathy were formally integrated into South Africa (Smillie 2010: VI and Van Rensburg 2014: 26). While the homoeopathic profession waits for this to occur, the development of a model for integration would assist at a later stage.

2.14 PUBLIC HEALTHCARE SYSTEM IN SOUTH AFRICA

South Africa has a dual healthcare system- it consists of a public and private sectors. For the sake of the study, the researcher will focus on literature relating to the public healthcare system. The public healthcare system services the bulk of the South African population (Sibiya 2009: 37). The majority of the South African population rely on the public sector as they have no means to reach services provided in the private sector (Kautzky and Tollmen 2008: 24). Thus, allowing good healthcare to become a commodity in South Africa (Khulumani 2015: 11).

Section 27 on the new constitution of the bill of rights states:

“Health care, food, water and social security

27. (1) Everyone has the right to have access to:

(a) Health care services, including reproductive health care;

(b) Sufficient food and water; and

(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

(3) No one may be refused emergency medical treatment".

Selected healthcare services such as homoeopathy remain an elite privilege for the few that have access to private healthcare. In retrospect, when the bill of rights was passed in 1994, it was tasked with transforming many fragmented systems within South Africa that were inherited from the apartheid era (Khulumani 2015: 3). In light of this deplorable inception and the growing population in South Africa, fulfilling section 27 of the bill of rights remains a difficult task for the government.

The government in South Africa allocated R187.5 billion in 2017 towards healthcare services, with district health services receiving R83.6 billion rand, central hospital services receiving R35.9 billion rand, provincial hospital services receiving R32.3 billion rand, facilities management and maintenance receiving R9.9 billion rand and other health services receiving R25.8 billion rand (National Treasury n.d: 1). Even with this amount of money being spent, evidence suggest that the public healthcare system is still unable to cater to all the people that it services. These figures reflect a disparity that exists between the amount of funding allocated in this sector and the number of users (Van Rensburg 2014:26). The public health sector is also faced with the burden of new medical graduates wanting to practice in the private sector, as opposed to the public sector as it offers fewer hours with more pay (Van Rensburg 2014: 26). Adding to this is the burden of communicable and non-communicable diseases (Van Rensburg 2014: 26). In contrast to the above, the private sector presents with sufficiency of practitioners and leading biomedical technology advancements that is able to cater to all its users.

With the public healthcare system being plagued with a variety of issues, the integration of homoeopathy into it presents as a viable solution, one that will

present with more practitioners moving into the public sector and the use of a more cost-effective medicine to treat communicable and non-communicable diseases (Solomon 2014: 4; Rossi *et al.* 2010: 282 and Roberts 2008: 49). Currently, the public healthcare system only makes provision for the use of orthodox medicine. The addition of homoeopathy would create a pluralistic, one that will assist in abolishing disciplinary silos, creating a harmony that will tackle the issues the public sector is faced with (Smillie 2010: 8). Ultimately, no discipline should exist on its own to attend to vast array of problems experienced in the public sector (Smilie 2010: 8).

2.15 PERCEPTION STUDIES ON THE INTER-PROFESSIONAL RELATIONSHIP BETWEEN ALLOPATHIC PRACTITIONERS AND HOMOEOPATHS

Moshabela, Zuma and Gaede (2016: 83) argue that it is impossible for traditional complementary medicine to co-exist with main-stream medicine in the public healthcare system due contradicting worldviews that exist between the two professions. However, some argue that the integration of traditional complementary medicine into the public healthcare system could create more plural health care, exposing the public healthcare sector users to more holistic and comprehensive care (Moshabela, Zuma and Gaede 2016: 83). Adding to this, perception studies conducted by Maharajh (2005: ii); Naicker (2008: iii); Pillay (2013: IV) and Thorvaldsen (2007: ii) hint at the fact that allopathic and homoeopathic practitioners can potentially exist in harmony in the public healthcare space.

Studies conducted by Maharajh (2005: ii); Naicker (2008: iii); Pillay (2013: IV) and Thorvaldsen (2007: ii), account for the perceptions that allopathic practitioners have towards alternative medicine. These studies particularly reflect the potential inter-professional relationship that might develop between the homoeopathy and allopathic profession if the integration of homoeopathy into the public health sector were to occur (Maharajh 2005: ii; Naicker 2008: iii; Pillay 2013: IV).

A study conducted by Maharajh (2005: ii) investigated the perceptions of general practitioners (GPs) and pharmacists towards homoeopathy. The majority of the participants were aware of what homoeopathy is. In addition, the majority felt that disciplinary silos need to be removed in order to improve communication and co-operation between mainstream medicine and homoeopathy profession for the benefit of the patient. In contrast, it was interesting to note that a study conducted by Naicker (2008: iii) on the perceptions and interactions of medical specialist towards homoeopathy in Durban revealed only a few participants had knowledge of what homoeopathy is. The participants that had very little knowledge on homoeopathy were mostly misinformed about the education and scope of practice of homoeopaths in South Africa (Naicker 2008: 65). Those participants that had a lot of knowledge on homoeopathy had embraced good relations with homoeopathic practitioners and embraced inter-referral relationships.

Allopi (2008: ii) conducted a study that investigated the perceptions of nurses in eThekwini towards homoeopathy. It is a known fact that nurses work very closely with patients in both public and private sectors. Therefore, they would probably have a huge influence towards the success of integrating of homoeopathy into the public sector. The study conducted by Allopi (2008: ii) revealed that 10% of the participants indicated that they were familiar with the homoeopathic profession and 39.9% of participants working in public hospitals regarded homoeopathy as a legitimate form of medicine. Though the study revealed that there is a poor communication between allopathic and homoeopathic practitioners, the majority of participants (70.06%) perceived homoeopathy as having a role to play in a hospital setting (Allopi, 2008: IV). A similar study conducted by Pillay (2013: IV) on the knowledge, attitudes and perceptions of primary healthcare nurses in the eThekwini Municipality District towards homoeopathy being included in public primary healthcare revealed that the majority of the participants felt that homoeopathy should be made available at hospitals and clinics. These results are in keeping with those obtained by Allopi (2008: IV).

The consistent factor that was established in the above-mentioned study was the lack of knowledge and communication that existed between the homoeopathy and allopathy professions. These are one of the components that have a likelihood of affecting successful integration in a study conducted by Majola (2015: 66). The proper educating of allopathic practitioners about homoeopathy and an open space for communication between the two professions would be an obvious resolution to these issues (Pillay 2013: V).

2.16 INTEGRATION OF HOMOEPATHY INTO THE PUBLIC HEALTHCARE SYSTEM

Various countries have chosen to integrate homoeopathy into its public healthcare system (Globimed 2015: para. 2 line 1). Based on the lack of literature available, most of these countries have not drawn up specific models of integration but have chosen to integrate homoeopathy in various clinical settings to make it available to the public at large. In this section, the researcher will highlight international models of integration that exist.

The word ‘integration’ appears to have multiple meanings. One of the descriptions proposed by Waddington and Egger (2008: 1) is “the various tasks which need to be performed in order to provide a population with good quality health services”. In keeping with this, the researcher therefore advocates for the addition of homoeopaths in the public healthcare system, as this would be in keeping with this definition. The aim of employing homoeopathy in the public healthcare system would not to replace allopathic medicine but rather to complement it in addressing problematic issues experienced currently in the public sector in order to create good healthcare services.

The following facts about homoeopathy motivate for the integration of this profession into the public health sector of any country that presents with a burdened public health sector:

- Homoeopathy is broadly applicable and it be used to address a wide array of health issues from physical to mental problems (Bloch and Lewis 2003: 24-25). This allows for this system of medicine to have a holistic healing approach and this can be instrumental in creating a sustainable healthcare system.
- Homoeopathic medication has minimal adverse side-effect (Dantas and Rampes 2000: 70). A study was conducted by Dantas and Rampes to evaluate the safety of homoeopathic medication by reviewing reports of adverse effects published in 1970 to 1995 (Dantas and Rampes 2000: 74). Though it was difficult to draw a conclusion from the reports reviewed, the appraisal revealed that homoeopathic medicine either minimal or no adverse effects.
- It is safe to use by pregnant women or new mothers, as well as children (Spigelblatt 2005 cited in Harripershad 2009: 23). A study was conducted in Canada amongst the Paediatric Society by Spigelblatt in 2005 to evaluate the use of homoeopathy amongst paediatrics (Harripershad 2009: 23). The result revealed that homoeopathy was more appealing in paediatric patients because of its non-toxic nature (Spigelblatt 2005 cited in Harripershad 2009: 23).
- Homoeopathy can be used in both chronic and acute conditions (Chappell 2005 cited in Watson 2015: 3).
- Homoeopathic medication is mainly made from natural substances and generally inexpensive to produce (Roberts 2008: 49). A study was done in Germany by an insurance company to evaluate the cost of homoeopathic medication against conventional medicine (Roberts 2008: 48). The results of this study revealed that patients who received homoeopathic treatment had improvement in their health for a similar cost (Roberts 2008: 48). Thus, it was concluded that homoeopathy is an affordable approach and it has a potential of alleviating pressure on the healthcare system by diminishing the billing medication cost.

- Homoeopathy has a non-invasive healing approach (Kayne 2008: 226).

Adding to the above facts mentioned about homoeopathy, is an exploratory study conducted by McIntosh (2008) that explored why people choose to consult with a homoeopath. This study looked into the enabling factors that made patients consult with homoeopaths. It also looked into the insufficiencies that existed in westernized medicine that motivated patients to consult with homoeopaths and it also looked into the patients' decision-making patterns (McIntosh 2008: 69). The results of the study revealed that all the participants of the study consulted with allopathic doctor first prior to consulting with a homoeopath (McIntosh (2008: 69). Some of the reasons why the participants ended up consulting with a homoeopath included the participants' concerns about the side-effects of long-term mainstream medication. The majority of the participants were frustrated with the manner in which an allopathic doctor would conduct their consultations as they felt rushed and allopathic providers do not ask in-depth questions like homoeopaths and this was an area of concern for some participants as they feel that this would lead to incorrect prescribing; some participants were unhappy about the bedside manner of their allopathic doctor as some allopathic doctors were difficult to talk to and judgmental (McIntosh 2008: 69).

If South Africa heads towards integrating homoeopathy into its public healthcare system, it can draw on the models for integration created in other countries (Dooley 2001: 40). There are various components involved with integrating homoeopathy in the public sector (Fisher 2004: 627). Some of these include governance and evaluation, system, professionalism, information and guidelines (Fisher 2004: 627). These components are in keeping with those drawn by Majola (2015:81); Myburgh, Hartvigsen and Grunnet-Nilsson (2008: 802); Wise (2010: 87-88) and Manchanda (2016: 1). Literature provided by these authors propose frameworks for integration and highlight changes that need to be implemented in each component prior to integration (Majola 2015:81; Myburgh, Hartvigsen and Grunnet-Nilsson 2008: 802; Wise 2010: 87-88; Manchanda 2016: 1).

Smallwood (2005: 81) advocates for two types of models when it comes to integrating complementary alternative medicine into the public sector. These models are the additive models: a model in which conventional medicine and complementary alternative medicine would complement each other by addressing each other's gaps and the transformative models: complement alternative medicine would still complement each other but would question each other's perspective (2005: 81). While the homoeopathy profession in South Africa waits for the possibilities of integration, the investment into research that would facilitate integration should be done. These shared ideals on integration, along with the data that will be collected for the study, will assist the researcher in creating a feasible model of integration.

In South Africa, registered homoeopaths are trained and permitted by law to make a diagnosis and treat a wide variety of illnesses and dispense medication. Thus, homoeopaths would be suitable for the Public healthcare system environment. Studies done by Babiker *et al.* (2014: 9); Clark *et al*. (2017: 23); Fisher (2004: 627) and Smallwood (2005: 81) not only reflect that homoeopathy is the resolution to some of the problems currently experienced in the public sector in South Africa but also reflect how homoeopathy complements allopathic medicine.

Supporting the phenomenon of an integrated healthcare system is a study conducted by Babiker *et al.* (2014: 9). In this study, Babiker *et al.* (2014: 9) states that, according to the WHO, an integrated healthcare is described as multi-specialty system formulated by a collaboration of health practitioners to treat a patient in need. This has become a global trend that poses itself as a remedy for a healthcare system that is fragmented (Grand, Caspar and MacDonald 2011: 125). Albeit, it is important to note that integrated healthcare does not necessarily mean the merger of roles and fields but rather refers to a cost-effective way to deal with patient subjected to multiple co-morbidities and one that require continuous care (Babiker *et al.* 2014: 9; Clark *et al.* 2017: 23).

According to Fisher (2004: 627), there are various components involved with integrating homoeopathy into the public sector. Some of these include governance and evaluation, government health system, professionalism, and information and guidelines (Fisher 2004: 627). These components are in keeping with those drawn by Majola (2015: 81); Myburgh, Hartvigsen and Grunnet-Nilsson (2008: 802); Wise (2010: 87-88) and Manchanda (2016: 5). Literature provided by these authors propose frameworks for integration and highlight changes that need to be implemented in each component prior to integration (Majola 2015:81; Myburgh, Hartvigsen and Grunnet-Nilsson 2008: 802; Wise 2010: 87-88 and Manchanda 2016: 10). Smallwood (2005: 81) on the other hand, speaks of two models when it comes to integrating complementary alternative medicine into the public sector. These models are the additive models: a model in which conventional medicine and complementary alternative medicine would complement each other by addressing each other's gaps and the transformative models: complementary alternative medicine and allopathy would still complement each other but would question each other's perspective (2005: 81).

The WHO suggests three healthcare models that describe the degree of how CAM has been integrated in different countries worldwide (Muweh 2011: 13):

- Monopolistic healthcare model: a model that only caters allopathic medicine and the practice of CAM is not encouraged. In this instance, CAM is practiced illegally.
- Tolerant healthcare model: a model where both allopathic medicine and CAM is practiced but the latter is not officially recognised. Parallel or dual healthcare model: a model where both allopathic medicine and CAM is practiced and recognised officially. In this instance, the two types of medicine exist separately in harmony and this model recognises that each type of medicine has its place to serve in the healthcare system.
- Integrative healthcare model: a model where both allopathic and CAM exist in one paradigm and practiced concurrently in harmony.

Based on the literature reviewed, one can assume that most countries enforce either the tolerant or the dual healthcare model and only a few have ventured into the integrative healthcare model. While the homoeopathy profession in South Africa waits for the possibilities of integration into the public healthcare system, the investment into research that would facilitate integration should be done. In other words, the purpose of this study would be to establish how South Africa can move from the dual healthcare model to the integrative healthcare model, where both homoeopathic and allopathic medicine is practiced together in harmony.

2.17 SUMMARY OF THE CHAPTER

This chapter attempted to give a background of what homoeopathy is, how it was developed and how it is used. The status of homoeopathy worldwide is also highlighted in this chapter. Based on the lack of literature, it is assumed that no study has been conducted locally to develop a model of integrating homoeopathy in the public healthcare system. In order to facilitate development of this model, another factor such as the current state of the public healthcare system in South Africa was looked at. Collectively, the literature reviewed points at the fact that integration of homoeopathy into the public healthcare systems should not be overlooked.

CHAPTER 3: THEORETICAL FRAMEWORK

3.1 INTRODUCTION

In this chapter, the researcher indicated the theoretical framework that has guided the study. The researcher first explained what a theoretical framework is and its importance to the study as well as went into detail regarding why the particular framework was chosen. This chapter also specified how a framework would assist in developing a model of integrating homoeopathy into the public healthcare system.

3.2 DEFINITION AND DESCRIPTION OF A THEORETICAL FRAMEWORK

A theoretical framework is defined as the anchor for a research study (Grant and Osanloo 2014: 12). It serves as a structure that supports the rationale of the study, problem statement, purpose and research questions (Grant and Osanloo 2014: 12). A theoretical framework, therefore, provides insight to the observer, on a research study. In this study, the theoretical framework was used as a guide to develop a model of integrating homoeopathy into the public healthcare system in South Africa. Hence, this section of the study is particularly important and will be established from the beginning of the study.

The purpose of a theoretical framework is as follows:

- Guide for concept generation;
- Describe how variables relate to each other and provide a rationale for predictions about their relationship;
- Inform the development of the intervention;
- Guides the data analysis phase;
- Assist with contextualising the results (Leighton *et al*. 2016: 6).

3.3 SELECTING A THEORETICAL FRAMEWORK

The selection of a theoretical framework is a deep and thought-filled process that requires a researcher to better acquit themselves with the research problem, significance, purpose and research questions (Grant and Osanloo 2014: 12). These four areas have been discussed in Chapter 1.

According to Leighton *et al*. (2016:6), a theoretical framework should form the basis of all decision made when designing a research study. The following is the sequence of events that can be followed when choosing a theoretical framework as suggested by Leighton *et al.* (2016: 6) and is the same sequence that was adopted by the researcher for the study:

- An idea for the study must be identified.
- The researcher must look into the problem surrounding the phenomenon and its dimension.
- A literature review must then be conducted to identify certain concepts.
- A theoretical framework that is best suited for the study must be chosen.
- Research questions (based on the theoretical framework) must be developed.

The idea for the study was as a result of a previous study that was conducted by the researcher regarding perceptions of homoeopaths and the role they could play in the public sector. The results of the researcher's previous study indicated that the majority of the homoeopathic doctors that took part in the study would welcome shifting from private to public sector (Majola 2015:1). Based on these results, the topic for the current study was identified. Upon further investigation using scientific search engines to identify related literature, the researcher observed the study phenomenon was under researched. As highlighted in the previous sections, many policies exist on integrated healthcare services. However, these policies make provision for only allopathic practitioners. Currently, in South Africa, there is no model or policy that highlights how homoeopathic services can be integrated into the

public healthcare system. In light of this reality, the researcher has chosen to adapt PATH's Framework for Integrated Healthcare Service as a guide for the study. PATH defines integration as an approach used in patients and their family to provide them with a continuum of health services. As depicted below in the Figure 3.1, there are potentially four levels that integration of healthcare services can occur at (PATH 2011: 1).

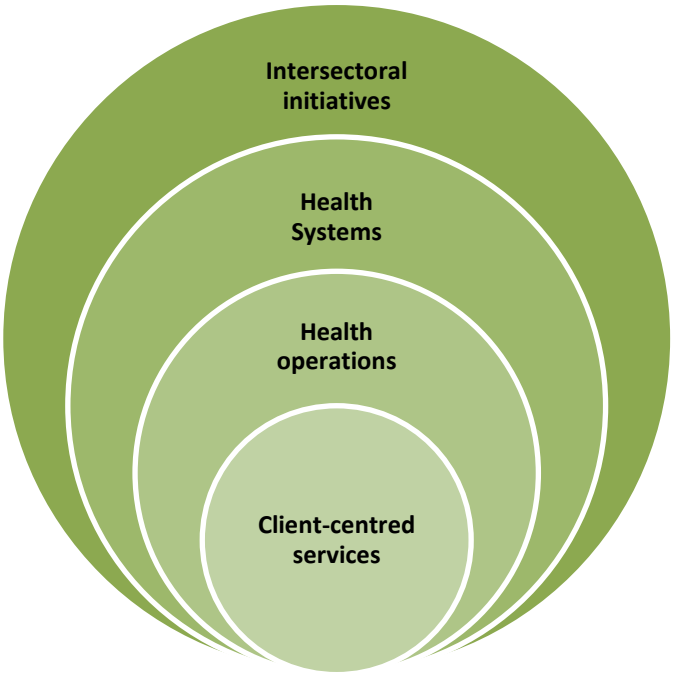

Figure 3.1: PATH's approach to integrated health services (PATH 2011: 2)

According to PATH (2011: 2), integration may occur at a client level, at a government level, at a health organisation level and at an inter-sectoral level. When integration occurs at a client-centre level, programmes are developed to fit the needs of a client and families as well as communities usually get involved (PATH 2011: 2; WHO 2016: 1). This type of integration may involve longer clinic hours but results in more efficient referral systems, increased use of preventative services and improved access to healthcare services. When integration occurs at a governance level, many entities, both private and public come together to coordinate as well as deliver integrated services (PATH 2011: 2). Integration at a health organisation level involves re-evaluation of how services are delivered to clients (PATH 2011: 2). This may

change how resources, time, money or expertise are allocated to different parts of the healthcare system. Lastly, inter-sectoral integration involves two sectors working together to achieve integration of healthcare services (PATH 2011: 2). In order to develop a model for integrating homoeopathy into the public healthcare system, the four levels at which integration may occur at will be explored in the study. Dickoff; James and Wiedebach (1968: 416) approach will also be used to formulate a model. The researcher will use the first three levels of the Dickoff, James and Wiedebach (1968: 416) approach. The first three levels respectively include factor isolating methods, factor relating and situation relating methods. The first level involves identification of concepts; the second level involves identification of a relationship between the concepts and the third, situation relating (Dickoff; James and Wiedebach 1968: 416). These guidelines will be used in the second phase of the study. The second phase of the study will also involve evaluation of the model developed for the study.

3.4 APPLYING THE THEORETICAL FRAMEWORK IN THE STUDY

It was important to identify a theoretical framework from the inception, as it dictated the direction for this study. It served to guide the research problem, literature review, data collection and analysis methods (Grant and Osanloo 2014: 21). Identifying a theoretical framework also allowed the researcher to move from a point of intuition to having a solid plan on understanding the research phenomenon (Grant and Osanloo 2014: 21). To develop a model of integration that is grounded within the South African context, the researcher used PATH's framework to guide the study; conducted a thorough literature review of both local and international sources; and then collected data from healthcare professionals that would potentially be involved in the process of integrating homoeopathy into the public healthcare system in South Africa. These healthcare professionals were identified to be homoeopathic doctors, nurses, nursing managers, Chief Operating Officers and medical doctors. Albeit, the many concepts that surround the topic of integration, the information collected from the respective healthcare professionals was guided

and organised according to PATH's approach to integrated health services. By doing so, it aided the researcher to develop a model of integration.

3.5 SUMMARY OF THE CHAPTER

In this Chapter, the researcher has demonstrated the theoretical framework that has guided the study and why it was selected. This chapter was very important, as the theoretical framework played the role of guiding the entire research study. The next chapter will discuss the specific methodology used to identify, collect and analyse data for this study. In the next chapter, the researcher has also motivated why certain research methodology were chosen for the study.

CHAPTER 4: RESEARCH METHODOLOGY

4.1 INTRODUCTION

This chapter attempted to discuss and justify the methodology chosen to conduct the study. Research methodology is defined as a set of techniques used to identify, select and process data on a particular topic. Therefore, this chapter has gone into details regarding the research design, paradigm, research setting, sampling process, data collection process data analysis process, trustworthiness and ethical consideration.

4.2 RESEARCH DESIGN

A mixed methods approach was used to achieve the aims and objectives of this study. This approach was best suited for this study as it employed both qualitative and quantitative methods (Archibald *et al.* 2015: 228). These methods are said to present numerous advantages, such as being able to harness the advantages of statistical reliability, generalisability, and test-retest reliability from quantitative research; along with the advantages of gaining insight and perspective from observers involved in the field, as offered by the techniques of qualitative research (O'Cathain, Murphy and Nicholl 2008: 92). Using the mixed-methods approach also offered thoroughness in developing a model for integration of homoeopathy into the public healthcare system of South Africa by analysing the perceptions of all parties involved in its integration.

The quantitative component of a mixed methods study involves the collection of data in numerical form such as statistics and percentages. This method can allow a researcher to reach a larger proportion of the population, thus providing room for generalisability (O'Cathain, Murphy and Nicholl 2008: 92). In contrast, the qualitative component involved the opposite, commonly used when data collected cannot be enumerated. This method can be used

particularly to gain better understanding of a phenomenon through capturing perceptions of those involved (Shenton 2004: 71).

In a mixed methods study, there are many designs that exist. These designs allow for the merging of both quantitative and qualitative components (Creswell 2014: 47). There are three types of designs commonly used in mixed methods research (Creswell 2014: 47). These are the convergent parallel design: which pertains to merging both the qualitative and quantitative data collected in order to produce comprehensive analysis; the explanatory sequential design: which involves collecting quantitative data first then using that data to further develop tools to collect qualitative data; and the exploratory sequential design: which occurs in reverse sequence to the explanatory sequential design (Creswell 2014: 48).

4.2.1 Explanatory sequential design

For this study in particular, the explanatory sequential design was used. The explanatory sequential research design dictates for a study to be conducted in two phases (Creswell 2014: 37). Phase 1 usually involves collecting and analysing quantitative data. As soon as this phase is finalised, the information gathered from it builds-up phase 2. Phase 1 usually builds the research instrument for phase 2 (Creswell 2014: 224). Though each phase in this design, may employ opposing methods, there are both linked by the fact that the one would have to build up and corroborate the findings of the other (Creswell 2014: 37). For this study, this design assisted in providing statistical and commentary data by capturing different perspectives of those involved in integration. Thus using this design came with the benefits of being able to thoroughly explain and interpret results of the study.

4.2.2 Background of mixed methods research

The context of a mixed methods study could be traced back to the 1950's. This was a pivotal period for this research methodology as it received a lot of attention from many methodologists, sociologist and philosophers (Maxwell

2016: 12). Research studies that used both the qualitative and quantitative approach concurrently were conducted prior to the 1950's, but were not labelled as a particular type of method as yet (Ngulube 2013: 13).

Campbell and Cook were one of the many methodologists who questioned the validity of results that were obtained from a mono-method study (Maxwell 2016: 12). The concept of mixing certain research techniques was explored by them but focused more on researching a point of triangulation (Maxwell 2016: 12). Triangulation, in research, refers to the act of using more than one method to collect data on the same phenomenon (Ngulube 2013: 13). This concept was first described by Denzin, who suggested that there were four types of triangulation (Teddlie and Tashakkori 1998: 18). The four types of triangulation described by Denzin were data triangulation; investigator triangulation; theory triangulation and methodological triangulation (Honorene 2016: 91). Respectively, these types of triangulation explored the use of several data source in one study; the use of several different researchers in one study; the use of several different perspectives to interpret the results of a study and the lastly, the use of several different methods to conduct a study (Teddlie and Tashakkori 1998: 18).

Equally important, Patton also suggested three types of triangulation. These are: across methods, within methods and across different analysis triangulation (Teddlie and Tashakkori 1998: 42). These three different types of triangulation reconciled qualitative and quantitative data; compared multiple different types of data sources and involved the use of using multiple perspectives from different observers (Teddlie and Tashakkori 1998: 42).

Sociologists such as Creswell, Green, Patton and Tashakkori have also contributed a lot of knowledge on triangulation and mixed methods research. Tashakkori would go to define mixed methods research as the use of both qualitative and quantitative methods in a single study (Ngulube 2013: 11). With many sociologists contributing to the knowledge of mixed method research, Patton developed three taxonomies for organizing the different

types of mixed methods designs that people had established (Teddlie and Tashakkori 1998: 43). These were the equivalent status designs, dominant-less designs and designs with multilevel (Teddlie and Tashakkori 1998:43). This study used an equivalent status type of design that was developed by Creswell. Equivalent status type of designs allowed for both qualitative and quantitative methods to have equivalent status in a study (Teddlie and Tashakkori 1998: 44). This type of design allowed for the study to be conducted in two phases and these phases could be either sequential or parallel to each other, according to Teddlie and Tashakkori (1998: 44).

Creswell believed that mixed methods designs could be either basic or advanced. Basic designs were further classified as being convergent designs, explanatory sequential designs or exploratory sequential designs (Creswell and Plano-Clark 2011: 69). Similarly, advanced designs were categorized into intervention designs, social justice designs or multistage evaluation designs (Creswell 2014: 35).

4.3 RESEARCH PARADIGM

A philosophical view is a set of beliefs that exist about a particular study phenomenon or reality that will have an influence on one's thinking pattern, mind-set and actions (Creswell 2014: 5). Philosophical view can be different amongst individuals and is also said to be 'one's philosophy of life' or 'outlook on life' which, cannot be replicated (Creswell 2014: 5). Hence, it will always determine the manner in which a researcher approaches a problem and conducts their study (Creswell 2009: 4). Lincoln and Guba (2004: 21) define the philosophical view as a *paradigm*, the researcher's own outlook; perceptions and interpretation of the nature of the world. According to Patel (2015: para. 5 line 1) and Creswell (2014: 6), there are four common types of paradigms. These are:

- *Positivists,* where individuals who believe there is a single reality and are most likely to use quantitative measures;

- *Constructivists,* where individuals who believe there is no single reality and are more likely to use qualitative methods;
- *Pragmatists,* where individuals who believe reality is constantly changing and not all problems would be resolved by a single solution but rather by a solution suitable for that problem at that particular period;
- *Transformative* paradigm, which advocates for the research conducted to have an action agenda that will transform or change the lives of the participants (Patel 2015: para. 5 line 1; Creswell 2014: 5).

The researcher's choice in paradigm was guided by four components, namely (Wahyuni 2012: 69-71):

- *Ontology*, which pertains to the reality that exists on the study phenomenon. For this study, this aspect was linked realities of both homoeopathic and allopathic practitioners.
- *Epistemology*, which pertains to the knowledge and justified beliefs that exist on the study phenomenon. This was explored in the study by means of an individual semi-structured interview as well as manual/ electronic surveys.
- *Axiology*, which pertains to the values and the researcher's philosophical ethics that exist about the study phenomenon. The researcher was subjected to being biased due to the direct involvement in the homoeopathy profession, this was avoided by ensuring that validity and trustworthiness is maintained throughout the study.
- *Methodology*, which pertains to the approach and style that the research will choose to conduct the study. To avoid drawing a biased conclusion, the researcher conducted a mixed methods study using the explanatory sequential design. The participant's experiences, perceptions and opinions were captured and used to draw model for integration.

The researcher resonated more with the pragmatist paradigm as the model of integration, that was formulated, was constructed through a combination multiple realities and existing literature (Creswell 2014: 6). The researcher believed that the research participants were key informants for this study as they are the ones who suggested a direction that the public health sector should take and would be directly involved in the implementation stages. The research participants shared their ideas and beliefs on how they foresee homoeopathic practitioners being integrated into the public healthcare sector that they service.

4.4 RESEARCH SETTING

The research setting is defined as the physical area in which the researcher chooses to conduct the study (Creswell 2014: 37). It is an area of particular interest as it is where the researcher will find participants to collect data from. In South Africa, there are 58, 8 million people scattered amongst nine provinces (Statistics South Africa 2019: V). These provinces are as follows: Western Cape, Eastern Cape, KZN, Gauteng, Mpumalanga, Northern Cape, Free State, Limpopo and North West Province. KZN is one of the provinces that accounts for the majority of the South African population as there are 11,3 million people which is approximately 19.2% of the South African population (Statistics South Africa 2019: 17). In addition to this, as depicted in Figure 1, the province is further segmented into 11 health districts, namely the Amajuba, eThekwini, iLembe, Harry Gwala, King Cetshwayo, uGu, uMgungundlovu, uMkhanyakude, uMzinyathi, uThukela and the Zululand health district (KZN Department of Health 2017a: 35). According to Statistics South Africa (2006: 29), the majority of these districts are considered to be rural. In fact, uMgungundlovu, Amajuba and the eThekwini districts are the only three which are categorized as urban.

Within the 11 health districts, there exist 685 public health facilities collectively (KZN Department of Health 2017b: 35). This collective total includes 594 clinics; 21 community health centers (CHC); 39 district hospitals; 17

specialized hospitals; 13 regional hospitals and 3 tertiary hospitals (KZN Department of Health 2017a: 35). Public health facilities in KZN are further organised into a referral system that depicts four levels of care (KZN Department of Health 2017c: para. 1 line 1). The facilities in the first level include primary healthcare clinics- which cater to the first step in the provision of healthcare services, CHC- which cater to the second step in the provision of healthcare services and district hospitals which cater to the third step in the provision of healthcare services (KZN Department of Health 2017c: para. 1 line 1). The KZN Department of Health (2017c: para. 4 line1) advises, if a patient cannot be managed in the level one facilities, their case is to be escalated to the level two facilities. Level two facilities include all regional hospitals and likewise, if there are not able to manage a case, there escalate matters to level three facilities (KZN Department of Health 2017c: para. 1 line 1). Level three facilities include only provincial tertiary hospitals. If a level three facility is unable to resolve a patient's ailment, then it is referred to level four hospitals which include central as well as specialized hospitals (KZN Department of Health 2017c: para 6 line 1). For the study, this referral system was overlooked as data was collected from willing participants located in any public health facility, irrespective of its level of care. Phase 1 and 2 was conducted in the same province. However, data collection occurred in various district districts within the same province.

The King Cetswayo district and the eThekwini district were the ideal locations for data collection. The King Cetswayo district had the highest number of nurses and doctors amongst the rural districts in KZN (Table 1). The eThekwini district was chosen for the same reasons, but represented the urban districts.

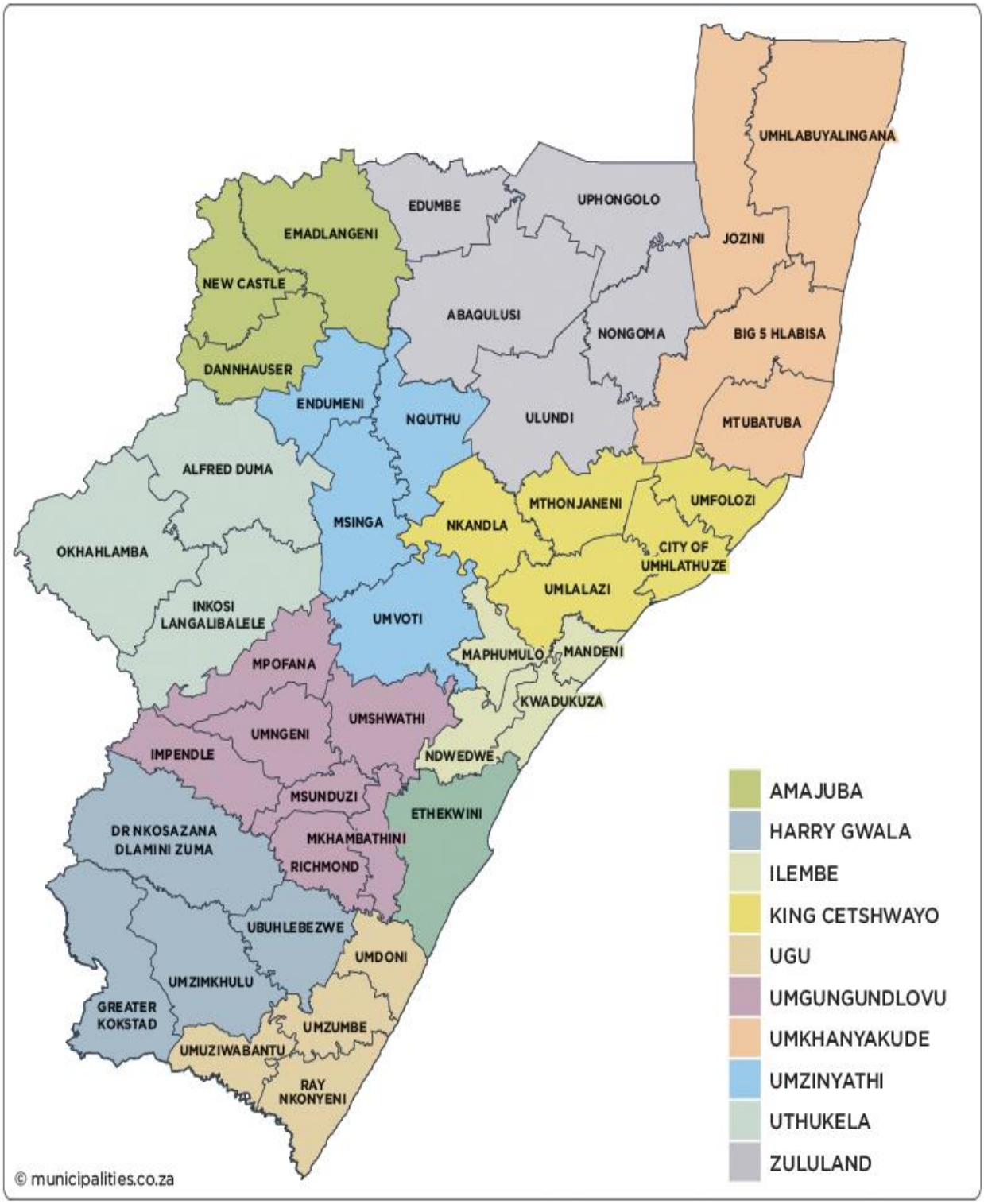

Figure 4.1: A map showing the 11 health districts in KZN (Municipalities of South Africa 2019)

4.5 RESEARCH POPULATION

According to Johnson and Christensen (2012: 213), a research population is a target group or individuals that will be chosen to collect data from and draw a conclusion. For the purpose of the study, each phase consisted of multiple target populations. These were considered as information-rich informants. Though each target population within both phases was different, their common link was the fact that each might have a role to play in the integration of homoeopathy into the public healthcare system. In Phase 1, the target population consisted of homoeopathic doctors that were practicing within KZN, nurses as well as medical officers that were operating within one of the public health facilities in KZN. At the time of data collection, there were approximately 107 homoeopaths registered to be practicing in KZN (Medpages n.d: para. 1 line 9), 33 135 nurses (inclusive of nursing assistants, staff nurses and professional nurses) and 3 496 medical officers (inclusive of medical specialist) (2018, pers. comm. 18 January).

