THE USE OF TRADITIONAL MEDICINE BY CAREGIVERS FOR CHILDREN UNDER THE AGE OF FIVE YEARS AS HEALTH SEEKING BEHAVIOUR

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DECLARATION

I, Shanitha Pillay, do hereby declare that the study titled "The use of traditional medicine by caregivers for children under the age of five years as a health seeking behaviour". All sources that I have utilised or quoted from are indicated and acknowledged by means of a complete reference record. Furthermore, this work has never been submitted before, for any other degree or at any other institution.

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ABSTRACT

Child health has always been a global priority for decades; however, despite efforts to reduce the child mortality statistics, 5.9 million children under the age of five years have deceased in 2015. IMCI guidelines are used to assess, classify and treat sick children under the age of five years, however, despite the prevalent use of traditional medicine for this age group of children, the guidelines excludes the use of traditional medicine, hence the tendency exists to ignore such questions being asked. It is this gap in the history taking pertaining to sick children seeking health care at clinics that the researcher has identified, therefore, this study is intended to highlight the use of traditional medicine in children under the age of five years. The researcher's methodology is a quantitative descriptive study by means of a self-developed structured questionnaire which was handed out to 183 caregivers attending a Gateway Clinic and 324 caregivers at Paediatric Out – Patient Department. The total sample size was 507 caregivers of children under the age of five years. Data was analysed using SPSS version 17. The data derived from this study indicated that although most caregivers would take their sick children to the clinic for first line treatment, there are a significant number who would rather use home remedies or seek care from traditional healers. The study reveals that 28.5% of caregivers were found to be administering traditional medicine with conventional medicine and 17.4% would do so concurrently. Evidence also revealed that 75.7% of the caregivers would disclose the use of traditional medicine for their children only if nurses enquired about it.

Recommendations arising from the study findings are that the IMCI guidelines should incorporate a classification chart for use by health care professionals in order

to identify children who were treated by traditional medicine preferably as “RED” - requiring urgent attention and possible admission to hospital, in view of the potential threat to life. Since the IMCI guidelines are also a teaching tool in nursing curricula, the assessment of sick children using traditional medicine will be incorporated into the formal teaching of nurses.

Key words used were Integrated Management of Childhood Illnesses, effects and use of traditional medicine on children.

TABLE OF CONTENTS

DEDICATION

This dissertation is dedicated to my dear husband Julian as well as my precious children Kaitlyn and Jaiden.

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LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

IMCI: Integrated Management of Childhood Illnesses

PHC: Primary Health Care

POPD: Paediatric Outpatient Department

UNICEF: United Children's Fund

WHO: World Health Organisation

SPSS: Statistical Package for the Social Sciences

ANNEXURES

CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Child health care remains a global priority and has been for decades. However, every year millions of children die before reaching their fifth birthday. According to the World Health Organisation (WHO), 5.9 million children under the age of five years died in 2015 (WHO Factsheet: January 2016) – this being an improvement from over 10 million per year in past years. The same report also indicated that the most common causes of death among children under the age of five are pneumonia, diarrhoea, malnutrition or a combination of these diseases that could have been prevented with early detection as well as affordable interventions. In a global comparison, children who live in Sub-Saharan Africa have a greater risk of dying by 14 times before they reach the age of five years (WHO Factsheet : January 2016). The WHO reviewed the Millennium Development Goals in September 2015, and 193 Member States agreed on adopting a new agenda- where 17 Sustainable Development Goals (SDG) were accepted. The proposed SDG target is to reduce child mortality to 25/1000 live births by 2030 (WHO Factsheet: January 2016).

In addition, to analysing the health care of children, the WHO has estimated that 80% of the population in developing countries use traditional medicine to meet their primary health care needs (Tabuti, Kukunda, Kawese and Kasilo

2012: 35). In recognition of the world wide use of traditional medicine, the WHO established the Traditional Medicine Strategy 2014- 2023 with one of its goals being “promoting safe and effective use of traditional medicine through regulation, evaluation and integration of traditional medicine products, practices and practitioners into health systems as appropriate”. Health care professionals always need to be vigilant when treating children who have used traditional medicines; however an accurate history needs to be taken.

This study intended to determine the use of traditional medicine in children under the age of five years and was conducted at a regional hospital in Durban South Africa. The Paediatric Out-Patient Department and Gateway Clinic were used. The study setting is described in detail in Chapter 3 of this dissertation. A quantitative descriptive study was conducted using a structured questionnaire which was handed out to caregivers attending a Gateway Clinic seeking health care for their sick children and the Paediatric Out – Patient Department where sick children are referred to from primary health care clinics. The data obtained was analysed with assistance of a statistician using a SPSS version 17.

1.2 BACKGROUND

The researcher is a professional nurse, specialised and trained in child nursing science. Having worked in paediatric wards, the use of traditional medicine in children has been identified as being widespread. However, the

use thereof is inadequately identified and sometimes not identified at all during preliminary assessments carried out by health care professionals.

Horwood (2011: 42) indicated that the Integrated Management of Childhood Illnesses [IMCI] programme was first introduced to South Africa in 1997, and has been the gold standard for assessing sick children at primary health care level. Saloojee (2007: 172) explained that IMCI is an assessment strategy that uses a syndromic approach – whereby specific signs and symptoms are the entry point. Sick children are assessed by IMCI trained practitioners and then 'classified' into one of three categories that are colour coded. Currently, IMCI does not have any guidelines for the assessment, classification and treatment pertaining to the use of traditional medicine.

The experience that the researcher has obtained thus far has been that the use of traditional medicine is only considered when children are critically ill. In the absence of no clear explanation of signs like renal and hepatic failure seen in otherwise healthy children who have displayed symptoms consistent with acute childhood illnesses such as diarrhoea and vomiting. The experience of the researcher is justified by Blanke, Godson and Lange (2008: 38), who found that children that were given traditional medicine before admission to hospital were more likely to die, especially in children who were younger and also having sought traditional medicine prior to seeking timeous health care at clinics, which resulted in causing a delay and possibly resulting in the subsequent demise of such children.

De Villiers (2003: 664) highlighted more than a decade ago, in a study conducted in South Africa, the dangers associated with traditional medicine use in children and that the use of some traditional medicines might be harmful if not detrimental to children by stating “Poisoning attributed to remedies prescribed by traditional healers is a common cause of death in South Africa. Children die due to herbal intoxication that causes severe liver and kidney damage.” This was also substantiated by Scott (2003: 87) who expressed that the inappropriate use of certain plant species are related to a high mortality rate, especially among children. These concerns still exist, more than ten years later, as according to Ekor (2013: 177) some traditional medicines have been shown to produce a wide range of adverse reactions some of which may lead to serious illness and even death.

It is evident from the above studies, as well as those discussed in Chapter 2 of this dissertation that the use of traditional medicine in children under the age of five years is prevalent and a harsh reality which can prove to be fatal in certain instances.

1.3 RESEARCH PROBLEM

Primary Health Care nurses use the IMCI guidelines to assess, classify, treat or refer sick children under the age of five years. The IMCI guidelines does not include an enquiry into the use of traditional medicine, hence, there is a tendency not to delve into it. Preliminary assessments of children who have been treated with traditional medicine will assist in the diagnosis and subsequent treatment of such children. Hence, adverse reactions stemming

from the use of traditional medicine can be monitored and referred timeously and in so doing prevent any further complications in a child. This has been identified by the researcher as a gap in the history taking pertaining to sick children attending Primary Health Care clinics seeking health care.

1.4 AIM OF THE STUDY

The aim of this research was to determine the use of traditional medicine as a health care seeking behaviour by caregivers of children who are under the age of five years.

1.5 OBJECTIVES

The objectives of this study were to determine:

1. The first line of treatment given to sick children by caregivers.
2. The health care seeking behaviour of caregivers for their sick children.
3. The health interventions after the first line of health care seeking.

1.6 RESEARCH QUESTIONS

1. What is the first line of treatment for sick children by caregivers?
2. What is the health seeking behaviour of caregivers for their sick children?
3. What medicines or practices are used after seeking help to manage sick children?

1.7 CONCEPTUAL FRAMEWORK

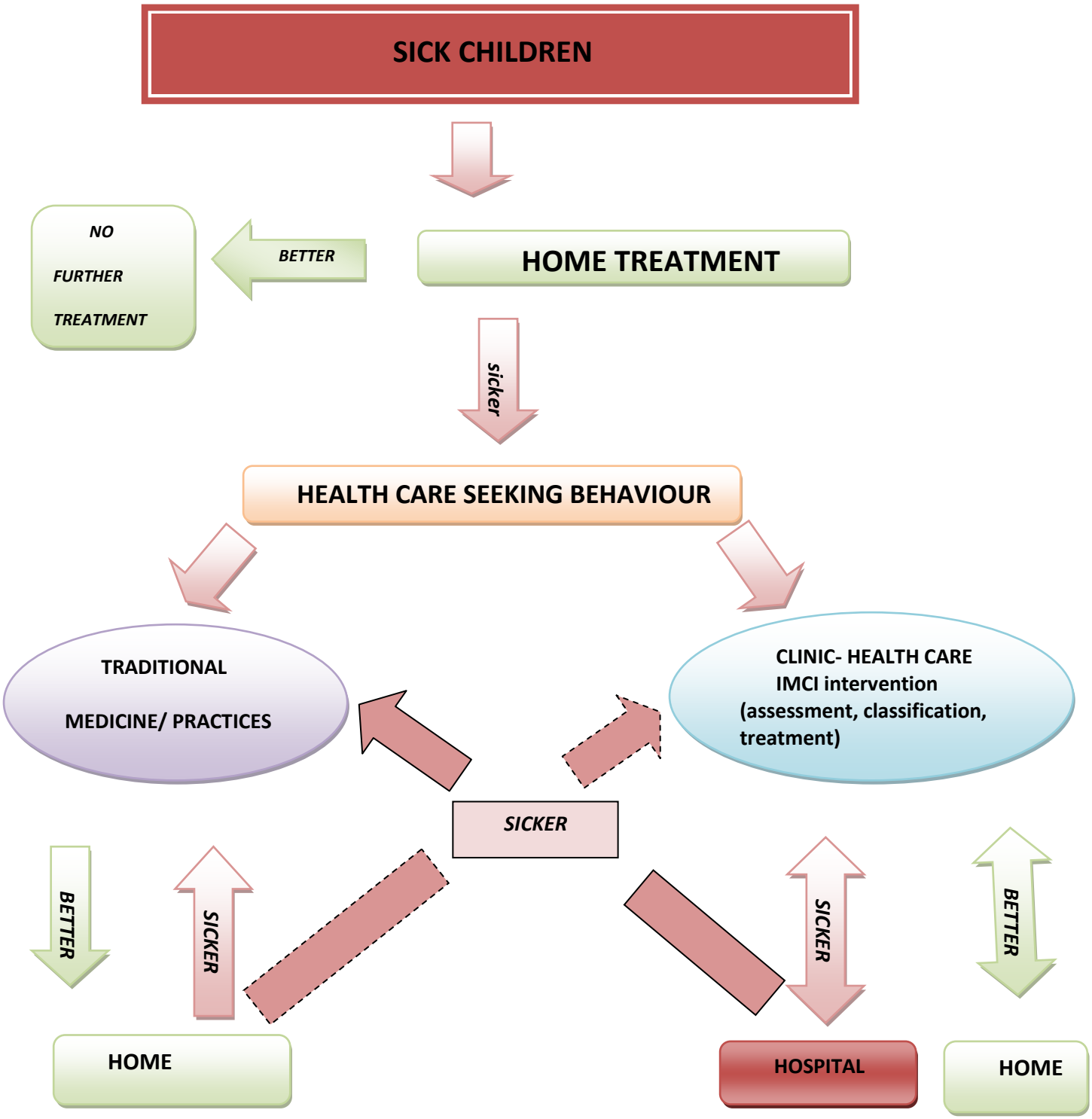

FIGURE 1.1: A CONCEPTUAL FRAMEWORK - THE HEALTH CARE SEEKING BEHAVIOUR OF CAREGIVERS FOR CHILDREN UNDER THE AGE OF FIVE YEARS

According to Grove, Burns and Gray (2013: 132), a conceptual framework pertains to a visual representation of the research framework. It is a schematic representation that illustrates the main concepts of the study and the link that exists among these concepts – (Polit and Beck 2012: 722).

The conceptual framework depicted in this study illustrates the use of traditional medicine as part of health care seeking behaviour in children under the age of five. The pathways that may be followed by the caregiver of a sick child, indicated in the framework has been predicted by reviewing previous studies; Luyckx, Steenkamp and Michael (2005: 35) indicated that patients only seek Western medicine once traditional medicines have failed or a complication occurs.

The conceptual framework depicts the sick child under the age of five years as the centre of this study. If the child gets better, it means that the home remedy has worked and there will be no further treatment as many South African caregivers prefer the use of home remedies that they may purchase from street vendors, pharmacists, muti- shops, Sharkey, Chopra, Jackson, Winch, Minkovitz (2012: 114). If the home remedies do not work and the child becomes sicker, the caregiver may proceed to seek help from either traditional practitioners or health care from clinics. Bamatraf, cited in Webair and Ghouth (2014: 587), concluded that mothers held greater confidence in traditional medicine than medical services, and that many of these practices led to either a delay or complete avoidance in seeking health care for sick children. When or if the use of traditional medicine fails or the child becomes

sicker, the caregiver may proceed to the clinic where the sick child is assessed and classified for treatment according to IMCI guidelines. In summing the health care seeking behaviour of the caregivers Towns, Eyi and Van Andel (2014), first line of treatment was to treat the sick child with herbal medicines at home for a few days, if that did not work, then to take the child to seek medical care, and if the child still remained sick then to go to a traditional healer. For the purpose of this study, sick children visiting private health care professionals will not be included.

1.8 ETHICAL CONSIDERATIONS

Written permission to conduct this study was obtained from the KwaZulu-Natal Department of Health The Health Research and Knowledge Management Component. The participants were fully informed about the study, they were given time to read and understand the consent, thereafter a written consent was obtained from each participant. To ensure anonymity and confidentiality of the participants, numbers were used on the questionnaires and not the names of participants.

The data was securely kept under lock and key. Ethical considerations are explained in detail in Chapter 3 of this dissertation.

1.9 DEFINITION OF CONCEPTS

Concept	Definition
1. Traditional Medicine	According to World Health Organisation factsheet number 134 (May 2003), "traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to treat, diagnose and prevent illnesses or maintain wellbeing." Also referred to as "muti" in the South African context.
2. Child	For the purpose of this study, reference is given to the child, which is any person under the age of five years.
3. Health seeking behaviour	Any sort of action taken by an individual who has a problem with health or illness in an attempt to find an appropriate remedy – (Webair and Ghouth 2014: 582)
4. Caregiver	For the purpose of this study, caregiver refers to an individual whose responsibility, at a given time, is the care of a child.