The eThekwini district has a total number of 10664 nurses and 1579 doctors. Therefore, a minimum of 292 nurses and 43 medical officers were required to participate in the study. The King Cetswayo district has a total number of 3112 nurses and 276 doctors. Therefore, a minimum of 85 nurses and 8 medical officers were required to participate in the study. Regarding the sample size for homoeopaths, 94 homoeopaths were required for the study, from a target population of 107. In light of this number, the researcher will extend the study to as many homoeopaths as possible. The target population for this phase is depicted further below in Tables 1 and 2.

In Phase 2, the target population consisted of CEOs of the public health facilities located within KZN as well as nursing managers. Each public health facility ideally has one CEO and one corresponding nursing manager. Therefore, within the 685 public health facilities in KZN, there were 685 CEOs and 685 nursing managers.

The target populations that were chosen for both phase 1 and 2 were selected based on their direct and indirect potential involvement in the process of integration, if it is to occur. The rankings and experience of each target population were overlooked as these characteristics did not have an effect on the study.

Table 4.1: Population size per district (2018, pers. comm. 18 January)

Region Description	Medical Officers	Medical Specialists	Professional Nurses / Nursing Managers	Staff Nurses	Nursing Assistants	Urban/Rural
UGu District	200	17	1264	622	428	Rural
UMgungundlovu District	567	140	2589	1206	722	Urban
UThukela District	120	14	851	502	277	Rural
Umzinyathi District	56	0	927	571	296	Rural
Amajuba District	165	14	891	451	391	Urban
Zululand District	52	1	1146	714	340	Rural
UMkhanyakude District	63	1	962	807	323	Rural
King Cetshwayo District	238	38	1576	1110	426	Rural
ILembe District	149	30	859	508	275	Rural
Harry Gwala District	47	1	748	362	302	Rural
EThekwini District	1245	334	5414	3083	2167	Urban
Grand Total	**2903**	**593**	**17252**	**9936**	**5947**	**36631**

Table 4.2: Sample size (2018, pers. comm. 20 March)

Allopaths						
						Sample with extra %
District	Nurses population	Doctors population	Total	Nurses	Doctors	Total
Urban district - EThekwini	10664	1579	12243	292	43	335
Rural district - King Cetshwayo	3112	276	3388	85	8	93
			15631			428
		Homoeopaths population	Minimum Sample			Sample with extra %
Homoeopaths		107	84		Approx.	94

4.6 SAMPLING PROCESS

The sampling process commences when a researcher chooses the participants of the study that will represent an entire population, thus allowing for generalisability of the data collected (Sekaran and Bougie 2013: 244). For mixed methods research, sampling can be complex as it involves two contrasting research methodologies. For this study, the researcher used a multilevel sequential sampling design as described by Johnson and Christensen (2012: 238). This sort of sampling involved making use of two different types of sampling in one study from different target populations. In mixed methods studies, this type of sampling is commonly used as these sorts of studies collect both qualitative and quantitative data sequentially on different target populations (Johnson and Christensen 2012: 238). Thus, it made sense to use this sort of sampling in this study. The sampling for each phase was as follows:

4.6.1 Phase 1

For the quantitative aspect, the researcher used simple random sampling. This sampling allows for every individual of the population to have an equal chance of being selected (Alvi 2016: 16). In Phase 1, the sample consisted of homoeopathic doctors, medical officers and nurses who were selected according to the inclusion criteria depicted below. There was no partiality in

the selection of the sample in order to gather open and unbiased data on the introduction of homoeopathy into South Africa public healthcare system.

4.6.2 Phase 2

For the qualitative aspect, the sample was gathered through expert sampling. Expert sampling is an exclusive sampling which is an approach used when a researcher has a prior purpose in mind (Alvi 2016: 30). In this regard, the sample will consist of individuals who can provide rich data. The sample in this phase, did not include everyone in the population that is available like in simple random sampling but rather those who are available and met the inclusion criteria as described below (Johnson and Christensen 2012: 231). Therefore, based on these characteristics, sample derived in this phase were more likely to provide insight and understanding to the researcher based on these characteristics (Marshall 1996: 523). With regards to the sample size for this phase, Guest, Bunce and Johnson (2006:59) suggests that sufficient data is generally collected from six to twelve subjects (Guest, Bunce and Johnson 2006: 59). However, for this phase there was no sample size as data collection seized when a point of saturation was reached. This was a point where the participants were no longer offering new information to the questions posed to them (Holloway and Wheeler 2010: 18).

4.7 INCLUSION CRITERIA

The inclusion criteria for the qualitative and quantitative aspect were different as the target population of each phase was different. The inclusion criteria for each target population were as follows:

4.7.1 Phase 1

For homoeopaths:

- Participants who are qualified and registered with the AHPCSA as homoeopathic doctors.
- Participants currently practicing in KZN.

For medical officers:

- Participants currently working in a public health facility within eThekwini and King Cetshwayo district in KZN.
- Participants who are qualified and registered with the HPCSA as medical doctors. The participants' ranking and specialty will be overlooked for the study.

For nurses

- Participants currently working in a public health facility within eThekwini and King Cetshwayo district in KZN.
- Participants who are qualified and registered with the SANC as nurses. The participants' ranking and specialty will be overlooked for the study.

4.7.2 Phase 2

For CEO's of public health facilities:

- Participants need to occupy the role of a CEO in a public health facility located in KZN.

For nursing managers of public health facilities:

- Participants need to occupy the role of a nursing manager in a public health facility located in the KZN.

4.8 EXCLUSION CRITERIA

4.8.1 Phase 1:

For homoeopaths:

- Participants who were not qualified and registered with the AHPCSA as homoeopathic doctors.
- Participants who were currently not practicing in KZN.

For medical officers:

- Participants who were currently not working in a public health facility within eThekwini and King Cetshwayo district in KZN.
- Participants who were not qualified and registered with the HPCSA as medical doctors.

For nurses

- Participants who were currently not working in a public health facility within eThekwini and King Cetshwayo district in KZN.
- Participants who were not qualified and registered with the SANC as nurses.

4.8.2 Phase 2:

For CEO's of public health facilities:

- Participants who did not occupy the role of a CEO in a public health facility located in KZN.

For nursing managers of public health facilities:

- Participants who did not occupy the role of a nursing manager in a public health facility located in the KZN.

4.9 DATA COLLECTION PROCESS

Data collection occurred in two phases. The collection of data in the two phases occurred as follows:

4.9.1 Phase 1

Quantitative data in this phase was either collected by means of a paper-and-pen or electronic survey. Based on the fact that homoeopaths either worked in sole practices or multidisciplinary practices, their geographical location might have varied. Therefore, data for this target population was collected via electronic surveys. These surveys were generated on the “survey monkey” website and distributed to as many willing homoeopaths who met the inclusion criteria of the study. In contrast, nurses and doctors who worked in the public healthcare system were restricted by the facilities they work in, therefore their geographical location would not have varied and it was easier to administer paper-and-pen surveys. Prior to approaching potential participants to take part in the study, permission was sought from the relative authority. Bearing in mind that there were three target populations in this phase, the exact sequence for data collection in each population was as follows:

4.9.1.1 Homoeopaths

The researcher obtained a list of registered homoeopaths from AHPCSA. The researcher then used the medpages website to locate homoeopaths that were practicing in KZN. Once this was done, the researcher then conducted a telephonic verification with each practitioner. Verification was done to confirm if the homoeopaths were still based in KZN and to notify them of the study. Once this process was completed, if the practitioner was willing to participate in the study and they met the inclusion criteria, they were then provided with a letter of information electronically (Appendix 5a) to acquaint themselves with the intended study. Before sending them an electronic survey, each participant was required to give a written consent (Appendix 5b). Once the researcher received back the consent form from a participant, a survey (Appendix 6) was then sent in return. Participants were notified electronically. If participants did not return surveys within this period, their feedback was not used for the study and it was discarded if returned after the due date.

4.9.1.2 Doctors and nurses

The researcher consulted the KZN Department of Health website to confirm its organisational structure and the individuals who occupied the authority roles. As stated above, data was collected from two districts. A total of 428 paper-and-pen surveys (Appendix 6) were randomly distributed among the two health district selected for the study. Before commencing with this, permission was sought and granted by the KZN Department of Health (Appendices 3a and 3b), eThekwini as well as the King Cetshwayo District Managers (Appendices 2b and 2d). Once gatekeeper permission was granted, the CEO's of the facilities selected will be approached telephonically and permission was requested to approach doctors and nurses to partake in the study (Appendix 4a). Once willing participants were selected and they met the inclusion criteria, a paper-and-pen survey was handed out. Once completed, all surveys were returned back to the researcher directly to ensure confidentiality. If a potential participant was interested in partaking in the study (in the absence of the researcher), copies of the surveys were left with the person-in-charge. These surveys were to be returned directly to the researcher.

4.9.2 Phase 2

Qualitative data was collected once, the data collected in phase 1 was analysed. Using the information provided in phase 1, an interview guide was developed by the researcher and contained questions that aided in the development of a model for integrating homoeopathy. This interview guide was validated by means of a pilot study. Prior to approaching potential participants within the within KZN to take part in the study, permission was sought and granted by the KZN Department of Health (Appendices 3a and 3b). Once this was granted, to facilitate the collection of qualitative data, the details of CEO's and nursing managers (target population) was extracted from the KZN Department of Health website. Two lists list were made with all the names listed alphabetically. One list was for CEO's and the latter for nursing managers. The potential participants were then selected alphabetically

according to that list. For this phase, there was no sample size therefore data was collected from each of the target population till a point of data saturation is reached. The potential participant was made aware of the study via email or by means of telephonic contact. The CEOs and nursing managers of public health facilities located within the KZN were contacted and those who met the inclusion criteria were selected to be part of the study. An appointment was then scheduled with these suitable participants. A place was recommended by the researcher for the interview location however, the final decision was up to the participant. Once willing participants were selected, each participant was provided with a letter of information (Appendix 5a) for them to acquaint themselves with the intended study. Before conducting an individual semi-structured interview, each participant was required to give a written consent (Appendix 5b). All information was treated with confidentiality and in the final dissertation, no names were mentioned at any point and each participant was assigned by a code that only the researcher had access to. A semi-structured interview was conducted with each participant using a guideline that was developed by the researcher. If the data collected became repetitive and the researcher felt that the situation was thoroughly explored, a point of saturation was reached and no further interviews were conducted (Terre Blanche, Durrheim and Painter 2006: 160).

All semi-structured interviews were audio-recorded as to preserve the words of the participant. In the event where a participant chose not to complete their interview, their wishes were respected. The information collected from an incomplete interview was kept in storage along with the rest of the information but was not be utilised in the final dissertation. Incomplete semi-structured interviews, in the case of this study, were interviews where the participants have chosen not to answer all the researcher's questions. In the event of the above occurring, replacement participants who satisfy the inclusion criteria were be interviewed.

4.10 DRAWING UP RESEARCH INSTRUMENT

In an explanatory sequential design, only the research instrument for the initial phase can be generated prior to the commencement of the study as the instrument for Phase 2 is generated after Phase 1 has been concluded (Creswell 2014: 37). For phase 1 of this study, a questionnaire was developed by the researcher in accordance with the flowchart of steps in constructing a questionnaire as depicted by Johnson and Christensen (2012: 189). This questionnaire was then modified by an experienced statistician. Johnson and Christensen (2012: 165) state that a questionnaire should be in line with the research objectives, therefore the questions generated for Phase 1 were in line with research objectives. The questionnaire generated was validated in the pilot study mentioned below.

4.11 PRE-TESTING OF THE DATA COLLECTION TOOLS

Conducting a pilot study is important as it ensures that mistakes linked to the measurement tool or collection phase are reduced, thus enhancing quality (Qwabe 2016: 31). The measurement tools that aided in data collection for this study were formulated by the researcher thus, the motivation for conducting a pilot study. By conducting a pilot study with the newly formulated measurement tools validation of these tools will be achieved as recommended by Teijlingen and Hudley (2002: 33). For Phase 1, four pilot participants were identified from the sites where the main study was not conducted. This site was within the eThekwini public health facilities. Paper-and-pen surveys were administered to doctors and nurses. Homoeopaths were sent electronic surveys. At the end of the pilot study, the researcher checked if there are any amendments that needed to be done on the data collection tools. The pilot study participants were not included in the main study.

4.12 DATA ANALYSIS

For this study, a multi-data multi-analysis method was used to analyses data collected. This method is described by Johnson and Christensen (2012: 238) as method that involves the crossing of two types of data with two types of analysis. For this study, as described above, the mixed methods approach dictates for this sort of analysis to occur sequentially where the quantitative data will be analyses first and then followed by the analysis of the qualitative data (Creswell 2014:35). The following methods of analyses were employed in each phase:

4.12.1 Phase 1

The data collected for the quantitative aspect was analysed using appropriate statistical tests for the variables being analysed, in order to determine statistically relevant associations between the data (Johnson and Christensen below 2012: 481). Once all questionnaires were received, the researcher captured the data onto an excel spreadsheet and an experienced statistician assisted to analyse the data by using version 25 of the SPSS software.

4.12.2 Phase 2

Qualitative data was analysed using appropriate techniques of thematic content analysis, involving procedures of codifying, generating themes, and understanding patterns within the qualitative data, as per the recommendations of Vaismoradi, Turunen and Bondas (2013: 398). Thus, in order to identify the emerging themes from the semi-structured interviews, the data was manually analysed using Tesch's eight steps for analysis (Tesch 1992: 143). This method of analysis is said to provide structure to qualitative data collected (Tesch 1992:143). The eights steps are as follows (Tesch 1992: 143) which one is correct:

- The researcher read the transcripts and compared them with the audio-taped interviews;

- The researcher read the transcript for the second time as to identify the underlying meaning;
- The researcher then selected the most interesting and informative interview notes that were made in the margins of the transcribed interview;
- The process was repeated for the rest of the interviews;
- Similar topics were then clustered together under topics;
- From these topics, the researcher then formed themes and sub-themes;
- An experienced person in the field of qualitative research then analysed the data separately and the identified themes will be discussed with the researcher;
- Literature was reviewed to verify the findings.

Once Phase 2 was finalised, the researcher went through the data collected for the entire study (both qualitative and quantitative), interpreted and discussed the build-up as well as links between the two phases as advocated by Creswell (2014: 36). Interviews were transcribed verbatim and analysed by the researcher.

4.13 VALIDITY

One of the researcher's most important task when conducting a mixed methods study lies in validating findings of both the qualitative and quantitative phases (Zohrabi 2013: 254). In mixed method studies, challenges usually arise from the possibilities of the researcher's viewpoints affecting the build-up of each phase (Johnson and Christensen 2012: 273). There are numerous ways in which mixed method findings can be validated. However, for this study the researcher followed Onwuegbuzie and Johnson's nine types of mixed research validity as depicted by Johnson and Christensen (2012: 273) below:

4.13.1 Inside-out validity

This refers to the degree at which the participants' subjective perceptions as well the researcher's objective view were represented in the study. To maintain this, all data collected for the study was captured verbatim and analysed using appropriate research tools.

4.13.2 Paradigmatic validity

This is the degree to which the researcher's paradigm is represented within the study. When presented accordingly, the researcher achieves the goals of the study and produces a defensible, logical and practical mixed methods study. This was maintained by doing a thorough literature review of the study phenomenon as well as research methods before conducting the study.

4.13.3 Commensurability mixing validity

This is the degree to which the qualitative and quantitative components are represented in the study. The researcher would usually need to merge both components to create a broader viewpoint and the researcher needs to be able to switch back to the individual component at any given point of the study. This switch is referred to as the *"Gestalt switches"*. The researcher maintained this by conducting a thorough literature review on the topic of the study as well as the mixed method approach for better familiarity. In addition to this, prior to conducting the actual study, a pilot study was conducted by the researcher to facilitate validity of the study.

4.13.4 Weakness minimization validity

The degree to which the researcher tries by all means to minimize the weakness by using either strengths of the either components of the mixed method study. An example of this would be to use the strengths of a semi-structured interview to eliminate the misinterpretation of the participants' views represented in the statistical findings (Johnson and Christensen below 2012: 273). This was maintained by using the most appropriate tool to collect data.

4.13.5 Sequential validity

This pertains to conducting research in sequential phases to minimise errors. In this validity the research also accounts for the research design chosen. The researcher conducted this study in two sequential phases as per the explanatory sequential mixed method design.

4.13.6 Conversion validity

This type of validity refers a point in the study where the researcher is able to convert statistical findings into themes or words and vice versa. This is referred to as qualitising and the latter quantising. This was maintained by using the most appropriate tools to analyse the data collected.

4.13.7 Sample integration

This is the degree to which the perspective of each sample is represented and integrated in the study. When this is done correctly, the researcher is able to make an appropriate conclusion and generalisation. For the study, all data collected was captured verbatim.

4.13.8 Political validity

This is the degree to which the values, interests and stakeholders are represented and understood in the study. This was maintained through using different methods to collect data as well as using the most applicable methods of analysis.

4.13.9 Multiple validities

This is the degree to which the researcher attempts to address and resolve all the validities involved in mixed research. This was discussed in much detail in the interpretation sections (see Chapters 5 – 8).

4.14 ETHICAL CONSIDERATIONS

Before the commencement of the study, ethical approval was sought from the Institutional Research Ethics Committee (IREC), REC 36/18 (Appendix 1). The researcher sought and obtained gatekeeper permission from the Health District Manager (Appendices 2a, 2b, 2c and 2d), KZN Department of Health (Appendices 3a and 3b) and Chief Executive Officers (Appendices 4a, 4b, 4c, and 4d) of the selected public health facilities within the KZN.

Potential participants were fully informed about the study aim and processes with the information letter (Appendix 5a). They were also informed that part-taking in the study was voluntarily. Their right to withdraw from the study anytime were respected. There was no penalty for such withdrawal from the study. Participants were thereafter, requested to sign an informed consent (Appendix 5b). Code numbers instead of names were used on the research documents to ensure anonymity and confidentiality (right to privacy). Signed consent forms were kept separately from the completed data collection tools.

The researcher also requested for permission from the participants to voice record the semi-structured interviews. If the request was declined, notes were taken by the researcher. All audio recordings were stored in a password protected computer. All documents, field notes and transcriptions were kept in a safe and secure area within the institution, for the research duration. After 5 years, this information will be destroyed.

4.15 SUMMARY OF THE CHAPTER

This chapter discussed the mixed methods approach in detail and further demonstrated why it was selected as the most suitable methodology for the study. The mixed-method approach aided in the formulation of a model for integration of homoeopathy into the public healthcare system in South Africa. The data collected for the study is depicted in the next two chapters.

CHAPTER 5: PRESENTATION OF RESULTS: PHASE 1 (QUANTITATIVE DATA)

5.1 INTRODUCTION

The results of the study will be presented in this chapter. A mixed methods study was conducted. Therefore the reporting of the results will be done in two separate parts. This chapter focused on results of the data obtained through electronic/ manual surveys. The purpose of the study was to develop a model for integrating homoeopathy into the public healthcare system in South Africa. As a guide to developing this model and fulfilling the objectives of the study, PATH's theoretical framework was used. Dickoff; James and Wiedebach (1968: 416) approach also guided this process.

Table 5.1 demonstrates objectives that were addressed by the quantitative component of the study. It also illustrated which tools and/or data collection methods were used for quantitative parts of the study.

Table 5.1: Objectives illustrated with respective research orientation and data collection tools

Objective	Research orientation	Data collection
Determine the enablers of integrating homoeopathy into the public healthcare system in South Africa.	Quantitative	Electronic/ manual surveys
Determine the barriers of integrating homoeopathy into the public healthcare system in South Africa.	Quantitative	Electronic/ manual surveys

The data collected in the quantitative phase was analysed with SPSS (version 25®) in relation to the objectives outlined in the Table 5.1. Data was collected from homoeopathic doctors, nurses and medical doctors that either work or have worked in public facilities. All study candidates were from the eThekwini

and King Cetshwayo District. Data was presented in a descriptive format using tables, graphs and bar charts.

For the quantitative component, manual surveys were distributed to nurses and medical doctors. Of the surveys distributed, 92.8% (n=557) were returned completed. Nurses and medical doctors who were not interested in completing the manual surveys (during the data collection phase) were encouraged to complete an electronic version of the survey. Homoeopathic doctors were approached to only complete the electronic surveys. Two hundred and thirteen respondents (inclusive of nurses, medical doctors and homoeopathic doctors) completed the electronic survey. Twenty-seven percent (n=213) of surveys were analysed. Reasons for using only 27.6% of data collected were linked to the validation process. The validation process was discussed in detail, in Chapter 3.

During data analysis, there was an application of different statistical tests for the identification of any scoring patterns and the level of significance was set at $p<0.05$. The statistical tests used included, the Chi-square goodness-of-fit-test, Chi-square test of independence, ANOVA test, binomial test, one-sample t-test and the Independent samples t-test. The Chi-square goodness-of-fit-test was a univariate test that was used on a categorical variable to test whether any of the response options are selected significantly more/less often than that of the others. On the other hand, the Chi-square test of independence was used on cross-tabulations to see whether a significant relationship existed between the two variables represented in the cross-tabulation. The ANOVA (Analysis of variance) test was used to test for several independent samples that compared two or more groups of cases in one variable and when it was required for the researcher to test whether a significant proportion of respondents selected one of a possible two responses, the binomial test was used. This was extended when data with more than two response options were split into two distinct groups. A one-sample t-test was used to test whether a mean score is significantly different from a scalar value and lastly,

the independent samples t-test was used to test that compared two independent groups of cases.

Factors that influenced the outcome of the study were identified as variables. Independent variables were seen as factors that the researcher had no influence over and were identified as the gender, age, occupation as well as home language. Dependent variables were seen as factors that were influenced by the independent variables and were identified as the knowledge and experience with homoeopathy that the participants had, as well as the perception and interest/support that the participants had towards homoeopathy. Under the null hypothesis, it was assumed that the demographic variables identified for the study had no effect over the knowledge, perception, experience, understanding, support and interest that the participants had towards homoeopathy. The alternative stated the demographic variables had a significant influence over the independent variables. The null hypotheses was rejected and the results obtained from the questionnaires aided in constructing the guideline used for the semi-structured interviews.

5.2 DEMOGRAPHIC DATA

5.2.1 Gender

Table 5.2 depicts the gender of the participants. It was found that the majority were female (65.3%), while male constituted only 34.7% (n=74) of the participants.

Table 5.2: Gender of the participants

		Frequency	Percent
Gender	Male	74	34.7
	Female	139	65.3
	Total	213	100.0

5.2.1.1 Gender of participants per occupational role

Table 5.3 describes the gender of participants, as per their occupational role. Across the different categories of participants, it was found that the majority (65.3%) were females. This majority existed among the participants who were medical doctors (n=80).

Table 5.3: Gender cross tabulation

			Gender		
			Male	Female	**Total**
Occ role	Nurse	Frequency	11	36	47
		Percent	23.4%	76.6%	100.0%
	Medical doctor	Frequency	50	80	130
		Percent	38.5%	61.5%	100.0%
	Homoeopath	Frequency	13	23	36
		Percent	36.1%	63.9%	100.0%
Grand Total		Total Frequency	74	139	213
		Total Percentage	34.7%	65.3%	100.0%

5.2.2 Age group

The age groups of the participants were given in Table 5.4. It is observed that more 43.2% (n=92) of the participants were within age group 21-25, followed by those within the age group 26-33 (36.6% n=78). On the other hand, 12.7% (n=27) of the participants were within 34-40 while only 5.6% (n=12) of them were within the age group 41 and above.

The below age group distribution strongly suggested that the participants were drawn from a relatively young population.

Table 5.4: Age group

		Frequency	Percent
Age group	18-20	4	1.9
	21-25	92	43.2
	26-33	78	36.6
	34-40	27	12.7
	41+	12	5.6
	Total	213	100

5.2.2.1 Age group of participants per occupational role

As depicted in Table 5.5, the majority of participants (43.2% n=92) were between the ages of 21-25 years. This majority existed among the participants who were medical doctors (n=71).

Table 5.5: Age group cross tabulation

			Age Group					Total
			18-20	21-25	26-33	34-40	41+	
Occ role	Nurse	Frequency	2	19	18	8	0	47
		Percent	4.3%	40.4%	38.3%	17.0%	.0%	100.0%
	Medical doctor	Frequency	2	71	44	10	3	130
		Percent	1.5%	54.6%	33.8%	7.7%	2.3%	100.0%
	Homoeopath	Frequency	0	2	16	9	9	36
		Percent	0%	5.6%	44.4%	25.0%	25.0%	100.0%
Grand Total		Total Frequency	4	92	78	27	12	213
		Total Percentage	1.9%	43.2%	36.6%	12.7%	5.6%	100.0%

5.2.3 Home language

As seen in Table 5.6, the home language of the participants were predominantly isiZulu (68.1% n=145), while 21.1% (n=45) claim English to be their home language and 2.8% (n=6) Afrikaans. In addition, 8.0% (n=17) spoke another South African language. Among the 8.0% who spoke another

South African language, 33.3% (n=6) of them spoke IsiXhosa and 66.7% (n=11) spoke Sesotho.

Table 5.6: Home language

		Frequency	Percent
Language	isiZulu	145	68.1
	English	45	21.1
	Afrikaans	6	2.8
	Other	17	8.0
	Total	213	100.0

5.2.3.1 Home language of participants per occupational role

As seen in Table 5.7, most of the participants selected isiZulu as their home language (68.1% n=145). The majority of these participants were medical doctors (n=94).

Table 5.7: Home Language cross tabulation

			Language				
			isiZulu	English	Afrikaans	Other	**Total**
Occ role	Nurse	Frequency	40	4	1	2	47
		Percent	85.1%	8.5%	2.1%	4.3%	100.0%
	Medical doctor	Frequency	94	21	2	13	130
		Percent	72.3%	16.2%	1.5%	10.0%	100.0%
	Homoeopath	Frequency	11	20	3	2	36
		Percent	30.6%	55.6%	8.3%	5.6%	100.0%
Grand Total		Total Frequency	145	45	6	17	213
		Total Percentage	68.1%	21.1%	2.8%	8.0%	100.0%

5.2.4 Occupational role

The occupational role of the participants is shown in Table 5.8. It was observed that medical doctors (61% n=130) constitute more of the participants followed by Nurses (22% n=47) and Homoeopath (17% n=36).

Table 5.8: Occupational role of the participants

		Frequency	Percent
Occupation	Homoeopathic doctor	36	17
	Nurse	47	22
	Medical doctor	130	61
	Total	213	

5.3 HEALTHCARE PROVIDERS' EXPERIENCE WITH HOMOEOPATHY

As explained in the research questionnaire, Merriam-Webster Dictionary (2019: para. 1 line 1) defined homoeopathy as a system of complementary alternative medicine in which ailments are treated by minute doses of natural substances that in larger amounts would produce symptoms of the ailment. The practice of homoeopathy has largely remained contentious with many medical practitioners having scepticism on the efficacy of the homoeopath's style of treatment. Part of this, has been attributed to the poor understanding of homoeopathy by the public. Thus, the definition for homoeopathy was included in the research questionnaire.

As this study sought for the inclusion of homoeopathy into the public healthcare system, it was expedient to know from the perspective of other stakeholders (medical doctors and nurses) and their experience with homoeopathy.

5.3.1 Knowledge of homoeopathy

A previous study conducted by the researcher in 2015, concluded that there is poor knowledge of homoeopathy amongst the South African population. Since this study was designed to develop a model that would incorporate homoeopathy into the primary health care system, it was sensible to know the extent of knowledge the medical doctors and nurses have about homoeopathy. As reflected in Table 5.9, it was gathered that 31.1% (n=55) of the medical doctors and nurses that participated in the survey have not heard of homoeopathy. It was noted that 23.7% (n=42) of them claimed to have heard of homoeopathy but do not know anything about it.

On the other hand, it emerged that 24.3% (n=43) have heard of homoeopathy and know a little about it. Regardless of this, 16.9% noted to have heard of homoeopathy and knows a lot about it whilst 1.7% (n=3) claim to have heard of homoeopathy and know a lot about it.

Table 5.9: Medical doctors and nurses' knowledge of homoeopathy

Knowledge	Frequency	Percent
I have not heard of homoeopathy	55	31.1
I have heard of homoeopathy but do not know anything about it	42	23.7
I have heard of homoeopathy and know a little about it	43	24.3
I have heard of homoeopathy and know quite a bit about it	30	16.9
I have heard of homoeopathy and know a lot about it	3	1.7
Total	173	97.7
Missing	4	2.3
Grand total	177	100.0

The proportion of medical doctors and nurses who have little or no knowledge about homoeopathy were statistically higher than those who claim to have some knowledge.

The chi-square goodness-of-fit test was applied to this question to test if any of the response options were selected significantly more than other. It was found that significantly more than expected of those who answered this question, indicated that they know at most a little about homoeopathy. Specifically, a significant 31.8% (n=55) indicated that they have not heard of homoeopathy. Only 1.7% (n=3) indicated that they know a lot about homoeopathy.

The results of the study revealed that the knowledge of homoeopathy differs significantly amongst the respondent in this sample. The chi-square test of independence was used to test for a relationship between the level of knowledge of homoeopathy and the demographic variables, including gender, age, language and occupational role (only nurses and medical doctors included here). No significant relationships were found to exist, p>.005.

5.3.2 Experiences with homoeopathy

The previous section had captured the knowledge of homoeopathy amongst the medical doctors and nurses. It was found that although majority of the participants appear to have little knowledge about homoeopathy, some of them, claim to have deep knowledge of homoeopathy. In light of this, it therefore made sense to have a section that seeks to know whether nurses and medical doctors have worked with or referred patients to homoeopathic doctors during their course of practice.

In attempt to provide answers to the above, a binomial test was used to gauge the extent of relationship that exists between the allopathic practitioners and homoeopaths. No significant difference was noted with respect to the response to the statement, “I have never worked with a homoeopath before”

(p=.879). This suggested that ‘equal’ numbers of participants answered yes for this statement. However, with the balance of the statements in this section, a significant difference was noted, p<.0005.

As shown in Figure 5.1, a significant (82% n=142) of the participants have not worked with a homoeopath in a private homoeopathic clinic (p<.0005). Similarly, it was found that a significant 68% (n=118) of the participants indicated that they have not worked with a homoeopath in a homoeopathic clinic where services are offered free of charge (p<.0005). Furthermore, it was also found that more (66.0% n=115) of the participants answered “no” to the statement “*I have worked with a homoeopath in a private multidisciplinary practice*”.

A noteworthy point was that 34% (n=58) of the participants claim to have worked with a homoeopath in a private multidisciplinary practice (p<.0005). This strongly suggests that there is partnership and collaboration amongst other healthcare providers in the private healthcare system and homoeopath. Regardless of this, it was found that only 10% (n=18) of the participants have referred chronic cases to a homoeopath while 90% (n=155) had never referred chronic cases to a homoeopath (p<.0005).

Equally, when asked whether they have referred acute cases to a homoeopath, only 14% (n=24) answered “yes” while majority (86% n=149) answered “no”. Expectedly, it emerged that majority (87%) have never referred palliative cases to a homoeopath while only few 11% (n=19) noted to have referred palliative cases to a homoeopath. Added to this, only 12% (n=20) of the participants have referred preventative measure cases to a homoeopath whilst majority (86.4%, n=153) have never referred preventative measures cases to a homoeopath (p<0005).

From the foregoing, it can be concluded that, although some of the participants have worked with a homoeopath in a private multidisciplinary setting, there is however, limited referral services to a homoeopath. This may

be attributed to contentious perception and lack of knowledge that allopathic practitioners have towards homoeopaths. Notwithstanding this, it also emerged that some allopathic practitioners have referred both chronic and acute cases to a homoeopath. Therefore, it is sufficient to assume that there could potentially be a stronger partnership and referral service among healthcare providers if there were properly educated about homoeopathy.

As shown in Figure 5.1, a significant (82%, n=142) of the participants have not worked with a homoeopath in a private homoeopathic clinic (p<.0005). Similarly, it was found that a significant 66.7% of the participants indicated that they have not worked with a homoeopath in a homoeopathic clinic where services are offered free of charge (p<.0005).

Furthermore, it was found that more (66% n=115) of the participants answered “no” to the statement “I have worked with a homoeopath in a private multidisciplinary practice”. A noteworthy point was that 34% (n=58) of the participants claim to have worked with a homoeopath in a private multidisciplinary practice (p<.0005). This strongly suggests that there is partnership and collaboration amongst other healthcare providers in the private healthcare system and homoeopath. Regardless of this, it was found that only 10% (n=18) of the participants have referred chronic cases to a homoeopath while 90% (n=155) had never referred chronic cases to a homoeopath (p<.0005).

Equally, when asked whether they have referred acute cases to a homoeopath, only 14% (n=24) answered “yes” while majority 86% (n=149) answered “no”. Expectedly, it emerged that majority (89% n=154) have never referred palliative cases to a homoeopath while only few 10.7% noted to have referred palliative cases to a homoeopath. Added to this, only 12% (n=20) of the participants have referred preventative measure cases to a homoeopath whilst majority (88% n=153) have never referred preventative measures cases to a homoeopath (p<0005).

From the foregoing, it can be concluded that, although some of the participants have worked with a homoeopath in a private multidisciplinary setting, there is however, limited referral services to a homoeopath. This may be attributed to contentious perception and lack of knowledge that allopathic practitioners have towards homoeopaths. Notwithstanding this, it also emerged that some allopathic practitioners have referred both chronic and acute cases to a homoeopath. Therefore, it is sufficient to assume that there could potentially be a stronger partnership and referral service among healthcare providers if there were properly educated about homoeopathy.

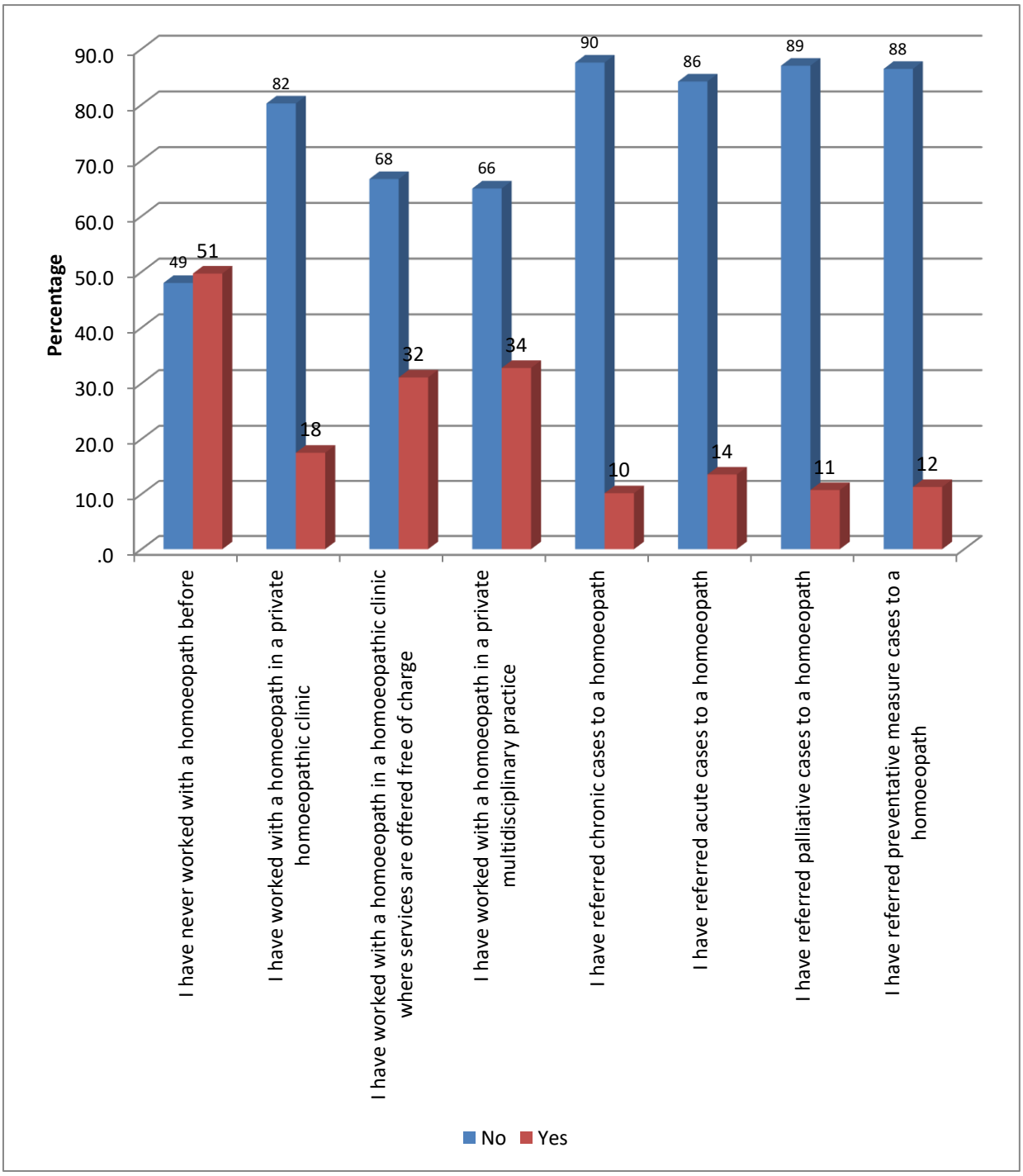

Figure 5.1: Participants collaboration with homoeopath

5.3.3 Relationship between biographical variables and experiences with homoeopathy

The previous section had examined the partnership that exists between the allopathic practitioners and homoeopath in terms of their working relationship. It was established that there is a limited working relationship particularly with respect to referral practices. This section explored the impact the biographical information such as gender, age, home language and occupational role played in the working relationship between the allopathic practitioners and homoeopaths. The chi-square test of independence (or fisher's exact test if conditions for the chi-square test are not met) was used for this. Only significant statements with respect to the biographical information are reported.

5.3.3.1 Relationship between gender and experiences with homoeopath

As shown in Figure 5.2, a significant number of males (62.7% n=37) indicated that they have never worked with a homoeopath before (p=.025).

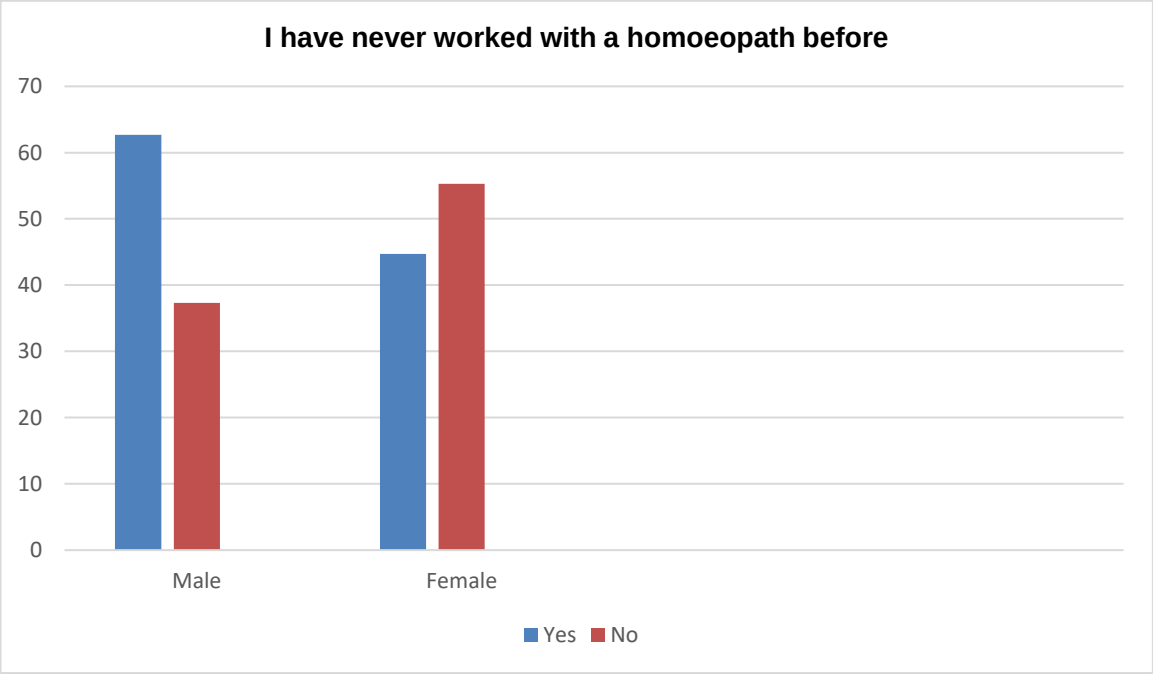

Figure 5.2: Relationship between gender and working with homoeopath before

5.3.3.2 Relationship between age group and experiences with homoeopath

A significant difference was noted, with respect to the age group of the participants and their answering to the statement, "*I have never worked with a homoeopath before*" (p=.009). It emerged that more participants within the age group 18-20 (66.7% n=2) and 21-25 year olds (61.4% n=54) have never worked with a homoeopath before. In contrast, it was found that more of the participants within the age group 26-33 (54.1% n=33), 34-40 (83.3% n=15), and 41+ year olds (66.7% n=2) indicated that they have worked with a homoeopath before.

From Figure 5.3, it can be deduced that a significant number of the younger participants have never worked with a homoeopath before whilst the older participants have worked with a homoeopath before.

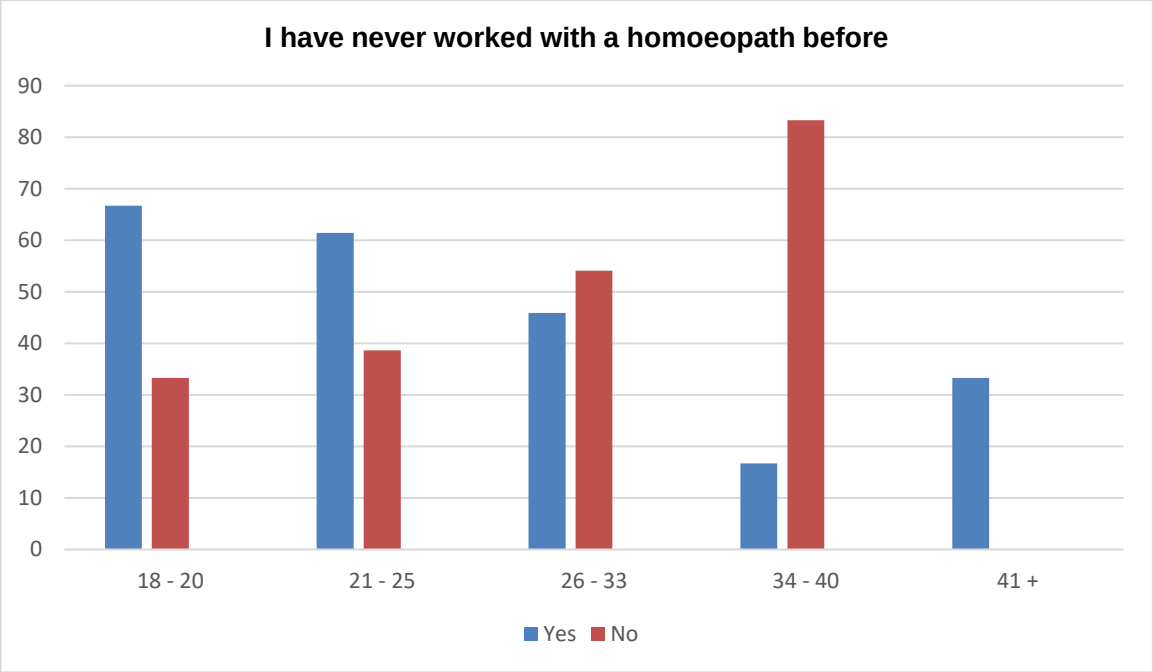

Figure 5.3: Relationship between age group and working with homoeopath before

Additionally, it was found that the responses to the statement, "*I have referred palliative cases to a homoeopath*" differs significantly by the age group of the participants as well (p=.020). It can be gleaned from Figure 5.4 that an overwhelming number of the participants across all age group indicated that they have never referred palliative cases to a homoeopath. This suggests that the lack of referral cases to homoeopath from the allopathic counterpart was dependent on age group of the participants surveyed.

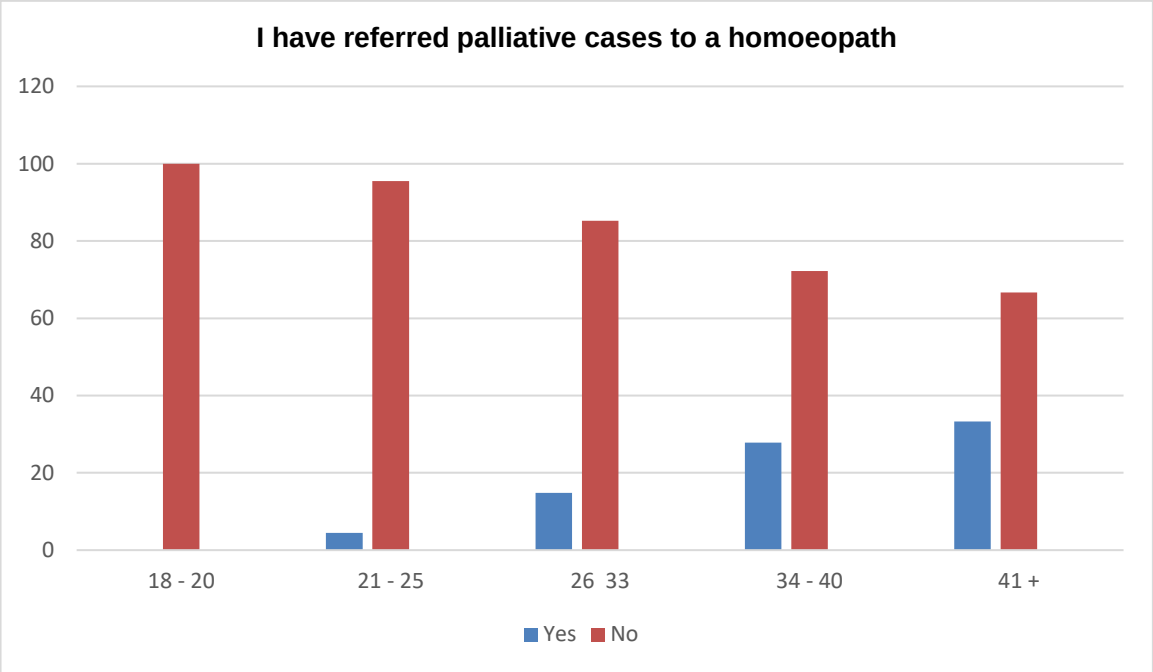

Figure 5.4: Relationship between age group and referring palliative cases to a homoeopath

5.3.3.3 Relationship between home language and experiences with homoeopath

This section examines the relationship that exists based on home language between the allopath and homoeopath with respect to referral practices. The p-value calculated, suggests that the responses to the statement, *"I have referred chronic cases to a homoeopath",* differs significantly amongst the participants (p=.013). It emerged (as depicted in Figure 5.5) that a good majority of the participants that speaks isiZulu (92.5% n=123), Afrikaans

(100.0% n=3) and other South African language (92.3% n=12) have never referred chronic cases to a homoeopath. Interestingly, it was found that 29.2% (n=7) of those who speak English as their home language have referred chronic cases to a homoeopath. This suggest that large proportion of English speakers as against those who claim to speak other South Africa home language have stronger ties with a homoeopath.

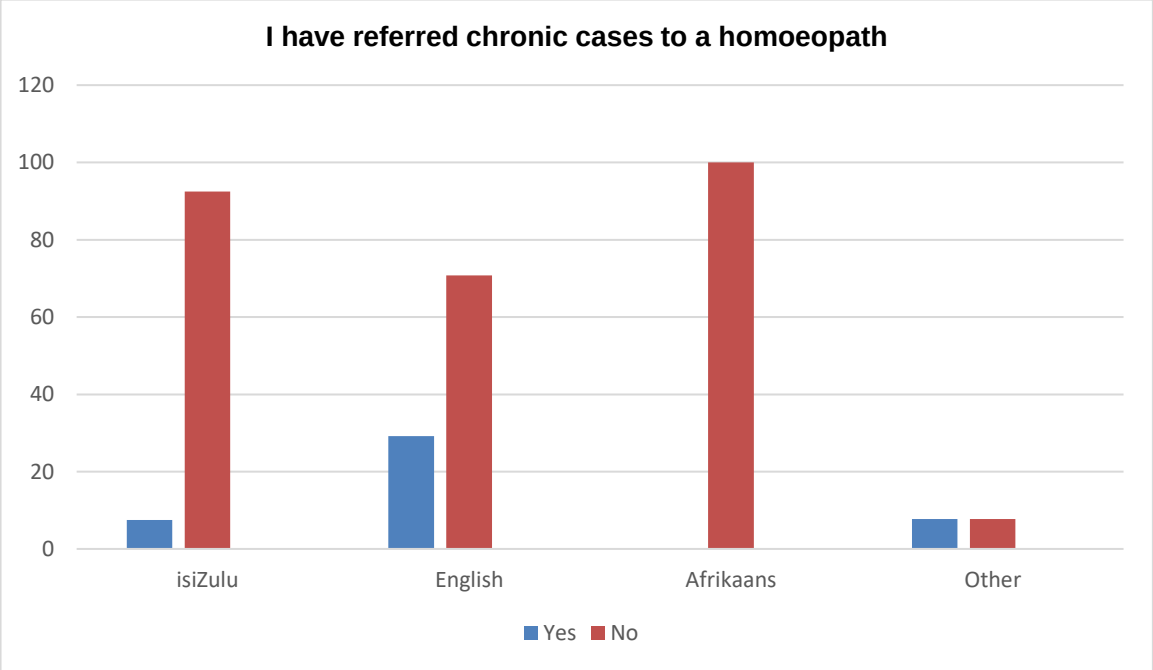

Figure 5.5: Relationship between home language and referring chronic cases to a homoeopath

Added to the above, it can be gathered from Figure 5.6 that the responses to the statement "*I have referred acute cases to a homoeopath"* differs significantly amongst the participants (p=.001). Although a large proportion of the participants that spoke isiZulu (91.0% n=121), Afrikaans (100.0% n=3) and other South African language (84.6% n=11) have never referred acute cases to a homoeopath, 41.7% (n=10) of those who speak English as their home language, have referred acute cases to a homoeopath. This strongly reinforces the previously stated assertion that English speaking allopath have stronger ties with a homoeopath.

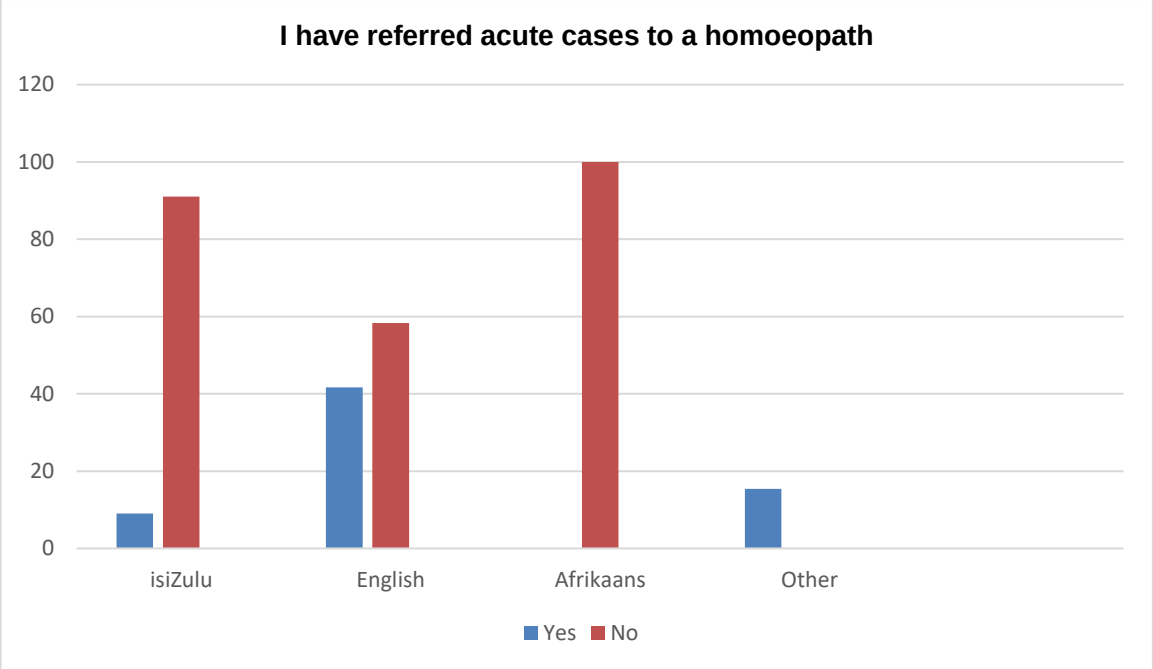

Figure 5.6: Relationship between home language and referring acute cases to a homoeopath

Going further (Figure 5.7), a similar pattern of responses as above were noted concerning the statement "*I have referred preventative measure cases to a homoeopath*". As indicated by the level of significance, it was found that a significant number of the participants that spoke isiZulu (91.7% n=122), Afrikaans (100.0%, n=3) and other South African language (69.2% n=9) have never referred preventative measure cases to a homoeopath (p=.037), whilst a good number (20.8% n=5) of those who speak English as their home language have referred preventative measure cases to a homoeopath.

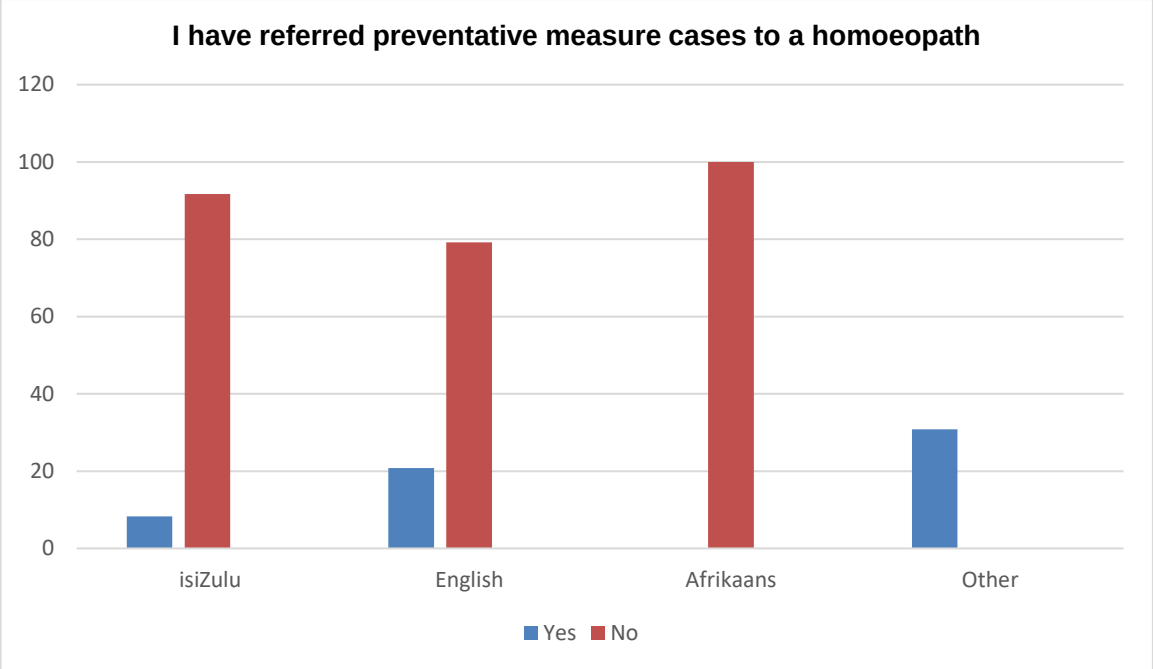

Figure 5.7: Relationship between home language and referring preventative measured cases to a homoeopath

5.4 INTEGRATION OF HOMOEOPATHY INTO THE PUBLIC HEALTHCARE SYSTEM

This section aimed to assess from the perspective of the homoeopaths, nurses and medical doctors their views regarding the integration of homoeopathy to the public healthcare system. It explored the barriers, enablers, and steps to be followed for the integration of homoeopathy to the primary health care system. To determine whether the scoring patterns per statement were significantly different per option, various statistical tests were done.

5.4.1 Perceptions of homoeopathy integration to public health care system

As indicated by the level of significance, the one sample test revealed that the participants scoring patterns concerning the integration of homoeopathy to the public healthcare system (Table 5.10) were statistically significant ($p<.0005$). There was also is a relatively significant agreement that homoeopathy should

be integrated into the public healthcare system, M=3.86, and homoeopathy should be integrated into the public healthcare system by adding it to existing public health facilities, M=3.64. For example, in the statement "*Homoeopathy should be integrated into the public health care system in South Africa*", it was observed that the majority (73.3%) of the participants were in agreement (Agree 35.9%; strongly agree 37.4%). Similarly, more than half (60.1%) of the participants agreed (Agree 32.3%; strongly agree 27.8%) that *"Homoeopathy should be integrated into the public healthcare system by adding it into existing public health facilities".*

On the other hand, it can be gleaned that participants were neutral to the statement *"Homoeopathy should be integrated into the public healthcare system by creating separate public health facilities*" (M=3.29 and p<.0005). It can therefore be assumed that the participants were sure about the creation of separate public health facilities for the homoeopathy. For instance, while 46.9% were in agreement (Agree 34.3%; strongly agree 12.6%), 28.8% were neutral that homoeopathy should be integrated into the public healthcare system by creating separate public health facilities.

Overall, as shown in Figure 5.10, it is sufficient to say the participants were in agreement for the integration of homoeopathy into the public healthcare system in South Africa.

Table 5.10: Participants perception of homoeopathy integration to primary health care

Statement	No	Likert scale					Mean	p value
		SD	D	N	A	SA		
Homoeopathy should be integrated into the public health care system in South Africa.	198	8.6%	7.1%	11.1%	35.9%	37.4%	3.86	0.000
Homoeopathy should be integrated into the public healthcare system by adding it into existing public health facilities.	198	6.1%	11.6 %	22.2%	32.3%	27.8%	3.64	0.000
Homoeopathy should be integrated into the public healthcare system by creating separate public health facilities.	198	6.1%	18.2 %	28.8%	34.3%	12.6%	3.29	0.000

5.4.2 Relationship between biographical information and perception of integration of homoeopathy into primary health care system

The previous section suggests that a good number of the participants were in support of the integration of homoeopathy to the primary healthcare system. This section examines whether the participants biographical information such as gender, age group, home language, and occupational role had an influence in their scoring pattern.

5.4.2.1 Influence of gender and perception of homoeopathy integration into primary healthcare system

To determine whether the scoring patterns per statement were significantly different per gender, the independent samples t-test was done. As shown in Table 5.11, it can be gathered the respondents gender did not differ in their scoring pattern with respect to the statement "*Homoeopathy should be integrated into the public healthcare system in South Africa*" (p=.337), and "*Homoeopathy should be integrated into the public healthcare system by adding it into existing public health facilities*" (*P*=.768). It can, however, be seen that males (M=3.52) agree significantly more than females (M=3.18) that

"homoeopathy should be integrated into the public healthcare system by creating separate healthcare facilities" (p=.038).

Table 5.11: Relationship between gender and perception of homoeopathy integration into primary healthcare system

Statement	Gender	N	Mean	p value
Homoeopathy should be integrated into the public healthcare system in South Africa.	Male	65	3.98	0.337
	Female	133	3.80	
Homoeopathy should be integrated into the public healthcare system by adding it into existing public health facilities.	Male	65	3.68	0.768
	Female	133	3.62	
Homoeopathy should be integrated into the public healthcare system by creating separate public health facilities.	Male	65	3.52	0.038
	Female	133	3.18	

5.4.2.2 Influence of age group and perception of homoeopathy integration into primary healthcare system

To determine whether the scoring patterns per statement were significantly different per age, the ANOVA test was done. As shown in Table 5.12, it can be gathered the respondents age group did not differ in their scoring pattern with respect to the statement "*Homoeopathy should be integrated into the public healthcare system by adding it into existing public health facilities*" (p=.155), and "*homoeopathy should be integrated into the public healthcare system by creating separate public health facilities*" (p=.254). There is, however, a significant difference in the average agreement to the statement "*Homoeopathy should be integrated into the public healthcare system in South Africa*" across age (M=3.454 p=.009). Specifically, the 26-33 age group (M=4.07) agree significantly more than the 18-20 age group (M=1.67).

Table 5.12: Relationship between age group and perception of homoeopathy integration into primary healthcare system

Statement	Age group	N	Mean	ANOVA p value
Homoeopathy should be integrated into the public healthcare system in South Africa.	18-20	3	1.67	0.009
	21-25	84	3.87	
	26-33	73	4.07	
	34-40	27	3.56	
	41+	11	3.82	
	Total	198	3.86	
Homoeopathy should be integrated into the public healthcare system by adding it into existing public health facilities.	18-20	3	2.00	0.155
	21-25	84	3.68	
	26-33	73	3.73	
	34-40	27	3.52	
	41+	11	3.55	
	Total	198	3.64	
Homoeopathy should be integrated into the public healthcare system by creating separate public health facilities.	18-20	3	2.00	0.254
	21-25	84	3.25	
	26-33	73	3.41	
	34-40	27	3.22	
	41+	11	3.36	
	Total	198	3.29	

5.4.2.3 Influence of home language and perception of homoeopathy integration into primary healthcare system

The ANOVA test was done to show the scoring patterns per statement, per home language spoken by the participants. There were no significant differences in all the statements. However, as per Table 5.13, it was observed that the isiZulu speakers were more in agreement in the integration of homoeopathy into the primary healthcare system in South Africa, M=4.04.

Table 5.13: Relationship between home language and perception of homoeopathy integration into primary healthcare system

Statement	Language	N	Mean
Homoeopathy should be integrated into the public healthcare system in South Africa.	isiZulu	134	4.04
	English	43	3.51
	Afrikaans	6	3.00
	Other	15	3.67
	Total	198	3.86
Homoeopathy should be integrated into the public healthcare system by adding it into existing public health facilities.	isiZulu	134	3.75
	English	43	3.40
	Afrikaans	6	3.17
	Other	15	3.53
	Total	198	3.64
Homoeopathy should be integrated into the public healthcare system by creating separate public health facilities	isiZulu	134	3.42
	English	43	3.12
	Afrikaans	6	2.83
	Other	15	2.87
	Total	198	3.29

5.4.2.4 Influence of occupational role and perception of homoeopathy integration into primary healthcare system

To determine whether the scoring patterns per statement were significantly different per occupational role, the ANOVA test was done. As shown in Table 5.14, it can be gathered the respondents' occupational role affects the scoring pattern with respect to the statements *"Homoeopathy should be integrated into the public healthcare system in South Africa*" (p=.001), and "Homoeopathy should be integrated into the public healthcare system by adding it into existing public health facilities" (p=.001).

In terms of the statement *"Homoeopathy should be integrated into the public healthcare system in South Africa*", it could also be gathered from Table 5.14 that nurses (M=4.07) and homoeopaths (M=4.45) agree more than the medical doctors (M=3.63). Similarly, nurses (M=3.91) and homoeopaths

(M=4.15) agreed more than the medical doctors (M=3.40) with regards to the statement *"Homoeopathy should be integrated into the public healthcare system by adding it into existing public health facilities*".

On the other hand, and as given in Table 5.14, there was no significant differences amongst the medical doctors, nurses, and homoeopaths in regards to the statement "*Homoeopathy should be integrated into the public healthcare system by creating separate public health facilities"* (p=.209).

Table 5.14: Relationship between occupational role and perception of homoeopathy integration into primary healthcare system

Statement	Occupational role	N	Mean	ANOVA p value
Homoeopathy should be integrated into the public healthcare system in South Africa	Nurse	45	4.07	0.001
	Medical doctor	120	3.63	
	Homoeopath	33	4.45	
	Total	198	3.86	
Homoeopathy should be integrated into the public healthcare system by adding it into existing public health facilities	Nurse	45	3.91	0.001
	Medical doctor	120	3.40	
	Homoeopath	33	4.15	
	Total	198	3.64	
Homoeopathy should be integrated into the public healthcare system by creating separate public health facilities	Nurse	45	3.49	0.209
	Medical doctor	120	3.18	
	Homoeopath	33	3.42	
	Total	198	3.29	

5.4.3 Barriers to homoeopathy integration to public health care system

This section examines the barriers that could hinder the successful integration of homoeopathy into the public healthcare system. To determine the participants' scoring patterns in this section, the one-sample test was done. As indicated by the level of significance, and excluding the statement that "*lack of unity amongst homoeopaths*" are barriers to the successful integration

of homoeopathy into the public healthcare system (p=.249), the one-sample test revealed that the participants scoring pattern with respect to the majority of the statements in Table 5.15 were statistically different (p<0.005). This suggests that the way the participants agreed or disagreed to the highlighted statements were not the same. For example, when asked to indicate their agreement that tension between allopathic and homoeopathic practitioners is a barrier to the successful integration of homoeopathy into the public healthcare system, more than half (51.0%) of them were neutral to the statement while 36.9% seems to be in agreement (Agree 27.3%; strongly agree 9.6%) that tension between allopathic and homoeopathic practitioners are barriers to the integration of homoeopathy into the public healthcare system (p<0.005). These results are depicted in Table 5.15.

With regards to misconceptions regarding homoeopathy as a barrier to the successful integration into the public healthcare system, it was found that more (65.2%) of the participants were in agreement (Agree 31.9%; strongly agree 33.3%) that misconception of homoeopathy contribute to the barriers to the integration of homoeopathy into the primary healthcare system (p<0.005). The misconception of homoeopathy could be attributed to the limited knowledge of homoeopathy amongst the general public. For instance, a large proportion of the 74.7% of the participants were in agreement (Agree 24.7%; strongly agree 50.0%) that the lack of education/knowledge about homoeopathy contributed to the barrier for the successful integration of homoeopathy into the public healthcare system (p<0.005).

In terms of influence support from allopathic practitioners, it was noted that (58.0%) of the participants concede (Agree 32.8%; strongly agree 22.2%) to the lack of support from allopathic practitioners as a barrier to the successful integration of homoeopathy into the public healthcare system (p<0.005).

Given the importance of legislation in healthcare practice restrictive legislation, it was not surprising that more than half (51.0%) of the participants, view (Agree 26.3%; strongly agree 24.7%) consider restrictive

legislation as a barrier to successfully integrate homoeopathy into the primary healthcare system. Equally, nearly half (47.5%) consider (Agree 26.3%; strongly agree 21.2%) lack of practical experience in newly qualified homoeopaths to be a barrier to the successful integration of homoeopathy into the public healthcare system; whilst 34.8% were neutral about the influence of practical experience to the integration of homoeopathy into the public healthcare system.

Moreover, and despite the perceive lack of knowledge and misconception of homoeopathy, only 49.5% were in agreement (Agree 28.3%; strongly agree 21.2%) that inadequacy of homoeopathic training for medical doctors/nurses contributes to barriers to successfully integrate homoeopathy into the public healthcare system. Equally significant, more than half (56.0%) of the participants were of the view (Agree 23.7%; strongly agree 32.3%) that lack of interest from patients /general public constitute a barrier to the successful integration of homoeopathy into the public healthcare system.

However, it was noted from the participants' responses that aversion of allopathic practitioners to homoeopathy may not be considered a barrier to successfully integrate homoeopathy into the public healthcare system. This is notwithstanding that some proportion of the participants in agreement that the aversion of allopathic practitioners to homoeopathy is a barrier to the successful integration into the public healthcare system.

Table 5.15: Participants perception on the barriers of homoeopathy integration to primary health care

Statement	No	Likert scale					Mean	p value
		SD	D	N	A	SA		
Tension between allopathic and homoeopathic practitioners	198	0.5%	11.6%	51.0%	27.3%	9.6%	3.34	0.000
Misconceptions regarding homoeopathy	198	1.0%	9.1%	19.7%	31.9%	33.3%	3.95	0.000
Lack of education/knowledge about homoeopathy	198	2.5%	8.1%	14.6%	24.7%	50.0%	4.12	0.000
Lack of support from allopathic practitioners	198	5.1%	8.1%	31.8%	32.8%	22.2%	3.59	0.000
Restrictive legislation	198	7.6%	5.6%	35.9%	26.3%	24.7%	3.55	0.000
Lack of practical experience in newly qualified homoeopaths	198	7.1%	10.6%	34.8%	26.3%	21.1%	3.44	0.000
Inadequacy of homoeopathic training for medical doctors/nurses	198	4.0%	11.6%	34.8%	28.3%	21.2%	3.51	0.000
Lack of interest from patients/general public	198	6.1%	18.2%	19.7%	23.7%	32.3%	3.58	0.000
Aversion of allopathic practitioners to homoeopathy	198	3.5%	14.1%	43.9%	24.2%	14.1%	3.31	0.000
Lack of unity amongst homoeopaths	198	4.0%	21.7%	47.0%	16.7%	10.6%	3.08	0.249

Overall, and as depicted in Figure 5.8, it can be gleaned that the participants consider lack of education/knowledge about homoeopathy (M=4.12), and misconceptions regarding homoeopathy (M=3.95) more of a barrier to the successful integration of homoeopathy into the public healthcare system.

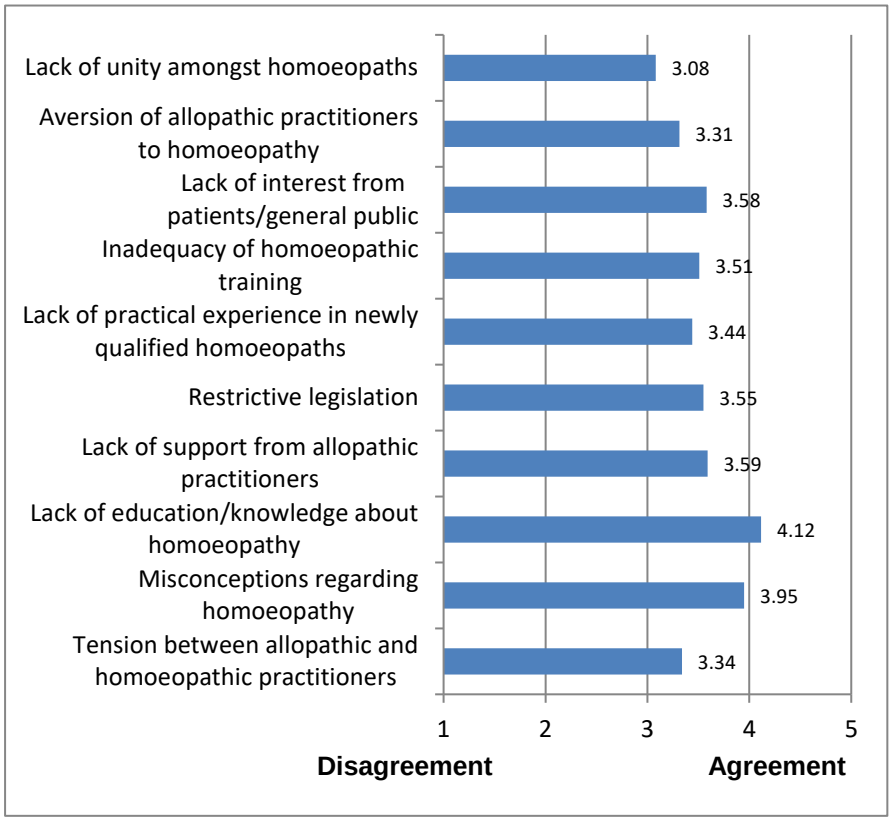

Figure 5.8: Factors constituting a barrier to homoeopathy integration into the public healthcare system

5.4.4 Relationship between biographical information and barriers to integration of homoeopathy into public healthcare system

This section examines whether the participants' biographical information such as gender, age group, home language, and occupational role had an influence in their scoring pattern regarding the barriers that to the successful integration of homoeopathy into the public healthcare system.

5.4.4.1 Influence of gender and perceived barriers to homoeopathy integration into public healthcare system

The gender of the participants had no significant influence on the scoring pattern of the participants with regards to the barriers to the successful integration of homoeopathy into the public healthcare system ($p>0.05$).

5.4.4.2 Influence of age group and perceived barriers to homoeopathy integration into primary healthcare system

As shown in Table 5.16, the ANOVA test suggest that no significant difference exist between the age group and perceived barriers such as an aversion of allopathic practitioners to homoeopathy, lack of unity amongst homoeopaths, lack of education/knowledge about homoeopathy and lack of practical experience in newly qualified homoeopaths. This suggest that the age group of the participants did not significantly influence their scoring pattern with respect to the listed barriers ($p>0.05$).

On the other hand, the ANOVA test indicated that the age group of the participants significantly influence their scoring of the barriers namely; tension between allopathic and homoeopathic practitioners ($p<0.005$); misconceptions regarding homoeopathy ($p=0.026$); lack of support from allopathic practitioners ($p=0.043$); restrictive legislation ($p=0.036$), inadequacy of homoeopathic training ($p=0.084$) and lack of interest from patients/general public ($p=0.007$).