Concept	Definition
5. Gateway Clinic	A Public Health Care Clinic where patients with minor ailments are assessed and treated by professional nurses, free of charge
6.Paediatric Out- Patient Department	An out- patient department that manages sick children under the age of 12 years. The patients are either referred from clinics within the drainage area for the Hospital, or are follow ups from the paediatric ward. Patients are examined by Paediatricians.
7.Home treatment	For the purpose of this study home treatment refers to any remedy made at home. This translates to a combination of therapies used concurrently to treat an ailment?
8. Other external treatment	For the purpose of this study, other external treatment refers to treatment obtained from a traditional healer or over the counter which is used to treat an ailment.
9. First line treatment	For the purpose of this study, first line treatment pertains to the first treatment sought by the caregiver for the sick child.
10. Health intervention	An act performed on behalf of a child for the purpose of improving the child's health condition. (WHO 2016)

1.10 SIGNIFICANCE OF THE STUDY

1.10.1 On nursing research

This study aimed at enhancing already existing knowledge pertaining to the use of traditional medicine by caregivers for children under the age of five years as a health care seeking behaviour. It has already been proven that the use of traditional medicine is widespread in South Africa since Sharkey *et al* (2012: 111) suggests that 70% of South Africans go to an approximate 200000 Traditional Healers that are practising throughout the country .The study also highlights that although public health services are freely available many caregivers still prefer using traditional medicine. Studies have also asserted the need for promoting safe and effective use of traditional medicine; Tabuti *et al* (2012: 35) concluded that there is a great need to verify the safety and efficacy of traditional remedies in order to render traditional medicine as being safe and effective. A lack of knowledge exists about the use of traditional medicine as a prevalent health-care seeking behaviour, as well as the potential harm it poses for sick children more especially when not adequately identified and included in initial care planning. In view of this, the study aimed at examining the health care seeking behaviour of caregivers for children under the age of five years and to determine how the assessment of the sick child by health care professionals can be improved upon.

1.10.2 On the assessment of sick children under the age of five years

Presently, sick children under the age of five years, are globally assessed and classified according to the Integrated Management of Childhood Illnesses (IMCI) strategy at primary health care facilities.

The (WHO) and United Children's Fund (UNICEF) created and implemented IMCI worldwide as a child survival strategy with the aim of enhancing the skills of health care professionals (Horwood 2011: 42-52). The assessment of sick children at primary health care level is guided by the IMCI strategy which uses a syndromic approach to assess, classify and treat sick children according to the signs and symptoms displayed. In 1997, (IMCI) was first implemented in South Africa to promote child health and reduce child mortality rates. Currently, no provision is made in the assessment strategy in (IMCl) to guide primary health care professionals with history taking pertaining to possible use of traditional medicines and the incorporation of this information into classification and treatment of the affected child. This omission, as identified by the researcher based on a vast amount of experience, can result in the ongoing use of traditional medicine concurrently with conventional medication which places the child at high risk for liver and renal impairment.

Adams, Dagenais, Clifford, Baydala, King, Hervas- Malo, Moher and Vohra (2013: 226) examined the use of complementary and alternative medicine by paediatric speciality outpatients and confirmed that there is a high percentage of children with chronic illnesses that use alternative medicine. Most children

were given complementary medication concurrently with conventional therapy (Adams *et al* 2013: 226).

In view of these crucial findings, the significance of this research was to determine whether a need exists for the inclusion of compulsory history taking pertaining to the use of traditional medicine in children under the age of five years, which will assist in better health care planning.

1.10.3 On child mortality

According to Professor Wittenberg (2005: 40), over a decade ago, more than one quarter of the children in the Paediatric intensive care unit at Pretoria Academic Hospital were admitted as patients with potential poisoning and were suspected to have had toxicity after the usage of traditional herbal medication, furthermore, such children have a higher mortality rate. Therefore, the study aimed to investigate the health care seeking behaviour of caregivers of children under the age of five years with regard to the use of traditional medicine.

1.11 OUTLINE OF THE STUDY

Chapter 1 begins with an introduction to the study. It presents the study background, the problem statement, purpose, objectives and research questions, significance of the study, definition of concepts, conceptual framework as well as the study outline.

Chapter 2 presents a literature review on the use of traditional medicine to treat sick children in South Africa, Africa as well as globally.

Chapter 3 outlines the research methodology employed by the researcher whilst conducting the study.

Chapter 4 presents the data analysis as well as an interpretation of the numerical data generated from the study.

Chapter 5 provides a discussion of the data findings from Chapter 4, study limitations, recommendations and conclusion of the dissertation.

1.12 CONCLUSION

This chapter provided an introduction and background on the use of traditional medicine to treat sick children as well as the potential harmful effects it has on sick children. The assessment strategy used by health care professionals to classify and treat sick children was also introduced. Despite, the use of traditional medicine on sick children has been the subject of much research; it still presents challenges for the accurate assessment of sick children. This chapter also indicated the research problem and outlined the aims, objectives for this study as well as the research questions. Concepts were defined and a conceptual framework was used to depict the health care seeking behaviour of caregivers for children under the age of five years. The significance of the study was described.

A literature review was presented in the next chapter.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews available literature as well as previous research conducted on the use of traditional medicines, with the focus being on the use of traditional medicine to treat sick children under the age of five years. Grove *et al* (2013: 97) explains that a literature review is a systematic, organised and written presentation of reviewed literature. Holbrook, Bourke, Fairbairn and Lovat (2007) cited in Grove *et al* (2013: 97), also states that the literature review is "central to scholarly work and disciplined enquiry." The literature review is a summary of information published on the relevant topic. According to Polit and Beck (2012: 95) a literature review should give readers an objective and organised summary of evidence on the relevant topic.

In this study, literature was reviewed with the sole purpose of obtaining information that could contribute to achieving the objectives of this study, which were to determine the following:

1. The first line of treatment given to sick children by caregivers.
2. The health care seeking behaviour of caregivers for their sick children.
3. The health interventions after the first line of health care seeking.

A search for empirical literature was undertaken relating to the use of traditional medicine in children under the age of five years. Research

terminology included the traditional medicine use in children, Integrated Management of Childhood Illnesses and its resultant effects of traditional medicine on children. Online databases were searched using Academic Search Complete on EBSCO web, EBSCO Host (CINAHL, Health Source-Nursing/ Academic, MEDLINE); Google Scholar, Wiley online library, Web of Knowledge, ProQuest, and South African e-publications via Sabinet. The search indicated that many studies have already been conducted on the use of traditional medicine in children; which was reviewed and presented in the literature review.

Grove *et al* (2013: 111), make mention that the review of literature should be presented as themes that are organised into sections therefore, for the purpose of this study the literature review has been depicted by the use of specific headings.

2.2 THE GLOBAL USE OF TRADITIONAL MEDICINE

The use of traditional medicine is seen to be widespread at a global level, as indicated by the World Health Organisation's estimation that at least three quarters of the global population depend on traditional medicines as a means of primary health care. There has been an increase in the use of traditional medicine in all regions of developing countries as well as industrialised countries whereby the use of traditional medicine is being preferred more, than the use of conventional medicine by two to three times (Gunjan, Naing, Saini, Ahmad, Naidu and Kumar 2015: 134). Dongre, Deshmukh and Garg

(2010: 11) further confirmed that the popularity in traditional medicine use in India, as faith healers were the preferred choice, by caregivers for obtaining treatment for sick children. Webair and Ghouth (2014: 588) found that caregivers would commence home remedies if their children had cough or diarrhoea and further indicated that they would only seek medical care if the children's condition became deteriorated without concern about the safety of these remedies since a mother stated "As grandmothers say, traditional medicine benefits and never hurts, regardless of amount and type". Ekor (2013: 177) suggested that the use of complementary and alternative medicine has become popular in developed countries such as United Kingdom, Europe; North America as well as Australia.

Loh (2009: 1162) explored the perceptions of parents about the use of traditional medicine in Singapore, and found that majority of the parents had used traditional Chinese medication to treat their children. The WHO (2003), confirmed the global use of traditional medicine by indicating that up to 50% of medicinal consumption in China comprises of traditional medicines, 50% of the population in Europe and Northern America have used traditional medicines. Marais, Steenkamp and Du Plooy (2015: 3) indicated a high usage of traditional medicine in India, Chile, Australia and Turkey.

In the United States, it has been estimated that more than a third of the population has used alternative medicine (Kathi, Vohra and Walls 2008: 1375). The same authors also indicated that 629 million visits were recorded for the year of study, to providers of alternative medicine; this exceeded the

number of visits to primary health care physicians in that same year. The use of alternative medicine has also been found to be high in the United States with an estimation of 50% of children with chronic illnesses (Kathi *et al* 2008: 1375).

According to Gunjan *et al (*2015: 136) the estimated global market for traditional medicine is valued at US$ 60 billion, annually. This proves the extent to which traditional medicine is utilised world- wide.

2.3 THE USE OF TRADITIONAL MEDICINE IN AFRICA AND SOUTH AFRICA

The healthcare seeking behaviour of caregivers in Sub-Saharan Africa is truly pluralistic, consisting of three main domains: biomedical care, traditional healing and popular knowledge, (Towns *et al* 2014). The use of traditional medicine in Africa, among children is a common occurrence. This is substantiated by Bakshi, McMahon, George, Yumkella, Banqura, Kabano & Diaz (2013: 46-52) whereby, children who had diarrhoea, and fever were given traditional medicine, the study concluded that traditional medicine use and the role of herbalists needed to be addressed to improve child survival in Sierra Leone.

Approximately 80% of the global population utilises herbal medicines and in developing countries the use is as high as high as 95% (Gunjan *et al* 2015: 136). Among the 80% of people using traditional medicine, a large percentage includes children because, according to Professor Wittenberg (2005: 40),

more than one quarter of the children in a Paediatric Intensive Care Unit at a Pretoria Hospital admitted as patients with potential poisoning are suspected to have toxicity after the use of traditional herbal medication, further more children such as these have a high mortality rate. Sodi (2011: 101) explained, it is not surprising that traditional medicines are the main and most easily accessible point of health care for most people living in rural areas, also of important note is that the marketing of traditional medicines is also now a thriving industry.

Marais *et al* (2015: 1) established that the use of traditional medicine in South African communities plays an important role and therefore health care professionals must be aware of ailments that are commonly treated with traditional medicine. The same study also revealed that some of the most commonly treated ailments; with traditional medicine are cough, influenza as well as digestive problems. To further justify this finding, Mwambete (2010) stated that almost half of the caregivers depended entirely on using traditional medicine to manage childhood diarrhoea.

The use of traditional medicine to treat sick children can cause a delay in seeking medical care because Bopape, Mothiba & Malema *(*2013: 148) indicated that sick children with childhood illnesses were taken to hospital only when they had become seriously sick. When the children's caregivers were probed about the use of traditional medicine, they indicated that they had indeed first consulted with a traditional healer for a cure and it was therefore evident that caregivers sought medical care once they found that their

children were not improving after using traditional medicines (Bopape *et al* 2013: 148).

2.4 PERCEPTIONS OF CAREGIVERS PERTAINING TO THE USE OF TRADITIONAL MEDICINE

A mother's perception of health and illness has a direct impact on children's health since women are to a large extent responsible for caring for children (Towns *et al* 2014).

Traditional medicine use is a worldwide practice that has been occurring over centuries, and the reasons for this use vary from culture to culture. Webair *et al* (2014: 587-588) indicated that caregivers perceiving an illness as "not for medical intervention" was the main reason for a delay in seeking appropriate health care for sick children. Among other reasons, three major reasons patients seek the use of traditional medicine was highlighted. Firstly the traditional healer makes sure that patients are satisfied that their condition is considered seriously, as well as they are given enough time to talk about their fears and concerns. Secondly, the patient is treated holistically and finally the patient is viewed as a part of a community rather than just an individual (Sodi, Mudhovozi, Mashamba, Radzilani-Makatu, Takalani & Mabunda 2011: 103).

Mwambete (2010: 48) found that traditional medicines have been perceived as useful in treating childhood diarrhoea as well as that a large number of caregivers understood diarrhoea as being part of normal growth of a child.

When exploring the reasons behind people choosing traditional medicine, Ekor (2013: 177) described some to include that patients were uncomfortable to talk to a health care professional regarding its use; they also felt that there may be in breach of maintaining confidentiality as well as the fear of being misdiagnosed whereby herbal intoxication may be the diagnosis instead of an actual medical illness. In addition to the factors mentioned, the same author indicated that manufacturers and sales personnel have captured the attention of consumers by mass media and advertising in a manner that leads people to give credibility to traditional medication.

Among other reasons, caregivers indicated that they used traditional medicine for sick children due to word of mouth by others who successfully used these medicines; they also feared adverse effects of conventional drugs, as well as the need for greater personal attention (Kathi *et al* 2008: 1375). When Loh (2009: 1164) gave the parents the option of choosing top five reasons for traditional medicine use; among the findings were that traditional medicine was more effective and that conventional medicine presented many side effects. Advertisements promoting traditional medications attract all age groups of people including children who are vulnerable, with the indication that traditional medicines contain essential ingredients for healthy growth and development (Ekor 2013: 177).

Despite the promotion of conventional medicine by international healthcare organisations, more than 80% of the African population prefer to use traditional medicine which could be as a result of the comprehensiveness of

care rendered for example, in Sub-Saharan Africa the health care consists of three key elements namely, bio-medical care, traditional healing and popular knowledge (Towns *et al* 2014).

Considering the studies conducted, it is evident that the perceptions of caregivers seems to direct their health care seeking behaviour which may be harmful to the sick child.

2.5SAFETY, EFFICACY AND QUALITY OF TRADITIONAL MEDICINES

2.5.1 Safety

The safety of most traditional medicines has not been proven from a scientific perspective. However, Marais *et al* (2015: 1) believes that most Traditional Healers practice with knowledge imparted to them from ancestors as well as from generation to generation. This sort of practice has resulted in numerous patients being hospitalised from the adverse effects and drug interactions that occur from the consumption of traditional medication.

In an attempt to understand reasons for traditional medicine not being proven safe, Ekor (2013: 177) established that many herbal medicines are actually classified as food or dietary supplements, hence, evidence of quality, safety and efficacy is not mandatory prior to marketing. In addition to this the same author further emphasised that in certain instances traditional healers are not even registered practitioners, therefore the safety of traditional medication is a major concern to the general public and the national health sector.

In emphasizing the importance of traditional medicine safety, Nyika (2007: 25) established that conventional medicine is practised under strict regulations and is surrounded by extreme ethical guidelines that originally stem from The Nuremburg Code, however, traditional medicine appears to be exempt from such frameworks, thereby creating gaps in the practice of traditional medicine as well as placing a patient's health at risk. Although attempts are being made to ensure the safety of traditional medicines, herbal medications contain hundreds of natural constituents, analysis of each ingredient is almost impossible due to the cost of analysing each and every ingredient used (Ekor 2013: 177).

There are no standard procedures or protocols to assess the competence levels of traditional healers in order to deem them as safe practitioners. Unlike the manner in which health care professionals undergo training and stringent examinations before they are able to render patient care, this is substantiated by Nethathe & Russell (2014: 222), who indicated that there is no way of measuring the competence of a traditional healer since it is not possible to measure or regulate a belief or any communication with ancestors.

There are ethical considerations however, that must be implemented when medications are being tested on people to ensure the safety of patients but Nyika (2007: 25) explained that a traditional healer may give a client any herb without asking any questions regarding the action, side-effects or contra-indications. The same study highlighted that traditional healers may have "discovered" traditional medicines for the treatment of ailments such as

HIV/AIDS and these are “tested” on people without their consent and in the absence of observing for any potential side- effects as is the case during ethically approved studies.