Specifically, the participants that were above 41+ years old were more in agreement that tension between allopathic and homoeopathic practitioners, misconceptions regarding homoeopathy; lack of support from allopathic practitioners contribute to the barriers to the successful integration of homoeopathy into the public healthcare system. However, it was observed that more of the participants within the age group 21-25 consider lack of interest from patients /general public to be a barrier to the successful integration of homoeopathy into the public healthcare system.

Table 5.16: Relationship between age group and perceived barriers to homoeopathy integration into public healthcare system

Statement	Age group	N	Mean	ANOVA p value
Tension between allopathic and homoeopathic practitioners.	18-20	3	2.67	0.000
	21-25	84	3.12	
	26-33	73	3.34	
	34-40	27	3.70	
	41+	11	4.27	
	Total	198	3.34	
Misconceptions regarding homoeopathy.	18-20	3	2.67	0.026
	21-25	84	3.87	
	26-33	73	4.10	
	34-40	27	3.74	
	41+	11	4.45	
	Total	198	3.95	
Lack of education/knowledge about homoeopathy.	18-20	3	3.33	0.370
	21-25	84	4.10	
	26-33	73	4.21	
	34-40	27	3.89	
	41+	11	4.45	
	Total	198	4.12	
Lack of support from allopathic practitioners.	18-20	3	3.33	0.043
	21-25	84	3.46	
	26-33	73	3.68	
	34-40	27	3.41	
	41+	11	4.45	
	Total	198	3.59	
Restrictive legislation.	18-20	3	3.00	0.036
	21-25	84	3.30	
	26-33	73	3.78	
	34-40	27	3.56	
	41+	11	4.09	
	Total	198	3.55	
Lack of practical experience in newly qualified homoeopaths.	18-20	3	2.33	0.383
	21-25	84	3.36	
	26-33	73	3.49	
	34-40	27	3.59	
	41+	11	3.64	
	Total	198	3.44	

Statement	Age group	N	Mean	ANOVA p value
Inadequacy of homoeopathic training.	18-20	3	3.33	0.084
	21-25	84	3.35	
	26-33	73	3.60	
	34-40	27	3.48	
	41+	11	4.27	
	Total	198	3.51	
Lack of interest from patients/general public.	18-20	3	3.67	0.007
	21-25	84	3.89	
	26-33	73	3.52	
	34-40	27	3.11	
	41+	11	2.73	
	Total	198	3.58	
Aversion of allopathic practitioners to homoeopathy.	18-20	3	3.67	0.333
	21-25	84	3.19	
	26-33	73	3.36	
	34-40	27	3.33	
	41+	11	3.82	
	Total	198	3.31	
Lack of unity amongst homoeopaths.	18-20	3	3.33	0.247
	21-25	84	2.92	
	26-33	73	3.12	
	34-40	27	3.37	
	41+	11	3.27	
	Total	198	3.08	

5.4.4.3 Influence of home language and perceived barriers to homoeopathy integration into public healthcare system

The relationship between the participants' home language and their response to the perceived barriers to homoeopathy integration into primary public healthcare system in South Africa is highlighted in Table 5.17. As indicated by the level of significance, the ANOVA test suggested that the scoring pattern of the participants with regards to perceived tension between allopathic and homoeopathic practitioners were significantly different ($p<0.005$). It was observed that more of the English speakers ($M=3.81$) were in average agreement. Concerning the scoring of lack of education/knowledge about

homoeopathy, more (M=4.28) of the isiZulu speakers significantly noted this as a barrier to successfully integrate homoeopathy into the public healthcare system (p=0.021). Similarly, more (M=3.89) of the isiZulu speaker averaged consider lack of interest from patients/general public as a barrier to successfully integrate homoeopathy into the public healthcare system (p<0.005). No significant relationships were observed in respect to other perceived barriers highlighted in Table 5.17 (p>0.05).

Table 5.17: Relationship between home language and perceived barriers to homoeopathy integration into public healthcare system

Statement	Language	N	ANOVA p value
Tension between allopathic and homoeopathic practitioners	isiZulu	134	0.000
	English	43	
	Afrikaans	6	
	Other	15	
	Total	198	
Misconceptions regarding homoeopathy	isiZulu	134	0.690
	English	43	
	Afrikaans	6	
	Other	15	
	Total	198	
Lack of education/knowledge about homoeopathy	isiZulu	134	0.021
	English	43	
	Afrikaans	6	
	Other	15	
	Total	198	
Lack of support from allopathic practitioners	isiZulu	134	0.717
	English	43	
	Afrikaans	6	
	Other	15	
	Total	198	

Statement	Language	N	ANOVA p value
Restrictive legislation	isiZulu	134	0.501
	English	43	
	Afrikaans	6	
	Other	15	
	Total	198	
Lack of practical experience in newly qualified homoeopaths	isiZulu	134	0.294
	English	43	
	Afrikaans	6	
	Other	15	
	Total	198	
Inadequacy of homoeopathic training	isiZulu	134	0.699
	English	43	
	Afrikaans	6	
	Other	15	
	Total	198	
Lack of interest from patients/general public	isiZulu	134	0.000
	English	43	
	Afrikaans	6	
	Other	15	
	Total	198	
Aversion of allopathic practitioners to homoeopathy	isiZulu	134	0.756
	English	43	
	Afrikaans	6	
	Other	15	
	Total	198	
Lack of unity amongst homoeopaths	isiZulu	134	0.571
	English	43	
	Afrikaans	6	
	Other	15	
	Total	198	

5.4.4.4 Influence of occupational role and perceived barriers to homoeopathy integration into public healthcare system

This section examines the relationship that exists between the occupational role of the participants and their scoring pattern with respect to the barriers to the successful integration of homoeopathy into the public healthcare system. In Table 5.18, the ANOVA test suggests that more homoeopaths significantly perceived that tension between allopath and homoeopathic practitioners contributes to the barrier to the successfully integration of homoeopathy into the public healthcare system ($p<0.005$). Similar significant trends could be observed as more homoeopaths were in agreement that misconceptions regarding homoeopathy (M=4.79), lack of education/knowledge about homoeopathy (M=4.79); lack of support from allopathic practitioners (M=4.30); restrictive legislation (M=4.55); inadequacy of homoeopathic training for medical doctors/nurses (M=4.00); aversion of allopathic practitioners to homoeopathy (M=3.94); and as well as lack of unity amongst homoeopaths (M=3.55) as barriers to the successful integration of homoeopathy into the public healthcare system.

On the other hand, more of the nurses (M=4.18) and medical doctors (M=3.68) significantly consider that lack of interest from patients/general public as the barrier to the successful integration of homoeopathy into the public healthcare system ($p<0.005$). No differences were noted amongst the medical doctors, nurses and homoeopaths in respect to the statement lack of practical experience in newly qualified homoeopaths as a barrier to the successful integration of homoeopathy into the public healthcare system ($p>0.05$).

Table 5.18: Relationship between occupational role and perceived barriers to homoeopathy integration into public healthcare system

Statement	Occupational role	N	Mean	ANOVA p value
Tension between allopathic and homoeopathic practitioners.	Nurse	45	3.18	0.000
	Medical doctor	120	3.22	
	Homoeopath	33	4.00	
	Total	198	3.34	
Misconceptions regarding homoeopathy.	Nurse	45	3.93	0.000
	Medical doctor	120	3.73	
	Homoeopath	33	4.79	
	Total	198	3.95	
Lack of education/knowledge about homoeopathy	Nurse	45	4.33	0.000
	Medical doctor	120	3.85	
	Homoeopath	33	4.79	
	Total	198	4.12	
Lack of support from allopathic practitioners	Nurse	45	3.49	0.000
	Medical doctor	120	3.43	
	Homoeopath	33	4.30	
	Total	198	3.59	
Restrictive legislation	Nurse	45	3.56	0.000
	Medical doctor	120	3.28	
	Homoeopath	33	4.55	
	Total	198	3.55	
Lack of practical experience in newly qualified homoeopaths	Nurse	45	3.51	0.893
	Medical doctor	120	3.42	
	Homoeopath	33	3.42	
	Total	198	3.44	
Inadequacy of homoeopathic training	Nurse	45	3.53	0.010
	Medical doctor	120	3.37	
	Homoeopath	33	4.00	
	Total	198	3.51	
Lack of interest from patients/general public	Nurse	45	4.18	0.000
	Medical doctor	120	3.68	
	Homoeopath	33	2.39	
	Total	198	3.58	
Aversion of allopathic practitioners to homoeopathy	Nurse	45	3.29	0.000
	Medical doctor	120	3.15	
	Homoeopath	33	3.94	
	Total	198	3.31	

Statement	Occupational role	N	Mean	ANOVA p value
Lack of unity amongst homoeopaths	Nurse	45	3.02	0.011
	Medical doctor	120	2.98	
	Homoeopath	33	3.55	
	Total	198	3.08	

5.4.5 Enablers to homoeopathy integration to public health care system

The previous sections had closely examined the perceived barriers that could hinder the successful integration of homoeopathy into the public healthcare system. It emerged that lack of education/knowledge about homoeopathy constitute the cardinal barrier to its successful integration. This section takes a different path by examining the enables that could potentially contribute to the integration of homoeopathy into the public healthcare system. One sample test was used to determine the similarities or differences in the scoring pattern of the participants (medical doctors, nurses, and homoeopaths). The results are summarised in Table 5.19.

As indicated by the level of significance, the one sample test revealed that the participants scoring pattern with respect to the statements that constitutes enablers to the integration of homoeopathy into the public healthcare system in Table 5.19 were statistically different (p<0.005). This suggests that the way the participants agreed or disagreed to the highlighted statements were not the same. For instance, when asked to indicate their agreement that to the statement "*Homoeopathy medicines are cost effective*", it was found that while 31.3% of the participants remain neutral, more than half (56.5%) of them were in agreement that homoeopathy medicines are cost effective (Agree 27.7%); strongly agree 28.8%). Therefore, given the high cost of allopathy medicine, the low cost of homoeopathy medicines would present a feasible alternative to the management of ailment particularly for the underprivileged South African population.

Equally important, while 35.4% of the participants were unsure (neutral) that there are homoeopathic practitioners who support integration and are ready to work in the public facilities, 53.1% of them positively agreed that homoeopathic practitioners support the integration and are ready to work in the public facilities. This is highly important when one considers the affordability of homoeopathy treatment. It is presumed that this would go a long way to reduce the cost of medical treatment and the burden of disease amongst the deprived in South Africa.

Interestingly, and given the number of participants (67.7%) who are in agreement (Agree 21.2%; strongly agree 46.5%) that there is a growing global interest in the use of natural medicines for preventative and palliative needs, it can be deduced that homoeopathy would present a viable alternative to drugs with potential side effects.

Furthermore, and in respect to the statement *"Homoeopathic medicines can be used in conjunction with other types of medication*", it emerged that 56% of the participants were in agreement (Agree 24.2%; strongly agree 31.8%) to the said statement while 31.8% were unsure (neutral). Similarly, nearly half (49%) of the participants believed that homoeopathy medication is non-invasive while 35.4% were neutral.

Additionally, and reinforcing the earlier assertion that homoeopathy drugs would present as a useful alternative for patients with potential side effects, more than half (51%) of the participants were in agreement (Agree 21.7%; strongly agree 29.3%) that homoeopathic medication does not have any harsh side effects. Going further, while 37.4% of the participants were neutral to the statement "*Patients cannot develop a resistance against homoeopathic medication"*, 46% of them, however, believe that patients cannot develop a resistance against homoeopathic medication.

Table 5.19: Participants perception on the enablers of homoeopathy integration to public healthcare system

Enablers	No	Likert scale					p value
		SD	D	N	A	SA	
Homoeopathic medicines are cost effective.	198	10.1%	7.1%	31.3%	27.7%	28.8%	0.000
There are homoeopathic practitioners who support integration and are ready to work in the public facilities.	198	6.1%	5.6%	35.4%	26.8%	26.3%	0.000
There is a growing global interest in the use of natural medicines for preventative and palliative needs.	198	5.1%	8.1%	19.2%	21.2%	46.5%	0.000
Homoeopathic medicines can be used in conjunction with other types of medication.	198	4.5%	7.6%	31.8%	24.2%	31.8%	0.000
Homoeopathy is non-invasive.	198	5.1%	10.6%	35.4%	16.7%	32.3%	0.000
Homoeopathic medication does not have any harsh side effects.	198	4.0%	10.1%	34.8%	21.7%	29.3%	0.000
Patients cannot develop a resistance against homoeopathic medication.	198	6.1%	10.6%	37.4%	26.8%	19.2%	0.000

Overall, and as depicted in Figure 5.9, it can be gleaned that the growing global interest in the use of natural medicines for preventative and palliative needs (M=3.96) is viewed by relatively high number of participants as the prominent enablers that could contribute to the successful integration of homoeopathy into the public healthcare system.

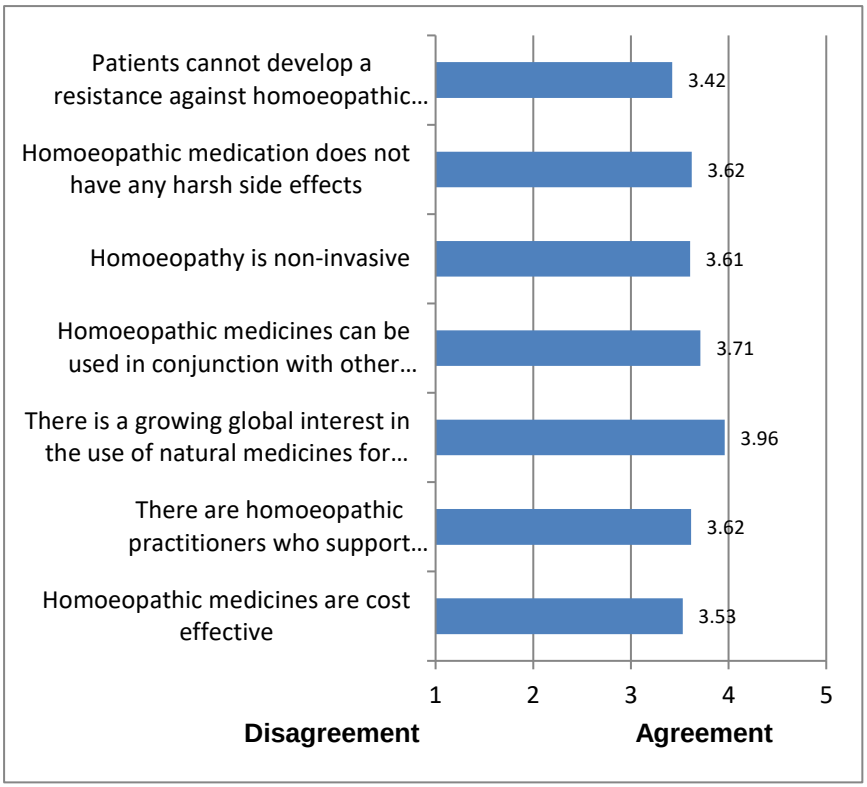

Figure 5.9: factors constituting enablers to homoeopathy integration into the public healthcare system

5.4.6 Relationship between biographical information and enablers to integration of homoeopathy into public healthcare system

This section examines whether the participants' biographical information such as gender, age group, home language, and occupational role had an influence in their scoring pattern regarding the enablers to the successful integration of homoeopathy into the public healthcare system.

5.4.6.1 Influence of gender and perceived enablers to homoeopathy integration into public healthcare system

The gender of the participants had no significant influence on the scoring pattern of the participants with regards to the barriers to the successful integration of homoeopathy into the public healthcare system.

5.4.6.2 Influence of age group and perceived enablers to homoeopathy integration into public healthcare system

As shown in Table 5.20, the ANOVA test suggest that no significant difference exist between the age group and perceived enablers regarding the statements namely; homoeopathic medicines are cost effective (p=.059); there is a growing global interest in the use of natural medicines for preventative and palliative needs (p=.338); homoeopathic medicines can be used in conjunction with other types of medication (p=.053); homoeopathy is non-invasive (p=.060); and patients cannot develop a resistance against homoeopathic medication (p=.072) This suggest that the age group of the participants did not significantly influence their scoring pattern with respect to the listed enablers (p>0.05).

On the other hand, more (M=4.18) of the older participants 41+ were in significant agreement that there are homoeopathic practitioners who support integration and are ready to work in the public affairs (p=.039). Equally, there were more (M=4.27) significant average agreement by participants within the age group 41+ that homoeopathic medication does not have any harsh side effects (p=.002).

Table 5.20: Relationship between age group and perceived enablers to homoeopathy integration into public healthcare system

Enablers	Age group	N	Mean	ANOVA p value
Homoeopathic medicines are cost effective.	18-20	3	2.67	0.059
	21-25	84	3.39	
	26-33	73	3.74	
	34-40	27	3.22	
	41+	11	4.18	
	Total	198	3.53	
There are homoeopathic practitioners who support integration and are ready to work in the public facilities.	18-20	3	2.67	0.039
	21-25	84	3.44	
	26-33	73	3.82	
	34-40	27	3.48	
	41+	11	4.18	
	Total	198	3.62	
There is a growing global interest in the use of natural medicines for preventative and palliative needs.	18-20	3	3.00	0.338
	21-25	84	3.99	
	26-33	73	4.03	
	34-40	27	3.67	
	41+	11	4.27	
	Total	198	3.96	
Homoeopathic medicines can be used in conjunction with other types of medication.	18-20	3	2.67	0.053
	21-25	84	3.51	
	26-33	73	3.90	
	34-40	27	3.74	
	41+	11	4.18	
	Total	198	3.71	
Homoeopathy is non-invasive.	18-20	3	2.33	0.060
	21-25	84	3.45	
	26-33	73	3.70	
	34-40	27	3.70	
	41+	11	4.27	
	Total	198	3.61	
Homoeopathic medication does not have any harsh side effects.	18-20	3	1.67	0.002
	21-25	84	3.45	
	26-33	73	3.70	
	34-40	27	3.89	
	41+	11	4.27	
	Total	198	3.62	

Enablers	Age group	N	Mean	ANOVA p value
Patients cannot develop a resistance against homoeopathic medication.	18-20	3	2.00	0.072
	21-25	84	3.32	
	26-33	73	3.45	
	34-40	27	3.67	
	41+	11	3.82	
	Total	198	3.42	

5.4.6.3 Influence of home language and perceived enablers to homoeopathy integration into public healthcare system

The ANOVA test was used to measure the influence of home language and perceived enablers to homoeopathy integration into public healthcare system is given in Table 5.21. Apart from the statement that measured *"There is a growing global interest in the use of natural medicines for preventative and palliative needs",* no significant differences were observed with respect to the home language and their scoring pattern in the statements noted in Table 5.21 ($p>0.05$). It can be seen that Afrikaans ($M=4.17$) and isiZulu ($M=4.16$) were significantly more in agreement that there is a growing global interest in the use of natural medicines for preventative and palliative needs is the driving push for the integration of homoeopathy into the public healthcare system ($p<0.05$).

Table 5.21: Relationship between home language and perceived enablers to homoeopathy integration into public healthcare system

Enablers	Home language	N	Mean	ANOVA p value
Homoeopathic medicines are cost effective.	isiZulu	134	3.63	0.512
	English	43	3.35	
	Afrikaans	6	2.83	
	Other	15	3.40	
	Total	198	3.53	
There are homoeopathic practitioners who support integration and are ready to work in the public facilities.	isiZulu	134	3.66	0.658
	English	43	3.53	
	Afrikaans	6	2.83	
	Other	15	3.73	
	Total	198	3.62	
There is a growing global interest in the use of natural medicines for preventative and palliative needs.	isiZulu	134	4.16	0.040
	English	43	3.44	
	Afrikaans	6	4.17	
	Other	15	3.60	
	Total	198	3.96	
Homoeopathic medicines can be used in conjunction with other types of medication.	isiZulu	134	3.74	0.482
	English	43	3.56	
	Afrikaans	6	4.33	
	Other	15	3.67	
	Total	198	3.71	
Homoeopathy is non-invasive.	isiZulu	134	3.68	0.723
	English	43	3.47	
	Afrikaans	6	3.67	
	Other	15	3.33	
	Total	198	3.61	
Homoeopathic medication does not have any harsh side effects.	isiZulu	134	3.66	0.780
	English	43	3.49	
	Afrikaans	6	4.00	
	Other	15	3.53	
	Total	198	3.62	
Patients cannot develop a resistance against homoeopathic medication.	isiZulu	134	3.46	0.943
	English	43	3.37	
	Afrikaans	6	3.17	
	Other	15	3.40	
	Total	198	3.42	

5.4.6.4 Influence of occupational role and perceived enablers to homoeopathy integration into public healthcare system

This section examines the relationship that exists between the occupational role of the participants and their scoring pattern with respect to the enablers to the successful integration of homoeopathy into the public healthcare system. The ANOVA test was done to determine the scoring pattern. It can be seen that more (M=4.48) homoeopaths significantly perceived that homoeopathic medicines are cost effective ($p<0.005$). As shown in Table 5.22, similar trends could be observed as more homoeopaths were in agreement that there are homoeopathic practitioners who support integration and are ready to work in the public facilities (M=4.67; $p<0.005$), there is growing global interest in the use of natural medicines for preventative and palliative needs (M=4.76; $p<0.005$); homoeopathic medicines can be used in conjunction with other types of medication (M=4.82; $p<0.005$); homoeopathy is non-invasive (M=4.82; $p<0.005$); homoeopathic medication does not have any harsh side effects (M=4.58; $p<0.005$); and as well as patients cannot develop a resistance against homoeopathic medication (M=4.09; $p=0.01$). This notwithstanding, the higher mean values observed for both nurses and medical doctors suggest that the above listed enablers present a potent motivation for the integration of homoeopathy into the public healthcare system in South Africa.

Table 5.22: Relationship between occupational role and perceived enablers to homoeopathy integration into public healthcare system

Enablers	Occupational role	N	Mean	ANOVA p value
Homoeopathic medicines are cost effective.	Nurse	45	3.44	0.000
	Medical doctor	120	3.30	
	Homoeopath	33	4.48	
	Total	198	3.53	
There are homoeopathic practitioners who support integration and are ready to work in the public facilities.	Nurse	45	3.51	0.000
	Medical doctor	120	3.37	
	Homoeopath	33	4.67	
	Total	198	3.62	
There is a growing global interest in the use of natural medicines for preventative and palliative needs.	Nurse	45	3.87	0.000
	Medical doctor	120	3.78	
	Homoeopath	33	4.76	
	Total	198	3.96	
Homoeopathic medicines can be used in conjunction with other types of medication.	Nurse	45	3.67	0.000
	Medical doctor	120	3.43	
	Homoeopath	33	4.82	
	Total	198	3.71	
Homoeopathy is non-invasive.	Nurse	45	3.56	0.000
	Medical doctor	120	3.29	
	Homoeopath	33	4.82	
	Total	198	3.61	
Homoeopathic medication does not have any harsh side effects.	Nurse	45	3.38	0.000
	Medical doctor	120	3.45	
	Homoeopath	33	4.58	
	Total	198	3.62	
Patients cannot develop a resistance against homoeopathic medication.	Nurse	45	3.24	0.001
	Medical doctor	120	3.31	
	Homoeopath	33	4.09	
	Total	198	3.42	

5.4.7 Acceptability of homoeopathy into the public health care system

The previous section suggests that the growing drive globally for the use of natural medicines for preventative and palliative reasons might stimulate the motivation for homoeopathy integration into the public healthcare system. This section aimed to know whether stakeholders (patients and healthcare providers) in the public healthcare space would accept the integration of homoeopathy. As such, the one-sample test was used to determine the similarities or differences in the scoring pattern of the participants (medical doctors, nurses, and homoeopaths). The results are summarised in Table 5.23.

It was gathered from Table 5.23 that the majority (77.3%) of the participants significantly were in agreement (Agree 48.0%; strongly agree 29.3%) that in their opinion, homoeopathy would be accepted by patients ($p<0.005$). Equally, more (61.5%) of the participants were in agreement (Agree 39.9%; strongly agree 22.2%) that in their opinion, homoeopathy would be accepted by healthcare providers ($p<0.005$).

Table 5.23: Participants perception acceptability of homoeopathy into public healthcare system

Factors contributing to acceptability	No	Likert scale					p value
		SD	D	N	A	SA	
In my opinion, homoeopathy would be accepted by patients.	198	0.5%	8.1%	14.1%	48.0%	29.3%	0.000
In my opinion, homoeopathy would be accepted by healthcare providers.	198	3.0%	10.1%	24.7%	39.9%	22.2%	0.000

Overall, it can be gleaned from Figure 5.10 that the high agreement by the participants suggest that homoeopathy would be highly accepted into the public health care system by other stakeholders notably patients and healthcare providers in the sector.

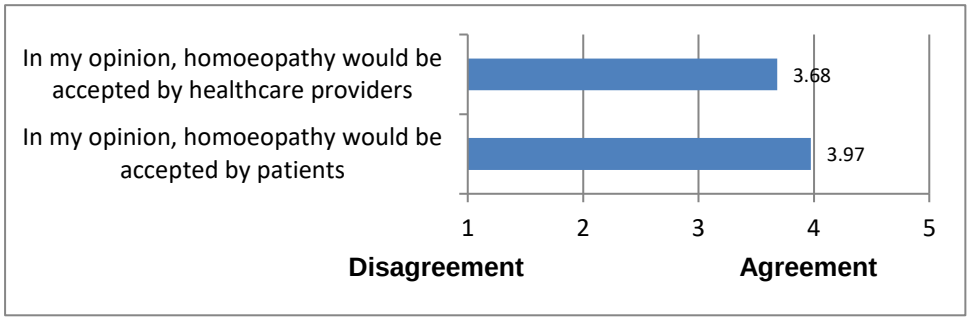

Figure 5.10: Acceptability of homoeopathy into the public healthcare system

5.4.8 Relationship between biographical information and the acceptability of homoeopathy into public healthcare system

This section examined whether the participants' biographical information such as gender, age group, home language, and occupational role had an influence in their scoring pattern regarding the acceptability of homoeopathy into the public healthcare system.

5.4.8.1 Influence of gender and perceived acceptability of homoeopathy into public healthcare system

The gender of the participants had no significant influence on the scoring pattern of the participants with regards to the acceptability of homoeopathy into the public healthcare system.

5.4.8.2 Influence of age group and perceived acceptability of homoeopathy into public healthcare system

The table below illustrates the relationship that exists with age group and perceived acceptability of homoeopathy into public healthcare system. The ANOVA test was done to establish the scoring pattern. Notably, it was observed in Table 5.24 that participants within the age group 41+ were more (M=4.18) in agreement that homoeopathy would be accepted by patients while those within the age group 18-20 (M=2.67) had the lowest agreement to the said statement (p=0.038). No significant differences were however observed with respect to the statement "*In my opinion, homoeopathy would be accepted by healthcare providers*" and the age group of the participants (p=0.052).

Table 5.24: Relationship between age group and acceptability of homoeopathy into public healthcare system

Statement	Age group	N	Mean	ANOVA p value
In my opinion, homoeopathy would be accepted by patients.	18-20	3	2.67	0.038
	21-25	84	3.86	
	26-33	73	4.08	
	34-40	27	4.11	
	41+	11	4.18	
	Total	198	3.97	
In my opinion, homoeopathy would be accepted by healthcare providers.	18-20	3	2.67	0.052
	21-25	84	3.82	
	26-33	73	3.73	
	34-40	27	3.48	
	41+	11	3.09	
	Total	198	3.68	

5.4.8.3 Influence of home language and perceived acceptability of homoeopathy into public healthcare system

Table 5.25 illustrates the relationship that exists between the home language of the participants and their perceived acceptability of homoeopathy into public healthcare system. The ANOVA test was done to establish the scoring pattern. It was observed that more of the participants that spoke isiZulu (M=3.91) were in agreement that homoeopathy would be accepted by healthcare providers whilst those that spoke English as their home language had the lowest (M=3.05) level of agreement ($p<0.005$). No significant differences were however observed with respect to the statement “In my opinion, homoeopathy would be accepted by patients” ($p=0.540$).

Table 5.25: Relationship between home language and acceptability of homoeopathy into public healthcare system

Statement	Home language	N	Mean	ANOVA p value
In my opinion, homoeopathy would be accepted by patients.	isiZulu	134	4.02	0.540
	English	43	3.88	
	Afrikaans	6	4.17	
	Other	15	3.73	
	Total	198	3.97	
In my opinion, homoeopathy would be accepted by healthcare providers.	isiZulu	134	3.91	0.000
	English	43	3.05	
	Afrikaans	6	3.00	
	Other	15	3.73	
	Total	198	3.68	

5.4.8.4 Influence of occupational role and perceived acceptability of homoeopathy into public healthcare system

Table 5.26 illustrates the relationship that exists between occupational role of the participants and their perceived acceptability of homoeopathy into public healthcare system. The ANOVA test was done to establish the scoring pattern. A significant difference were noted in respect to the statement “*In my*

opinion, homoeopathy would be accepted by patients" as more homoeopaths (M=4.58) were in agreement to the said statement while medical doctors had the lowest (M=3.78) level of agreement (p<0.005).

On the other hand, and surprisingly, more (M=3.93) of the nurses and medical doctors (M=3.74) significantly had more agreement that homoeopathy would be accepted by healthcare providers when compared against homoeopaths (M=3.12) (p=0.001).

Table 5.26: Relationship between home language and acceptability of homoeopathy into public healthcare system

Statements	Occupational role	N	Mean	ANOVA p value
In my opinion, homoeopathy would be accepted by patients.	Nurse	45	4.04	0.000
	Medical doctor	120	3.78	
	Homoeopath	33	4.58	
	Total	198	3.97	
In my opinion, homoeopathy would be accepted by healthcare providers.	Nurse	45	3.93	0.001
	Medical doctor	120	3.74	
	Homoeopath	33	3.12	
	Total	198	3.68	

5.4.9 Steps for the successful integration of homoeopathy into the public health care system

From the previous section, it would be sufficient to assume (based on the high number of positive responses received for integrating homoeopathy into the public healthcare system) that homoeopathy would be supported and approved by both the patients and other healthcare providers. This section aimed to evaluate the steps that would be needed to successfully integrate homoeopathy into the public healthcare system. The one-sample test was used to determine the scoring patterns of the participants (medical doctors, nurses, and homoeopaths). The results are summarised in Table 5.27.

With regards to the step required such as support of integration from government, the one-sample test suggest that the number (63.6%) of participants in agreement (Agree 28.8%; strongly agree 34.8%) were highly significantly more than those who were in disagreement ($p<0.005$). This suggests that more of the participants call for the support of the government in order for homoeopathy to be successfully integrated into the public healthcare system. Expectedly, more (61.1%) of the participants were in significant agreement (Agree 27.8%; strong agree 33.3%) that having laws that are in the interest of both homoeopathy and allopathy professions are steps needed for the successful integration of homoeopathy into the public healthcare system ($p<0.005$).

In terms of creating marketing campaigns to promote homoeopathy to the public and allopathy practitioners, a large proportion (71.2%) of the participants significantly agreed (Agree 21.2%; strongly agree 50.0%) to this that it is the needed step for the integration of homoeopathy into the public healthcare system ($p<0.001$). Similarly, more (58.0%) of the participants positively (Agree 23.7%; strongly agree 34.3%) believed that holding of conferences that include both homoeopathy and allopathy professionals are critical step for the integration of homoeopathy into the public healthcare system ($p<0.005$).

Furthermore, it was noted that including homoeopathy modules in the nursing/ medical school curriculum was viewed (Agree 29.3%; strongly agree 32.8%) by more (62.1%) of the participants to be important steps for the integration of homoeopathy into the public health system ($p<0.005$). Added to this, more (65.2%) of the participants significantly think (Agree 26.8%; strongly agree 38.4%) that creating an internship programme that would allow for student nurses, doctors and homoeopaths to work together while they are still students would be a crucial step to the integration of homoeopathy into the public healthcare system ($p<0.005$).

Lastly, more of than half (56.1%) of the participants were in significant agreement (Agree 26.8%; strongly agree 29.3%) that altering the homoeopathy curriculum to increase their knowledge about allopathic medicine and medical practice would be an important step to the successful integration of homoeopathy into the public healthcare system ($p<0.005$).

Table 5.27: Participants perception on the steps required of homoeopathy integration to public healthcare system

Steps	No	Likert scale					p value
		SD	D	N	A	SA	
Support of integration from government.	198	7.1%	13.1%	16.2%	28.8%	34.8%	0.000
Having laws that are in the interest of both homoeopathy and allopathy professions.	198	7.1%	12.1%	19.2%	27.8%	33.3%	0.000
Creating marketing campaigns to promote homoeopathy to the public and allopathic practitioners.	198	7.6%	8.1%	13.1%	21.2%	50.0%	0.000
Holding of conferences that include both homoeopathy and allopathy professionals.	198	4.5%	10.6%	26.8%	23.7%	34.3%	0.000
Including homoeopathy modules in the nursing/medical school curriculum.	198	5.6%	9.1%	23.2%	29.3%	32.8%	0.000
Creating an internship programme that would allow for student nurses, doctors and homoeopaths to work together while they are still students	198	5.6%	9.6%	19.7%	26.8%	38.4%	0.000
Altering the homoeopathic curriculum to increase their knowledge about allopathic medicine and medical practice.	198	6.1%	9.1%	28.8%	26.8%	29.3%	0.000

5.4.10 Relationship between biographical information and the steps for the successful integration of homoeopathy into public healthcare system

This section examines whether the participants' biographical information such as gender, age group, home language, and occupational role had an influence in their scoring pattern regarding the steps required for homoeopathy to be successfully integrated into the public healthcare system.

5.4.10.1 Influence of gender and perceived steps required for the successful integration of homoeopathy into public healthcare system

The gender of the participants had no significant influence on the scoring pattern of the participants with regards to the steps required for the integration of homoeopathy into the public healthcare system.

5.4.10.2 Influence of age group and perceived steps required for the successful integration of homoeopathy into public healthcare system

Table 5.28 illustrates the relationship that exists between age group and perceived steps for integration of homoeopathy into public healthcare system. The ANOVA test was done to establish the scoring pattern. It can be gathered that participants within the age group 41+ were significantly more in agreement (M=4.27) that support of integration from government is the right step needed for the integration of homoeopathy into the public healthcare system (p=.011). Similarly, more of the participants within the age group 41+ were significantly in agreement that having laws that are in the interest of both homoeopathy and allopathy professions (M=4.09; p=.021); creating marketing campaigns to promote homoeopathy to the public and allopathic practitioners (M=4.36; p=.027); as well as holding of conferences that include both homoeopathy and allopathy professionals (M=4.27; p=.034) were in significant suggested that the listed steps could be implemented for the successful integration of homoeopathy into the public healthcare system.

On the other hand, no differences were noted in respect to the including homoeopathy modules in the nursing/medical school curriculum (p=.642); creating an internship programme that would allow for student nurses, doctors and homoeopaths to work together while they are still students (p=.230) and altering the homoeopathic curriculum to increase their knowledge about allopathic medicine and medical practice (p=0.859). This suggested that the participants regardless of the age group were unified in the agreement or disagreement that the aforementioned steps are important to the successful integration of homoeopathy into the public healthcare system.

Table 5.28: Relationship between age group and steps for the integration of homoeopathy into public healthcare system

Statements	Age group	N	Mean	ANOVA p value
Support of integration from government.	18-20	3	1.33	0.011
	21-25	84	3.73	
	26-33	73	3.73	
	34-40	27	3.67	
	41+	11	4.27	
	Total	198	3.71	
Having laws that are in the interest of both homoeopathy and allopathy professions.	18-20	3	1.67	0.021
	21-25	84	3.68	
	26-33	73	3.84	
	34-40	27	3.41	
	41+	11	4.09	
	Total	198	3.69	
Creating marketing campaigns to promote homoeopathy to the public and allopathic practitioners.	18-20	3	2.33	0.027
	21-25	84	4.10	
	26-33	73	4.04	
	34-40	27	3.48	
	41+	11	4.36	
	Total	198	3.98	
Holding of conferences that include both homoeopathy and allopathy professionals.	18-20	3	2.00	0.034
	21-25	84	3.64	
	26-33	73	3.85	
	34-40	27	3.63	
	41+	11	4.27	
	Total	198	3.73	

Statements	Age group	N	Mean	ANOVA p value
Including homoeopathy modules in the nursing / medical school curriculum.	18-20	3	3.33	0.642
	21-25	84	3.65	
	26-33	73	3.85	
	34-40	27	3.67	
	41+	11	4.09	
	Total	198	3.75	
Creating an internship programme that would allow for student nurses, doctors and homoeopaths to work together while they are still students.	18-20	3	3.67	0.230
	21-25	84	3.62	
	26-33	73	4.00	
	34-40	27	3.85	
	41+	11	4.27	
	Total	198	3.83	
Altering the homoeopathic curriculum to increase their knowledge about allopathic medicine and medical practice	18-20	3	4.00	0.859
	21-25	84	3.56	
	26-33	73	3.67	
	34-40	27	3.67	
	41+	11	3.91	
	Total	198	3.64	

5.4.10.3 Influence of home language and perceived steps required for the successful integration of homoeopathy into public healthcare system

Table 5.29 illustrates the relationship that exists between age group and perceived steps for integration of homoeopathy into public healthcare system. The ANOVA test suggests that no significant difference were observed for the perceived steps namely: support of integration from government (p=.125; having laws that are in the interest of both homoeopathy and allopathy professions (p=.129); holding of conferences that include both homoeopathy and allopathy professionals (p=.907); including homoeopathy modules in the nursing/medical school curriculum (p=.226); creating an internship programme that would allow for student nurses, doctors and homoeopaths to work together while they are still students (p=.535) and altering the homoeopathic curriculum to increase their knowledge about allopathic medicine and medical practice with respect to their home language (p=.606).