The global use of herbal medication continues to grow as does the concern pertaining to the safety surrounding these medications however it is clear that some herbal medications have advantages, yet most that are used, remain untested nor is the use monitored, this makes information of their side effects extremely limited (Ekor 2013: 177).

2.5.2 Efficacy

Semenya & Potgieter (2014) indicated that 90% of traditional healers in their study determined the efficacy of their traditional medicines through consultations with ancestors and thereby concluded that there is a need to determine the safety and efficacy of traditional medicines through a scientific process.

Tabuti *et al* (2012: 35) revealed that there is a great need to verify the safety and efficacy of traditional remedies. The fact that traditional medicines have been consumed for many years does in no way prove that these are safe and effective according to Nyika (2007: 25) especially since the knowledge of traditional medication is passed on from generation to generation without any documentation of guidelines pertaining to safe dosages or potentially harmful adverse effects.

Tabuti *et al* (2012: 35) agree and have highlighted that there is a need to establish the safety and efficacy of traditional medicines, since knowledge on treating ailments was acquired mainly from parents and grandparents.

2.5.3 Quality

The quality of any medication consumed by people is of vital importance however Katerere (2008: 793) discovered that the potential for contamination of African traditional medicines was high, especially since the trading of medicinal plants in South Africa has become a multi- million rand business, and because of the great demand, the harvested plants are not scrutinised for contaminants. Clearly this puts the consumer of these herbal preparations, at risk of side effects arising from the organisms that could be contained in the medicine. The quality of the herbs and materials sourced to manufacture herbal medications to a large extent determines the efficacy of it however difficulties arise in monitoring the environmental conditions, collection practices as well as plant selection and cultivation (Ekor 2013: 177).

The quality of traditional medicines could also be compromised by the environment and the actual preparation, as Eseigbe, Anyiam, Ogunrinde, Wammanda & Zoaka (2012) indicated that poor hygiene in preparing herbal medication as well as the concurrent use with conventional medication makes these concoctions dangerous to those consuming it.

2.6 EFFECTS OF TRADITIONAL MEDICINES

There are many desired effects that caregivers seek by administering traditional medication, among these are; to cause diarrhoea and vomiting (Gunjan *et al* 2015: 145). Nethathe & Russell (2014: 224), indicated that there is a ritual of cleansing that involves traditional medicines that cause purging, and this ultimately results in liver dysfunction with the potential of death. Loh (2009: 1164) has shown that most of the caregivers sought to use traditional medicine for gastro- intestinal disorders inclusive of diarrhoea and vomiting. According to Loh (2009: 1164) parents viewed the traditional medicine as being preventative and that the child was being treated as a whole and not merely the illness. This author also indicated that 75% of the parents who used the traditional medicine felt that their children's condition had improved.

2.7 BENEFITS OF TRADITIONAL MEDICINE

Despite many problems and negativity surrounding the use of traditional medication in children, there are also some benefits to it. Aworinde and Erinoso (2015: 9); emphasised that traditional medicines have and always will be an integral part as an alternative health care system. Adeyeye *et al* cited in Borokini, Ighere, Clement, Ajiboye & Alowonle (2013: 14), reported that more than half of their respondents who are asthmatics successfully used traditional preparations and also concluded that there are many therapeutic properties of plants that can be used to treat various diseases.

According to Nethathe & Russell (2014: 223), another advantage of traditional medicine is that traditional healers often speak the same language as their

clients, so this allows for better client understanding and co-operation. This study also indicated a benefit to be that the explanations of illness was done in correlation with cultural beliefs.

2.8 PRIMARY HEALTH CARE ASSESSMENT STRATEGIES FOR A SICK CHILD

Horwood (2011: 42) indicated that Integrated Management of Childhood Illnesses [IMCI] was first introduced to South Africa in 1997, and has been the gold standard for assessing sick children at primary health care level. The study also reflected that IMCI is a child survival strategy that was created by the World Health Organisation and UNICEF, with the aim of enhancing the skills of primary health care professionals. In a study on IMCI, Saloojee (2007: 172) explained that IMCI is an assessment strategy that uses a syndromic approach – whereby specific signs and symptoms are the entry point. Sick children are assessed by IMCI trained practitioners and then "classified" into one of three categories that are colour coded. The colour coding is done according to the clinical signs and symptoms that the sick child presents with, and guides the health care practitioner in planning the appropriate care for the child.

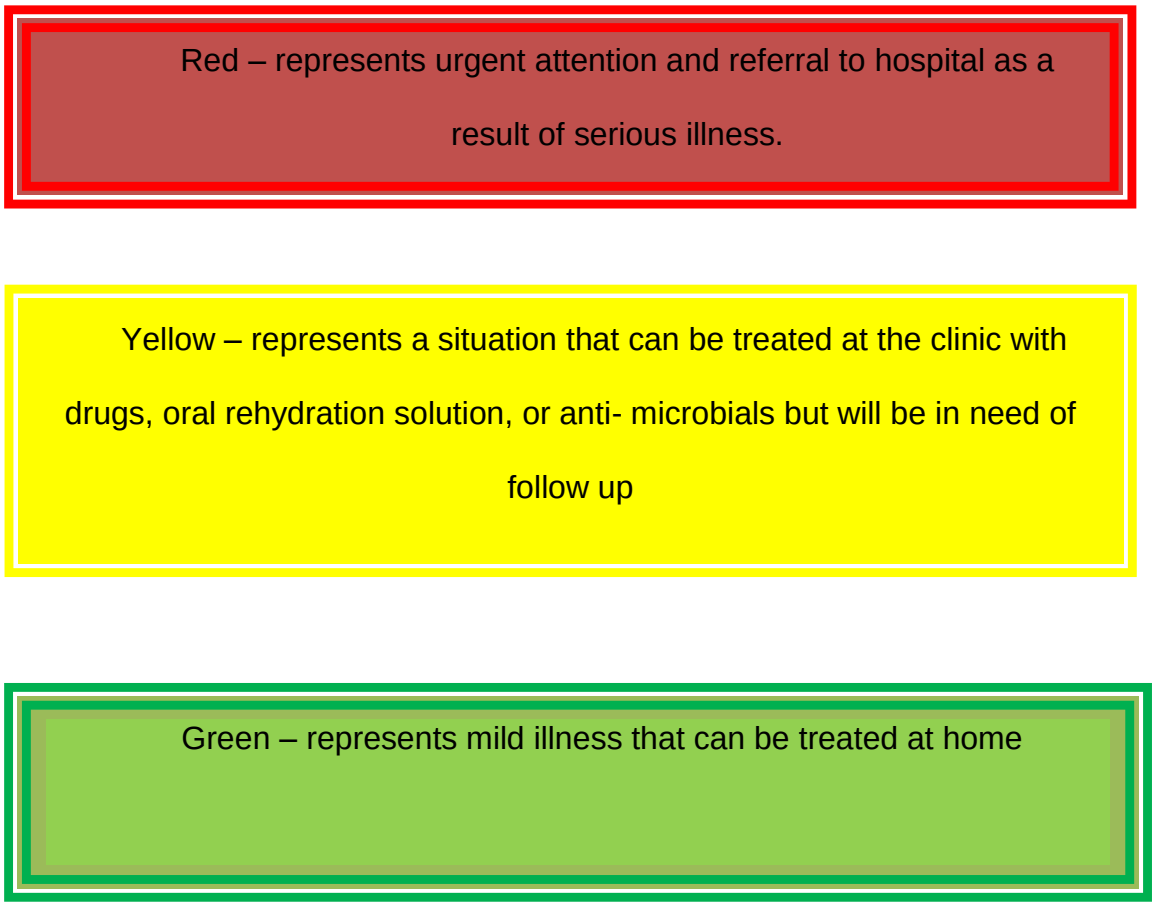

Figure 2.1: Classification of a sick child under the age of five years according to IMCI

The purpose of classifying is to guide the primary health care provider to choose a plan for management of the sick child. Horwood (2011: 42) also stipulated IMCI insists that health care professionals make the necessary effort to do a thorough and holistic assessment of each child. Overall, the implementation of IMCI resulted in a 25 – 30% decline in child mortality (Horwood 2011: 42). However, Cheema, Stephen & Westwood (2013: 43) conducted a study on Paediatric Triage in South Africa and found that while

IMCI was a very valuable assessment tool at primary health care level, it has an incomplete rapid evaluation for conditions that are life threatening like poisoning, severe pain and temperature.

The management of a child with diarrhoea is a critical component of the IMCI programme. Without early and appropriate treatment, complications such as dehydration and shock can occur. Electrolyte imbalances like hyponatremia, hypernatremia, hypokalaemia, hypoglycaemia and renal failure may follow Terblanche (2010). These complications may occur as a result of ongoing administration of traditional medicines with the intention being to 'cleanse' child as indicated by (Luyckx *et al* 2005: 40).

According to the IMCI assessment guidelines, children under the age of five years, presented to Primary Health Care facilities for diarrhoea and vomiting, classified as "no visible dehydration" or "some dehydration", are sent home with oral rehydration solution, to follow up in five or two days respectively. With no history taken from the caregiver, by the health care professional pertaining to the use of traditional medicine, there is the possibility that the caregiver may resort to the use of; or continue the use of traditional medicine concurrently with conventional medicine (Eseigbe *et al* 2012).

2.9 CHILDHOOD ILLNESSES TREATED WITH TRADITIONAL MEDICINES

Table 1 indicates the childhood illnesses commonly occurring in children under the age of five years and the use of traditional medicines as care

seeking behaviour by caregivers. These childhood illnesses are also addressed by IMCI.

Table 2.1: Childhood illnesses treated with traditional medicines

	Childhood Illness	Traditional medicine used	Source
1.	Convulsions	Ash Yes "African civet meat, dead shrewd, *Allium asaclonicum* bulb, fresh *Nicotiana tabacum* fruit, dry chameleon are all soaked in leaf juice from *Crinum jagus* or *Crinum glacum."*	Tabuti *et al* 2012:35 Towns *et al* 2014 Borokini *et al* 2013:5
2.	Lethargy	Yes	Towns *et al* 2014
3.	Vomiting	Yes	Towns *et al* 2014
4.	Cough	Red soil, fat	Tabuti *et al* 2012:35
		Home remedies made from herbs	Webair *et al* 2014:581
		Costus afer stem, *Garcinia kola* seeds	Borokini *et al* 2013:5
		Terminalindusindica	Gunjan *et al* 2015: 145
5.	Diarrhoea	Red soil	Tabuti *et al* 2012:35
		Cut on child's fontanelle and apply herbs	Bopape *et al* 2013:152
		Herbs, seeds e.g. Artemisia	Webair *et al* 2014:581
6.	Fever	Ash	Tabuti *et al* 2012:35
		Hot oil, or herbs, or special massage	Webair *et al* 2014:581
		Azadirachtaindica *Aconitum ferox*	Gunjan *et al* 2015: 145
7.	Rash/Measles	Yes	Towns *et al* 2014
8.	Ear Pain	Yes	Towns *et al* 2014
		Salt and honey mixture, extract from *Ageratum conizoides* leaves	Borokini *et al* 2013:5
9.	Weight loss	Yes	Towns *et al* 2014
10.	HIV	Imbiza, Canova, Tre-en-en	Peltzer *et al* 2011:337
11.	Tuberculosis	Fat	Tabuti *et al* 2012:35
		Seeds of unripe *Carica papaya*-blended	Borokini *et al* 2013:5

	Childhood Illness	Traditional medicine used	Source
12.	Cholera	*"Sarcocephalus latifolius* root bark is grinded till it becomes homogenised, mix with a glass cup full of *Citrus aurantifolia* fruit juice in a bottle."	Borokini *et al* 2013:5
13.	Prevention against all ailments	*"*Put complete intestines of a white cock, white male duck and male big rat in a white covered container. Mix some of the blood of the three and add it to your bath water. Soak the intestines with palm kernel oil and add *Enantia chlorantha* bark. Take 2 spoons every 3 days."	Borokini *et al* 2013:8

2.10 THE IMPACT OF TRADITIONAL MEDICINE USE ON CHILD MORBIDITY AND MORTALITY

Sharkey *et al* (2012: 114), indicated that hospital based audits on child mortality suggest that many sick children present late to seek medical attention especially in under resourced places. The same authors also implied that when caregivers of sick children eventually seek health care either at local clinics or hospitals, there is a lack of a detailed assessment of traditional medicine use in the sick child, and care planning is done without consideration of the traditional medicine being used and this could result in the caregiver continuing to administer traditional medicine in conjunction with conventional treatment and the effects on the renal system and the liver could be detrimental to the sick child.

Having considered the findings by the above mentioned authors, it is evident that some caregivers will either seek traditional medicine to treat childhood diarrhoea and vomiting or they may actually induce it as a means of

"cleansing" the child therefore traditional medicine should be considered when assessing a child with diarrhoea and vomiting.

Towns *et al* (2014) indicated that the childhood illnesses posed the greatest concern to the WHO which includes diarrhoea, respiratory conditions and malaria and are in some instances being treated by using medicines made from plants, as well as these traditional medicines which were self-administered was shown to have been preferred as compared to seeking medical care. The concurrent use of traditional medicine with conventional medicine poses a great threat to the lives of patients more especially if healthcare professionals do not identify the use of traditional medicine before prescribing conventional treatment. The use of traditional medicines may at some level expose the patient to toxins however when combined with other chemicals it can be fatal (Nyika 2007: 33). In countries where the health care facilities provide adequate care, it is the care seeking interventions by caregivers that actually have the potential to considerably reduce child mortality, this was realised more than a decade ago by Hill *et al* (2003: 668) who explained that the increased mortality among children in developing countries where the children die without even reaching a health care facility and those children who are taken to hospital but die anyway as a result of a delay in seeking appropriate medical care. Terra de Souza – cited in Hill *et al* (2003: 668), found that majority of child deaths in developing countries were linked to delay in seeking health care. Approximately ten years later Buchwald *et al* (1992) cited in Webair *et al* (2014: 581) justified this finding when they

explained that using traditional healing maybe unfavourable especially if this caused a delay in patients seeking timeous medical care as well as some of these practices may be harmful.

Blanke *et al* (2008: 38), found that children who were given traditional medicine before admission to hospital were more likely to die, more so in children who were younger. The same study also identified that seeking traditional medicine first, caused a delay in seeking timeous health care. Childhood deaths arising from complications of diarrhoea include dehydration, impaired renal function, acidosis, as well as hypertension and this is further complicated by a delay in initiating proper treatment which results in a high morbidity among children, especially in the light of diarrhoea being a common health problem in developing countries (Mwambete 2010).

Over 95% of caregivers knew a remedy derived from plants, to treat top statistical causes of childhood mortality, these include diarrhoea, respiratory disorders and malaria which prove that traditional medicines are actually being used to treat disorders that are indicated in the IMCI assessment strategy which provides evidence to greatly suspect the probability of traditional medicine usage in a sick child prior to seeking healthcare and therefore the need for a more comprehensive healthcare system (Towns *et al* 2014).