On the contrary, and as given in Table 5.29, the isiZulu speakers were significantly more in agreement when compared to other speakers that creating marketing campaigns to promote homoeopathy to the public and allopathic practitioners would be an important step to the integration of homoeopathy into the public healthcare system (p=.014).

Table 5.29: Relationship between home language and steps for the integration of homoeopathy into public healthcare system

Statement	Home language	N	Mean	ANOVA p value
Support of integration from government.	isiZulu	134	3.89	0.125
	English	43	3.30	
	Afrikaans	6	3.50	
	Other	15	3.40	
	Total	198	3.71	
Having laws that are in the interest of both homoeopathy and allopathy professions.	isiZulu	134	3.86	0.129
	English	43	3.40	
	Afrikaans	6	3.50	
	Other	15	3.13	
	Total	198	3.69	
Creating marketing campaigns to promote homoeopathy to the public and allopathic practitioners.	isiZulu	134	4.24	0.014
	English	43	3.40	
	Afrikaans	6	3.67	
	Other	15	3.47	
	Total	198	3.98	
Holding of conferences that include both homoeopathy and allopathy professionals.	isiZulu	134	3.77	0.907
	English	43	3.63	
	Afrikaans	6	3.83	
	Other	15	3.60	
	Total	198	3.73	
Including homoeopathy modules in the nursing / medical school curriculum.	isiZulu	134	3.85	0.226
	English	43	3.37	
	Afrikaans	6	4.17	
	Other	15	3.73	
	Total	198	3.75	
Creating an internship programme that would allow for student nurses, doctors and homoeopaths to work together while they are still students	isiZulu	134	3.91	0.535
	English	43	3.65	
	Afrikaans	6	4.17	
	Other	15	3.47	
	Total	198	3.83	
Altering the homoeopathic curriculum to increase their knowledge about allopathic medicine and medical practice.	isiZulu	134	3.69	0.606
	English	43	3.70	
	Afrikaans	6	3.17	
	Other	15	3.27	
	Total	198	3.64	

5.4.10.4 Influence of occupational role and perceived steps required for the successful integration of homoeopathy into public healthcare system

Table 5.30 illustrates the relationship that exists between the occupational role of the participants and perceived steps for integration of homoeopathy into public healthcare system. The ANOVA test was done to establish the scoring pattern. Expectedly, in all the steps outlined in Table 5.30, homoeopaths were significantly more in agreement that these would successfully integrate homoeopathy into the public healthcare system if followed and implemented ($p<0.005$). This was not surprising as homoeopaths are the ones who have an intimate relationship with what is hindering the growth of homoeopathy in the healthcare system of South Africa.

Table 5.30: Relationship between occupational role and steps for the integration of homoeopathy into public healthcare system

Statement	Occupational role	N	Mean	ANOVA p value
Support of integration from government.	Nurse	45	3.84	0.000
	Medical doctor	120	3.44	
	Homoeopath	33	4.52	
	Total	198	3.71	
Having laws that are in the interest of both homoeopathy and allopathy professions.	Nurse	45	3.84	0.000
	Medical doctor	120	3.37	
	Homoeopath	33	4.67	
	Total	198	3.69	
Creating marketing campaigns to promote homoeopathy to the public and allopathic practitioners.	Nurse	45	4.00	0.002
	Medical doctor	120	3.78	
	Homoeopath	33	4.67	
	Total	198	3.98	
Holding of conferences that include both homoeopathy and allopathy professionals.	Nurse	45	3.71	0.000
	Medical doctor	120	3.48	
	Homoeopath	33	4.67	
	Total	198	3.73	
Including homoeopathy modules in the nursing / medical school curriculum.	Nurse	45	3.84	0.000
	Medical doctor	120	3.50	
	Homoeopath	33	4.52	
	Total	198	3.75	
Creating an internship programme that would allow for student nurses, doctors and homoeopaths to work together while they are still students.	Nurse	45	3.93	0.000
	Medical doctor	120	3.51	
	Homoeopath	33	4.85	
	Total	198	3.83	
Altering the homoeopathic curriculum to increase their knowledge about allopathic medicine and medical practice.	Nurse	45	3.78	0.000
	Medical doctor	120	3.39	
	Homoeopath	33	4.36	
	Total	198	3.64	

5.5 SUMMARY OF THE CHAPTER

This chapter presented the results of the quantitative parts of the study. The next chapter will present the qualitative results of the study. Subsequent to this, these results will be discussed and triangulated, to formulate a model of integration.

CHAPTER 6: PRESENTATION OF FINDINGS: PHASE 2 (QUALITATIVE DATA)

6.1 INTRODUCTION

The data collected in Phase 2 of the study will be presented in this chapter. This phase is the qualitative component of the study. Phase two of the study presents the findings of the study that were collected through semi-structured interviews. Table 6.1 demonstrates objectives that were addressed in Phase 2 of the study. It also illustrates which tools and/or data collection methods were used for this part of the study.

Table 6.1: Objectives illustrated with respective research orientation and data collection tools

Objective	Research orientation	Data collection
Identify steps of how we can overcome the challenges that might present with integrating homoeopathy into the public healthcare system in South Africa	Qualitative	Semi-structured interviews
Explore the perceptions of healthcare professionals in KZN, in regards to homoeopathy being integrated into the public healthcare system in South Africa.	Qualitative	Semi-structured interviews

The data collected in the quantitative phase was analysed using Tesch's eight steps for analysis in relation to the objectives outlined in the Table 6.1. The researcher targeted public healthcare professionals in KZN (located within eThekwini and King Cetswayo district only), as the research population for this study. Hence, these participants shared their various experiences as it relates to integration of homoeopathy into the public healthcare system. Data collection seized when a point of saturation was reached and as a result,

there were 12 participants for this phase. Once the data was analysed, it was presented in a thematic format.

6.2 DEMOGRAPHICS

The demographics of the participants were represented in this section. This data was presented in a descriptive format using tables, graphs and bar charts for analysis of the participants' biographical data.

6.2.1 Age

The age groups of the participants are given in Table 6.2. It was observed that 50% (n=6) of the participants were within the age group of 40 – 49 years.

Table 6.2: Age of participants

Age group in years	Frequency
30 – 39	3
40 – 49	6
50 - 59	3

6.2.2 Gender

Figure 6.1 depicts the gender of the participants. It was found that there was an even number of male and females among the participants.

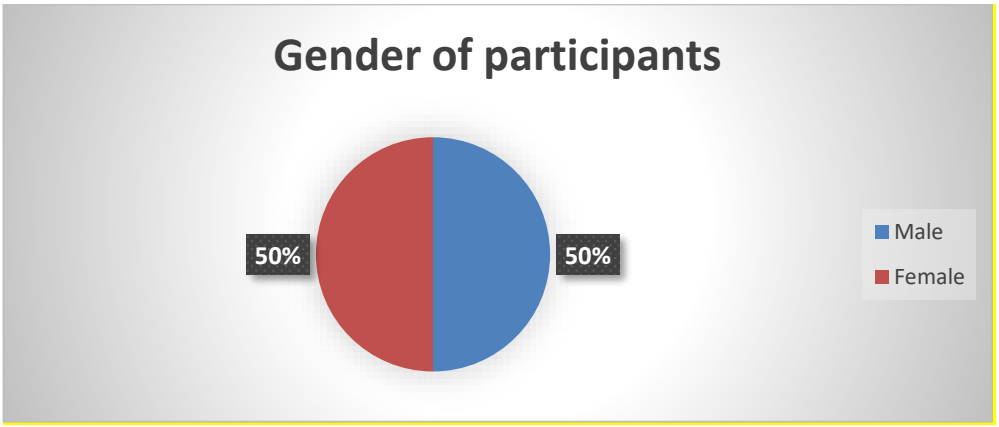

Figure 6.1: Gender of the participants

6.2.3 Race

Figure 6.2 describes the race of the participants. The participants for this phase were either African or Indian. The majority of the participants were African (83%).

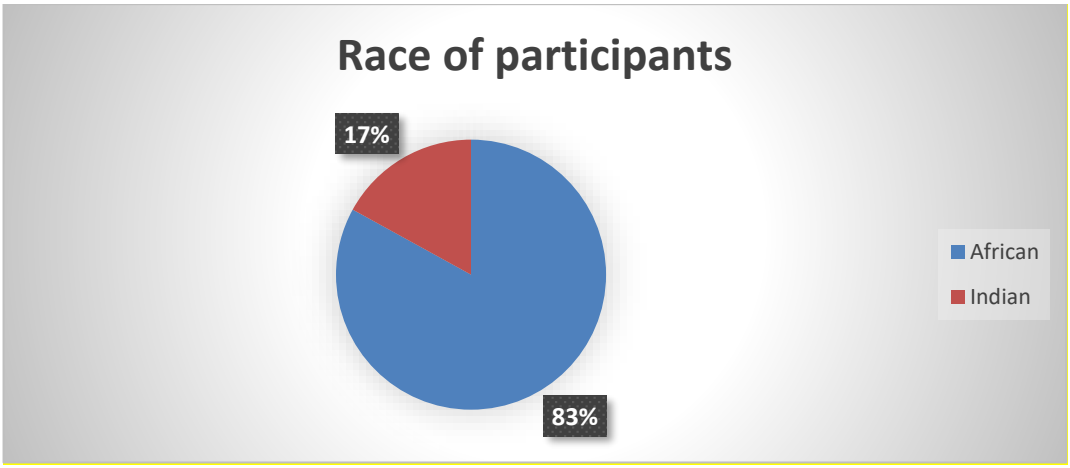

Figure 6.2: Race of participants

6.2.4 Home language

Figure 6.3 depicts the home language of the participants. It was found that the home language of the participants was either isiZulu or English. The majority (75%) of the participants stated that isiZulu is their home language.

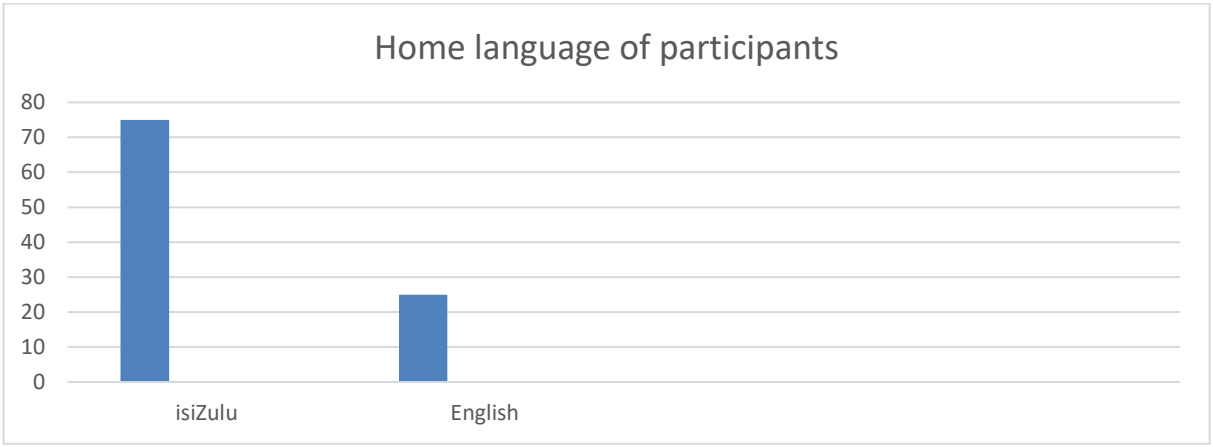

Figure 6.3: Home language of participants

6.2.5 Current occupation

Figure 6.4 depicts the current occupation of the participants. It was observed that the majority (67%) of participants were CEO's of public health facilities.

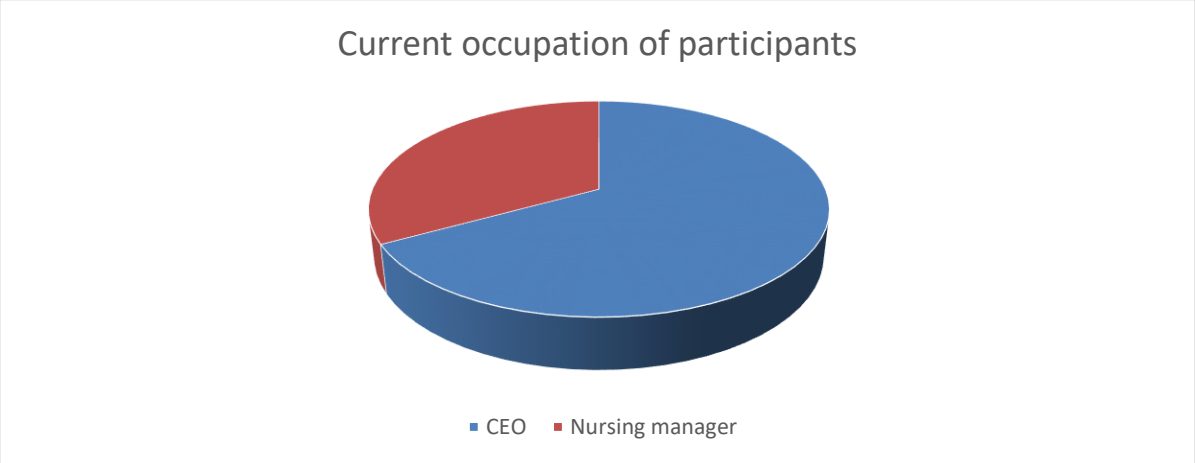

Figure 6.4: Current occupation of participants

6.2.6 Years of experience in the current position

Table 6.3 depicts the number of years; participants have occupied their current position. It was noted that 42% of the participants had less than 6 years of experience in their current role. This indicated that the majority of the participants were still fairly new in their current position.

Table 6.3: Years of experience in the current position

Years of experience in the current position	Frequency
1 – 5	5
6 – 10	4
11 – 15	3

6.2.7 Highest qualification

Figure 6.5 depicts the highest qualification of the participants. The participants either had a postgraduate diploma as their highest qualification, a degree, a master's degree or a doctorate. The majority of the participants either had a postgraduate diploma as their highest qualification or a degree.

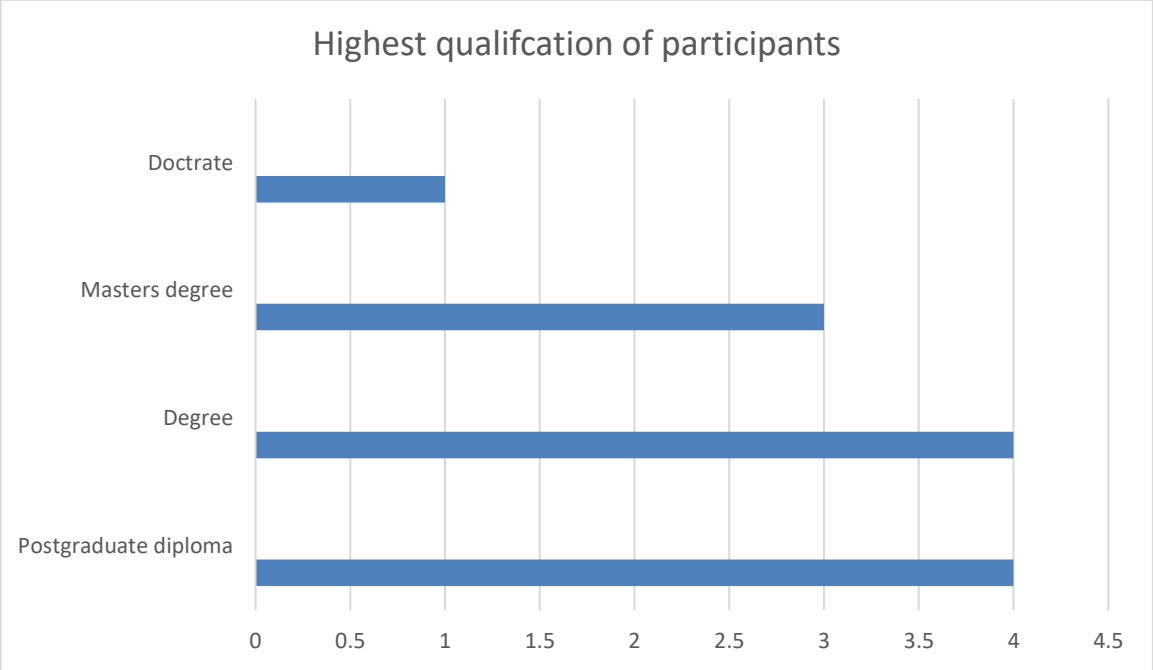

Figure 6.5: Highest qualification of participants

6.3 PRESENTATION OF THE FINDINGS

A semi-structured interview was conducted with each participant to ascertain their perception on the integration of homoeopathy into the public healthcare system. There were two sections in the semi-structured interview. The first section focussed on the participants' experience with homoeopathy and the second section focussed on the participants' perception towards the integration of homoeopathy in the public healthcare system. An overview of some of the responses that were distinctive in this section, were provided in this below.

6.3.1 Perceptions towards homoeopathy in South Africa

Figure 6.6 depicts an overview of the different responses that participants had when interrogated about their perceptions towards Homoeopathy in South Africa.

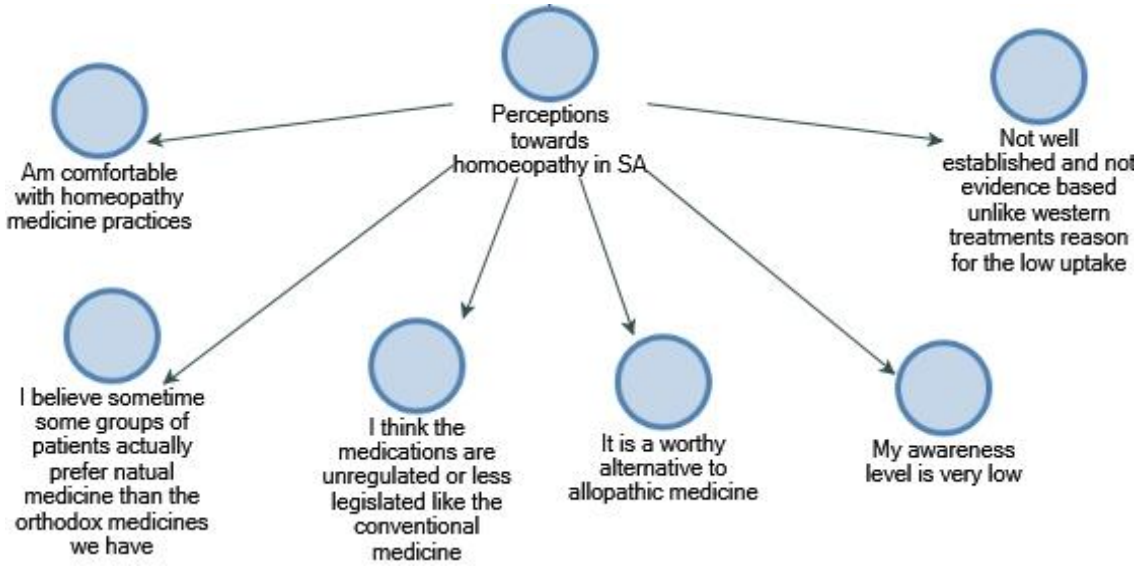

Figure 6.6: Perceptions towards homoeopathy in South Africa

6.3.2 Professional experience with homoeopathy

Figure 6.7 depicts an overview of the different responses that participants had when questioned about their professional experience with Homoeopathy.

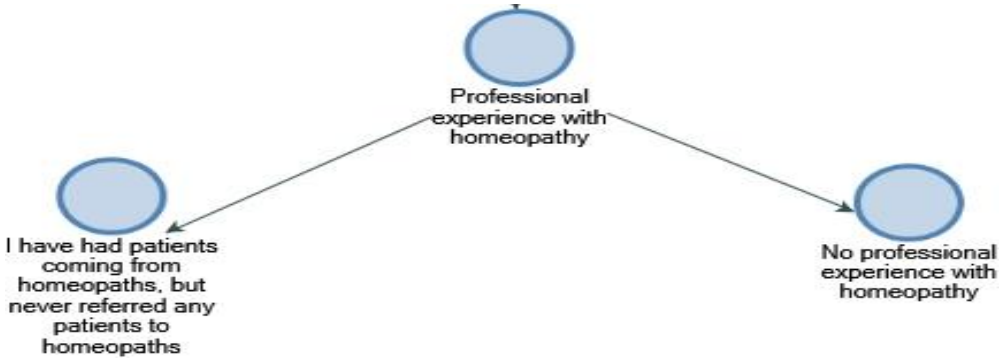

Figure 6.7: Professional experience with homoeopathy

6.3.3 Level of awareness of the different types of Complementary Alternative Medicines (CAMs) that exist in South Africa

Figure 6.8 depicts an overview of the different responses that participants had different when they were question about their level of awareness of the different types of CAMs that exist in South Africa.

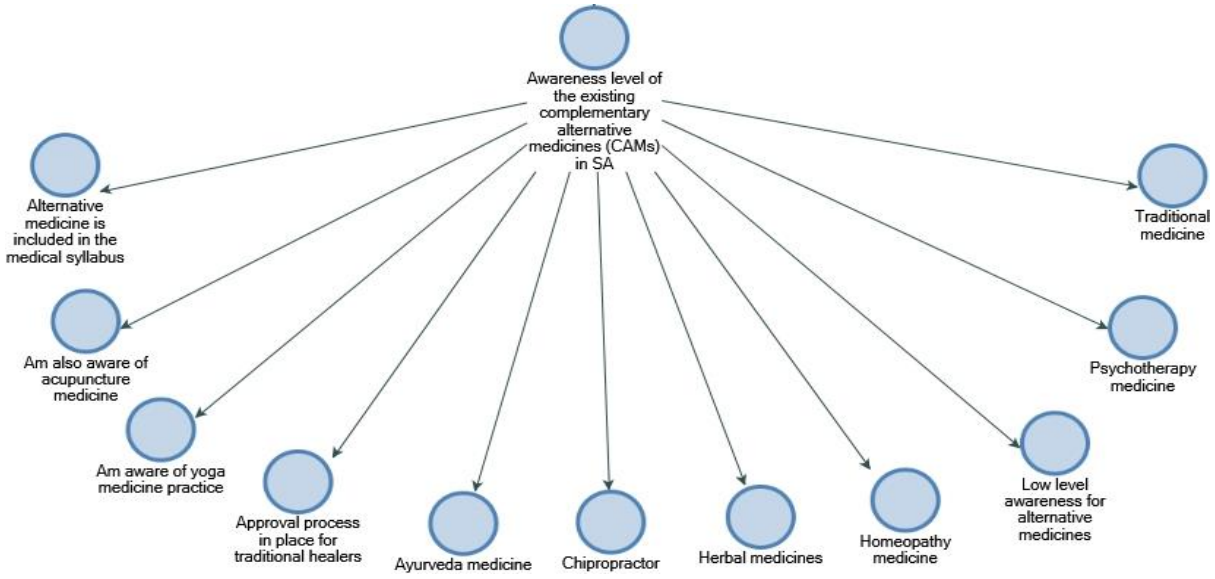

Figure 6.8: Level of awareness of the different types of Complementary Alternative Medicines (CAMs) that exist in South Africa

6.3.4 Level of awareness in terms of CAMs (specifically homoeopathy) in other countries

Figure 6.9 depicts an overview of the different responses that participants had, when they were asked about their level of awareness in terms of CAMs (specifically homoeopathy) in other countries.

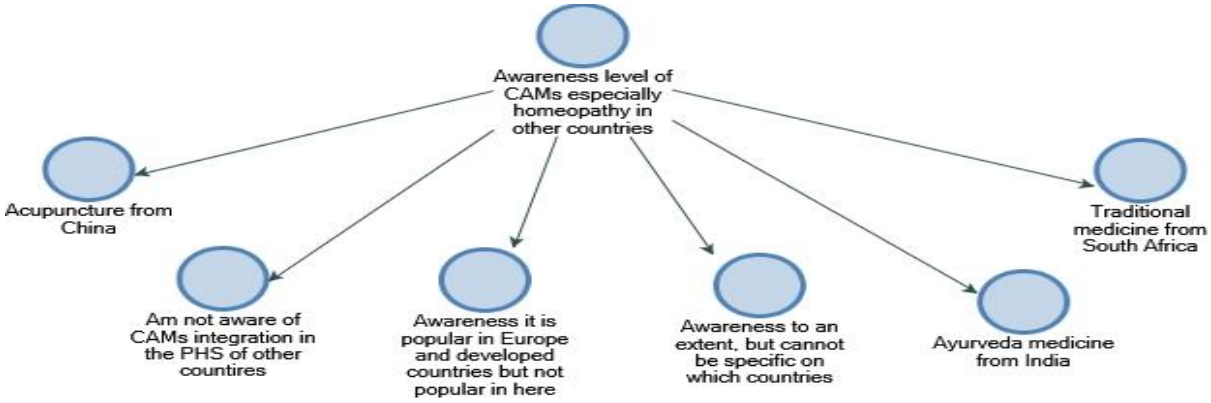

Figure 6.9: Level of awareness in terms of CAMs (specifically homoeopathy) in other countries

6.3.5 Referring a patient to a homoeopath and justification

Figure 6.10 depicts an overview of the different responses that participants had when asked if they would refer a patient to a homoeopath. A justification for their responses was required.

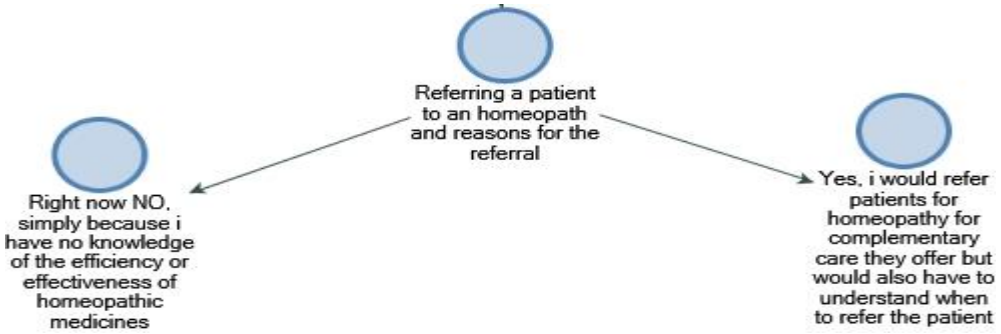

Figure 6.10: Referring a patient to a homoeopath and justification

6.3.6 Role of homoeopathy in the public healthcare system in South Africa

Figure 6.11 depicts an overview of the different responses that participants had when questioned about the role homoeopathy could play in the public healthcare system in South Africa?

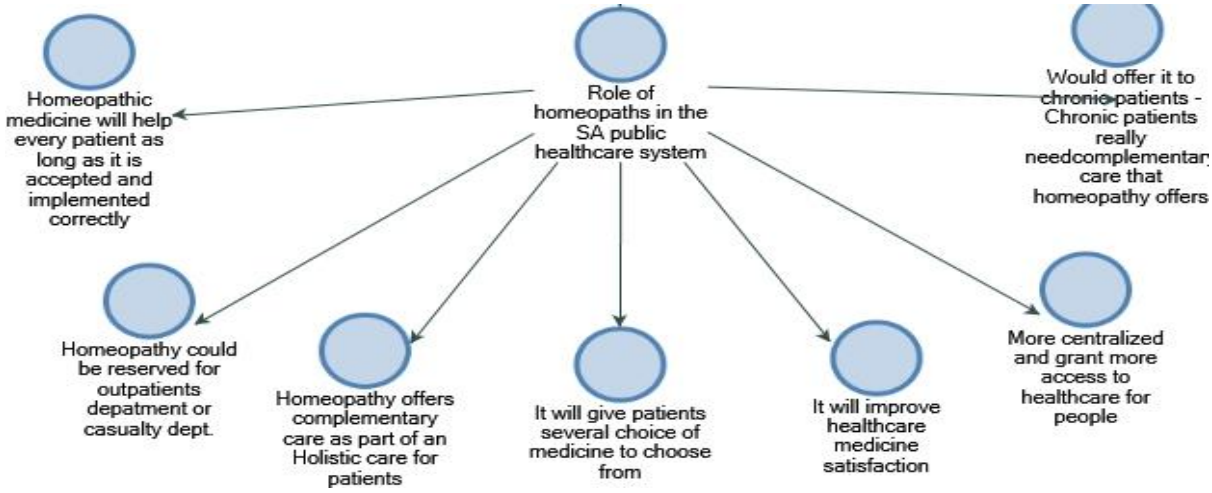

Figure 6.11: Role of homoeopathy in the public healthcare system in South Africa

6.3.7 Perception on the future of homoeopathy in South Africa

Figure 6.12 depicts an overview of the different responses that participants had when they were asked to give their perception of the future of homoeopathy in South Africa.

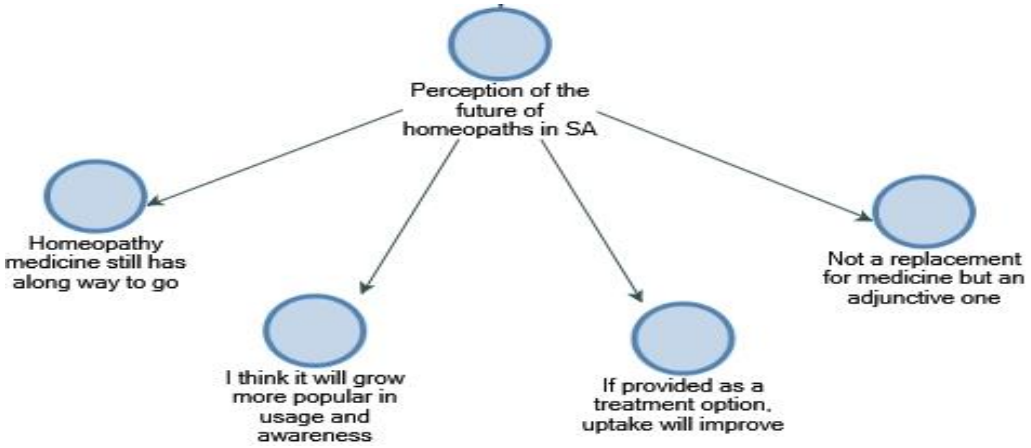

Figure 6.12: Perception on the future of homoeopathy in South Africa

6.3.8 Enabling factors of integration

Figure 6.13 depicts an overview of the different responses that participants had, when they were asked to elaborate on how they envisioned homoeopathy being successfully integrated into the public healthcare system. In this section, participants were also asked to state the enabling factors of integration.

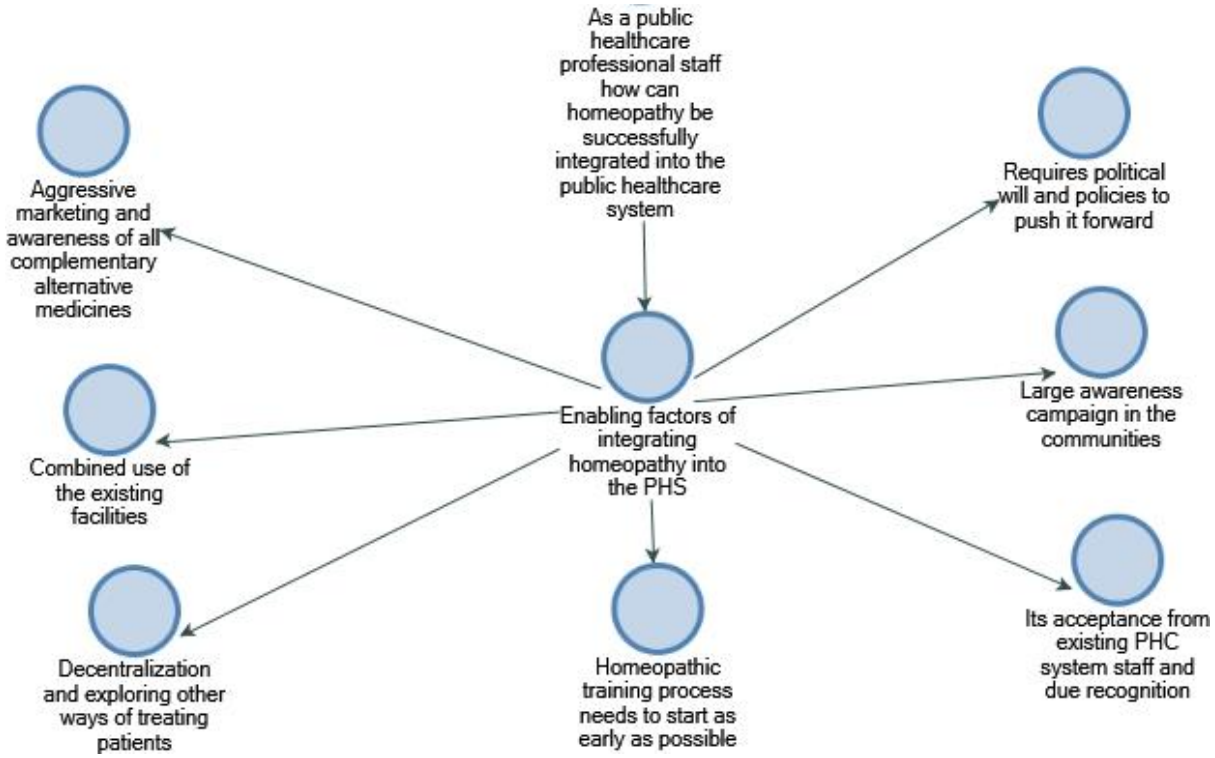

Figure 6.13: Enabling factors of integration

6.3.9 Barriers of integration

In addition to the above, participants were asked to state the barriers of integration and how these barriers could be tackled. This is depicted in Figure 6.14.

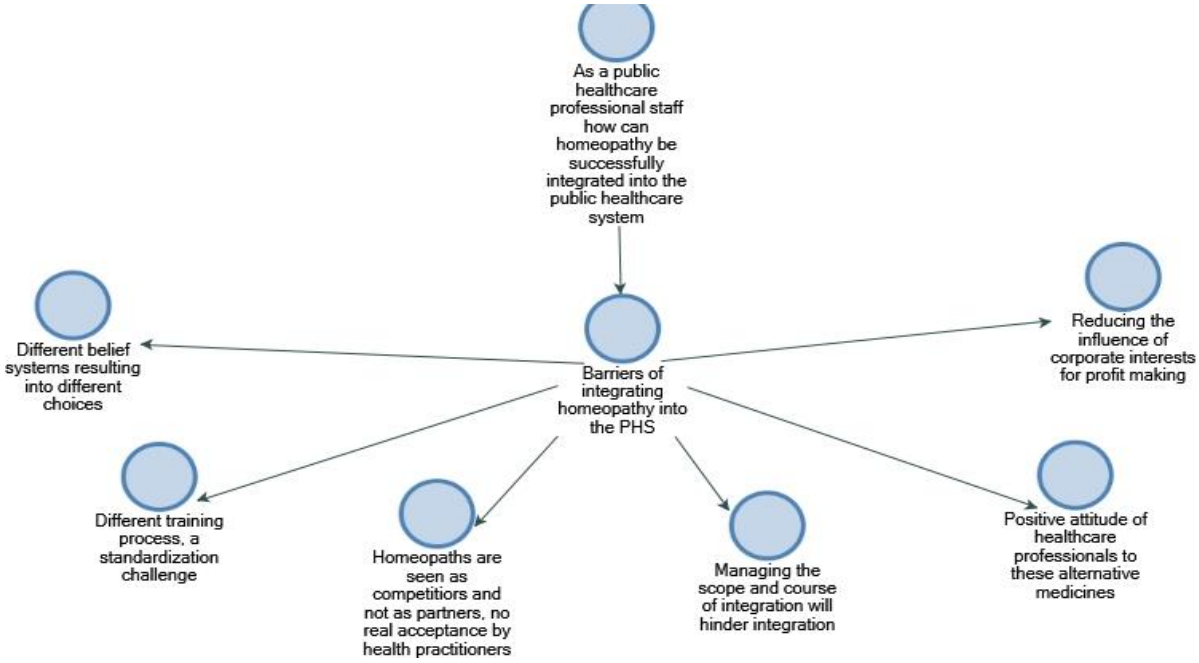

Figure 6.14: Barriers of integration

6.3.10 Overcoming the challenges of integration

Figure 6.15 depicts an overview of the different responses that participants had, when they were asked to share their perceptions, regarding overcoimng the barriers of intgeation.