2.11 DISCUSSIONS BETWEEN HEALTH CARE PROFESSIONALS AND CAREGIVERS

According to Vlieger, Vliet & Jong (2011: 619) majority of paediatricians did not enquire from patients about the use of traditional medicine despite a large number of children in the general population and majority of children with chronic illnesses had used traditional medicine. It was also highlighted that although there was a high prevalence of traditional medicine use, paediatricians and parents did not discuss this during the assessment of sick children (Vlieger *et al* 2011: 629). The lack of discussion between caregivers and health care professionals was also re-enforced by Araz (2011: 21) who found that most of the parents did not inform their children's doctor that they had used alternative medicine and therefore concluded that health care professionals should discuss the use of alternative medicines with parents of sick children in view of the potential risks to the sick child. Oshikoya *et al* (2008) also indicated that none of the parents in their study had disclosed the use of traditional medicine to the doctor, however 85% of parents would have disclosed this information if they were asked by the examining paediatrician.

Fesharakinia & Mohammadreza (2014: 111) revealed that almost all the mothers in their study were completely unaware of the potential side effects of the traditional medicine they had used for their children and further recommended that in view of the high potential to have conventional drugs interact with the herbs used, paediatricians must enquire about the use of traditional medication and advise caregivers accordingly. Many patients only seek Western medicine once traditional medicines have failed or a

complication occurs, (Luyckx et al 2005: 39). This adds confirmation to Adams *et al* (2013: 228), with their finding that although the use of complementary medication is so prevalent among children, there are very few caregivers who actually disclose the use to the attending health care professional with some of the reasons for non- disclosure included the concern of a negative response from the health care professional, the physician did not need to know and also that the health care professional did not ask about alternative medication.

In trying to understand the use of traditional medicine, Marais *et al* (2015: 1), indicated that patients are often unwilling to disclose to health care professionals that they have made use of traditional medicine; more so from fear that they may be judged negatively. The same study also highlighted that health care professionals are also to blame for not always asking their patients about traditional medicine use; as the lack thereof could result in drug –herb interactions, potential treatment failure, and even death.

Loh (2009: 1163) also highlighted that although it is often thought that traditional herbal remedies are safe since these are natural products, concurrent use of these herbal medicines with conventional medicine poses a great risk for drug – herb interactions. Adams *et al* (2013: 228) strengthens the findings by Loh, by stating that the use of complementary medication concurrently with conventional medicine is actually widespread, and this leaves the sick child in danger as caregivers may be unaware of potential medication interactions. Children who are given alternative medicine are quite

likely to visit a paediatrician for an illness, and take conventional medicine concurrently with alternative medicine; however most of the caregivers do not disclose this use to their child's doctor therefore it was suggested that doctors attending to sick children establish an open relationship with caregivers to foster clear communication pertaining to the use of alternative medicine.

Although the lack of discussion between health care professional and caregivers has been described in previous studies for over 10 years, there still remains place for health care assessment of sick children to improve (Adams *et al* 2013: 228).

2.12 CONCLUSION

As reviewed in this chapter, research has proven that the use of traditional medicines among sick children is widespread in South Africa and globally.

However, based on some studies done, evidence exists that traditional herbal preparations can be beneficial in certain instances. Questions that arise from these discussions are; as to what sort of screening is done to ensure that the herbs are harvested from a safe environment? As well as on what basis are doses calculated and administered to ensure safe dosing especially in younger children?

Several other studies have found that traditional medicines are used to actually cause diarrhoea and vomiting in children as a desired effect for "cleansing purposes", which can further escalate to acute renal failure, liver toxicity and an increased risk of mortality. The literature review also provided

evidence that there is a delay with referral of children with diarrhoea from Primary Health Care level to hospital. Studies have also indicated that there is high mortality rate in children who have been given traditional medicines.

The literature reviewed has also indicated that many of the disorders for which traditional medicine has been sought, is among the common childhood illnesses that are assessed in IMCI.

It is evident from the various studies discussed under number 9- which indicates that there is a dire need for health care professionals to delve further into the history of the patient by asking about as well as managing the use of traditional medicine in sick children. Many of the studies concluded that a lack of enquiring from caregivers about the use of traditional medicine could result in potential death. Therefore, it is imperative that the use of traditional medicine be identified in every sick child being assessed by a health care professional so as to incorporate this information into the planning of medical care which would ultimately include the implications of traditional medicine usage.

The next chapter describes the research methodology employed by the researcher whilst conducting the study. The methodology includes the population, sampling and data collection.

CHAPTER 3
RESEARCH METHODOLOGY

3.1. INTRODUCTION

This chapter presents the research methodology that was used in this study which is inclusive of the research design, research setting, sampling process, instrument, and data collection process. The application of ethical considerations specific to this study is also described in this chapter. The chapter also provides an insight to the methods of data analysis used in this study.

3.2. RESEARCH METHODOLOGY

3.2.1 Quantitative research

According to Polit and Beck (2012: 13), quantitative research pertains to a positivist, scientific method by which to acquire information. Positivism reflects a broad cultural movement that gives emphasis to the rational, and positivists also view objectivity as a goal and persevere to be neutral and unbiased (Polit and Beck 2014: 6). Quantitative researchers move in a logical manner from defining a problem, selecting concepts to focus on and proceed to how to solve the existing problem. Grove *et al* (2013: 35) explain that applied research using the quantitative approach is a scientific investigation which is carried out to add to existing knowledge and thereby improve or influence clinical care rendered. In this study the researcher conducted an investigation

to try and generate information to improve on the assessment of sick children under the age of five years.

Polit and Beck (2014: 6) explain that quantitative research involves the gathering of empirical evidence which is gathered systematically with the use of a formal data collecting instrument and this information is analysed statistically (Polit and Beck 2014: 6). A quantitative methodology was applied in this study since it provided a pre-specified, logical and orderly plan for the researcher to utilise.

3.2.2 Research Design

Grove *et al* (2013: 214) believe that a research design is a blueprint for carrying out a study and also that it ensures control over aspects that could interfere with the validity of research findings.

The researcher used a descriptive design. According to Grove *et al* (2013: 66); descriptive studies are carried out in order to address a problem that requires a solution. The researcher has identified that the use of traditional medicine in sick children is prevalent; however this is not adequately identified and incorporated into the assessment and care planning of the affected children. Grove *et al* (2013: 66) further explain that descriptive researchers identify an area that lacks specific knowledge or information, which can be addressed by seeking the perspectives of the people most affected. The researcher has determined a potential gap in the health assessment of sick children under the age of five years and therefore, seeks to obtain information

from the caregivers of sick children under the age of five years regarding their health seeking pathways. Ultimately, the goal of descriptive research is to develop an intervention that will be of benefit to the population (Grove *et al* 2013: 66). The researcher intended to emphasize that it is imperative for health care professionals to consider health seeking behaviour of caregivers in terms of potential traditional medicine use, during assessment of all sick children.

According to Grove *et al* (2013: 49), the main purpose of descriptive research is not only to explore but also to describe real life situations. The approach is used to generate new information about phenomena about which little is known. A descriptive design can be used to detect problems that occur with current practice. This study identified the need for health care professionals to enquire about the use of traditional medicine for sick children.

3.2.3. Research setting

The setting pertains to the actual location of where the study will be conducted (Grove *et al* 2013: 49). This study was conducted at a regional hospital which serves an urban community as well as the surrounding rural areas. The hospital serves as a referral hospital to other hospitals, as well as 40 clinics from surrounding areas. Sick children from the surrounding clinics, who are classified according to IMCI guidelines as “requiring urgent attention and referral to hospital as a result of serious illness”, are referred to the Paediatric Out – Patient Department (POPD). This is also a department where stable children who have been discharged from the paediatric ward are

followed up until they are completely well. Children with chronic medical illnesses are also assessed, treated and monitored in POPD at the designated hospital. The children at POPD are first assessed by the nurses who monitor and record the children's vital signs, triage them and then direct the children to the doctor to be examined and treated. An average of 1000 children under the age of five years are reviewed and treated at POPD on a monthly basis.

An average of 250 children under the age of five years, with minor ailments or requiring immunisation, attends the Gateway Clinic which is situated at this hospital. They are assessed and managed at the Gateway Clinic directly from home. The children under the age of five years are attended to separately from the adults. Primary Health Care (PHC) trained nurses who use IMCI guidelines, assess, classify and treat or refer these children accordingly.

3.3. RESEARCH POPULATION

A population pertains to the entire aggregation of cases which share common characteristics in which the researcher is interested (Polit and Beck, 2012). In this study the population was all the caregivers with sick children attending the Gateway Clinic and Paediatric Out-Patient Department at the hospital.

The target population refers to the whole set of individuals who met the sampling criteria (Grove et *al* 2013: 351). In this study the target population was all the caregivers who are 18 years and older with sick children zero to

five years of age, attending the Gateway Clinic and Paediatric Out-Patient Department (POPD) at the hospital.

Accessible population refers to a portion of the target population to which the researcher has reasonable access (Grove *et al* 2013: 351). The researcher had reasonable access to the caregivers at Gateway Clinic and POPD.

3.4. SAMPLE TECHNIQUE

3.4.1 Selection of the research setting

A research setting pertains to the actual place where the research study takes place (Polit & Beck, 2012). The data collection sites, which were POPD and Gateway Clinic at a regional hospital, had been selected using purposive sampling technique. Purposive sampling was used by a researcher to subjectively select the research setting based on what he/she thinks would be representative of the population (Polit & Beck, 2012). In this study the researcher selected Gateway Clinic and POPD at the regional hospital since forty surrounding clinics refer children to this hospital. The researcher viewed this as a representation of a large portion of the population in the area.

There are three commonly used settings that are used in nursing research; a natural setting, a partially controlled setting or a highly controlled setting (Grove *et al* 2013: 49). In this study a natural setting was used since it was not in any way controlled by the researcher, it was a real life setting, whereby caregivers were approached to voluntarily participate in the study as they were waiting to be assessed by a healthcare professional.

3.4.2 Selection of the respondents

The researcher used a sample consisting of caregivers who were 18 years and older, with their sick children under the age of five years, attending the Gateway Clinic and Paediatric Out-Patient Department. According to Grove *et al* (2013: 709) sampling involves a process of choosing a group of people or other elements that are representative of the population studied. Purposive sampling technique was applied to this study. In this type of sampling the researcher exercises judgements in selecting sample members who possess the characteristics of interest, Polit and Beck (2012) which in this case were caregivers of children under the age of five years, since they have been directly involved in seeking healthcare for their children.

Caregivers with sick children under the age of five years at the Gateway Clinic were representative of children seeking first line of health care. Whereas, caregivers with sick children under the age of five years at the Paediatric Out – Patient Department were representative of children referred from a primary health care clinic to hospital. POPD also reviews children who have been admitted to the ward and discharged once they have recovered as follow up. Monitoring of chronically ill children is also ongoing in POPD. Once the children were assessed by the nurse and seated in the waiting room, the researcher approached the caregivers individually. The caregivers were addressed prior to them consulting the doctor since the waiting time ranged from one to three hours. Therefore the caregivers had sufficient time to complete the questionnaire.

3.5 SELECTION CRITERIA

3.5.1 Inclusion criteria

Only caregivers who were 18 years and older with sick children under the age of five years attending the Gateway Clinic and Paediatric Out-Patient Department designated hospital were included in this study.

3.5.2 Exclusion criteria

Caregivers under the age of 18 years were excluded since this may be viewed as a vulnerable age group.

Caregivers with sick children seeking health care from the private sector were also excluded.

Caregivers with children who were critically ill, in view of the increased anxiety experienced.

3.6. SAMPLE SIZE

The sample size for this study was calculated by a statistician, who used the statistics of the selected departments as provided by the researcher, based on the statistics of the chosen hospital.

- One hundred and eighty three (183) caregivers with children under the age of five years attending the Gateway clinic and,
- Three hundred and twenty four (324) caregivers with children under the age of five years at POPD.

- Therefore the total sample size amounted to five hundred and seven (507) caregivers.

3.7. DATA COLLECTION INSTRUMENT

A self- developed, simply worded questionnaire was used to collect data for this study (Annexure K, Annexure L). According to Grove *et al* (2013: 425) a questionnaire is a printed self- report form which is created to elicit data in written form from a respondent. Questionnaires can be designed to obtain facts about respondents, their beliefs, attitudes, or their intentions (Grove *et al* 2013: 425). It may appear easy to design a questionnaire however one that is well- designed requires a considerable amount of effort for example literatures searches to match the requirements of the study (Grove *et al* 2013: 426).

3.7.1 Development of the questionnaire

The development of the questionnaire was guided by the literature review conducted as well as reviewing the IMCI guidelines for assessing and classifying sick children. Section A pertains to the participant's demographic data. Section B comprises of the health seeking behaviour of the caregivers for children under the age of five years. The illnesses depicted in the questionnaire are derived from the classification of illnesses indicated in the IMCI strategy. Table 3.1 provides a summary of the various sources that were used in developing the data collection tool thereby rendering justification as to the reasons for asking specific questions to caregivers.

TABLE 3.1: ORIGINS OF THE DATA COLLECTION INSTRUMENT- SECTION B

Dimension	Question	Source
1.Relation to child	How are you related to this child	Towns *et al*(2014)
2.Age of child	How old is your child?	IMCI
3.Safest treatment option	What treatment do you consider to be the safest in treating your sick child?	Webair *et al* (2014:587) Towns *et al*(2014)
4.General Danger Signs	What type of treatment would you first give your child should he/she have the following illnesses [convulsions (fits), lethargy(floppy), vomit everything?	IMCI
5.Time taken to seek care	If your child had any of the above mentioned signs, how long after the onset will you seek help?	Mwambete (2010) Towns *et al*(2014)
6.Cough	What type of treatment would you first give your child should they have the following illnesses? **[** Dry cough, Cough with chest in-drawing, Fast breathing, Noisy breathing, Wet cough**]**	IMCI & Webair *et al* (2014:587)
7.Diarrhoea and vomiting	What type of treatment would you first give your child should they have the following illnesses? **[**Watery stools, Blood in stools, Sunken eyes, Not able to drink anything, Sunken fontanelle (soft spot on head)**]**	IMCI & Mwambete (2010) Webair *et al* (2014:587-558
8.Fever	What type of treatment would you first give your child should they have the following illnesses? **[**Feels hot to touch, Has stiff neck, Bulging fontanelle (soft spot on head that is bulging)**]**	IMCI & Marais *et al* (2015:1)
9.Measles or Rash	What type of treatment would you first give your child should they have the following illnesses? **[**Rash on body and feels hot to touch, Red eyes, Mouth sores/ whitish spots in mouth**]**	IMCI & Marais *et al* (2015:1)
10.Ear problem	What type of treatment would you first give your child should they have the following illnesses? **[**Ear pain, Ear discharge, Child wakes up at night with ear pain, Has swelling behind ear**]**	IMCI Towns *et al*(2014)

Dimension	Question	Source
11.Malnutrition and Anaemia	What type of treatment would you first give your child should they have the following illnesses? **[**Mild weight loss, Severe weight loss, Swelling of both feet, Pale palms**]**	IMCI
12.HIV Infection	Has your child been tested for HIV Infection?	IMCI
13.HIV Infection	What type of treatment would you first give your child should they have the following illness? **[**HIV Infection**]**	IMCI
14.Tuberculosis	What type of treatment would you first give your child should they have the following illnesses? **[**Cough for more than 7 days, Fever for 14 days or more, Child is tired all the time, Losing weight, Has been in contact with a person who has TB**]**	IMCI & Webair *et al* (2014:587-558
15.Preferred treatment	Which of the following method/s of treatment do you prefer to use when your child is sick? [Traditional only, Western only, Both Traditional and Western, Other (please specify)_____]	Adams *et al* (2013) Kathi *et al* (2008) Towns *et al*(2014)
15.Failure of first intervention	If your child became sicker while on clinic medicine, what would you do?[Stop the medicine, Go back to the clinic, Continue until the medication is finished, Go to the traditional healer, Other (please specify) _____	Adams *et al* (2013) Kathi *et al* (2008) Towns *et al*(2014)
16.Caregiver perception on treatment methods	Indicate your level of agreement that the following are reasons why you would choose to take your child to a traditional healer/ use traditional medicine: (Answer all the questions) I have always used traditional medicine. My child could not be cured at the clinic. There are no clinics close to my home. Western medicines are too expensive. I prefer to use herbs/ home medication that I / elders at home prepare. Traditional medicine is effective for my child. Western medicine does not always help make my child better. Western medicine has too many side effects. It is easier to communicate with a traditional healer. Family and friends encourage me to go to a traditional healer. Natural medicine is better.	Loh (2009:1164); Sodi *et al* (2011:103); Webair *et al* (2014:587-558) Kathi *et al* (2008)
17.Discussion of traditional medicine use with health care provider	If you used traditional medicine, and a doctor or nurse asked you about the traditional medicine, would you talk to them about it?	Adams *et al* (2013) Kathi *et al* (2008)

Dimension	Question	Source
	If your child were to get sicker after giving traditional medicine would you stop giving the medicine?	Adams *et al* (2013) Towns *et al*(2014)
	If the clinic/ hospital doctor asked you to stop the traditional medicine while your child is on western medicine, would you comply?	Adams *et al* (2013)
	. Are you happy to discuss the use of traditional medicine with your clinic/ hospital doctor or nurse?	Adams *et al* (2013) Kathi *et al* (2008)
	If you had started giving your child traditional medicine and the medical doctor prescribed western medicine as well, would you give both together?	Adams *et al* (2013) Marais *et al* (2015:1)
	Indicate whether the following are reasons why you would not tell the clinic doctor or nurse about using traditional medicine: Fear The staff will not understand It is not relevant to Western medicine	Adams *et al* (2013) Bopape *et al* (2013:148) Kathi *et al* (2008)

3.7.2 Validity of the questionnaire

According to Grove *et al* (2013: 393) validity of an instrument refers to the extent to which it is able to actually measure the construct being studied. Validity of a study depends on the soundness of evidence produced, and whether the study is unbiased and well-grounded (Polit & Beck, 2012). The validity of the data collection tool is discussed below.

3.7.2.1. Face validity

Grove *et al* (2013: 394) explain that face validity is when the instrument basically looks like it is valid and furthermore that the instrument appears like it will measure the construct being studied. Face validity is based on the judgments of those who are deemed knowledgeable in that specific field

(Neuman, 2012). The data collection instrument used in this study was scrutinised by;

a) Experts in the formulation of questionnaires

b) A statistician,

c) The Departmental Research Committee and the Research for Higher Degrees Committee of Durban University of Technology, and

d) The Research Ethics Committee of Durban University of Technology.

Suggestions that they have made were incorporated into the research instrument.

3.7.2.2. Content validity

According to Grove *et al* (2013: 394), content validity determines the extent to which the method of measurement includes the major factors that are relevant to the construct which is being measured. In this study the content of the questionnaire was compiled from the literature reviewed on the use of traditional medicine in children, as well as the IMCI assessment strategy currently used to assess, classify and manage sick children at primary health care clinics - Integrated Management of Childhood Illnesses. This has been achieved by explaining signs and symptoms of childhood illnesses in the questionnaire, according to IMCI guidelines of assessing and classifying sick children. (See table 3.1 – Origin of the data collection instrument).

The research questions were also considered during development of the data collection tool, this is depicted in table 3.2 Research questions in relation to the data collection tool.

TABLE 3.2: RESEARCH QUESTIONS IN RELATION TO THE DATA COLLECTION TOOL

RESEARCH QUESTIONS	QUESTIONS THAT CONTRIBUTE TO THE RESEARCH QUESTIONS
What is the first line of treatment for sick children by caregivers?	Section B questions 4 to 12
What is the health seeking behaviour of caregivers for their sick children?	Section B questions 3 to 12
What medicines or practices are used after seeking help to manage sick children?	Section B questions 13 and 12

Consistency in the manner the questionnaire was administered is also a vital aspect to the validity, Grove *et al* (2013: 393). Therefore for the purpose of ensuring consistency, the researcher administered each questionnaire personally to the respondents.

3.8. STUDY VALIDITY

Study validity refers to how accurate and truthful a claim is. It is the foundation for generating sound evidence to improve practice Grove *et al* (2013: 197). Validity is classified into two categories:

3.8.1. Internal validity: pertains to the degree to which the factors detected in the study are a true reflection of what is real – (Grove *et al* 2013: 199). In this

study all the information generated from the data collection process is a true reflection of the caregiver's health care seeking behaviour for the sick child under the age of five years. Every effort was made by the researcher to encourage participants to be honest about their health care seeking behaviour and they were reassured of their anonymity and confidentiality.

3.8.2. External validity: according to Grove *et al* (2013: 202), this is with regard to what extent the study findings can actually be generalised in other settings and by using other samples. A study is deemed to be externally valid if the sample represents a broader population and the study setting represents other environments. The study setting that was selected is a public institution that provides health care to a large community which includes forty surrounding clinics. On average, 1250 children under the age of five years are assessed, and treated at this institution; therefore the information generated from this study represents a broader population and other public health care institutions in Kwa Zulu- Natal.

3.9. RELIABILITY

The data collection instrument was tested for reliability by means of a pilot study. Polit and Beck (2012: 195) explain that a pilot study is a trial run which is done to test the method that will be used in a larger study. For the purpose of this study, a pilot study was conducted prior to the actual data collection. The researcher handed out questionnaires to five caregivers who met the inclusion criteria at the Gateway Clinic prior to the actual data collection for this study. The researcher explained to the respondents the reasons for the

pilot study as well as that the data obtained was not to be used in the study but to test the reliability of the instrument. A fully informed consent was obtained from respondents engaging in the pilot study. Confidentiality was maintained throughout the process of the pilot study. The pilot study was conducted in an attempt to detect and correct any potential misconceptions and ambiguity pertaining to the questionnaire.

The findings from the pilot study suggested that the questionnaire adequately obtained the information required from respondents. There were no misconceptions by the respondents and the questions were easily understood. Therefore no changes were made to the questionnaire. The data from the pilot study was not included in the study.

3.10. DATA COLLECTION PROCESS

The researcher gave the respondents a face to face explanation of the purpose and benefits of the study, the value of their participation in the study as well as their rights. The researcher ensured that at each data collection session, an interpreter for isiZulu speaking caregivers was available. After a clear explanation of the study was given to the caregivers, a written letter of information was handed out to each voluntary respondent, in English (Annexure F) for those who spoke and understood English and in Isi-Zulu (Annexure H) for those who spoke Isi-Zulu. The English version of the questionnaire (Annexure K), letter of information (Annexure H) and consent (Annexure I) was translated to IsiZulu by an IsiZulu speaking lecturer in community nursing. Written, informed consent was obtained prior to data

collection. Data was collected using a structured questionnaire (Annexure K) for English speaking respondents and in Isi-Zulu (Annexure L) for those who spoke in Isi-Zulu. These were handed to caregivers who met the inclusion criteria. The researcher gave the respondents a verbal explanation as to how to answer the questionnaire. The researcher ensured that a health care provider who was fluent in IsiZulu was readily available in the event translation or any explanation was needed. In the event of a respondent being unable to read or write, the researcher assisted with completion of the questionnaire. The average time taken by the respondents to complete the questionnaire was 25 to 30 minutes.

The respondents were not given any incentive to participate in the study. Questionnaires were answered by the respondents while they were seated in the waiting area to consult the doctor in POPD or the PHC nurse at Gateway Clinic. Once the respondents had completed the questionnaires, they were thanked by the researcher for their valuable contributions to the study. Confidentiality was maintained at all times. The data collection process was conducted by the researcher over two months at Gateway Clinic and over four months at POPD.

3.11. DATA ANALYSIS

The main aim of data analysis is to provide results of the study conducted (Polit and Beck 2012:472). Data was analysed descriptively using SPSS version 17 with assistance from a statistician. There were various tests that were used to analyse the data collected. Descriptive statistics including

means and standard deviations were used where applicable. Frequencies were represented in tables or graphs. Chi-square goodness-of-fit-test which is a univariate test was used on a categorical variable to test whether any of the response options are selected significantly more/less often that the others. Chi-square test of independence was used on cross-tabulations to see whether a significant relationship exists between the two variables represented in the cross-tabulation. When conditions are not met Fisher's exact test which is a statistical significance test used in the analysis of contingency tables was used. Binomial test was also used and this tests whether a significant proportion of respondents select one of a possible two responses. This can be extended when data with more than 2 response options is split into two distinct groups. One sample t-test was used for the agreement questions, to test whether a mean score is significantly different from a scalar value

Chapter 4 provides a detailed description of data analysis.

3.12. ETHICAL CONSIDERATIONS

Written permission was sought from the following authorities/ individuals:

1. The Research Ethics Committee of Durban University of Technology, which is a formal committee that reviewed proposed research plans. The key areas that govern the decisions made by the ethics committee include minimizing risks to participants, ensuring that informed consent is obtained and documented, and ensuring the privacy and confidentiality of the participant is

maintained. The ethics committee can approve or disapprove a research plan (Polit and Beck 2012: 154). Ethical clearance was obtained from the The Research Ethics Committee of Durban University of Technology (Annexure A)

2. The Kwa -Zulu Natal Department of Health (Annexure C).

3. The Chief Executive Officer of the selected hospital (Annexure E).

4. Respondents in the study (Annexure G, Annexure I).

Participation was voluntary and withdrawal at any time was allowed with no penalties.

All information was coded and the master list containing the names of participants with codes will be stored for five years then destroyed by shredding. Data pertaining to the study that is stored on electronic devices will be deleted.

3.12.1. Application of the right to self determination

Grove *et al* (2013: 164), describe the right to self-determination as a basic human right which allows people to control their own destiny. The researcher has ensured that respondents were treated as autonomous individuals, by informing them verbally as well as in writing, the purpose of the study. The researcher also sought written and informed consent from the respondents once they voluntarily agreed to participate in the study. Each respondent was assured that they were allowed to withdraw from the study at any point in time without any penalties. Respondents were not in any way coerced, no rewards

were given to those who participated and no penalties implemented for those who did not wish to participate.

3.12.2. Application of the right to full disclosure

Polit and Beck (2012: 154), explain that full disclosure pertains to a person's right to make a fully informed and voluntary decision to participate in a study. In this study the researcher fully described the nature of the study to prospective respondents, and allowed them time to decide on whether to participate in the study or not, with no coercion. Once caregivers decided to participate, a letter of information was handed to each respondent and once it was read and fully understood, a written consent was obtained from the respondent.

3.12.3. Application of the right to fair treatment

Grove *et al* (2013: 173), explain that the right to fair treatment is actually derived from the ethical principle of justice. In the research setting, the respondent's right to fair treatment includes how the researcher selects respondents (Grove *et al* 2013: 164). In this study, the researcher did not consider race, religion, gender or social standing of the respondents. The only consideration was that of the inclusion criteria being met. All respondents were treated with respect and dignity by the researcher throughout the data collection process.

3.12.4. Maintenance of confidentiality

Confidentiality was maintained throughout the study. No personal details linking the participants to the study were elicited. The consent form was signed and kept away in no particular order, so that when the questionnaire was answered by the respondent, there was no link to the consent form and no personal information was indicated on the questionnaire. This is pertinent for the study as caregivers may fear expressing their opinions truthfully.

3.13. CONCLUSION

Chapter three described the methodology adopted for this study. Details were provided about the selection of respondents, the sample size as well as the inclusion and exclusion criteria. The research setting was also described. The development of the data collection tool, the data collection process and the pilot study has been explained. The ethical considerations that guided the study have been outlined. The tests used for data analysis have been named and described.

The next chapter provides details of the data collected and the analysis thereof**.**

CHAPTER 4

PRESENTATION OF THE FINDINGS

4.1 INTRODUCTION

The study findings are presented in this chapter, which includes an analysis of the data collected. The purpose of this study was to determine the use of traditional medicine as health care seeking behaviour by caregivers of children who are under the age of five years. A self-developed questionnaire derived from various sources including the IMCI assessment tool was used to collect data from a total of five hundred and seven (507) participants.

4.2. STATEMENT OF FINDINGS, INTERPRETATION AND DISCUSSION OF DATA

The results and discussion of findings obtained from the data collection tool will be presented in this chapter. The data collected from the participants was analysed with the assistance from a statistician using a SPSS version 17. Tables and graphs have been used to summarise and describe the data findings.

4.3. THE DATA COLLECTION INSTRUMENT

The data collection instrument consisted of items for caregivers of children under the age of five years to answer. The instrument was divided into two sections namely:

Section A: Demographic Data

Section B: Relationship to child and health care seeking behaviour.

Five hundred and seven respondents who met the inclusion criteria for this study answered the questionnaire.

4.4. PRESENTATION OF DATA

4.4.1. Section A: Demographic Data

4.4.1.1 Respondent Age

Majority of the caregivers 41.8% (n=212) were between the age of 26 to 35 years, 38.1% (n=193) were between the age of 18 to 25 years and 19.9% (n=101) were above the age of 36 years.

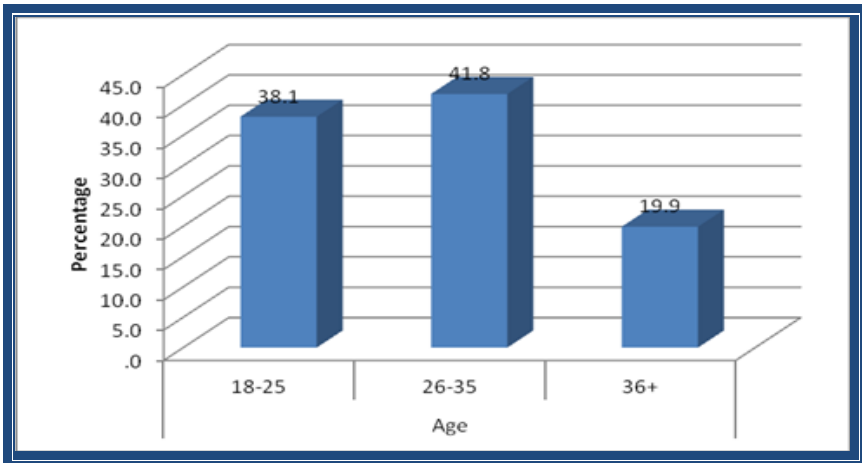

Figure 4.1: Age group of the respondents.

4.4.1.2. Area of residence

A significant number of the respondents 67.1% (n=340) indicated that they reside in an urban area, while 32.5% (n=165) live in a rural area.