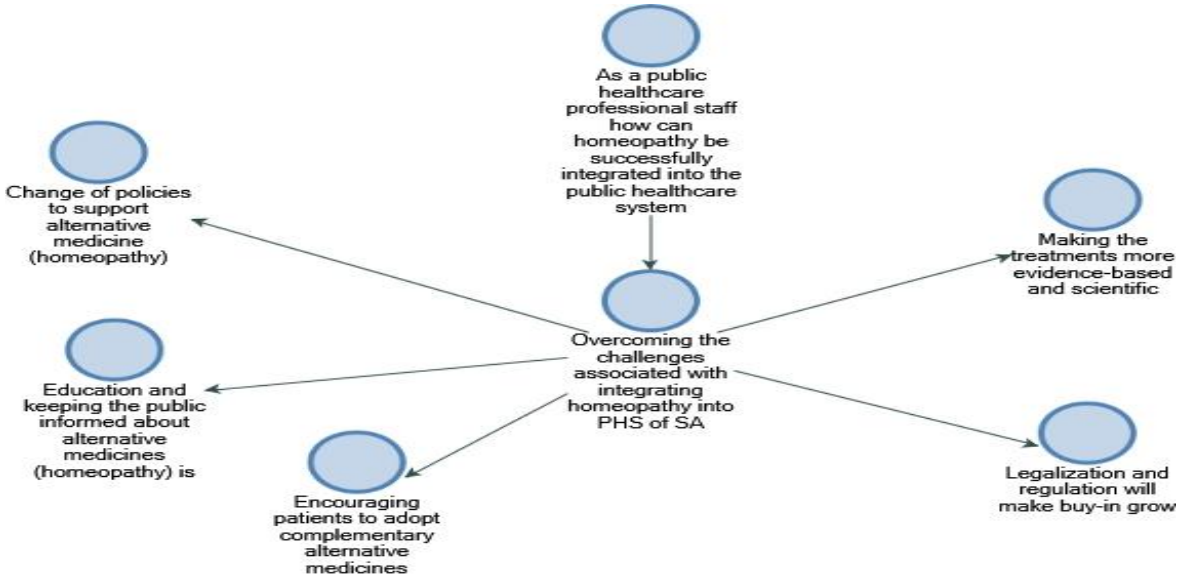

Figure 6.15: Overcoming the challenges of integration

6.3.11 Perceived outcome of integration

Figure 6.16 depicts an overview of the different responses that participants had when they were asked what they perceived to be the outcomes of integration. Participants were also asked to elaborate on how they thought healthcare professionals and patients would react to integration.

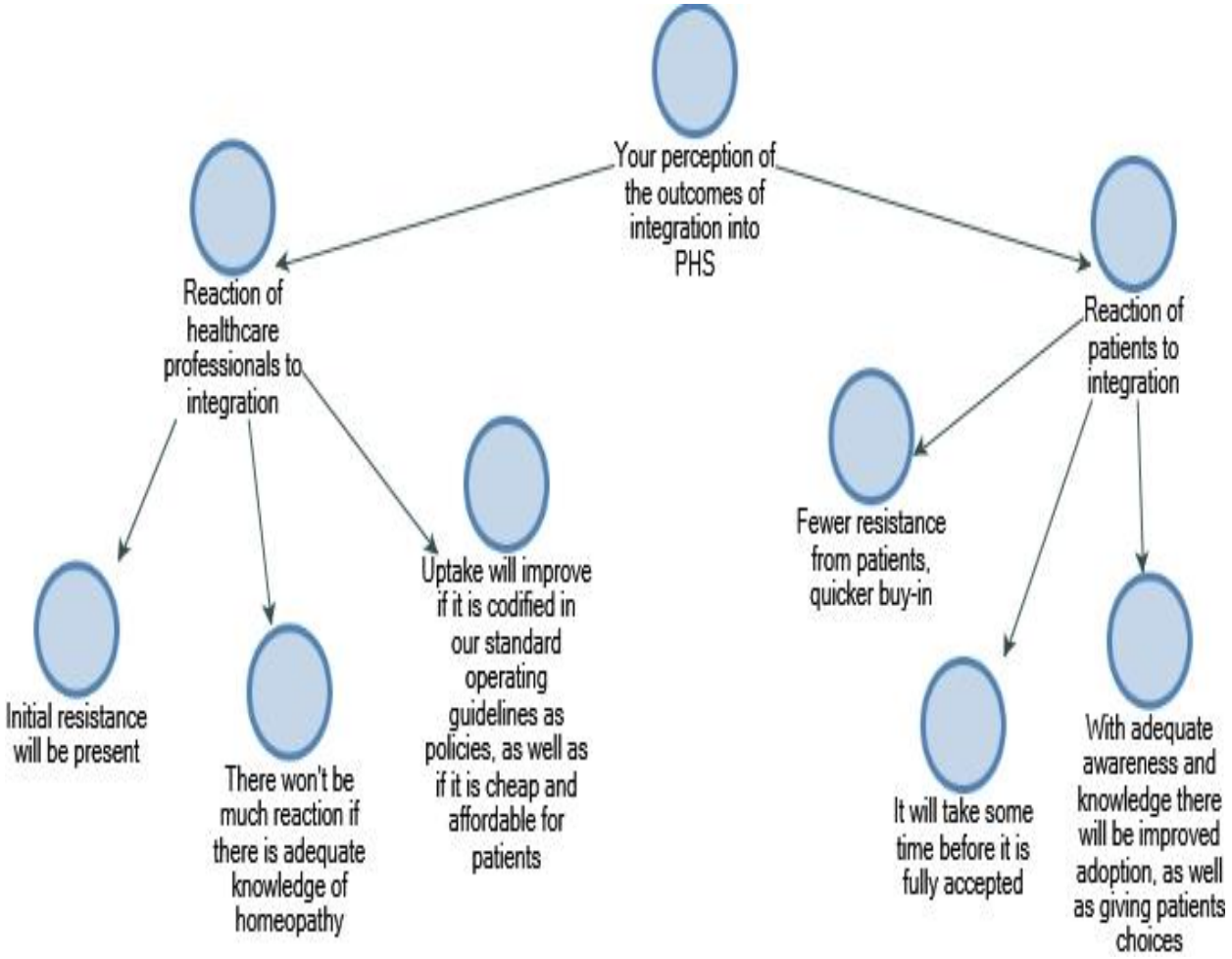

Figure 6.16: Perceived outcome of integration

6.4 EMERGED THEMES

An overview of the themes that were identified during data analysis is presented in Figure 6.17 below.

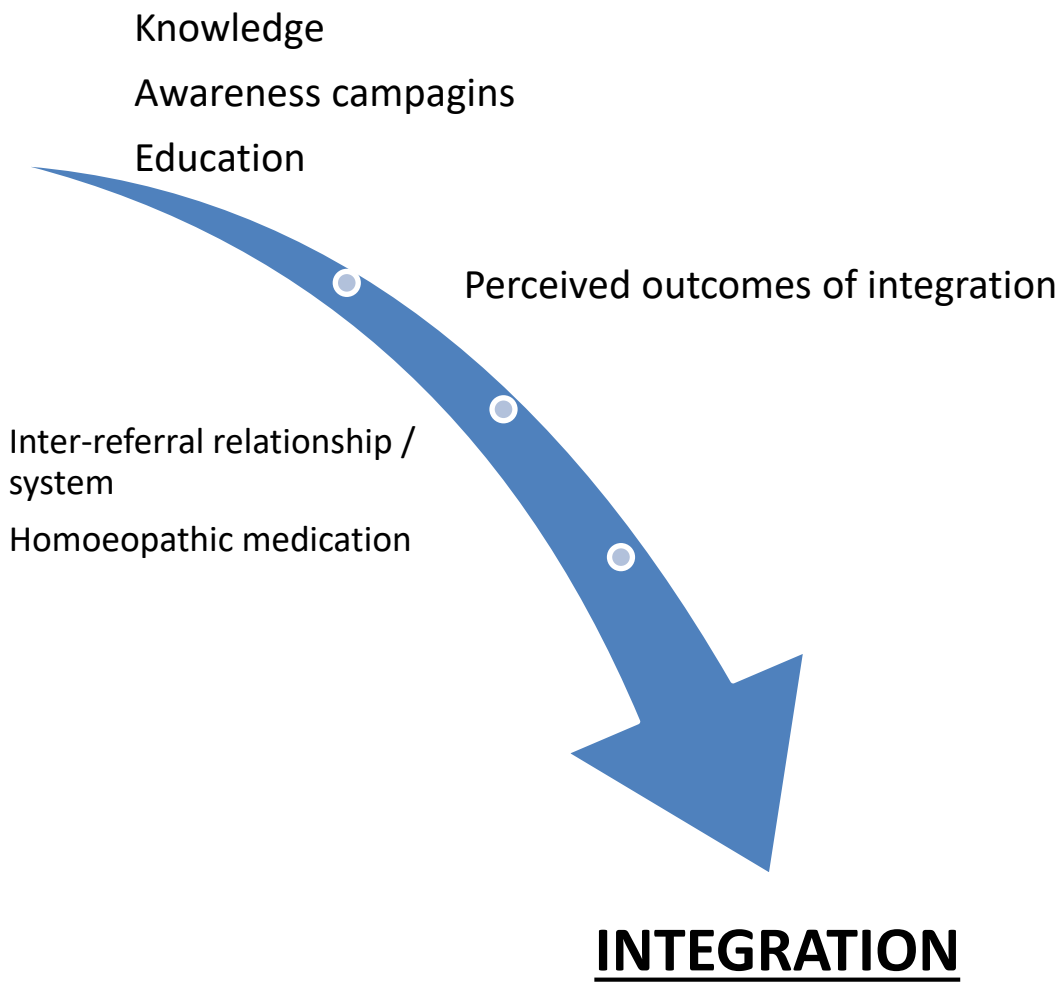

Figure 6.17: Overview of the themes

The themes that emerged were only prevalent in the majority of the participants. In addition, further analysis of each theme enabled the researcher to thoroughly interrogate the variation and frequency of each theme. A summary of the emerged themes and sub-themes is presented in Table 6.4

Table 6.4: A summary of themes and sub-themes

Themes	**Sub-themes**
Knowledge	• Knowledgeable • Lack of knowledge • Misconception
Awareness campaigns	• Awareness campaigns
Education	• Inclusion of homoeopathy in allopathy syllabus
Referral system	• Boundaries for inter-referrals
Homoeopathic medication	• Cost-effectiveness • Usage of homoeopathy in various cases • Regulation of homoeopathic medication
Outcome of integration	• Positive views • Negative views • Uncertain views

6.4.1 Knowledge

The theme of knowledge was consistent amongst all participants. The participants were either aware of what homoeopathy is or they had a lack of knowledge. A misunderstanding was also observed among the participants that advised they had some knowledge of the different types of natural therapies that exist. This was noted when participants were requested to share their level of awareness of the different types of natural medicines that exist in South Africa and in the rest of the world. The lack of knowledge that participants had towards homoeopathy was linked to its lack of usage. The excerpts from interviews that reflect the various levels of awareness on

homoeopathy and other types of natural therapies were illustrated in Table 6.5.

Table 6.5: Excerpts linked to the theme of knowledge

Sub-theme	**Excerpt**
Knowledgeable	*"I have no problem with it as I think it is an alternative to allopathic medicine. I have visited a homoeopath once*" (Participant 1). *"No, I do not lack the knowledge of it. I have a good knowledge of it. Just that there is one of the many reasons why many people trust normal medicine. They is normally some form of evidence of what the content of the medicine is and some kind of accountability in terms of the damage it might have to the human being and the people that use it. With Most alternative medicine, you just talk to the guy that gives you and it ends there for the most part"* (Participant 3).
Lack of knowledge	*"My thinking is that it is not known. Because if it is known, people were going to use homoeopathy more than western medicine"* (Participant 7). *"It is not known and understood especially in Africans"* (Participant 8). *"I do not think it is well known and people do not really use it. When I say people, I mean both healthcare practitioners and patients. They are not informed of what it is, what it does and when and how to refer"* (Participant 9).
Misconception	*"Because natural remedies are not really a quick cure. My understanding is that for the most part its things that you kind have to integrate in your life and will cure things in the long run"* (Participant 3). *"According to my knowledge, I always thought of homoeopathy as the traditional part of it*" (Participant 5).

6.4.2 Awareness campaigns

The majority of the participants advised, awareness campaigns are needed among the healthcare professionals and general public. This theme was subsequently linked to the theme of lack towards knowledge. The excerpts from interviews that reflect that participants would support awareness campaigns are depicted in Table 6.6.

Table 6.6: Excerpts linked to the theme of awareness campaigns

Sub-theme	Excerpt
Awareness campaigns	*"I think through education and keeping people informed about what homoeopathy is and about other alternative treatments can do – then you will win"* (Participant 1). *"I think it does. I think it does have a role to play because western medicine was not used by many in the olden days because they didn't believe in it or didn't know about it. I think it is all about awareness"* (Participant 6). *"If they buy into it and they start to campaign. I am sure it will be easy for people to be aware. So it will require a lot of political will and push to drive the integration it through public sector"* (Participant 10).

6.4.3 Education

The theme of education was observed among certain participants. Participants linked their lack of knowledge of homoeopathy to the current allopathic education system. Many advised that if they were thoroughly taught about homoeopathy at a tertiary level, there would not have a lack of knowledge of what homoeopathy is. As a means to overcome the lack of knowledge they had towards homoeopathy, some participants suggested it should be included as in allopathy training courses. The excerpts from interviews that reflect these views are illustrated in Table 6.7.

Table 6.7: Excerpts linked to the theme of education

Sub-theme	Excerpt
Inclusion of homoeopathy in allopathy syllabus	*"Enabling factors would be for it to be given the same priority or respect, in terms of where it started and what people look at. If it was studied in the same environment as physiotherapy, dentistry – a medical school, kind of setup, for me that would be the starting point"* (Participant 9) *"I think first of all, everything has a beginning. Homoeopathy should be mentioned in the training facilities. In training facilities for nurses and doctors. It should be incorporated in the training facilities so that when there go into the work environment, they already know and it is easy to engage with a homoeopath. They are not introduced at the work place; they are introduced at school. You have curriculum reviewed and curriculum review implements current trends of nursing and managing patients. So it needs to be introduced at a training level. Just an introduction knowing that there's this and this and that. Just like marijuana. This was there and it was taught as a schedule something but now the current trend states that a patient can use it. So even with a homoeopath, it can be introduced like that. There is a category of people that contribute in the care of patients. They can be introduced, and then when professionals come, they also know that as much aa I am managing this acute patient, I can work with somebody or invite someone to intervene and then we manage a patient comprehensively. I think they may be welcomed but they need to be introduced at a training level*" (Participant 2). *"I think it is known by many but in most situations it is not used because it is not included in the nursing curriculum or medicine"* (Participant 4)

6.4.4 Referral system

Many participants advised they had never referred a patient to a homoeopath before. Their lack of lack of what homoeopathy is, was linked to this notion. A few participants indicated they have had patients referred to them by homoeopaths. As a means to form an inter-referral relationship between allopathic practitioners and homoeopaths, the majority of the participants

indicated that they need to know what homoeopathy is and when to refer to them. The majority of the participants also indicated that homoeopathy needs to be integrated into the existing public facilities in order for a proper inter-referral relationship to be formed. The excerpts from interviews that reflect these views are illustrated in Table 6.8.

Table 6.8: Excerpts linked to views an inter-referral relationship / system that needs to be formed

Sub-theme	Excerpt
Boundaries for referrals	*"Maybe on that, Sindile, as much one would be aware – I just mentioned one aspect, and then I said, "one knows very little". You know it still poses a question, like when a patient has a discharge, some of them would say, should I come to you as a GP or should I go straight to the gynaecologist. So as much as I wouldn't know, so when would I refer. Do I refer to gynae first or refer to you first? Do you understand? Under what circumstances, because I may know your scope but now I have patient who has eczema, what do I do? Do I refer them to a dermatologist or a homoeopath? Which one comes first? Biomedicine would say no; you send to a dermatologist. But does that mean, only when a dermatologist has not succeeded, can I then send a patient to you? As much as you guys said you are primary healthcare physicians but the line of referral. When and how? Even when we know the scope, it is still not clear to us*" (Participant 9). *"I am not sure if my level of awareness is right- would refer any of patients. My answer right now would be no. Why? Because I am not really aware or have knowledge on what they do. I might have the wrong perception of how they work and what they do and the medicine they will. I would not want to jeopardize my patient in anyway. That is my only reason. But maybe after now when I start reading about this, maybe I might just change my mind perception of referring a patient to a homoeopath"* (Participant 10).

6.4.5 Homoeopathic medication

Various perceptions were shared about homoeopathic medication. Various viewpoints were shared about homoeopathic medication being useful for chronic or acute cases and being used as an adjunctive to allopathic medicine. When participants were asked to elaborate why they felt that homoeopathic could be used for these cases, the majority of participants quoted the limit or inefficacy of allopathic medication towards these cases. The cost effectiveness and regulation of homoeopathic medication was also a sub-theme that emerged in the theme of homoeopathic medication. In contrast to the above sub-theme of homoeopathic medication being used for various cases in the public facilities, the majority of participants stated their concern of the regulation of homoeopathic medication and how some of them are not evidence-based. The excerpts from interviews that reflect these views are illustrated in Table 6.9.

Table 6.9: Excerpts linked to the theme of homoeopathic medication

Sub-theme	Excerpt
Cost-effectiveness	*"So I don't what the cost difference is, but I think long term you would actually end probably saving, if you could use some adjunctive therapy that would lead to a more natural and healthier life. I think that would be the way you get the buy in"* (Participant 12). *"I think, currently we are struggling with the issue of antibiotics – resistance and all of that and they are pricey. Medicines are expensive now and I think it terms of cost. When you look at this, it is much cheaper, number two, it is beneficial. When you look at the benefits comparing westernized medicine. The benefits are more or else the same or the benefits on the other side are higher than westernized medicine. Yet it is cheaper. We look at the financial status of the people in our country. It is really bad and it as going down. People are still compromised in terms of healthcare. People who don't have money have to go to the public sector and wait for long. Others have to book appointment for procedures and it takes time. Yet if we have this kind to medicine, that can work quicker and at a cheaper rate then I think the community will benefit"* (Participant 5).
Usage of homoeopathy in various cases	*"Because we have patients with chronic pain issues. We have patient with a lot of issues that we feel sometimes we over prescribe medication and it is not necessary to that extent. I see it a lot here. I see a lot of patients with polypharmacy, whereas maybe something simple that would treat the root cause and safer to the body – because we also see toxicity from our medication and dependency. I think a lot of things especially pain medication – a lot of them do become dependent on it. If there's a deeper root and it is known more and marketed to healthcare professions then I am sure we would utilise it*" (Participant 12).

Sub-theme	Excerpt
Usage of homoeopathy in various cases	*"I think homoeopathy can be useful in the maintenance phase of a condition. Once they come to us, there are usually in the acute phase. Once the acute phase passes on, then they would need to be maintained. I think homoeopathy can come there in terms of chronic maintenance"* (Participant 2). *"I think there is no need for us to create other facilities for homoeopathy. Maybe integrate them to the existing medicine as I said, patients must be given options because they have rights to choose whether they want to be treated with western medicine or with homoeopathy because the treatment for different conditions are not the same. For example with acute conditions, we can use homoeopathy or with chronic conditions, we can mix homoeopathy with western medicine*" (Participant 7).
Regulation of homoeopathic medication	"*Well the doctor as well, they will accept. Because when the condition is not that severe, you cause homoeopathy. Because once we are having it in black and white in our EDL, that when you treating this condition, you use this and it is in the guideline – once we have the guideline and the policies then they will accept. Because even when they are training their patients with western medicine, they use their protocol and guidelines" (*Participant 7). *"I think if there were better legislated. The thing with medicine and especially doctors we come from a very scientific background. So everything about it, is evidence based medicine. I think if it was more legislated, if there were proper guidelines and policies of how we could utilise it and the effectiveness of it then I think they would be a greater push and understanding for the doctors……..I don't have a great knowledge of it, but sort of what I said, I think the pharmaceutical companies are under the MCC, and legislated quite heavily. The same could be done for homoeopathy and natural remedies. If it is not already. So that the NDOH can say this is a legislated form of therapy*" (Participant 12).

6.4.6 Outcome of integration

The majority of participants gave a positive response when they were asked to share their perception on the outcomes of integration. Those that gave a negative response towards the outcome of integration were asked to substantiate their answer. Theses participants gave various responses. Their responses included people being generally negative to change and the lack of knowledge that people have towards homoeopathy. The excerpts from interviews that reflect these views were illustrated in Table 6.10.

Table 6.10: Excerpts linked to the outcome of integration

Sub-theme	Excerpt
Positive	*"It would be accepted after a long-term education and exposure. But you can't expect it to be accepted immediately because it is something. Not that it is something new but it something new but that is not taught in our current education system"* (Participant 4). *"I think they can accept it, provided they have more knowledge about it. Because you cannot promote something, you do not know. As long as they have information, because it will help them if patients have other alternative means of treating their ailments. Their workload would decrease through more staff/other type of practitioners being integrated into the public facilities"* (Participant 6). "*Well I think the first people that would welcome it would patients. Patients are willing to try anything when they are sick as long as it is credible. I think those are the first people. Doctors would warm up to it once they see the results but we have to deal with the attitude first and understand. Because the attitude would come from lack of understanding*" (Participant 9).
Negative	*"Like I said, there will be obviously resistance. If ever anything changes life and even in work, there's always resistance to change"* (Participant 12).

Sub-theme	Excerpt
Negative	*"I think whenever you introduced change, people always resist but you have to push for it to happen and you have to make sure they is no complications. Yes they might be resistance but eventually they will allow it to happen in the public sector - both service providers and patients. I do not think you will have a lot of resistance in terms of the patients. But people like the directors, doctors and all of them may create problems but eventually they will get around"* (Participant 5).
Uncertain	*"Well, I think things always start for a reason, continue for a different reason and collapse for different reasons. It is very seldom that stuff through its life cycle kick off for the same reason. So whether or not this whole integration is successful, will depend on how the integration is done in the first place. So If it is done properly in the same and transparency is there – where people know what they taking, and the side effects Where people know what is happening – people might accept it in the long run but then again, the question is who gets the profits, that's always going to be the question. But there's always – even if things changes in the country, there's always that political element. People's jobs and profits. We have to make tough decisions. I think there are just way too many external factors to just look at these things purely by themselves"* (Participant 3).

6.5 SUMMARY OF THE CHAPTER

This chapter presented the qualitative results of the study. The results of this phase indicated that the majority of participants had a lack of knowledge of what homoeopathy is. To overcome this, many participants were interested in receiving training on this field of medicine. Various perceptions were also shared on how homoeopathy could be integrated into the existing facilities. Although certain participants were uncertain about the outcome of the proposed integration, the majority stated that both the general public and allopathy healthcare professionals would eventually accept integration, over time. The next chapter will present an integration of the results received in

Phases 1 and 2. Subsequent to this, these results will be discussed and corroborated using various literature sources.

CHAPTER 7: INTEGRATION OF FINDINGS FROM PHASE 1 AND PHASE 2

7.1 INTRODUCTION

As mentioned in the previous chapters, a mixed methods study using the explanatory sequential design was conducted. This meant that the study had a quantitative and qualitative component. Phase one involved collecting data using quantitative methods and Phase two involved collecting data using qualitative methods. The previous chapters presented the results of each phase separately. This chapter will illustrate how the results of the two phases are connected.

7.2 TRIANGULATION

Creswell and Plano-Clark (2011: 68) describe triangulation as a method that encompasses the blending of both the qualitative and quantitative techniques to develop one complete understanding of a research phenomenon. There are four different types of triangulation:

a. Method triangulation, which refers to the use of multiple methods of data collection. To ensure method triangulation, this study employed an explanatory sequential design.
b. Investigator triangulation, which refers to the participation of two or more researchers in the same study to provide multiple views and conclusions.
c. Theory triangulation, which refers to the use of different theories when analysing and interpreting the data. To ensure theory triangulation, this study was guided by two theoretical frameworks.

Data source triangulation is a process in which data is collected from multiple sources including communities, individuals, groups or families in order to validate the data and to obtain different dimensions of the phenomenon

(Carter *et al*. 2014: 545). In this study, data source triangulation was employed.

Triangulation, for this study, was used to establish the link between Phase 1 and Phase 2. The results received in Phase 2 of the study, allowed the researcher to have more insight into the results collected in Phase 1. Triangulation was also adopted to establish the trustworthiness of the data collected. Through triangulation, the researcher was able to ascertain whether the views of the participants of that were seen as the pillar of the public healthcare system were aligned or at a disjuncture with the views of the management staff of the healthcare system. This allowed the researcher to gain a holistic view before attempting to develop a model for integrating homoeopathy into the public healthcare system. Table 7.1 illustrates how the quantitative component of the study informed the qualitative component. In keeping with the previous chapter, the triangulation of the results was demonstrated per themes and sub-themes identified.

Table 7.1: Triangulation of results obtained in Phase 1 and Phase 2

Theme	Quantitative results	Qualitative results
Knowledge on homoeopathy	45.2% of the participants revealed that they had some knowledge on homoeopathy. Of the 45.2%, the majority indicated they had little knowledge on homoeopathy and only a few had indicated they knew a lot about homoeopathy.	The analysis of excerpts on the knowledge that participants' had on homoeopathy supported the results of phase 1. Only a few participants indicated they knew what homoeopathy was. The participant's knowledge was linked to their previous personal and professional experience with homoeopathy.
Lack of knowledge on homoeopathy	The results of phase 1 revealed that 54.8% (n=97) of the participants have never heard of homoeopathy.	The analysis of excerpts in phase 2 also revealed that the vast majority of participants had a lack of knowledge on homoeopathy. The participants linked their lack of knowledge on the lack of support that homoeopathy receives from the government and it not being included in the current allopathy training.

Theme	Quantitative results	Qualitative results
Awareness campaigns	71.2% of the participants in phase 1, agreed that awareness campaigns need to be created to promote homoeopathy to the public (*P*<0.005). These campaigns were discussed as one of the enablers of integrating homoeopathy to the public healthcare system.	The majority of the participants in phase 2 also discussed awareness campaigns as an enabler for integration. The participants in this phase attributed their lack of knowledge and misconceptions on homoeopathy towards the lack of awareness campaigns that exists on homoeopathy.
Inclusion of homoeopathy in allopathy curriculum	The theme of the inclusion of homoeopathy into the allopathy curriculum was observed in phase one. 62.1 % of the participants agreed that this would be one of the enablers of integration. The majority of the participants in this phase were also in agreement with the fact that conferences that include both homoeopathy and allopathy professionals need to be created. The creation of an internship programme that will allow both allopathy and homoeopathy professionals to practice alongside each other was also discussed as an enabling factor as well as the altering of the homoeopathic curriculum to increase their knowledge about allopathic medicine should be looked at.	This theme was consistent amongst the majority of participants in phase two. This inclusion meant that the allopathy practitioners would become more familiar with natural therapies and in eventually become more tolerant of these natural therapies - an element of familiarization through frequent exposure.

Theme	Quantitative results	Qualitative results
Inter-referrals relationships	51% of the participants advised that they had never referred a patient to a homoeopath before. The balance of the participants of the study indicated that they had referred various cases to homoeopaths before. These included acute, chronic, palliative and preventative cases. This indicated that there was a referral system that existed between some homoeopathy and allopathy professionals.	In contrast, it was unanimously mentioned by all participants that they had never referred any patients to a homoeopath before. However, a few participants did mention that there had received referrals from homoeopaths. The lack of referrals to a homoeopath was attributed to the fact that allopathy practitioners had little or no knowledge on the scope of practice of a homoeopath and how homoeopathic medications work. Linked to the lack of referrals done to a homoeopath, some participants questioned the efficacy of homoeopathic medication and the appropriate time to refer to a homoeopath.
Cost-effectiveness of homoeopathic medicine	The majority (56.6%) of the participant agreed that homoeopathic medication are cost-effective.	Majority of the participants in this phased advised homoeopathic medication appear to be cost-effective and the public healthcare system would benefit from this. Some participants stated that allopathic medication is generally expensive and perhaps the inclusion of a natural modality will reduce it's over usage.

Theme	Quantitative results	Qualitative results
Usage of homoeopathy in various cases	The majority (M=3.71) of participants in phase 1 indicated that homoeopathic medicines would be useful if used in conjunction with allopathy. The different type of cases that allopathy professionals would refer to a homoeopath was not explored in this phase. However, the type of cases that allopathy practitioners have previously referred to a homoeopath, gave an indication of the type of cases they would prefer referring to a homoeopath. The majority (14%) of participants that had previously referred patients to homoeopaths indicated that they had mostly referred preventative cases.	The addition of homoeopathy as a natural modality for chronic cases was discussed by all participants in phase 2. Those that had the knowledge of what homoeopathy is even suggested that homoeopathy could potentially be useful in the acute, emergency and post-surgery cases.
Regulation of homoeopathic medication	The regulation of homoeopathic medicine was not a theme that was observed in phase 1. However, 61.1 % of the participants advised that laws that would be in the interest of both homoeopathy and allopathy professions need to be created as a step for successful integration.	In the analysis of excerpts of phase 2, it was noted that the regulation of homoeopathic medication and how they are used was a theme that was observed in the majority of participants. These participants felt that proper regulation, development of protocols and guidelines are key to a successful integration.
Outcomes of integration	The perceived outcome of integration was discussed in the first phase. It was gathered that the majority (77.3%) of the participants significantly were in agreement homoeopathy would be accepted by patients ($P<0.005$). Equally so, 61.5% of the participants that homoeopathy would be accepted by other healthcare providers.	The participants' feedback on the perceived outcomes of integration varied. Some participants perceived that they would be a positive outcome. These participants linked their perception to the fact that many patients of the public healthcare system already use natural medicine and consider seeking help from their facilities as the last option. In contrast, some participants perceived the outcome of integration to be negative. This was linked to the fact that people do not know what homoeopathy is.

7.3 SUMMARY OF THE CHAPTER

This section of the study presented the results of Phase 1 and 2. A comparison in the results received between the two phases was done. It was concluded that the majority of the themes observed in Phase 1 were aligned with the themes observed in Phase 2. This meant that the staff of the public healthcare system had views and perceptions that were possibly aligned with the views of their management staff. In both phases, the majority had little or no knowledge about homoeopathy. Some of the participants agreed with the fact that more awareness campaigns need to be created on homoeopathy or it needs to be included as a module in the training of allopathy practitioners. The lack of knowledge was also linked to the lack of an inter-referral relationship between homoeopaths and allopathic practitioners. Homoeopathic medication was a theme observed in both phases. Some Participants felt that these medications are cost-effective and this could possibly enable integration. In addition, some practitioners felt that the strict regulation of homoeopathic medication would also be an enabling factor. The usage of homoeopathy in various cases was also discussed and participants in both phases perceived that homoeopathy would be welcomed by both the general public and healthcare professionals. There were participants that disagreed with this notion. Their negative feedback was attributed to the lack of knowledge people had on homoeopathy.

The next chapter will discuss the themes identified in the both phase one and two of the study. This discussion will be reinforced by literature that either supports or negates the results of the study.

CHAPTER 8: DISCUSSION OF RESULTS

8.1 INTRODUCTION

This chapter will discuss the results obtained in Phase 1 and 2 of the study. The results will be discussed in relation to the literature presented in Chapter 2. Literature that was not included in Chapter 2 was also used to further discuss the results obtained. In keeping with the previous chapter, the discussion will be presented in the form of themes. Five themes were identified in the results. These themes consisted of knowledge on homoeopathy, awareness campaigns, education, referral system, homoeopathic medication and as well as the perceived outcomes of integration. Sub-themes were discussed under each theme.

8.2 KNOWLEDGE

There were a range of views that were identified under the theme of knowledge. Participants were either familiar with homoeopathy or they didn't know about it. With participants who were familiar with homoeopathy, a lot of misconceptions were demonstrated in their responses. These three patterns observed were identified as the sub-themes.

8.2.1 Knowledge on homoeopathy

Participants were questioned about their knowledge of homoeopathy, in both Phases of the study. In Phase 1, participants were questioned whether they knew what homoeopathy was. The same question was asked indirectly in Phase 2. Phase 2 allowed for the researcher to have an open conversation about participants' knowledge and awareness on homoeopathy. It was not surprising that the some of the participants had knowledge on homoeopathy. It was expected that some participants would have knowledge on this type of natural therapy. This expectation is as a result of the lengthy history that homoeopathy has in South Africa. According to Gower (2013: 1),

homoeopathy was introduced by European missionaries in 1820. With the initial usage of homoeopathy, there were no regulatory bodies. However, in 1972, the government introduced a regulatory body (Majola 2015: 9). Currently, the regulatory body that exists to monitor the usage of homoeopathy is the AHPCSA, established through the Act 63 of 1982. This regulatory body is accountable to the minister of health and its purpose is to *"promote and protect the health of the public; manage, administer and set policies relating to the professions registered with the AHPCSA; investigate complaints relating to the professional conduct of practitioners, interns and students; administer the registration of persons governed by the AHPCSA; and set guidelines for the education and training of prospective practitioners"* (AHPCSA 2018b: para. 2 line 1). The existence of this regulatory body (to date), is an indication that some parts of the South African population do use homoeopathy. The extent of usage could not be corroborated as no literature could be found on the number of people in South Africa that use homoeopathy.

Approximately 80% of the population in the African continent rely on traditional medicine for basic health needs (Mahomoodally 2013: 1). In addition to this, there is a growing number of homoeopathic practitioners scattered all over South Africa as well as an increased usage of natural therapies (Majola 2015: 22 and Prinsloo 2011: para.3 line 1). This means that the chances of one of the participant having knowledge on homoeopathy were possible. This assumption is also supported by the fact that social networks have an informative role to play in the utilisation of certain healthcare resources (Deri 2002: 106 and Devillanova 2008: 265).

In Phase 1, two percent of participants advised they had comprehensive knowledge on homoeopathy. The results of this Phase also revealed that the knowledge on homoeopathy was demographically related. Participants who had claimed to have extensive knowledge on homoeopathy were younger and chose English as their home language. No literature could be found to explain or corroborate this demographic relation, however the researcher postulated

that these findings could possibly be in keeping with the fact that homoeopathy is only available in the private healthcare system (Majola 2015: 12). It is estimated that 20% of the South African population use private healthcare resources (Sibiya 2009: 34). This meant that the majority of the South African population relied on the public resources for basic healthcare needs. Van Rensburg (2014: 26) states that the majority of the sub-population that utilises the public healthcare system weas black older South Africans-thus, the demographic relation.

The few participants that advised they had comprehensive knowledge on homoeopathy, in both Phases of the study, advised that their knowledge was through their personal experience with a homoeopath and some advised their knowledge was gained through their professional experience with homoeopathy. As aforementioned, the professional and personal experience that participants' had with homoeopathy was possibly linked to the number years homoeopathy has existed in South Africa as well as the fact that people within the African continent have a general inclination to use natural therapies for their ailments.

8.2.2 Lack of knowledge of homoeopathy

A lack of knowledge on homoeopathy was demonstrated among the majority of the participants in Phase 1 and 2 of the study. These results were not surprising to the researcher as results done by previous homoeopathy graduates had similar findings (de Villiers' 2006: ii; Lamula 2010: iii; Macquet 2007: ii; Harripershad 2009: iii; Ngobese 2018: 23 and Smillie 2010:8). In Phase 1, it was revealed that 54.8% of participants didn't know what homoeopathy is. These results are in keeping with the results of Phase 2, as the majority of the participants in this Phase also had a lack of knowledge on homoeopathy. These results were expected, as South Africa is not among the countries that popularly practice homoeopathy (Prasad 2007: 1679). In addition to this, homoeopathy is only available to individuals that make use of the private sector resources. It is a known fact that the resources in the

private sector are not used by the majority of the South African population (Kautzky and Tollmen 2008: 24). In addition to this, efforts made to make homoeopathy available to the public at large have an insignificant effect as the outreach programmes that have been established by various tertiary institutions are restricted to the small communities that are targeted by these institutions. Albeit certain members of the community receiving treatment from these outreach programmes, recent studies done by Khumalo (2015: iii) and Ngobese (2018:53) revealed that patients attending these clinics still had a lack of knowledge on homoeopathy. This indicated to the researcher that there is still a huge gap that needs to be filled regarding information on homoeopathy being readily available to everyone.

In Phase 2 of the study, there was room for a conversation regarding why certain participants had a lack of knowledge on homoeopathy. Some linked their lack of knowledge to the non-existent popularity of homoeopathy in their area. As indicated previously, South Africa is not among the countries that popularly practice homoeopathy (Prasad 2007: 1679). In addition to this, a market survey conducted by the Health Products Association of South Africa between 2001 and 2003 indicated that out of the R192 billion spent on natural health care products in 2003, 61 billion was used on homoeopathy medication. This accounted for just 5% of sales and supported the fact that homoeopathy is not one of the natural therapies that are popularly used in South Africa.