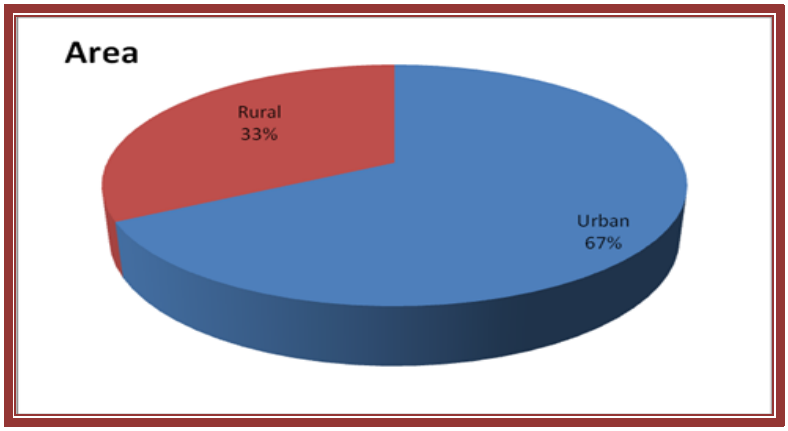

Figure 4.2: The area of residence

4.4.1.3. Employment

Just more than half of the respondents 60% (n=304) were unemployed while 40% (n=203) indicated that they were employed.

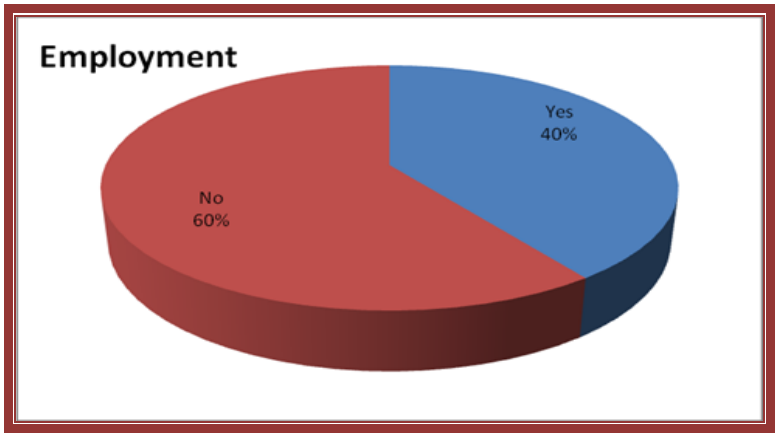

Figure 4.3: The employment status of the caregivers.

4.4.1.4. Closest health care provider

Figure 4.4 depicts the radius of the closest health care provider to the respondent's home. A significantly large number of respondents, 96.6% (n=490) indicated that a clinic was the closest health care provider to them, whereas 2.2% (n=11) reflected that a traditional healer was the closest care provider. Of the 1% (n=5), 0.4% (n=2) indicated a hospital was the closest, 0.2% (n=1) showed that none of the health care providers were close to home, and 0.2% (n=1) did not indicate which health care provider was the closest.

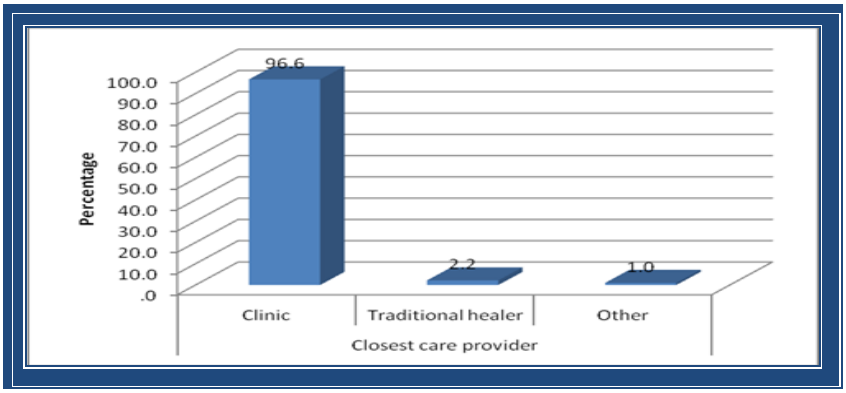

Figure 4.4: The closest health care provider in relation to the respondent's home

4.4.2. Section B: Relationship of caregiver to child and health care seeking behaviour

4.4.2.1. Relationship of caregiver to child

Table 4.1 indicates the relationship of the caregiver to the child. A significant number of respondents 89.7% (n=455) was the mother of the children brought to the clinic. 3% (n=15) were the fathers of the children. Other caregivers who brought the children for treatment were the grannies 4% (n=20), 1.4% (n=7) were aunts, foster mum 0.2% (n=1), foster dad 0.2% (n=1), a tenant 0.2% (n=1), and a relative 0.2 %(n=1). 0.2% (n=1), was not specified (p<.0005).

Table 4.1: The relationship of caregiver to child

		Frequency	Percentage
	Mother	455	89.7
	Father	15	3.0
	Other	34	6.7
	Total	504	99.4
Total		507	100.0

4.4.2.2. Age of the children

Just more than half of the children 50.5% (n=257) fell into the age group of 1 to 5 years, 36.3% (n=184) of the children were between the ages of 2 to 12 months while 13% (n=66) were less than 2 months of age (p<.0005).

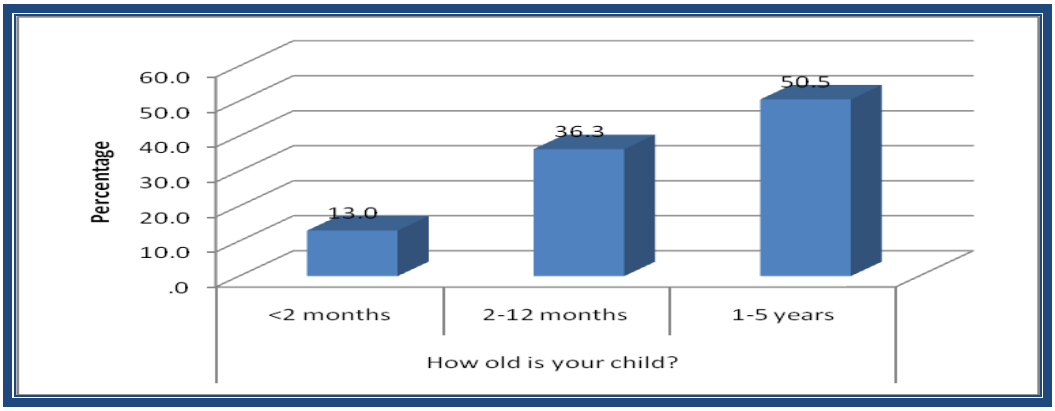

Figure 4.5: The age group of the children

4.4.2.3. Treatment considered to be the safest in treating sick child

A significant majority of respondents 94.1% (n=477) indicated that a clinic provided the safest care for their child, 3.9% (n=20) revealed that home remedies were safer, while 1.2% (n=6) indicated that a traditional healer was the safest. There were 0.4% (n=2) of respondents who felt the hospital provided the safest care while 0.2% (n=1) indicated that both a clinic and traditional medicines were safe (p<.0005).

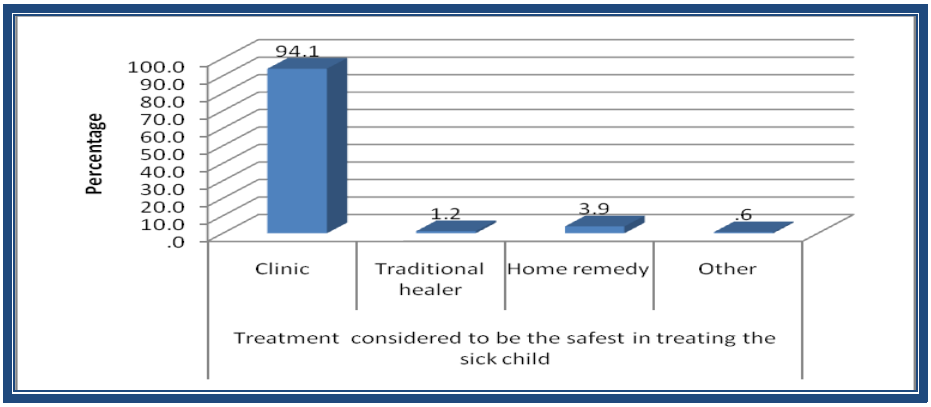

Figure 4.6: The treatment that respondents considered to be the safest for their children.

The following portion of the questionnaire sought to determine the first line of treatment for the general danger signs that a child may present with.

4.5. GENERAL DANGER SIGNS

General danger signs can be classified as very severe disease according to IMCI guidelines and require urgent attention and referral.

4.5.1. Convulsions

When asked about the first treatment choice for convulsions, a majority of the caregivers 86% (n=437) would go to the clinic, 5.9% (n=30) would use home remedies, 5.5% (n=28) would use traditional medicine while 1% (n=5) would use other treatment which include doctor, hospital or giving the child a key to hold ($p<.0005$).

Table 4.2: The first line of treatment to be sought for convulsions.

	Treatment choice	Frequency	Percentage
	Clinic	437	86.2
	Home remedy	30	5.9
	Traditional muti	28	5.5
	Other	5	1.0
	None	5	1.0
	Total	505	99.6
Total		507	100.0

4.5.2. Lethargy

A significant majority of caregivers 90.1% (n=457) would go to the clinic if their child was lethargic, 6.9% (n=35) indicated home remedy to be the first treatment, 1.2% (n=6) would use traditional medicine while 0.2% (n=1) would go to the doctor

Table 4.3: The first line of treatment for lethargy

	Treatment choice	Frequency	Percentage
	Clinic	457	90.1
	Home remedy	35	6.9
	Traditional muti	6	1.2
	Other	1	.2
	None	1	.2
	Total	500	98.6
Total		507	100.0

4.5.3. Vomit everything

When asked about the first line of treatment to be sought for a child who vomits everything, majority of the respondents 90.3% (n=458) indicated they would go to the clinic, 6.3% (n=32) would give home remedy, 1.6% (n=8) chose traditional medicine while 3% (n=3) would go to hospital or a doctor. Of note 0.4% (n=2) would not seek any care (p<.0005).

Table 4.4: The first line of treatment for a child vomiting everything

	Treatment choice	Frequency	Percentage
	Clinic	458	90.3
	Home remedy	32	6.3
	Traditional muti	8	1.6
	Other	3	.6
	None	2	.4
	Total	503	99.2
Total		507	100.0

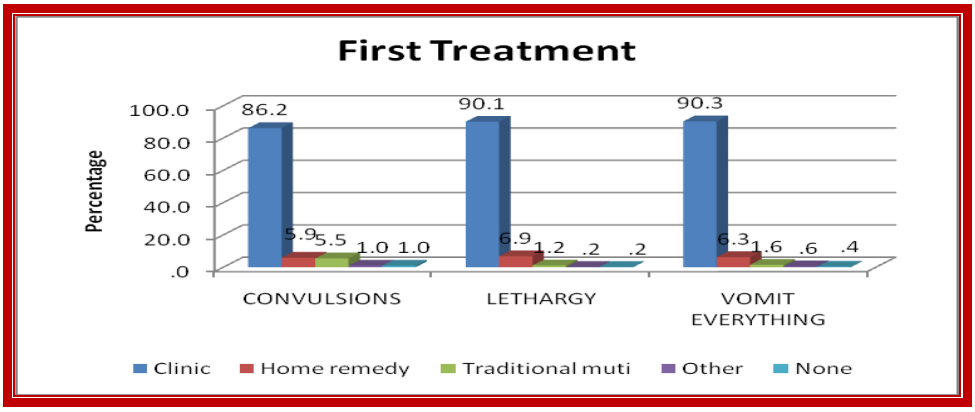

Figure 4.7: The first line of treatment by caregivers for children who may have a general danger sign.

4.5.4. Time taken to seek help for general danger signs

Just over half of respondents 62.9% (n=319) indicated they would seek help after 1 day, 33.5% (n=170) after 2 – 3 days, 2.6% (n=13) after 4 -5 days while 0.4% (n=2) would seek help after 5 days (p<.0005).

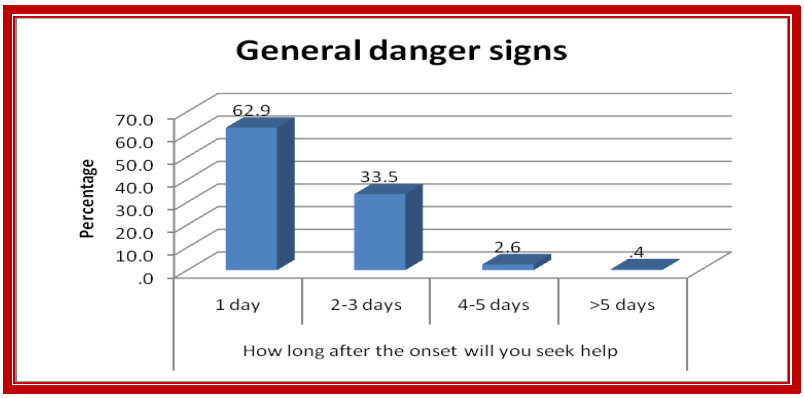

Figure 4.8: Time taken to seek help for general danger signs.

4.6. COUGH

Caregivers were asked about treatment of cough in their children. The description of cough was according to IMCI assessment guidelines.

4.6.1. Dry cough

When asked about the first treatment sought for children with a dry cough just over half of the caregivers 56.4% (n=286) indicated they would seek care from the clinic, 33.7% (n=171) would use home remedy, 1.4% (n=7) would use traditional medicine while 0.2% (n=1) indicated other- they would give cough mixture (p<.0005).

Table 4.5: The first line of treatment for dry cough

Treatment choice	Frequency	Percentage
Clinic	286	56.4
Home remedy	171	33.7
Traditional muti	7	1.4
Other	1	.2
None	42	8.3
Total	507	100.0

4.6.2. Cough with chest in-drawing

Majority of the respondents 92.3% (n=468) indicated they would go to the clinic if their child had cough with chest in-drawing, 4.3% (n=22) would give home remedy, 1.8% (n=9) would give traditional medicine, 0.2% (n=2) indicated they would other care which was the hospital and salt water.0.2% (n=1) indicated they would not seek any care (p<.0005). Table 4.6 stipulates the care sought for cough with chest in-drawing.

Table 4.6: The first line of treatment for cough with chest in-drawing

	Treatment choice	Frequency	Percentage
	Clinic	468	92.3
	Home remedy	22	4.3
	Traditional muti	9	1.8
	Other	2	.4
	None	1	.2
	Total	502	99.0
Total		507	100.0

4.6.3. Fast breathing

When asked about the child having cough with fast breathing, majority 92.9% (n=471) expressed they would go to the clinic as first line of treatment, 4.3% (n=22) would use home remedy, 0.8% (n= 4) would use traditional medicine, 0.8% (n=4) would not seek care while 0.6% (n=3) selected other and indicated they would calm the child, go to general practitioner, go to hospital. (p=<.0005).

Table 4.7: The first line of treatment for fast breathing.

	Treatment choice	Frequency	Percentage
	Clinic	471	92.9
	Home remedy	22	4.3
	Traditional muti	4	.8
	Other	3	.6
	None	4	.8
	Total	504	99.4
Total		507	100.0

4.6.4. Noisy breathing

When caregivers were asked about their first treatment choice for cough with noisy breathing, majority 95.7% (n=485) revealed they would take their child to the clinic, 2% (n=10) would use home remedy, 1% (n=5) would use traditional medicine, 0.6% (n=3) indicated other as an option with general practitioner, hospital and rub baby as choices. 0.6% (n=3) revealed they would not seek any care (p<.0005). Table 4.8 specifies the first line of treatment for noisy breathing.

Table 4.8: The first line of treatment for cough with noisy breathing

	Treatment choice	Frequency	Percentage
	Clinic	485	95.8
	Home remedy	10	97.8
	Traditional muti	5	98.8
	Other	3	99.4
	None	3	100.0
	Total	506	
Total		507	

4.6.5. Wet cough

Just over half of respondents 67.6% (n=342) would seek care from the clinic first, 31% (n=157) would use home remedy, 0.6% (n=3) would use traditional medicine, 0.4%(n=2) selected other as an option and indicated they would use camphor to smell and general practitioner. 0.4% (n=2) indicated they would not seek any care (p<.0005).

Table 4.9: The first line of treatment for wet cough

	Treatment choice	Frequency	Percentage
	Clinic	342	67.5
	Home remedy	157	31.0
	Traditional muti	3	.6
	Other	2	.4
	None	2	.4
	Total	506	99.8
Total		507	100.0

4.6.6. Time taken to seek help for cough

Just below half of the respondents 45.4% (n=230) indicated they would seek help after 2-3 days, 43.6% (n=221) after 1 day, 7.9% (n=40) after 4 -5 days while 2.8% (n=14) would seek help after 5 days (p<.0005).

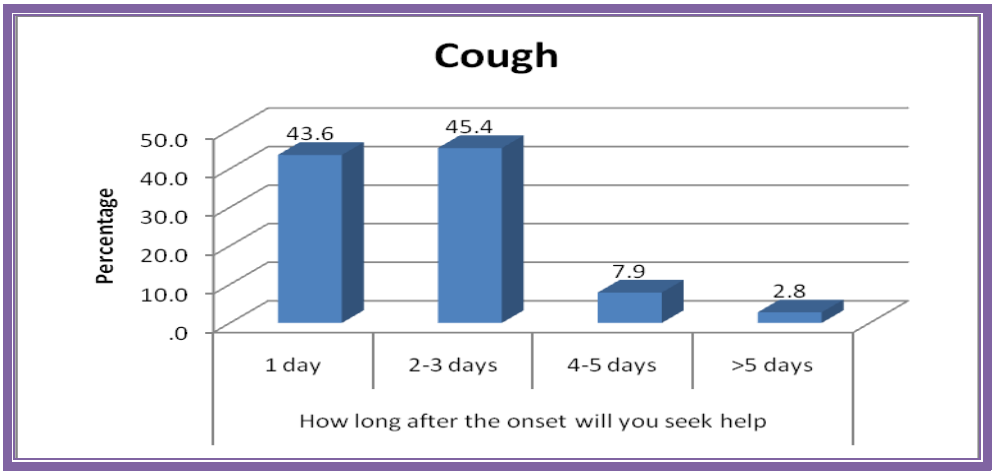

Figure 4.9: The time taken to seek help for cough.

4.7. DIARRHOEA AND VOMITING

Diarrhea and vomiting is assessed in IMCI using the clinical signs which are, watery stools, blood in stools, sunken eyes, not able to drink anything and sunken fontanelle.

4.7.1. Watery stools

Just over half of the respondents 61.1% (n=310) revealed that they would seek care from the clinic, 37.5% (n=190) would give home remedy, 0.8% (n=4) would use traditional medicine, while 0.6% (n=3) chose other as an option which included glucose, hospital, sorol (p<.0005). Table 4.10 specifies treatment choices for watery stools.

Table 4.10: The treatment for watery stools

Treatment choice	Frequency	Percentage
Clinic	310	61.1
Home remedy	190	37.5
Traditional muti	4	.8
Other	3	.6
Total	507	100.0

4.7.2. Blood in stools

A significant majority of the respondents 97.6% (n=495) revealed they would seek care from the clinic, 0.8% (n=4) would give traditional medicine, 0.6% (n=3) would use home remedy, 0.6% (n=3) selected other as an option and specified they would go to a doctor and hospital. 0.4% denoted that they would not seek care (p<.0005).

Table 4.11: The treatment for blood in stool.

Treatment choice	Frequency	Percentage
Clinic	495	97.6
Home remedy	3	.6
Traditional muti	4	.8
Other	3	.6
None	2	.4
Total	507	100.0

4.7.3. Sunken eyes

A significantly large number of respondents 90.9% (n=461) indicated they would seek care from a clinic, 5.3% (n=27) would use home remedies, 1.6% (n=8) would make use of traditional medicine while 1.4% (n=7) specified they would other treatment including doctor, glucose, hospital and turned water. 0.4% (n=2) indicated they would not seek care (p<.0005).

Table 4.12: The treatment choices for sunken eyes.

	Treatment choice	Frequency	Percentage
	Clinic	461	90.9
	Home remedy	27	5.3
	Traditional muti	8	1.6
	Other	7	1.4
	None	2	.4
	Total	505	99.6
Total		507	100.0

4.7.4. Not able to drink anything

A significantly large number 92.9% (n=471) of respondents indicated they would seek clinic care, while 4.1% (n=21) would use home remedy, 1.4% (n=7) would use traditional medicine, 0.8% (n=4) selected other and specified hospital. 0.6% (n=3) revealed that they would not seek any care (p<.0005).

Table 4.13: The treatment for not able to drink anything

	Treatment choice	Frequency	Percentage
	Clinic	471	92.9
	Home remedy	21	4.1
	Traditional muti	7	1.4
	Other	4	.8
	None	3	.6
	Total	506	99.8
Total		507	100.0

4.7.5. Sunken fontanelle

When caregivers were asked about their first treatment for child with sunken fontanelle, majority 76.9% (n=390) specified they would seek care from a clinic, while17.2% (n=87) would use traditional medicine, 3.7% (n=19) would use home remedy, whereas 1.2% (n=6) selected other and stipulated the use of doctor, hospital, massage, rub. 0.4% (n=2) opted not to seek any care ($p<.0005$).

Table 4.14: The treatment for sunken fontanelle

	Treatment choice	Frequency	Percentage
	Clinic	390	76.9
	Home remedy	19	3.7
	Traditional muti	87	17.2
	Other	6	1.2
	None	2	.4
	Total	504	99.4
Total		507	100.0

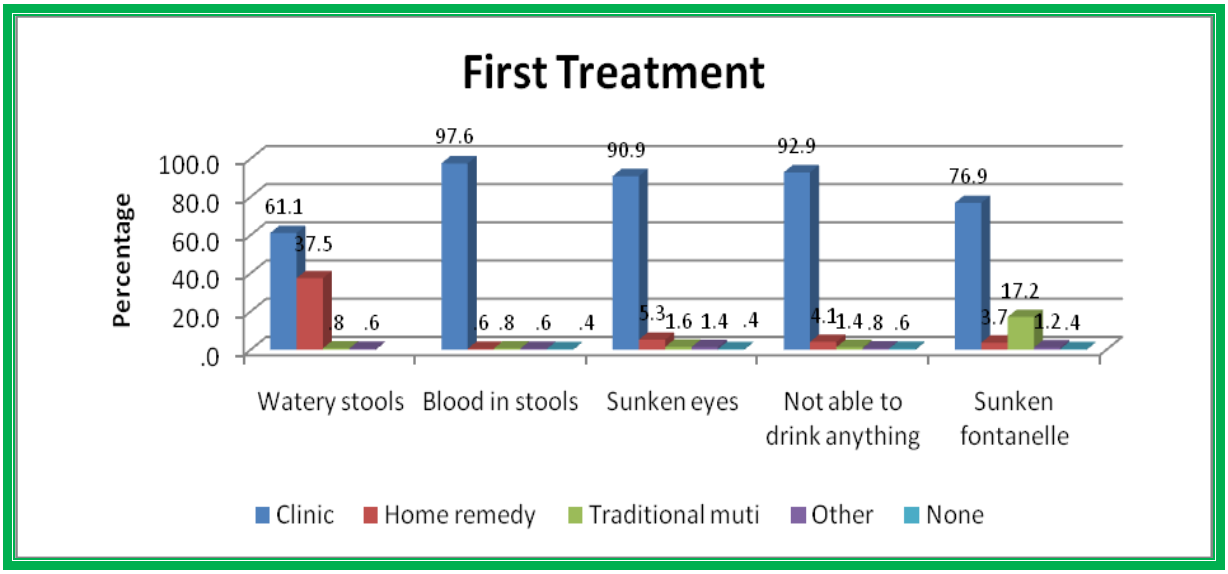

Figure 4.10: The care sought for children with diarrhoea.

Just over a third of the respondents, 77.5% (n=393) indicated they would seek care between 1-3 days, 11.6% (n=59) between 4-6 days, 9.3% (n=47) between 7-14 days, 0.6% (n=3) more than 14 days. 0.2% (n=1) indicated they would not seek care (p<.0005).

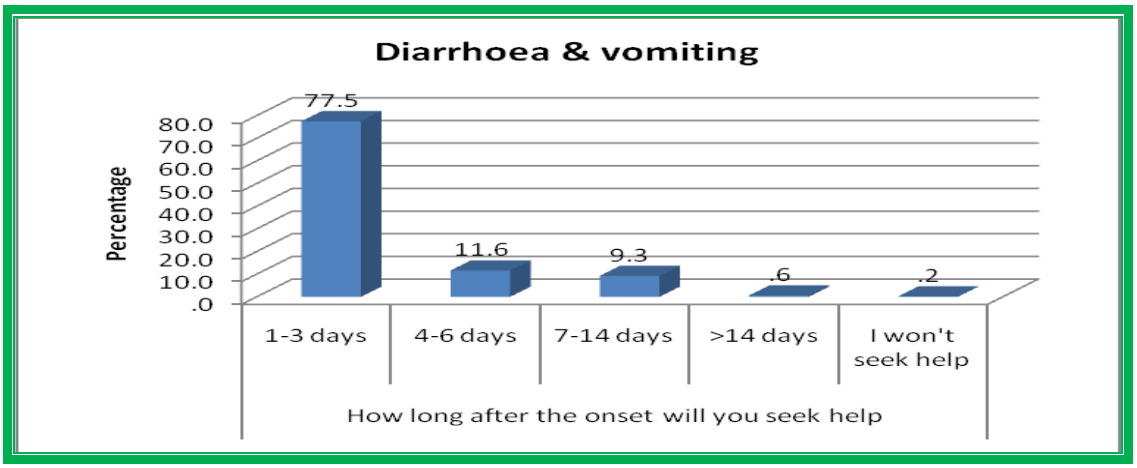

Figure 4.11: The time taken to seek care for diarrhoea.

4.8. FEVER

When caregivers were asked about fever in their children, this was described as classified in IMCI assessment guidelines.

4.8.1. Feels hot to touch

Just over half of respondents 62.9% (n=319) indicated they would seek care from a clinic, 35.9% (n=182) would use home remedy, 0.4% (n=2) chose other and specified they would go to doctor, give allergex, use a wet cloth. 0.2% (n=1) revealed they would use traditional medicine (p<000.5).

Table 4.15: The care seeking behaviour for a child who feels hot to touch.

Treatment choice	Frequency	Percentage
Clinic	319	62.9
Home remedy	182	35.9
Traditional muti	1	.2
Other	2	.4
None	3	.6
Total	507	100.0

4.8.2. Has a stiff neck

The majority 84.9% (n=428) opted to seek clinic care, 9.3% (n=47) home remedy, while 4.1% (n=21) would use traditional medicine. 1.4% (n=7) indicated other as an option and stipulated general practitioner, hospital, massage, rub. 0.2% (n=1) opted not to seek any care (p<.0005).

Table 4.16: The treatment if a child has a stiff neck

	Treatment choice	Frequency	Percentage
	Clinic	428	84.4
	Home remedy	47	9.3
	Traditional muti	21	4.1
	Other	7	1.4
	None	1	.2
	Total	504	99.4
Total		507	100.0

4.8.3. Bulging fontanelle

Caregivers were asked about the first treatment choice for child with bulging fontanelle, and majority of the respondents, 83% (n=421) stipulated they would seek care from a clinic, 11.6% (n=59) would use traditional medicine, 3.4% (n=17) would use home remedy while 1% (n=5) selected other and indicated they would go to general practitioner, hospital, massage. 0.2% (n=1) opted not to seek care (p<.0005).

Table 4.17: Bulging fontanelle (soft spot on head that is bulging)

	Treatment choice	Frequency	Percentage
	Clinic	421	83.0
	Home remedy	17	3.4
	Traditional muti	59	11.6
	Other	5	1.0
	None	1	.2
	Total	503	99.2
Total		507	100.0

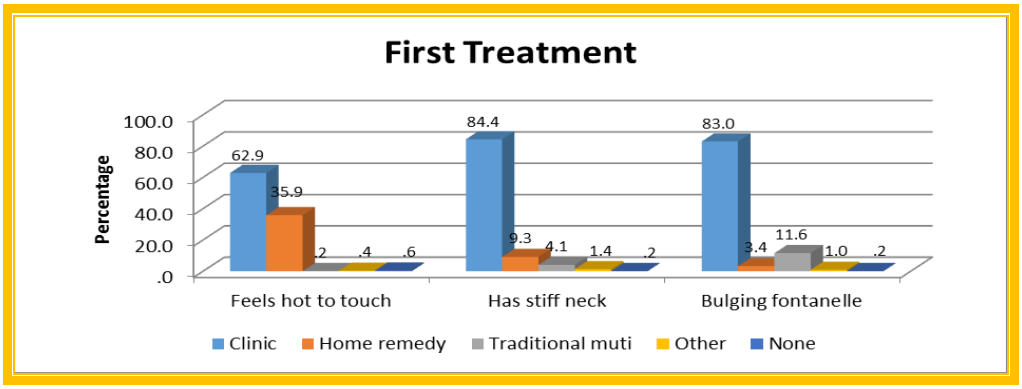

Figure 4.12: The first treatment to be sought for children with fever.

4.8.4. Time taken to seek care for fever

Less than half of the respondents 49.3% (n=250) stipulated they would seek care within 1 day, 47.1% (n=239) between 2-3 days, 2.8% (n=14) between 4-5 days and 0.4% (n=2) would seek care more than 5 days of onset (p<.0005).

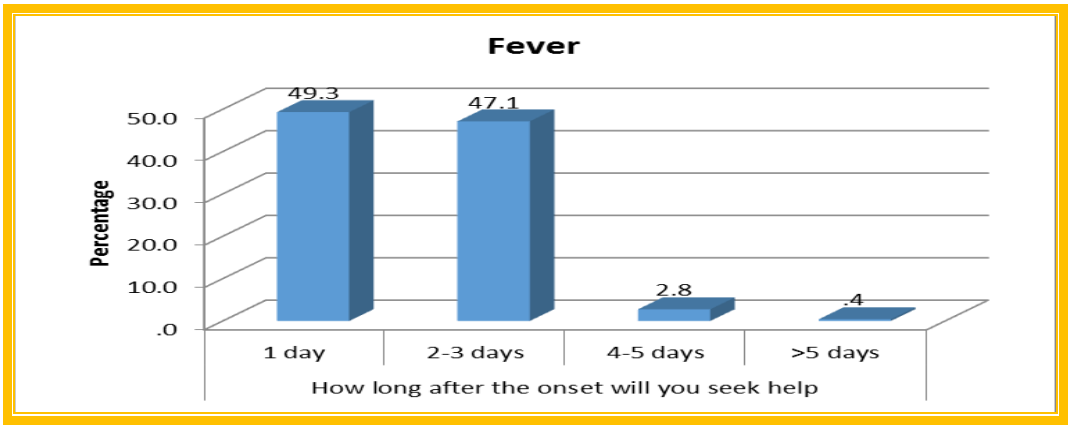

Figure 4.13: The time taken to seek care for children with fever.