Participants also linked their lack of knowledge on the minimal efforts put on marketing homoeopathy to the public. According to the AHPCSA, Act 62 of 1983 states that a homoeopathic practitioner is not allowed to advertise. However, a sign to display their services (including the practitioner's name, profession, registered qualification, contact details, hours of consultation, AHPCSA registration number, BHF practice number and Value-Added Tax (VAT) registration if applicable) may be hung outside their practice (South African Government, 1982). Marketing of unknown healthcare services is beneficial to both the patient and doctor (Sarafis *et al.* 2009: 115). However,

this was not consistent with findings of a study done by Boshoff and du Plessis (1992: 13) and Kidd 2011: 67). It was found that practitioners felt that the inability to advertise did not hinder their practice, but simply incurred unnecessary costs (Boshoff and du Plessis (1992: 13) and Kidd 2011: 67).

Participants also linked their lack of knowledge to the low numbers of registered homoeopathic practitioners practicing within the healthcare system as a whole. This meant that the South African population had negligible exposure to homoeopathy. Currently, there are approximately 600 homoeopathic practitioners registered with the AHPCSA. This amount was said to be small, compared to the number of allopathy practitioners that exist in the public healthcare system.

Participants also linked their lack of knowledge to the fact that homoeopathy is not mentioned at all in their years of training. The researcher was unable to find literature that validates homoeopathy being taught in any medical or nursing school in South Africa. Medical schools play an important role in reducing the segregation of medical students from CAM practitioners (Thorvaldsen 2007: 34). Therefore, it would make sense for CAM training to be included at medical school as well as nursing institutions. The addition of such changes would allow the allopathy professionals to have an understanding of all the health services their patients may be accessing. In turn, this would allow allopathy professionals to assess and respond appropriately to any possible interactions between various treatments (Brundin-Mather, Avinashi, and Verhoef 2005: 53).

Albeit, participants demonstrated a lack of knowledge on homoeopathy in both Phase 1 and 2, none of them were resistant in wanting to know more about this type of natural therapy. Participants demonstrated an interest in homoeopathy through their request for pamphlets on this type of natural therapy as well as research articles. This finding is in keeping with a study done by Thorvaldsen (2007: 3). Sixty-eight percent of the respondents in her study showed interest in learning more about homoeopathy, while ninety-two

percent of these respondents indicated the importance for a medical doctor to know more about alternative medicine (Thorvaldsen 2007: 64). Nurses and medical practitioners are among the group of several professionals that usually widespread interest in natural therapies (Leach 2004: 13).

8.2.3 Misconceptions

It was observed by the researcher that misconceptions exist as a result of a lack of knowledge. This was demonstrated in participants who said they knew about homoeopathy but when asked to substantiate their response, they shared views that were misconstrued. This was in keeping with the fact that many members of the public are still confused on what homoeopathy is (Prinsloo 2000 para. 1 line 1). In an era where there is an effective mass communication through various media platforms and technological advancement, it was surprising that some of the participants misunderstood what homoeopathy was. This supported the researcher's theory that there was still a huge gap that needed to be filled regarding accessing information on homoeopathy.

Direct questions about the misconceptions of homoeopathy were asked in Phase 1. On the other hand, no direct questions were asked about misconception in Phase 2. When participants were corrected about their misunderstandings, none of them showed resistance. They showed interest as they requested more information to be given to them during the data collection phase. This finding was in keeping with the results of Thorvaldsen's (2007: ii) study. Sixty-eight percent of the respondents in her study showed interest in learning more about homoeopathy (Thorvaldsen 2007: ii).

Misconceptions, in both phases of the study were definitely seen as a barrier of integration. To address these misconceptions participants advised that various marketing campaigns need to be done. Interestingly, the same findings were identified when a study was conducted by Pillay (2013: 148). A need for an education programme for healthcare professionals especially

those that are working in Primary Health Care was identified (Pillay 2013: 148).

8.3 AWARENESS CAMPAGINS

Awareness campaigns were a theme that was directly linked to the sub-theme of misconceptions. It was unanimously mentioned by all participants that awareness campaigns play a pivotal role in getting people to know about homoeopathy. This theme was consistent in both Phase 1 and 2. This meant that the opinions of participants in both Phases were in line with each other. According to the participants of the study, giving talks about homoeopathy to various groups and writing articles are deemed necessary to grow public awareness on homoeopathy. These sentiments were echoed by the participants of a study conducted by Solomon (2014: 78). Participants of this study felt that both the general public and healthcare professionals would benefit from awareness campaigns before integration is considered (Solomon (2014: 78). Awareness campaigns were seen as an enabling factor for integration by the participants of this study. The type of awareness campaigns that need to be done was not discussed in either Phase. This appeared to be a topic for different study.

"The government cannot integrate something the people don't know of", Participant 6. The results of the study were evident in describing the lack of knowledge on homoeopathy that people had. The results also reflected that there clearly is a need for provision of information on homoeopathy. Educating the public on their choices and available providers within the community promotes health-seeking behaviour and removes barriers to utilisation (Ensor and Cooper 2004: 69). In addition to this, Participant 3 stated, "*Medical practitioners would warm up much easier if awareness campaigns promoting homoeopathy existed*".

Participants in both Phase 1 and 2 indicated that awareness campaigns should be used as a tool to drive away misconceptions that exist about homoeopathy. Various bad press and negative stereotypes about homoeopathy exist in several media platforms. Ottermann (2010: para.1 line 1) alludes that the success of homoeopathy has allowed it to be discredited by its oppositions. The different types of misconceptions that were discussed by the participants included homoeopathy not being regulated and no scientific evidence being available to the general public on homoeopathic medication. Participants also mentioned the fact that homoeopathy is the same as other types of traditional medicine, while others mentioned homoeopathic medication are placebo. The researcher attempted to correct these misconceptions mentioned by the participants, without going into detail regarding the efficacy of homoeopathic medication, as this was not one of the objectives of the study. Albeit the numerous misconceptions that exist on homoeopathy, it was interesting to note that there has been an increase in the usage of homoeopathy worldwide (Naicker 2008: iii). Naicker (2008:5) suggests that this increased usage is probably linked to people being disillusioned or being disgruntled by conventional medicine.

Views shared by participants on awareness campaigns suggest that certain members of the public would actually welcome awareness campaigns on homoeopathy. These findings are keeping with the results of numerous studies conducted by previous homoeopathy graduates (de Villiers 2006: ii; Harripershad 2009: V and Macquet 2007: iii). Awareness campaigns would not only promote the growth of the profession but would be advantageous to South Africa as a whole because homoeopathy has a potential to assist with some of the challenges confronting the healthcare system (Smillie 2010: 8).

8.4 EDUCATION

The theme of education was consistent in both Phases 1 and 2. This theme is regarding medical and nursing institutions having a proper in-depth training about homoeopathy as well as other types of natural therapies. Specific questions were asked about the inclusion of homoeopathy modules in the allopathy training institutions in Phase 1 of the study. The inclusion of homoeopathic modules in both medical training institutions was seen as an enabling factor by the majority of participants in Phase 1. No direct questions were asked in Phase 2 about homoeopathy being included in medical training institutions but participants voluntarily stated that they would welcome this idea. As aforementioned, at present, no specific medical school in South Africa goes into discussing homoeopathy in detail and its mechanism.

On the topic of training, it is interesting to note that the homoeopathic courses offered at UJ and DUT make provision for their students to get training on conventional medicine. Courses offered in these training institutions were constructed based on the medical programme available in South Africa (Majola 2015: 11). Ross (cited in Majola 2015: 9), mentions that the homoeopathic programme at DUT incorporates an intensive study of allopathic medical sciences in the first three years of training and student often focus on homoeopathic training in the last two years of study. He further stated that this allowed for well-versed homoeopathic practitioners to be produced. On the other hand, prior to 2013, if medical personnel wanted to practice homoeopathy, there were courses available for allopathic practitioners through the South African Faculty of homoeopathy (South African Faculty of homoeopathy 2012: para 1. Line 1). Based on the fact that the homoeopathic course is similar to the medical school curriculum, medical doctors who wanted to register and practice as homoeopaths could obtain a postgraduate diploma through the South African Faculty of homoeopathy (South African Faculty of homoeopathy 2012: para. 1 line 5). This course was clearly not well marketed as none of the participants knew about it. However, this institution could have possibly been instrumental in the development of an

appropriate homoeopathic module that can be included in allopathy training institutions. In 2012, this institution notified the AHPCSA of its closure and no intake of new students took place since 2013 (HSA 2019b: para. 8 line 2)

Evidence suggests that the lack of training on CAM in medical training institutions exist not only in South Africa but in the rest of the world as well (Thorvaldsen 2007: 33). Baugniet, Boon and Ostbye (2000: 179), states that perhaps the skepticism and lack of knowledge that exist among allopathy professionals is as a result of this deficiency. Training in CAM should not necessarily overshadow the existing curriculum but merely just allow allopathy practitioners to have an understanding of all healthcare services being utilised by their patients (Brundin-Mather, Avinashi, and Verhoef 2005: 54).

The interest shown by the participants of the study regarding receiving training on homoeopathy are congruent with the interest shown by medical students in certain countries. Institutions such as the University of Southampton have created a module in CAM for their medical students in their third year. Such steps were influenced by the interest that was shown by their students, in familiarizing themselves with natural therapies (Owen and Lewith 2001: 74). The inclusion of CAM in the medical schools in the USA increased from 46 out of 125 schools in the periods of 1996-1997 and up 75 schools in 1998-1999. Initially training on CAM in the educational setting was originally defined as unconventional treatment modalities (Owen and Lewith 2001: 74). This has now changed as it is seen as integrative medicine and holistic approach to healthcare as it takes into account alternative healing systems (Lie and Broker 2004: 165).

The theme about education was mentioned multiple times by certain participants. This allowed the researcher to believe that this is a critical component for integration. When this pattern was observed and analysed, it made sense as having one source distributing knowledge on homoeopathy (instead of having multiple media platforms sharing different things) could

possibly could possibly counter the misconceptions that exist on this natural therapy.

Thorvaldsen (2007: 33) suggests that the logistical challenges that may present themselves by incorporating CAM training in medical school programmes include establishing administration approval, finding time within the existing curriculum, validating teaching resources and finding knowledgeable instructors. These barriers are not insurmountable and they merely suggest that if these logistical challenges are not dealt with accordingly, they may present as a barrier for integration.

On the other hand, it was interesting to note that some participants shared their views on the creation of a joint internship. Participants were adamant that if allopathy practitioners were exposed at an earlier stage in the career to other types of natural therapies, it would be easier for them to develop tolerance and understanding of other methods of treating a patient. Most medical schools in South Africa offer a 6-year course leading to the degrees of Bachelor of Medicine and Bachelor of Surgery (MBChB). This is usually then followed by 2 years of internship and one-year community service (University of KwaZulu Natal 2019: 22). On the other hand, homoeopathic training consists of a 5-year training course that incorporates both theory and practical training. There is no internship programme that is currently enforced. Therefore, creation of a joint internship programme would be an interesting venture. This could possibly mean that both homoeopathic and allopathic need to be revamped in order for them to be aligned with each other. Owen and Lewith (2001: 74) advocate for the integration of CAM training in allopathy institution as this would create an opportunity to bring together the strengths and weaknesses inherent in different systems of health care.

8.5 REFERRAL SYSTEM

The majority of participants spoke about the lack of inter-referral relationship between homoeopaths and allopathy practitioners. Direct and indirect questions were asked about this theme. In Phase 1, the majority of participants felt that an inter-referral relationship between homoeopaths and allopathy practitioners would be an enabler for integration. In Phase 2 of the study, when participants were asked if they had any professional experience with homoeopathy, the majority gave a negative response. To be precise, it was unanimously stated by all participants that they had never referred a patient to a homoeopath before. However, two out of the twelve participants stated that they had received referrals from a homoeopath. The results received from both Phases were not shocking because the majority of participants in (in both Phases) didn't know what homoeopathy is. Additionally, those that had some knowledge about homoeopathy demonstrated a few misunderstandings. The extent of the type of inter-referral relationship that should be developed was not discussed by participants in both phases.

With all the positive perceptions shared about the development of an inter-referral relationship, it was interesting to note that some negative aspects were shared about this theme. These negative aspects included participants stating that an inter-referral relationship cannot be formed as a lot of allopathy practitioners would have to get in-depth training on homoeopathy and its exact mechanism.

In Phase 1, participants were asked about the type of setting they have worked in with a homoeopath. The majority stated that they had worked with homoeopaths in a multi-disciplinary setting. These results were somehow related to that of Phase 2 as the majority of participants stated that if integration was to occur, they would prefer working with a homoeopath in a multi-disciplinary setting as this would allow for the development of a conducive, inter-referral relationship.

A referral is defined as a process where a healthcare worker, having insufficient resources to manage a clinical condition, seeks assistance of a better resourced facility or provider at the same or higher level (WHO n.d: 1). The WHO (n.d: 1) described four key reasons of why a provider would refer. Healthcare workers or facilities usually initiate a referral:

- To seek expert opinion regarding the client;
- To seek additional or different services for the client;
- To seek admission and management of the client;
- To seek use of diagnostic and therapeutic tools.

There are different types of referral systems used in different countries (WHO n.d: 3). The referral system utilised in the public healthcare system of South Africa is facility specific. As highlighted in Chapter 4, there are four levels of care within the public facilities. When a facility in one level of care is unable to treat a patient, there would usually escalate that patient's case to the next level (KZN Department of Health 2017c: para. 1 line 1). Although there are different types of referral systems that exist in the world, the WHO argues that there are seven standard components of a referral system. These components include a) service providers and the quality of care they render, b) performance expectations and involvement of organisations, c) initiating facility, d) referral practicalities, e) receiving facility, f) supervision and g) capacity building as well as continuous quality improvement (WHO n.d: 2). If the components of the referral system exist accordingly, then that system is deemed effective. The WHO suggests that an effective referral system will result in clients receiving optimal care, the appropriate usage hospital facilities optimally and cost-effectively, patients accessing specialist care in a timely way as well as the utilisation of primary healthcare services (WHO n.d: 2). No literature could be found on a referral system that can potentially exist between homoeopaths and allopathic practitioners. The guidelines provided by the WHO could be the necessary building blocks to develop one.

When the participants of the study advised that they had no professional experience with homoeopathy, the researcher enquired why this was so.

Apart from the lack of knowledge they had, participants stated that there are many reasons why they have not and would not refer patients to a homoeopath. The lack of open communication that exists between the two professions was one of the reasons. These findings are somewhat related to the findings of a study done by Bableta kis (2006: 174), Kidd (2011: ii) and Majola (2015: iii). Unlike the participants of the current study, the participants of the studies conducted by Bableta kis (2006: 174); Kidd (2011: ii) and Majola (2015: iii) were homoeopaths and it was interesting to note that the same outcomes were established. Homoeopaths who participated in these studies observed a huge communication gap that exists between them and allopathy practitioners. The findings of these studies, established that this gap is also influenced by Act 56 of 1974 enforced by the HPCSA. Rule 9(1) of the Health Professions Act, 56 of 1974, restricts free communication between CAM professionals and allopathic practitioners (Republic of South Africa 2004: 1). This Act has caused unnecessary restriction and has led to homoeopaths further isolating themselves from allopathic professionals (Bableta kis 2006: 175) and Sweidan (2007: 175). Overcoming the communication gap that exists between homoeopathic and allopathic practitioners could possibly build a solid foundation for integration (Frenkel and Borkan 2003: 324-332).

Negative stereotypes about the homoeopathy profession were also mentioned as a barrier of referral. These negative stereotypes were not discussed by the participants in detail but it was assumed by the researcher that the participants were referring to the negative press that exist on the efficacy of homoeopathy. Other barriers of referrals included allopathy practitioners not knowing when to reefer to homoeopaths. This was in keeping with the theme of knowledge as the majority of participants indicated that they had a lack of knowledge on homoeopathy. These findings are also in keeping with the conclusion Naicker (2008: 65) arrived at. When a perception study was done on medical specialist regarding their interaction with homoeopathy, it was established by Naicker that participants in her study that participants who had positive views about homoeopathy and were more likely to refer if they had higher knowledge of this type of natural therapy (Naicker 2008: 65).

Participants who had little knowledge about homoeopathy and were very uncomfortable with it and there were no referrals from this group (Naicker 2008: 65).

A combination of homoeopathic and allopathic services could potentially establish an integrated medical system where patient's needs for a '*one-stop shop*' are fulfilled (Mercer and Reiley 2004: 17). Having other modalities available within the public healthcare system could also potentially address the variety healthcare needs of the patients that are not resolved by conventional medicine. This could overall benefit patients as they would have access to optimal health benefits (Bhardwaj 1980: 209; Bhishop, Yardley and Lewith 2008: 1700). Access to different healthcare modalities has been found to have strong links to the reduction disease. Such could benefit the healthcare system as a whole in South Africa.

One of the biggest barriers of the development of a referral system among homoeopaths and allopaths is the contradicting '*schools of thought'* (Majola 2015: 70). Interestingly, none of the participants mentioned this. This was unsurprising as the majority of the participants had a lack of knowledge on homoeopathy. As mentioned in Chapter 2, the schools of thought for both homoeopathy and allopathy profession were developed by the same individual (Hippocrates). Conventional medicine overshadowing natural therapies such as homoeopathy has possibly allowed people to believe that it is more superior. However, the two professions should not exist in isolation. In fact, healthcare issues experienced around the world call for both these professions to work hand in hand (Malhi, Ram and Saina 2013: 32). Hence, a necessary condition, prior to integration taking place, would be for all the barriers of referring to be addressed accordingly.

8.6 HOMOEOPATHIC MEDICATION

The topic of homoeopathic medication was discussed in both in Phase 1 and 2. Positive attributes were discussed about homoeopathic medication in Phase 1. In Phase 2, both positive and negative attributes of homoeopathic medication emerged. Participants were asked in Phase 1 whether the benefits of using homoeopathic medication could be an enabling factor. The majority agreed with this statement. No specific questions were asked about homoeopathic medication in Phase 2. However, it was highlighted by several participants that the proper mechanism of how homoeopathic medication works needs to be communicated to both the public and health care professionals. This was unsurprising, as the majority of participants had a lack of knowledge on homoeopathy. These participants believed that this would results in people possibly warming up to homoeopathy and dispel some of the misconceptions that exist on it.

The positive attributes that were discussed about homoeopathic medication included their cost-effectiveness. Participants also stated that it could attend to chronic, acute and palliative cases that have been failed by conventional medicine. The negative attributes discussed, included the misconceptions people had about homoeopathic medication. Many participants assumed that homoeopathic medication were not regulated or tested. These participants advised that these negative attributes need to be dealt with first prior to steps of integration can be considered. The negative and positive attributes raised by the participants were discussed as sub-themes of this theme.

8.6.1 Cost-effectiveness of homoeopathic medication

The majority of participants in both Phases 1 and 2 believe the cost-effectiveness of homoeopathic medication and other natural therapies would benefit the public healthcare system. There are various reasons why homoeopathic medication and other natural therapies are viewed as cost-effective. One of these reasons includes the fact that these medications can be made from any natural substances under certain guidelines (Getoff 2013:

84). There have been countries which have implemented homoeopathy into their public healthcare system and have reaped the benefits of its cost-effectiveness (Mclntyre and Gibson 2002: 1640). These include countries such as Italy, the UK and Cuba.

A retrospective study was done on patients who attended the Campo di Marte hospital in Tuscany, Italy. This study was done to evaluate the cost of homoeopathic medication versus conventional therapy in patients who had chronic respiratory diseases. The study was conducted between 1998 and 2003. It was concluded that the homoeopathic treatment received for respiratory diseases was associated with a reduction in the use of conventional medicine (Rossi *et al.* 2009: 3). In addition to this, patients' recurrent respiratory infections were observed to have steadily reduced. These were considered to be positive results considering the fact that conventional healthcare cost tend to rise (Bornhöft and Matthiessen 2011: 163).

The cost-effectiveness of homoeopathy has been a topic of discussion in many countries who have integrated homoeopathy into their public sector (Bornhöft and Matthiessen 2011: 163). When cost minimisation analysis of homoeopathy and conventional medicine was done, the data used suggested a potential cost saving with the use of homoeopathy (Rossi *et al.* 2009: 4). In contrast, authors such as Becker-Witt *et al.* (2003: 121) initially observed a higher direct cost linked to the usage of homoeopathy. However, a reduction in the over usage of healthcare resources such as laboratory and other technical services was also seen.

In the UK, homoeopathy has been partially integrated into their public sector (Roberts 2008: 48). When an observational study was done to evaluate the effectiveness of its inclusion in the healthcare system, it was concluded that homoeopathy had positive health changes on a large proportion of patients presenting with chronic conditions (Roberts 2008: 49 and Spence, Thompson and Barron 2005: 797). Such positive findings are important to consider if a

country aims to make its healthcare system sustainable (Spence, Thompson and Barron 2005: 795).

The inclusion of alternative medicine therapies into the healthcare system of Cuba was motivated by the economic constraints as the health sector suffered greatly after the disintegration of the USSR in 1991 (Nayeri and Lopez-Pardo 2005: 797). This integration contributed on ensuring the development of a sustainable health care system as well as the improvement of healthcare standards of the locals (Rossi *et al.* 2010: 280).

South Africa allocates billions to its public healthcare system yet this is still not enough resolve some of the issues that exist in it and service all of its users (Van Rensburg 2014: 26). Whilst the public sector experiences deficiencies, evidence suggest that the private sector has grown, allowing for these services that exist in this sector to be a commodity (Harris *et al.* 2011: 107). With the benefit of cost-effectiveness of homoeopathic medication, it would make sense for the government to at least consider cost-effective alternatives to resolving some of the issues currently experienced in the public facilities.

8.6.2 Homoeopathy used in various vases

In light of the fact that, the majority of participants had a lack of knowledge on homoeopathy, it was interesting to note that perceptions regarding how homoeopathic medication can assist in various medical cases were shared. The majority of the participants spoke about how homoeopathy can assist with chronic diseases that plague the healthcare system. Only a few participants shared their views on how homoeopathic medication can assist acute and emergency medical cases. These findings add to the body of evidence that exists on how effective homoeopathic medication has been with various medical cases.

Numerous patients suffer from conditions (such as eczema and cancer) that are difficult to treat or remain untreatable by conventional medicine worldwide

(Yu-Hin 2011:184). Developed countries such as France and Germany have also started depicting trends of using homoeopathy and other natural therapies for palliative purposes (WHO 2002: para. 4 line 1).
Cancer has been said to be a major cause of morbidity and mortality in many low-income countries (Mathew *et al.* 2017:1485). A study done by Moodley (2008: iii) on the effects a homoeopathic similimum has on cancer was able to demonstrate that all the participants that took part in the study had reported less severe side-effect after taking a homoeopathic similimum. Findings of Moodley's study reinforce the suggestion made by a few research participants regarding homoeopathy being used for palliative purposes.

A 12 month-study conducted by Keil (2006: 15) on homoeopathic treatment versus conventional treatment of children with eczema was done. The study was done to compare the quality of life and eczema signs and symptoms with the different medications patients were treated with. Children between the ages of 1-16 were recruited from primary care practices. Outcomes were measures using various numerical scales and it was concluded a better quality of life was observed with conventional medicine. Similar results were obtained in studies done by Witt *et al*. (2009: 329) and Ernst (2012: 1170).

A 6-year study done on homoeopathic treatment for diseases was done at a university outpatient facility. The aim of the study was to observe the changes that occurred with routine homoeopathic treatment. Homoeopathic medication offered improvement in a range of chronic and recurring pathologies to a substantial proportion of the patients that were included in the study. (Spence, Thompson and Barron 2005: 795).

Antibiotic illnesses have been reported worldwide. Viksveen (2003: 99) conducted study that examined how homoeopathy could assist with the antibiotic resistance displayed by certain microorganisms. Viksveen (2003: 99) it was concluded that homoeopathy had a role to play in fighting antibiotic resistance as it was effective in the treatment of upper respiratory tract

infections in children, which often lead to the inappropriate prescription of antibiotics.

8.6.3 Regulation of homoeopathic medication

The majority of participants mentioned that before integration is to occur, scientific evidence about homoeopathic medication need to be presented to all stakeholders. Participants also mentioned that homoeopathic medication needs to be strictly regulated and monitored prior to their integration into the public facilities as well as passed by the Medical Control Council. In Chapter 2, the process of homoeopathic medication was highlighted. It was mentioned that homoeopathic medication can be made from any natural substance and the crude form of these natural substances are diluted and energized using standards stipulated in the homoeopathic pharmacopeia (Bloch and Lewis 2003: 28). New homoeopathic medication undergoes the same process. However, to determine its therapeutic effect, a proving is conducted (Ross 2011: xxxii). Once the therapeutic effect of a new substance is determined, this is recorded onto the materia medica and repertory (Swayne 2000: 132-133). A repertory and materia medica are used by all homoeopaths to facilitate prescribing the correct medication to their patients (Lilley 2008 cited in Smillie 2010: 10). With this information available to everyone, through various platforms, there still exists scepticism over homoeopathic medications and their efficacy. Anecdotal evidence suggests that this is because of homoeopathic medication not being strictly monitored and scheduled in the same effect as conventional medicine. The different regulatory frameworks (for the production of homoeopathic medication) that exist in different countries could possibly contribute to this as well.

Under the Federal Food, Drug, and Cosmetic Act, homoeopathic drug products should be subjected to the drug requirements for approval (U.S. FDA 2017: para. 5 line 2). However, the prescription of drug products labelled as homoeopathic medicine has been distributed without U.S. FDA approval since 1988. On December 18, 2017, U.S. FDA proposed a new, risk-based

enforcement approach to monitor drug products labelled as homoeopathic. Drug products that are subjected to this protocol are homoeopathic products with "*reported safety concerns, products that contain or purport to contain ingredients associated with potentially significant safety concerns, products for routes of administration other than oral and topical, products intended to be used for the prevention or treatment of serious and/or life, threatening diseases and conditions, products for vulnerable populations and products deemed adulterated under section 501 of the FD&C Act" (U.S. FDA 2017: para 8. Line 5).* No evidence could be found that validates any homoeopathic medication is regulated being approved by the U.S. FDA and included in the essential drug list of South Africa. To remove the scepticism over homoeopathic medication, it was suggested by one of the participants that perhaps this should be considered.

8.7 PERCEIVED OUTCOMES FOR INTEGRATION

Participants in both phases were asked direct questions about their perceived outcomes of integration. In Phase 1, more than sixty percent of the participants thought that homoeopathy would be welcomed by both public and healthcare professions. In Phase 2, when participants were asked to share their views on this topic, three sub-themes emerged in their responses. Some participants had negative perceptions about the outcomes of integration. Some shared positive views while others shared views of uncertainty.

8.7.1 Negative perceived outcomes for integration

A few participants had negative perceptions regarding the outcome of integration. These participants were asked to elaborate on their responses. Their negative perceptions were based on the current state that our country is in and current status of homoeopathy in South Africa. These participants also advised that, if things were different, they would have had a more positive perception. Issues highlighted included the lack of resources within the public facilities. More than 42% of the government's expenditure goes towards servicing the public health sector (Sibiya 2009: 37). With billions being spent

on this sector, evidence suggests that it is still not able to cater to its users (Kaytzky and Tollmen 2008: 24). Eighty percent of the South African population relies on the public sector (Sibiya 2009: 37). Therefore, the perceptions shared by the participants regarding the lack of resources being available in the public healthcare system corresponds with the evidence that suggests the public healthcare system cannot cater to all of its users. Benefits that come with the integration of homoeopathy could possibly assist alleviate some of the burdens that exist in the public healthcare system (Solomon 2014: 4; Rossi *et al.* 2010: 282; Roberts 2008: 49).

The issue of the lack of resources that exists in the public sector is linked to the insufficiency of staff as well as the shortage of medication. This issue is made worse by the numerous users that utilise the public sector as well the double burden of communicable and non-communicable diseases (Van Rensburg 2014: 26). Of most concern to the researcher is the insufficiency of staff and shortage of medication as this can be countered through the addition of healthcare personnel that are willing to assist in the public sector as well as the addition of a cost-effective modality.

Though homoeopathy is not formally included in the public healthcare in South Africa, institutions such as UJ and DUT have tried to make it available to the public at large through outreach programmes. Most of these outreach programmes have been evaluated by previous homoeopathy graduates. Positives results, motivating for the integration of homoeopathy into the public healthcare system in South Africa were established (Khumalo 2015: iii; Love 2016: V). Outreach programmes on making homoeopathy available to the public at large stretch beyond South Africa. Some of the countries that have these initiatives include Senegal, Ivory Coast, Nigeria, Botswana and Ghana (Grimes 2009: para. 1 line 5 and Smillie 2010:42). The majority of patients attending these initiatives have stated they preferred being treated homoeopathically at these projects as they particularly appreciate the holistic approach used (Bingley *et al.* 2014: 36). In addition, the homoeopathic medication used in these initiatives has assisted many patients in recovering

from opportunistic infections (Bingley *et al.* 2014: 36). The most significant outcomes of these initiatives are that more than 90% of the patients showed improvement in their health, the homoeopathic therapy provided were cost-effective, easy administrate, no resistance was developed through the utilisation of homoeopathic medication, no side-effects were reported and some medication had a rapid effect (ARF 2008: 7). With the overall satisfactory progress seen in these initiatives, the researcher postulates that integration could potentially have the same desired results. Thus, this would attend to the concern on raised by the participants regarding the lack of resources.

Participants also indicated that their negative perceived outcome was linked to the lack of knowledge people had on homoeopathy and the bad press that exist on homoeopathy regarding its efficacy. These attributes were discussed in the preceding themes and it would make sense to counter these points through the creation of awareness campaigns.

8.7.2 Uncertain perceived outcomes of integration

Linked to the previous sub-theme, some participants were just uncertain on what the outcome of integration could be. These participants stated that certain circumstances would need to change before they could answer this question and based on these changes, the outcome of integration could possibly be predicted. These circumstances included the public and healthcare professionals being introduced to homoeopathy. Participants advised that it would be difficult to predict whether these two groups would welcome homoeopathy or be resistant to it as they are used to conventional medicine. These statements contradict the fact that they have been increased usage of homoeopathy and other natural therapies because patients are being disillusioned conventional medicine and find it satisfying to seek assistance from CAM practitioners (Erwin, Marks and Couchman 2013: 8). In addition, it has been said that the use of natural therapies resonates with

people as natural substances are viewed as less harmful to the body and environment (Clark 2000 cited in Erwin, Marks and Couchman 2013: 8).

8.7.3 Positive perceived outcomes for integration

The majority of participants in Phase 2 shared positives views about their perceived outcome for integration. Participants voluntarily elaborated on their positive responses. These participants believed that homoeopathy could be the answer to some of the issues experienced in the public sector. Issues mentioned by these participants included the insufficiency of staff within the public sector. These results are in keeping with the results obtained by a study conducted by Majola (2015: 22). The majority of the participants, who were homoeopaths, showed interest in willing to assist in the public sector (Majola 2015: 89). The willingness to assist was surprising as the majority of healthcare professionals prefer working in the private sector once they have graduated (Majola 2015: 18; Van Rengburg 2014).

Participants also mentioned the fact that integration could possibly assist with the financial constraints (as the medication are cost-effective) as well as the multiple cases of polypharmacy that have been observed. Polyphamarcy is defined as the prescription of several drugs for chronic ailments and has been identified as a problematic issue within the healthcare sector (Sinnott and Bradley 2015: 29). Polypharmacy have been said to reduce a good clinical outcome, quality and life expectancy of patients, increased adverse drug events which may require hospitalisation and even death (Molokhia and Majeed 2017: 70). With the rise of polypharmacy, Fisher and Jacobs (2013: 4) state that the addition of natural modalities is slowly becoming a necessity instead of a luxury.

8.8 SUMMARY OF THE CHAPTER

This chapter discussed the results of the study. It has been established that the resolution of many issues precedes the integration of homoeopathy into the public healthcare system. These issues were discussed through the

themes that emerged. Both negative and positive attributes of each theme were discussed. Links between each theme were identified and this provided further insight and understanding into the phenomenon of integration. Through the analysis of the themes of the study using local and international literature, it is evident that integration cannot occur as an isolated entity. The next chapter will present a model developed for the integration of homoeopathy into the public healthcare system.

CHAPTER 9

A MODEL FOR THE INTEGRATION OF HOMOEOPATHY INTO THE PUBLIC HEALTHCARE SYSTEM IN THE PROVINCE OF KWAZULU-NATAL, SOUTH AFRICA

9.1 INTRODUCTION

The purpose of this study was to engage with various stakeholders regarding their thoughts and views on integrating homoeopathy into the public healthcare system. Currently, within the South African context, no models exist to facilitate the integration of homoeopathy and other types of natural therapies into the public healthcare system. Although there are numerous models that exist to integrate certain healthcare services into the public healthcare system, these models are well suited for allopathic practitioners. It was clear in the results of the study that integration indeed means different things to different people and it may occur in various forms. This was consistent with the definition provided by the Waddington and Egger (2008: 1).

The purpose of this Chapter is to illustrate a model that has been created to integrate homoeopathy into the public healthcare system. This chapter will also demonstrate how the theoretical framework aided in shaping the results of the study, in order to develop this model. The purpose of the model will be discussed in this chapter, its key concepts and the events that are to take place in order for integration to occur successfully.

Various definitions exist for the word model. A definition that was most relevant to the study was as follows: a graphical representation, that will depict the manner in which health services can be delivered to a population (Agency for Clinical Innovation 2013: 3). The Agency for Clinical Innovation (2013: 4) state that, when developing a model, its ultimate results should bring

about improvement in service delivery. In the case of this study, the healthcare services in question would be homoeopathy. The benefits of utilising this type of therapy within the public sector include the addition of healthcare providers and the addition of a cost-effective way of treating as well as preventing illnesses. Chinn and Kramer (2011: 175) also provide a similar definition to the word model. Adding to the above definition, Chinn and Kramer define the word model as a process of structuring theory and concepts from research (Chinn and Kramer 2011: 185). As a guide to developing the model, PATH's theoretical framework was used in the study. PATH's framework states that integration of healthcare services may occur at four different levels within the healthcare system (PATH 2011: 2). It may occur at a client level, at a government level, at a health organisation level and at an inter-sectoral level (PATH 2011: 2). Based on the results of the study, Figure 9.1 illustrates that integration should occur at all four levels. When integration occurs at all four levels, new polices and processes ought to be developed as well as the significant involvement of various organisation based in public and private sector. The next section will illustrate the model developed.

9.2 A MODEL FOR THE INTEGRATION OF HOMOEPATHY INTO THE PUBLIC HEALTHCARE

Figure 9.1 depicts the model of integration. The balance of this section is dedicated to defining the purpose, key concepts, requirements and interventional strategies of the model.

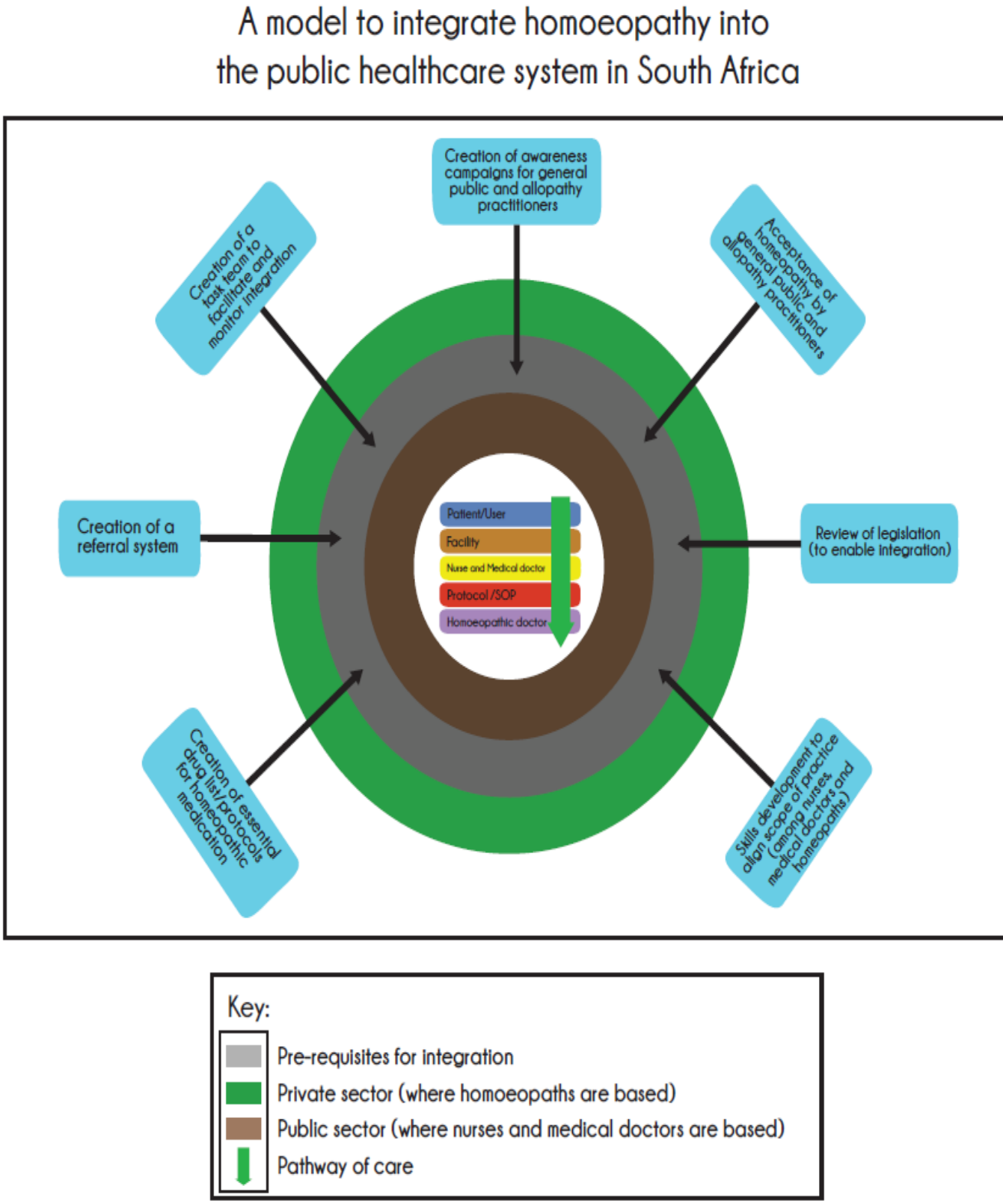

Figure 9.1: Model of integration

9.2.1 Purpose of the model

The aim of the model was to provide a graphical illustration of how the integration of homoeopathy into the public healthcare system may occur. If integration will be considered, this model will possibly facilitate a well-structured, programmatic and functional integration process.

9.2.2 Key concepts

The key concepts of integration are the facility, patient, nurse, medical doctor and homoeopathic doctor. It was established from the results of the study that each key concepts have an integral part to play in integration. This is described in the sections below.

9.2.2.1 Pre-requisites for integration

Pre-requisites were seen as the changes that need to occur in order for the desired goal of integration to be achieved. Each key concept of the model would be required to initiate certain changes prior to integration taking place. The proposed changes are depicted in Table 9.1 below.

Table 9.1: Pre-requisites of integration per key concept

Key Concept	Change required
Patient	• Needs to participate in awareness in awareness campaigns. • Needs to accept homoeopathy.
Facility	• Needs to facilitate making arrangements for the additions of homoeopaths onto the facility.
Nurse	• Needs to participate in awareness in awareness campaigns. • Needs to be educated toughly about homoeopathy law and mechanism of action for homoeopathic medication. • Needs to accept or be tolerant of homoeopathy. • Training institutions require skill alignment.
Medical doctor	• Needs to participate in awareness in awareness campaigns. • Needs to accept or be tolerant of homoeopathy. • Needs to be educated thoroughly about homoeopathy law and mechanism of action for homoeopathic medication. • Training institutions require skill alignment.
Homoeopathic doctor / fraternity	• Need to provide requirements to facility in order to facilitate smooth integration. • Need to produce reputable awareness campaigns. • Need to facilitate educating allopathic practitioners on homoeopathy. • Need to re-visit legislation that regulate profession (to better suit integration. • Training institutions require skill alignment. • Need to compile an essential drug list. • Need to compile protocols and SOP's to facilitate referrals from either nursing staff or medical doctors.

9.2.2.2 Facility

South Africa is made up of nine provinces. These provinces are further segmented into various health districts. Within each health district, there are various amounts of healthcare facilities. Facilities included in each district can either be Community Health Centres (CHC), provincial clinics or provincial hospitals. It was established from this study that if integration of homoeopathy

was to occur, then it should be within the existing public facilities. This will be beneficial to all stakeholders involved. Benefits established in the study included easy referrals between healthcare professionals and based on the socio-economic status of the public sector users, this would be cost-effective. The model depicted in Figure 9.1 is not facility specific and can be used in any type of facility.

9.2.2.3 Patient

The patient is defined as the user of the public healthcare facility and the model illustrates the patient being at the starting point of it. It was established in the study that, the patient needs to request or accept referrals to homoeopaths as there cannot be forced to use it. Therefore, prior to integration occurring, the patients would need to be well informed about homoeopathy. The patient would benefit from integration, as there would have a variety of options to use in treating their ailments and more healthcare professionals to attend to them.

9.2.2.4 Nurse

Nurses are depicted in the model as being right at the centre of it. Which is in keeping with the fact, nurses are indeed the backbone of any healthcare system (Cohen 2005: 720). The nurse is described in the model as being the professional to initiate the referral to the homoeopath. Based on the model illustrated, the addition of more nursing staff would not be required in order for integration to occur successfully. However, there would need to be educated about homoeopathy.

9.2.2.5 Medical doctor

Medical doctors are depicted in the model as being one the healthcare professionals to initiate a referral to a homoeopath or accept a referral from a homoeopath. Based on the model illustrated, the addition of more medical

doctors would not be required in order for integration to occur successfully. However, there would need to be educated about homoeopathy.

9.2.2.6 Homoeopathic doctor

Homoeopaths are depicted towards the end of the model and not at the starting point of the model. This means that no patient can simply walk in from the reception of any public facility and see a homoeopath. There would either need to be seen by a nurse or medical prior to being seen by the homoeopath. This essentially would ensure that the patient is seen by the right provider, at the right time and for the right reasons. This would also would ensure that they would not be any duplication of services or avoid over usage of public resources unnecessarily.

9.3 EVALUATION OF THE MODEL

The evaluation of a model is an integral part of its development as it facilitates finding the best way to represent data (Moriasi *et al.* 2007: 885). The model created was evaluated by the supervisor of the study, who is an expert in model development. During the triangulation process, the data collected in both phases was cross-examined in order to verify the themes and concepts that emerged. The model developed for the study was based on these themes and concepts.

9.4 SUMMARY OF THE CHAPTER

It has been established that integration would involve various stakeholders and change in certain actualities in order for it to effectively work. This is depicted in the model above. Right at the center of the model is a pathway of care. The pathway of care clearly illustrates how patients would gain access to homoeopathic services. Nurses and medical doctors are portrayed as the gatekeepers to these services. The symbiotic relationship that should be created between these three healthcare professionals would be guided by the SOP’s and protocols that are to be compiled by various stakeholders. The

next chapter will present the conclusion, limitation, recommendation and final observations of the study.

CHAPTER 10: CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

10.1 INTRODUCTION

In the previous Chapter, a model to facilitate the integration of homoeopathy into the public healthcare system of South Africa was presented. This model was described and evaluated. In Chapter 10, the conclusion of the study, limitations, recommendations and final observations will be discussed.

10.2 SUMMARY OF THE STUDY

The summary will be discussed in terms of the research objectives. The findings of the study have revealed that integration is not an isolated event and if were to occur, would involve the participation of various stakeholders. Currently, homoeopathy only exists in the private sector, along with the other natural therapies as well as mainstream medicine. The public sector only offers mainstream medicine and this has been a reality since inception of this sector. Though there have been some talks of certain natural therapies, such as traditional medicine being integrated into the sector, no solid discussions have been concluded. The initiation of this study was influenced by this and the results of the study should be used to further drive these discussions.

As noted in Chapter 2, the public healthcare sector in South Africa is under increasing pressure. The users of this sector are not always guaranteed health benefits and are unfortunately not able to receive the same quality of care as those who can afford the services of the better resourced private healthcare sector. The integration of homoeopathy as a modality presents as a possible solution to some of the issues experienced. The government in South Africa has raised the possibilities of an integrated approach to healthcare to address these issues, albeit it has been unclear how such integration will take place. That is why it was imperative for the study to be done, in order to possibly suggest a direction. It has become a worldwide

trend to establish a plural healthcare system. Given the participants' openness to integration, it is recommended that this should not be overlooked.

The views of medical doctors, nurses, homoeopaths, CEO's and medical managers were captured in both Phases of the study. The views of various stakeholders were important in many ways as it provided the much-needed foundation to initiate creating a model of integration. These views were also important as it allowed the researcher to fulfil the objectives of the study. Two of the objectives of the study were to explore the enablers and barriers of integration. These objectives were explored in both phases of the study. Many factors were noted as being enablers and barriers of the study. These factors were further segmented into themes and incorporated in the model that was created. It was interesting to note that the opinions of participants in both Phases were aligned. This was observed when the perceptions of healthcare professionals in KZN were explored fulfilling the third objective of the study. Finally, the last objective was to create a model for integration. This was created in the previous Chapter. It is important to note that this model has not been tested or implemented. The model created for the study, does not contain intricate details of the type of integration that should occur. However, it suggests how integration should occur and it demonstrates the pathway of care.

10.3 LIMITATIONS

A number of areas demonstrated as potential limitations for the study. The majority of these limitations were observed after the data analysis phase was finalised. Patients/public sector users being excluded from the study was seen as one of the biggest limitations. The researcher believed that patients' perceptions are equally important as those of the practitioners. What also stood out as limitations for the study were the conflicting times of availability between the participants and researcher, the participants' lack of knowledge on homoeopathy and a language barrier. The conflicting times of availability

presented as a limitation of the study as it directly affected the length of the study. The lack of knowledge on homoeopathy presented as a limitation of the study as this was directly linked to the lack of interest shown by potential participants. The model not being tested and implemented presented as a limitation of the study. This meant that further research ought to be considered regarding the phenomenon being investigated. Lastly, the exclusion of students in the nursing, medical and homoeopathic field was seen as a limitation of the study.

10.4 RECOMMENDATIONS

The following recommendations are based on the findings of the study. The recommendations for the study made special reference to further research, the medical profession, the homoeopathy profession and further policy development.

10.4.1 Further research

The topic of integrating homoeopathy into the healthcare system in South Africa is under-researched. Though the current study managed to develop a model of integration, not all aspects of integration were explored. It is recommended that further research regarding the pre-requisites identified on the model, be done. Seven pre-requisites were identified for the study. Prior to integration occurring, each pre-requisite should be explored in an isolated research study.

It is also recommended that the perceptions of all stakeholders involved in integration should be investigated. Therefore, a study to determine the perceptions of patients as well as other types of allopathic practitioners should be done prior to integration taking place. It would be interesting to see if there is a difference in opinion among the different types of allopathy professionals. A nationwide study regarding integration of homoeopathy into the public sector is also recommended. The suggested study ought to include all parties that would be affected by integration.

This study focused on certain elements of integration. Hence, it is recommended that further research should focus on other components of integration. The study was limited to KZN. Therefore, it is also recommended that the study be extended to other parts of South Africa before integration occurs.

Future studies on the phenomenon of integration should be designed using other types of research methods. Other methods may be better methods of acquiring data. Linked to the recommendation of using a different research methodology, is the research instrument used for Phase 1 of the study. A lengthy questionnaire was used to obtain the greater insight required from the participants. This presented as a limitation of the study as most potential participants were busy and had limited time on their hands. A slightly shorter questionnaire, focusing on pertinent questions, might have yielded a better response rate within the allocated time and are recommended for future studies.

10.4.2 Medical profession

It was noted that although the majority of the participants had a lack of knowledge on homoeopathy and other types of natural therapies. The majority of these candidates were not resistant towards it. This meant that there was a great potential to initiate building a relationship between the homoeopathy and allopathy profession. Some participants were resistant towards this type of natural therapy. Therefore, it is recommended that awareness be done for these allopathy practitioners. This would be one of the ways of dispelling the misconceptions that they harbour. The dispelling of misconceptions would also allow the allopathy providers to see how a symbiotic relationship can be formed with homoeopaths. In addition to this, it would make sense for allopathy practitioners to gain more knowledge on all type of natural therapies as this would facilitate them treating all their patients holistically. It is also recommended that, in order to curb the lack of knowledge among allopathy

practitioners, homoeopathy ought to be included as a module in their training institutions.

10.4.3 Homoeopathy profession

One of the pre-requisites for integration was that there needs to be a skills alignment between allopathy and homoeopathy profession, if integration is to take place. It is recommended that, in order for integration to take place effectively, the barriers ought to be addressed prior. Some of the barriers discussed, regarding the homoeopathy profession, included the speculations surrounding the efficacy of homoeopathic medication, the lack of research articles available on homoeopathic medication, as well as the speculations surrounding the mechanism of homoeopathy. It is therefore recommended that the homoeopathy profession engage with the allopathy profession to address these uncertainties surrounding their profession. Engaging with the allopathy professions in a medical congress or conference is recommended and should be included as a requirement to maintain registration within the relevant council. An internship, post qualifying as a homoeopath, is also recommended as this is not current practice. This internship should not be restricted to homoeopathic facilities but facilities where homoeopaths would have exposure to working with allopathic practitioners. With this suggestion, it is recommended that the homoeopathy curriculum should be re-evaluated in order for it to be aligned with the current mainstream medicine curriculum.

Legislations that restrict the homoeopathy profession should be re-evaluated, prior to integration taking place. Some of the regulations discussed in the study were seen as barriers of integration. Lastly, it is recommended that studies that explore the efficacy and cost-effectiveness of homoeopathy within a public sector context be done. Further recommendations for this profession are provided in the pre-requisite section of the model developed.

10.4.4 Policy development

At present, there are many policies that have been developed to integrate various services to our healthcare system. Unfortunately, these policies speak to the integration of the different types of allopathic care and they do not speak to natural therapies. It is recommended that policies that speak to this phenomenon be developed, prior to integration being initiated. Integration does not entirely rely on the development these policies. However, this initiative could potentially guide and facilitate integration in the right path.

10.5 CONCLUDING REMARKS

Undoubtedly, integration of homoeopathy into the public healthcare system is complex in nature. As per the findings of the study, there are clearly no quick and easy ways of achieving integration. It requires the participation of various stakeholders and, if one is left out of the process, integration might not be viable. The researcher evoked a spectrum of responses ranging from acceptance to uncertainty in both phases of the study. The assorted views on the research phenomenon allowed the researcher to believe that integration should not occur until acceptance of homoeopathy is observed in the majority of people in South Africa. Based on the limitations identified in this study, further research needs to be conducted to investigate this phenomenon.

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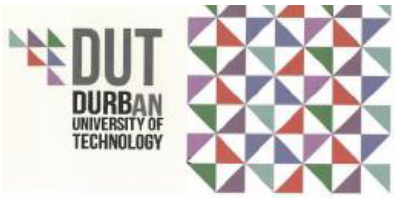
APPENDICES

Appendix 1: University Ethics clearance



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P.O. Box 771
Clernaville
3612

Dear Dr Majola

A model for the integration of homeopathy into the public healthcare system in the province of KwaZulu-Natal, South Africa

The Institutional Research Ethics Committee acknowledges receipt of your final data collection tool for review.

We are pleased to inform you that the data collection tool has been approved. Kindly ensure that participants used for the pilot study are not part of the main study.

In addition, the IREC acknowledges receipt of your gatekeeper permission letters.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

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 Standard Operating Procedures (SOP's).

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 Health District Manager

2 Ilala Place
Rainbow Gardens
Wyebank
3610

The District Manager
EThekwini Health District
P/Bag X54318
Durban
4000

Dear Mrs P Msimango

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

My name is Sindile Majola, a doctoral student at the Durban University of Technology. The research I wish to conduct for my Doctoral thesis involves *"A model for the integration of homoeopathy into the public healthcare system in the province of KwaZulu-Natal, South Africa".*

I hereby seek for permission to conduct semi-structured interviews with the CEO's of public health facilities located within the eThekwini district. I also seek for permission to distribute questionnaire surveys to patients located within the eThekwini district at the time of data collection.

I have provided you with a copy of the summary of the proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me telephonically on 0624814432 or via email address drsindilemajola@gmail.com or my supervisor Prof M.N. Sibiya on nokuthulas@dut.ac.za. Thank you for your time and consideration in this matter.

Yours sincerely,

_____

Dr Sindile Majola
Durban University of Technology
Email: drsindilemajola@gmail.com

Appendix 2b: Approval letter from the Health District Manager

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE: CORPORATE SERVICES

83 King Cetshwayo Highway
Mayville, Durban, 4001
Tel: 031 240 5455 Email: avashni.harrichandparsad@kznhealth.gov.za
www.kznhealth.gov.za

ETHEKWINI HEALTH DISTRICT OFFICE

29 May 2018

Dear Dr. S Majola

Re: Permission To Conduct Research at eThekwini District Facilities.

This letter serves to confirm that your application to conduct the research study titled "A model for the integration of homoeopathy into the public healthcare system in the province of KwaZulu-Natal, South Africa", in the eThekwini district at the following health care facilities has been recommended:

Addington hospital
Hillcrest hospital
King Edward VIII hospital
Mahatma Gandhi hospital
RK Khan hospital
St Mary's hospital
Clairwood hospital
Inkosi Albert Luthuli Central hospital
King George V hospital
Prince Mshiyeni hospital
St Aidan's hospital
Wentworth hospital

Cator Manor CHC
Inanda "C" CHC
KwaDabeka CHC
KwaMashu CHC
Newtown CHC
Phoenix CHC
Tongaat CHC

Kindly upload this letter together with your application as required to the Health Research and Knowledge Unit for the KZN Department of Health for Approval.

Please also note the following:

1. This research project should only commence after final approval by the KwaZulu-Natal Health Research and Knowledge Unit, and full ethical approval, has been granted,
2. That you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
3. All research activities must be conducted in a manner that does not interrupt clinical care at the health care facility,
4. Ensure that this office is informed before you commence your research
5. The District Office/Facility will not provide any resources for this research
6. All logistical details must be arranged with the CEO/medical manager /operational manager of the facility,
7. You will be expected to provide feedback on your findings to the District Office/Facility

Yours sincerely

Dr. A. Harrichandparsad
pp Ms. T. P. Msimango
Chief Director
eThekwini Health District

Appendix 2c: Letter of permission to the Health District Manager

2 Ilala Place
Rainbow Gardens
Wyebank
3610

The District Manager
King Cetshwayo Health District
P/Bag X20034
Durban
3910

Dear Mrs PPT Dlwati

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

My name is Sindile Majola, a doctoral student at the Durban University of Technology. The research I wish to conduct for my Doctoral thesis involves *"A model for the integration of homoeopathy into the public healthcare system in the province of KwaZulu-Natal, South Africa".*

I hereby seek for permission to conduct semi-structured interviews with the CEO's of public health facilities located within the King Cetshwayo district. I also seek for permission to distribute questionnaire surveys to patients located within the eThekwini district at the time of data collection.

I have provided you with a copy of the summary of the proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me telephonically on 0624814432 or via email address drsindilemajola@gmail.com or my supervisor Prof M.N. Sibiya on nokuthulas@dut.ac.za. Thank you for your time and consideration in this matter.

Yours sincerely,

_____

Dr Sindile Majola
Durban University of Technology
Email: drsindilemajola@gmail.com

Appendix 2d: Approval letter from the Health District Manager

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: No. 2 Cornet Lood Avenue & Chrome Crescent, Empangeni, 3910
Postal Address: Private Bag X20034, Empangeni, 3910
Tel: 035 787 6206/6319 Fax: 035 787 0644 Email: Phakama.dlwati@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
District Management

Reference: Research Study

Date: 11 June 2018

TO: Principal Investigator: Dr. SF Majola
Student No. 20900969
Durban University of Technology
Health Sciences
Email Address: drsindilemajola@gmail.com

CC: **1. Dr. Elizabeth Lugte: Manager: Research Unit KZN DOH**

RE: PERMISSION TO CONDUCT RESEARCH "A MODEL FOR THE INTEGRATION OF HOMEOPATHY INTO THE PUBLIC HEALTHCARE SYSTEM IN THE PROVINCE OF KWAZULU-NATAL"

I have pleasure in informing you that permission has been granted to you by the King Cetshwayo to conduct research on "A Model for the Integration of Homeopathy into the Public Healthcare System in the Province of KwaZulu-Natal".

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received approval of your study from the Provincial Health Research and Ethics Committee (PHREC) in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office/Facility will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office/Facility.
6. You are required to contact this office regarding dates for providing feedback when the research has been completed.

Thanking you.

Ms. PPT Dlwati
Acting Director: DHO
King Cetshwayo District

Appendix 3a: Letter of permission to the KwaZulu-Natal Department of Health

2 Ilala Place

Rainbow Gardens
Wyebank
3610

The Health Research and Knowledge Management Component
KwaZulu-Natal Department of Health
Private Bag X9051
Pietermaritzburg
3201

Dear Dr Lutge

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

My name is Sindile Majola, a doctoral student at the Durban University of Technology. The research I wish to conduct for my Doctoral thesis involves *"A model for the integration of homoeopathy into the public healthcare system in the province of KwaZulu-Natal, South Africa".*

I hereby seek for permission to conduct semi-structured interviews with the CEO's of public health facilities located within the eThekwini district and policy-makers operating at a national level. I also seek for permission to distribute questionnaire surveys to patients located within the eThekwini district at the time of data collection.

I have provided you with a copy of the summary of the proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me telephonically on 0624814432 or via email address drsindilemajola@gmail.com or my supervisor Prof M.N. Sibiya on nokuthulas@dut.ac.za. Thank you for your time and consideration in this matter.

Yours sincerely,

_____

Dr Sindile Majola
Durban University of Technology
Email: drsindilemajola@gmail.com

Appendix 3b: Approval letter from the KwaZulu-Natal Department of Health

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

330 Langalibalele street,
Private Bag X9051 PMB, 3200
Tel: 033 395 2805/3189/3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management (HKRM)

Reference: HRKM237/18
KZ_201806_019

09 July 2018

Dear Dr S F Majola
(DUT)

Subject: Approval of a Research Proposal

1. The research proposal titled **'A model for the integration of homeopathy into the public healthcare system in the province of KwaZulu-Natal, South Africa'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at the selected facilities at eThekwini and King Cetshwayo Districts.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facilities 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 Ms G Khumalo on 033-395 3189.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 12/07/18

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 4a: Letter of permission to the Chief Executive Officers

2 Ilala Place
Rainbow Gardens
Wyebank
3610

The Chief Executive Officer
XXX Hospital
XXXX
XXXX
XXXX

Dear XXXX

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

My name is Sindile Majola, a doctoral student at the Durban University of Technology. The research I wish to conduct for my Doctoral thesis involves *"A model for the integration of homoeopathy into the public healthcare system in the province of KwaZulu-Natal, South Africa".*

I hereby seek for permission to distribute questionnaire surveys to patients located within your at the time of data collection.

I have provided you with a copy of the summary of the proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me telephonically on 0624814432 or via email address drsindilemajola@gmail.com or my supervisor Prof M.N. Sibiya on nokuthulas@dut.ac.za. Thank you for your time and consideration in this matter.

Yours sincerely,

_____
Dr Sindile Majola
Durban University of Technology
Email: drsindilemajola@gmail.com

Appendix 4b: Approval letter from the Chief Executive Officers of Mahatma Gandhi Memorial Hospital

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

MAHATMA GANDHI MEMORIAL HOSPITAL

Physical Address: 170 Phoenix Highway, Phoenix
Postal Address: Private Bag X13, Mount Edgecombe, 4300
Tel: 031 5021719 ext 2012 Fax: 086 6737 0612 Email: nancy.bridgemohan@kznhealth.gov.za
www.kznhealth.gov.za

Reference: Research 09/18

29 August 2018

DR S F MAJOLA
DUT

RE: PERMISSION TO CONDUCT RESEARCH AT MAHATMA GANDHI MEMORIAL HOSPITAL

I have pleasure in informing you that permission has been granted to you by Mahatma Gandhi Memorial Hospital to conduct research on "A model for the integration of homeopathy into the public healthcare system in the province of KwaZulu Nattal South Africa".

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. Please ensure this office is informed before you commence your research.
3. The Hospital will not provide any resources for this research.
4. You will be expected to provide feedback on your findings to the Hospital.
5. You are required to contact this office regarding dates for providing feedback when the research has been completed.

DR C. PERSAD
MEDICAL MANAGER
MAHATMA GANDHI MEMORIAL HOSPITAL

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 4c: Approval letter from the Chief Executive Officers of Prince Mshiyeni Memorial hospital

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE: Senior Medical Manager

Mangosuthu Highway, Private Bag X 07
MOBENI
Tel: 031 907 8317/8304 Fax: 031 906 1044 Email:myint.aung@kznhealth.gov.za
www.kznhealth.gov.za

Prince Mshiyeni Memorial Hospital

Enquiry: Dr M AUNG
Ref No: 43/RESH/2018
Date: 30/08/2018

TO: Dr SF Majola

RE: LETTER OF APPROVAL TO CONDUCT RESEARCH AT PMMH

Dear Researcher;

I have pleasure to inform you that PMMH has granted to conduct research on **"A model for integration of homeopathy into the public health care system in the province of KwaZulu-Natal."** in our institution.

Please note the following:

1. Please ensure this office is informed before you commence your research.
2. The institution will not provide any resources for this research.
3. You will be expected to provide feedback on you finding to the institution.

With kind regard

MYINT AUNG
Senior Medical Manager & specialist in Family Medicine
MBBS, DO(SA), PGDip in HIV (Natal), M.Med.Fam.Med (natal), PhD
Tel: 031 9078317
Fax: 031 906 1044
myint.aung@kznhealth.gov.za

Appendix 4d: Approval letter from the Chief Executive Officers of Addington Hospital

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

ADDINGTON HOSPITAL

P.O. BOX 977
DURBAN
4000
Tel: 031-327-2970 Email: reshma.boodhai@kznhealth.gov.za
www.kznhealth.gov.za

OFFICE OF THE CHIEF EXECUTIVE OFFICER

Reference: *9/2/3/R*

Date: 19th September 2018

Principal Investigator:
- **Dr S Majola**

PERMISSION TO CONDUCT RESEARCH AT ADDINGTON HOSPITAL: "A MODEL FOR THE INTEGRATION OF HOMOEOPATHY INTO THE PUBLIC HEALTHCARE SYSTEM IN THE PROVINCE OF KWAZULU-NATAL, SOUTH AFRICA"

I have pleasure in informing you that permission has been granted to you by Addington Hospital Management to conduct the above research.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards 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 this office is informed before you commence your research.
4. Addington Hospital will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to Addington Hospital.

DR M NDLANGISA
HOSPITAL MANAGER
ADDINGTON HOSPITAL

Appendix 4e: Approval letter from the Chief Executive Officers of Ngwelezane Tertiary Hospital

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:
Office of the CEO
Ngwelezana Tertiary Hospital

Ngwelezana Hospital, Thanduyise Road, Ngwelezana Township
Private Bag X 20021, Empangeni 3880
Tel: 035 901 7000 Fax: 035 794 1883 Email: ceosecretary.ngwelezana@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Ms. N. Sibiya
Date : 24 August 2018

Dear Dr SF Majola

PERMISSION TO CONDUCT RESEARCH ON A MODEL FOR THE INTERGRATION OF HOMOEOPATHY INTO THE PUBLIC HEALTHCARE SYSTEM IN THE PROVINCE OF KWAZULU NATAL

I have pleasure in informing you that permission has been granted to you by Ngwelezana Hospital to conduct research on: "**A model for the integration of homoeopathy into the public healthcare system in the province of KwaZulu Natal**"

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. Please ensure that the office of the CEO is informed before you commence your research.
3. The District Office/Facility will not provide any resources for this research.
4. You will be expected to provide feedback on your findings to the District office/Facility.

Thanking you.

Sincerely

Dr BS Madlala
Chief Executive Officer
Ngwelezana Hospital

Appendix 5a: Letter of information

Dear Participant

Thank you for agreeing to participate in the study. The information about the study is as follows:

Title of the Research Study: A model for the integration of homoeopathy into the public healthcare system in the province of KwaZulu-Natal, South Africa.

Principal Investigator/s/researcher: Dr Sindile Majola, PhD: Health Sciences Candidate.

Co-Investigator/s/supervisor/s: Professor M.N. Sibiya, D. Tech: Nursing and Dr PB Nkosi, PhD: Health Sciences.

Brief Introduction and Purpose of the Study: The aim of this study is to develop a model for integrating homoeopathy into the public healthcare system in KwaZulu-Natal. Based on the limited literature that exist on the study phenomenon, it can be assumed that a model has yet to be developed in South Africa. Internationally, models of integration exist. The combination of the existing international models along with the perceptions of those involved in integration will allow the researcher to develop a model for integrating homoeopathy into the public healthcare system in KwaZulu-Natal.

Outline of the Procedures: You are kindly requested to participate in this study. You will be required to either fill out a hardcopy paper-pen survey; electronic survey or participate in a semi-structured interview. In which ever method of data collection you will be chosen to participate in, you will be asked questions to ascertain your views on the integration of homoeopathy into the public healthcare system in South Africa. Prior to commencing with data collection, all participants will be asked to fill out a consent form. Once that has been completed, if you are chosen to complete either a paper-pen survey or electronic survey, please follow the instruction carefully on the questionnaire. If you are chosen to take part in the semi-structured interview, please be advised, an appointment will be made with you to suit your availability. All semi-structured interviews will be recorded. At the end of the study, when the data is presented in the form of a thesis, no names will be mentioned.

Reason/s why the Participant May Be Withdrawn from the Study: You are free to withdraw from the study at any time and there is no penalty that will be imposed on you.

Benefits: A developed model for the integration of homoeopathy into the public healthcare system may be adopted by the KZN Department of Health in improving the quality of health care services in the province.

Remuneration: You will not receive any remuneration of any kind for participation in this study.

Costs of the Study: You do not pay anything to participate in the study.

Confidentiality: All information and data will be kept strictly confidential. The interview guide will be coded; no names will be written on the guide. The list of names and corresponding research numbers will be kept on the pass word protected computer. Only the supervisors will have access to this data. Upon completion of the study, the research material 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, Sindile Majola at 062 481 4432 or via email at drsindilemajola@gmail.com or my supervisor Prof M.N. at 031-373 2704 or the Institutional Research Ethics Administrator on 031-373 2375. Complaints can be reported to the Director: Research and Postgraduate Support, Prof C. Napier on 031-373 2577 or carinn@dut.ac.za

Appendix 5b: Consent

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Ms S.F. Majola 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, Ms Sindile F. Majola herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	**Date**	**Signature**

_____	_____	_____
Full Name of Witness (If applicable)	**Date**	**Signature**

_____	_____	_____
Full Name of Legal Guardian (If applicable)	**Date**	**Signature**

Appendix 6: Questionnaire for nurses, medical doctors and homoeopaths

Instructions

1. Please mark the correct answer by putting X in the relevant box.
2. Do not write your name in the questionnaire.
3. Please respond to all the questions.

Section A: Demographic information

1. Gender

Male	
Female	

2. Age

18-20	
21-25	
26-33	
34-40	
41 and above	

3. Home language

isiZulu	
English	
Afrikaans	
Other: Please specify _____	

4. Occupational role

Nurse	
Medical doctor	
Homoeopath	

Section B: Experience with homoeopathy

This section (B) is to be completed by nurses and medical doctors

1. Homoeopathy is a system of complementary alternative medicine in which ailments are treated by minute doses of natural substances that in larger amounts would produce symptoms of the ailment (Merriam-Webster Dictionary 2019: para. 1 line 1). Which **ONE** of the following statements applies to you? (**Tick ONE option only**)

I have not heard of homoeopathy	
I have heard of homoeopathy but do not know anything about it	
I have heard of homoeopathy and know a little about it	
I have heard of homoeopathy and know quite a bit about it	
I have heard of homoeopathy and know a lot about it	

2. Indicate which of the following situations apply to you. (**Tick ALL that apply**)

Situation	Yes	No
2.1 I have never worked with a homoeopath before		
2.2 I have worked with a homoeopath in a private homoeopathic clinic		
2.3 I have worked with a homoeopath in a homoeopathic clinic where services are offered free of charge		
2.4 I have worked with a homoeopath in a private multidisciplinary practice		
2.5 I have referred chronic cases to a homoeopath		
2.6 I have referred acute cases to a homoeopath		
2.7 I have referred palliative cases to a homoeopath		
2.8 I have referred preventative measure cases to a homoeopath		

Section C Integration

<u>This section is to be completed by homoeopaths, nurses and medical doctors</u>

3. Indicate your agreement with the following statements:

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
3.1 Homoeopathy should be integrated into the public healthcare system in South Africa					
3.2 Homoeopathy should be integrated into the public healthcare system by adding it into existing public health facilities					
3.3 Homoeopathy should be integrated into the public healthcare system by creating separate public health facilities					

4. Indicate your agreement that the following factors are **<u>barriers</u>** to the successful integration of homoeopathy into the public healthcare system:

Barriers	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
4.1 Tension between allopathic and homoeopathic practitioners					
4.2 Misconceptions regarding homoeopathy					
4.3 Lack of education/knowledge about homoeopathy					
4.4 Lack of support from allopathic practitioners					
4.5 Restrictive legislation					
4.6 Lack of practical experience in newly qualified homoeopaths					
4.7 Inadequacy of homoeopathic training for medical doctors/nurses					
4.8 Lack of interest from patients/general public					
4.9 Aversion of allopathic practitioners to homoeopathy					
4.10 Lack of unity amongst homoeopaths					

5. Indicate your agreement that the following factors would **enable** the successful integration of homoeopathy into the public healthcare system:

Enablers	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
5.1 Homoeopathic medicines are cost effective					
5.2 There are homoeopathic practitioners who support integration and are ready to work in the public facilities					
5.3 There is a growing global interest in the use of natural medicines for preventative and palliative needs					
5.4 Homoeopathic medicines can be used in conjunction with other types of medication					
5.5 Homoeopathy is non-invasive					
5.6 Homoeopathic medication does not have any harsh side effects					
5.7 Patients cannot develop a resistance against homoeopathic medication					

6. Indicate your agreement with the following statements:

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
6.1 In my opinion, homoeopathy would be accepted by patients					
6.2 In my opinion, homoeopathy would be accepted by healthcare providers					

7. Indicate your agreement that the following steps would assist in overcoming the challenges that might be present with integrating homoeopathy into the public healthcare system in South Africa:

Steps	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
7.1 Support of integration from government					
7.2 Having laws that are in the interest of both homoeopathy and allopathy professions					
7.3 Creating marketing campaigns to promote homoeopathy to the public and allopathic practitioners					
7.4 Holding of conferences that include both homoeopathy and allopathy professionals					
7.5 Including homoeopathy modules in the nursing / medical school curriculum					
7.6 Creating an internship programme that would allow for student nurses, doctors and homoeopaths to work together while they are still students					
7.7 Altering the homoeopathic curriculum to increase their knowledge about allopathic medicine and medical practice					

THANK YOU FOR COMPLETING THE QUESTIONNAIRE

Appendix 7: Interview guide

Experiences with Homoeopathy

- What are your perceptions towards Homoeopathy in South Africa?
- What has been your professional experience with Homoeopathy?
- Highlight your level of awareness of the different types of Complementary Alternative Medicines (CAMs) that exist in South Africa.

Integration of Homoeopathy into the public healthcare system

- What is your level of awareness in terms of CAMs (specifically homoeopathy) in other countries?
- Would you refer a patient to a homoeopath? Please justify your response.
- What role can homoeopathy play in the public healthcare system in South Africa?
- What do you perceive to be the future of homoeopathy in South Africa?
- As a management staff, how do you envision homoeopathy being successfully integrated into the public healthcare system?

Probe: What do you think are the enabling factors and barriers of integration?

Probe: How we can overcome the challenges that might present with integrating homoeopathy into the public healthcare system in South Africa?

- What do you perceive to be the outcomes of integration?

Probe: What do you think will be healthcare professionals and patients reactions to integration?

Appendix 8: Letter from the statistician

Gill Hendry B.Sc. (Hons), M.Sc. (Wits), PhD (UKZN)

Mathematical and Statistical Services

Cell: 083 300 9896
email: hendryfam@telkomsa.net

11 June 2019

Re: Assistance with statistical aspects of the study

Please be advised that I have assisted Sindile Fortunate Majola (Student number 20900969), who is presently studying for a PhD: Health Sciences at DUT, with the sampling as well as the development and validation of the questionnaire for his study.

Yours sincerely

Gill Hendry (Dr)

Appendix 9: Letter from the professional editor

NJOJO COMMUNICATIONS

3 Cottage Gardens
17 Payne Street
Pinetown
3610

Njojo Communication (PTY) LTD
Co. Reg No. 2015/ 207751/ 07
B-BBEE Procurement Recognition: 135%
B-BBEE Status Level : Level 1

CONFIRMATION OF SERVICES RENDERED

This is to confirm that Sindile Fortunate Majola (Student Number 20900969), currently studying towards a PhD: Health Sciences at the Durban University of Technology, gave her work for copyediting services (South African English) to be rendered and those services were performed on the document (Thesis).

Sakhile Khulekani Gumede

BT: Language Practice (DUT)

Email: sk47gumede@gmail.com
Cellphone: 071 874 5653

BE SEEN • BE HEARD • BE KNOWN