4.9. MEASLES OR RASH

4.9.1. Rash on body and feels hot to touch

When caregivers were asked about the first line of treatment for children who had a rash on the body and feels hot to touch, the majority 78.3% (n=397) would seek clinic care, 18.1% (n=92) would use home remedy, 1.8% (n=9) would use traditional medicine, while 1% (n=5) chose other as an option and indicated they would go to doctor, rub turmeric. 0.6% (n=3) would not seek care (p<.0005).

Table 4.18: Rash on body and feels hot to touch

	Treatment choice	Frequency	Percent
	Clinic	397	78.3
	Home remedy	92	18.1
	Traditional muti	9	1.8
	Other	5	1.0
	None	3	.6
	Total	506	99.8
Total		507	100.0

4.9.2. Red eyes

Majority 77.5% (n=393) of the respondents indicated they would seek care from a clinic, 19.5% (n=99) would use home remedy, 1.6% would not seek any care while 0.8% (n=4) selected other and stipulated doctor, milk, eye drops. 0.4% (n=2) would use traditional medicine (p<.0005). Table 4.19 shows the care for children with red eyes.

Table 4.19: Treatment choices for red eyes

	Treatment choice	Frequency	Percent
	Clinic	393	77.5
	Home remedy	99	19.5
	Traditional muti	2	.4
	Other	4	.8
	None	8	1.6
	Total	506	99.8
Total		507	100.0

4.9.3. Mouth sores/ whitish spots in mouth

The majority 92.1% (n=467) stipulated they would seek care at a clinic for mouth sores/ whitish spots in mouth, 5.3% (n=27) would use home remedy, while 1.4% (n=7) chose other and reflected they would go to doctor, use glycerine, salt water gargle. 1% (n=5) would use traditional medicine (p<.0005).

Table 4.20: Treatment choices for mouth sores/ whitish spots in mouth

	Treatment choice	Frequency	Percent
	Clinic	467	92.1
	Home remedy	27	5.3
	Traditional muti	5	1.0
	Other	7	1.4
	Total	506	99.8
Total		507	100.0

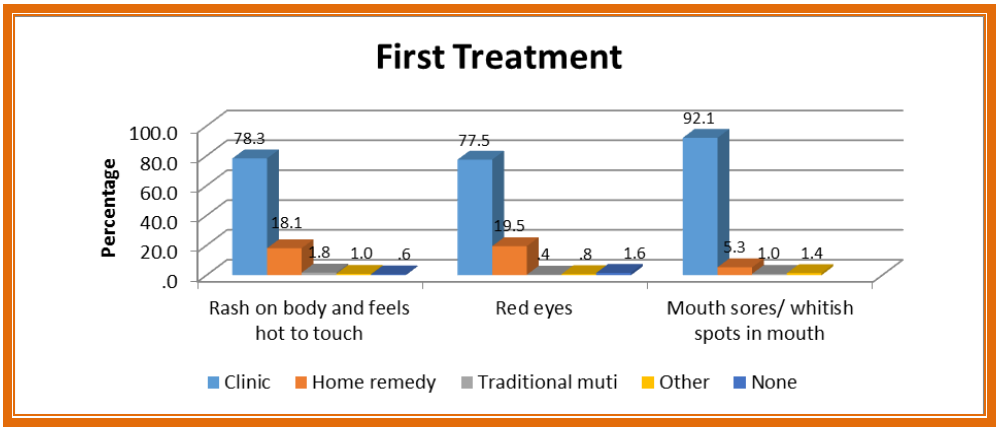

Figure 4.14: The first treatment to be sought for measles.

4.9.4. Time taken to seek care for rash and fever

Figure 4.16 outlines the time taken to seek care for rash and fever. Almost half of the respondents, 48.3% (n=245) indicated they would seek care within 1 day of the onset, 46.4% (n=235) between 2-3 days, 3.7% (n=19) between 4-5 days while 0.6% (n=3) would seek care more than 5 days of onset. 0.2% (n=1) would not seek care (p<.0005).

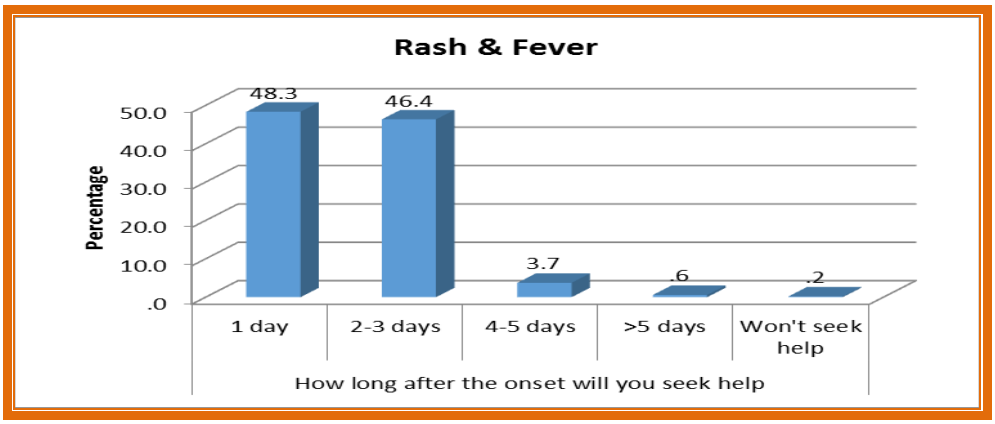

Figure 4.15: The time taken to seek care for rash and fever

4.10. EAR PROBLEM

When caregivers were asked about ear problems in their children, the classification used in IMCI was applied. This included ear pain, ear discharge, child wakes up at night with ear pain and child has swelling behind the ear.

4.10.1. Ear pain

Majority of the respondents 72.4% (n=367) indicated they would seek clinic care for ear pain experienced by their child, 25.4% (n=129) would use home remedy, 0.8% (n=4) would use traditional medicine, while 0.8% (n=4) chose

other as an option and stipulated they would go to general practitioner, garlic oil, mother in law tongue plant juice heated and put into ear, warm olive oil, warm oil (p<.0005).

Table 4.21: The care sought for ear pain.

	Treatment choice	Frequency	Percentage
	Clinic	367	72.4
	Home remedy	129	25.4
	Traditional muti	4	.8
	Other	4	.8
	None	3	.6
	Total	507	100.0

4.10.2. Ear discharge

A significantly large number of respondents 92.7% (n=470) indicated they would get care from a clinic if their child had an ear discharge, 5.1% (n=26) home remedy, 1% (n=5) selected other and stipulated doctor, hospital, marigold juice. 0.8% (n=4) would use traditional medicine (p<.0005).

Table 4.22: Treatment choice for ear discharge

	Treatment choice	Frequency	Percentage
	Clinic	470	92.7
	Home remedy	26	5.1
	Traditional muti	4	.8
	Other	5	1.0
	Total	505	99.6
Total		507	100.0

4.10.3. Child wakes up at night with ear pain

Table 4.23 depicts the care for children who wake up at night with ear pain. Majority of the respondents 64.7% (n=328) stipulated they would seek care from a clinic if their child woke up at night with ear pain, 25.2% (n=128) would use home remedy, 7.7% (n=39) revealed they would use traditional medicine, 1% selected other and stipulated doctor, hospital, garlic oil, warm oil. 0.8% (n=4) would not seek any care (p<.0005).

Table 4.23: Choice of treatment if a child wakes up at night with ear pain

	Treatment choice	Frequency	Percentage
	Clinic	328	64.7
	Home remedy	128	25.2
	Traditional muti	39	7.7
	Other	5	1.0
	None	4	.8
	Total	504	99.4
Total		507	100.0

4.10.4. Has swelling behind ear

A significantly large number of respondents 94.5% (n=479) selected clinic care if their child had swelling behind the ear, 3% (n=15) home remedy, 0.6% (n=3) would use traditional medicine, 1% (n=5) selected other and specified doctor, general practitioner, hospital, massage, massage oil. 0.2% (n=1) would not seek any care (p<.0005).

Table 4.24: The treatment choice for swelling behind ear

	Treatment choice	Frequency	Percentage
	Clinic	479	94.5
	Home remedy	15	3.0
	Traditional muti	3	.6
	Other	5	1.0
	None	1	.2
	Total	503	99.2
Total		507	100.0

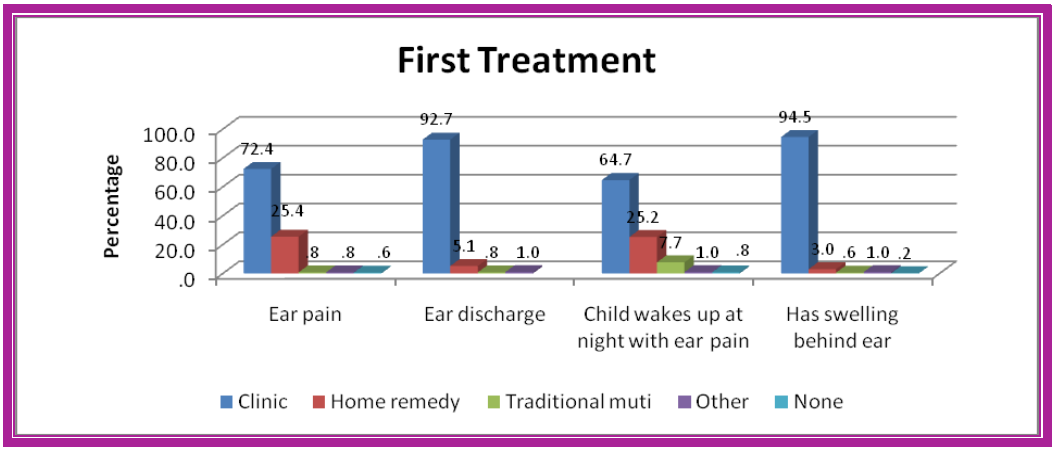

Figure 4.16: First treatment sought for ear problems

4.10.5. Time taken to seek care for ear problems

Figure 4.17 illustrates the time taken to seek care for children with ear problems. Just over half of the respondents 59.8% (n=303) would seek care in 1 day of the onset of symptoms, 35.9% (n=182) between 2-3 days, 3.2% (n=16) between 4-5 days and 0.6% (n=3) would seek care after 5 days. 0.2% (n=1) indicated they would not seek care (p<.0005).

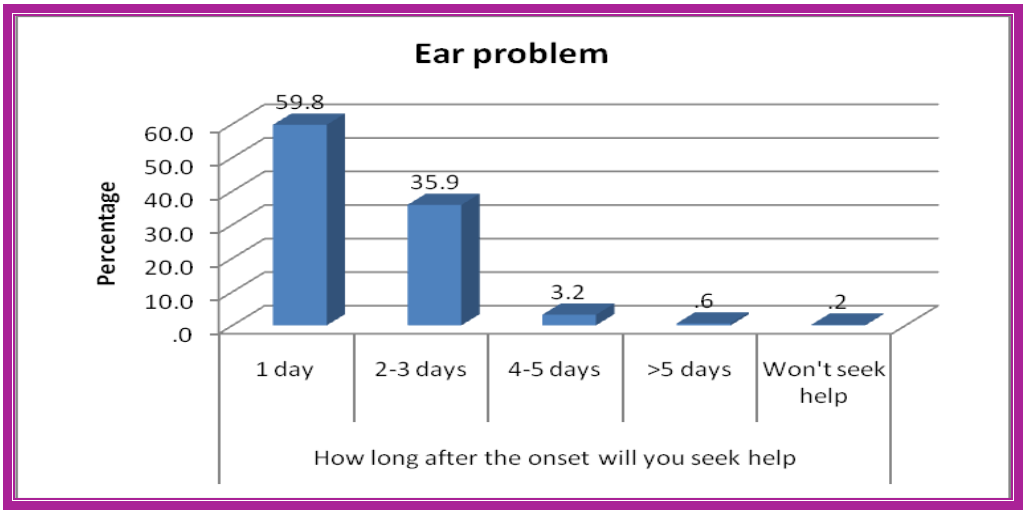

Figure 4.17: Time taken to seek care for ear problems

4.11. MALNUTRITION AND ANAEMIA

Malnutrition and anaemia was enquired about using the classification found in IMCI assessment guidelines.

4.11.1. Mild weight loss

Just over half of respondents 63.7% (n=323) indicated they would seek care from a clinic if their child had mild weight loss, whereas 23.3% (n=118) would use home remedy, 12.2% (n=62) revealed they would not seek any care, 0.6% (n=3) would use traditional medicine, while 0.2% (n=1) indicated other and stipulated the hospital (p<.0005).

Table 4.25: Mild weight loss

Treatment choice	Frequency	Percentage
Clinic	323	63.7
Home remedy	118	23.3
Traditional muti	3	.6
Other	1	.2
None	62	12.2
Total	507	100.0

4.11.2. Severe weight loss

A significant majority of respondents 93.5% (n=474) would go to the clinic if their child had severe weight loss, 4.5% (n=23) would use home remedy,1% (n=5) selected other and specified doctor, general practitioner, hospital. 0.6% (n=3) indicated they would use traditional medicine while 0.2% (n=1) would not seek care (p<.0005)

Table 4.26: The treatment choice for severe weight loss

	Treatment choice	**Frequency**	**Percentage**
	Clinic	474	93.5
	Home remedy	23	4.5
	Traditional muti	3	.6
	Other	5	1.0
	None	1	.2
	Total	506	99.8
Total		507	100.0

4.11.3. Swelling of both feet

When asked about their first treatment choice for swelling of both feet, the majority of respondents 90.9% (n=461) chose clinic treatment, 5.9% (n=30) would use home remedy, 1.8% (n=9) traditional medicine and 1.2% (n=6) opted for other and stipulated doctor, hospital, cold towel, salt water soak (p<.0005).

Table 4.27: Treatment chosen for swelling of both feet

	Treatment choice	Frequency	Percentage
	Clinic	461	90.9
	Home remedy	30	5.9
	Traditional muti	9	1.8
	Other	6	1.2
	Total	506	99.8
Total		507	100.0

4.11.4. Pale palms

When asked about pale palms, majority 91.7% (n=465) indicated they would seek care from the clinic, whereas 5.3% (n=27) would utilise home remedy, 1.4% (n=7) traditional medicine, 0.8% (n=4) selected other and specified general practitioner, hospital, beetroot. 0.6% (n=3) would not seek care (p<.0005).

Table 4.28: Treatment choice for pale palms

	Treatment choice	Frequency	Percentage
	Clinic	465	91.7
	Home remedy	27	5.3
	Traditional muti	7	1.4
	Other	4	.8
	None	3	.6
	Total	506	99.8
Total		507	100.0

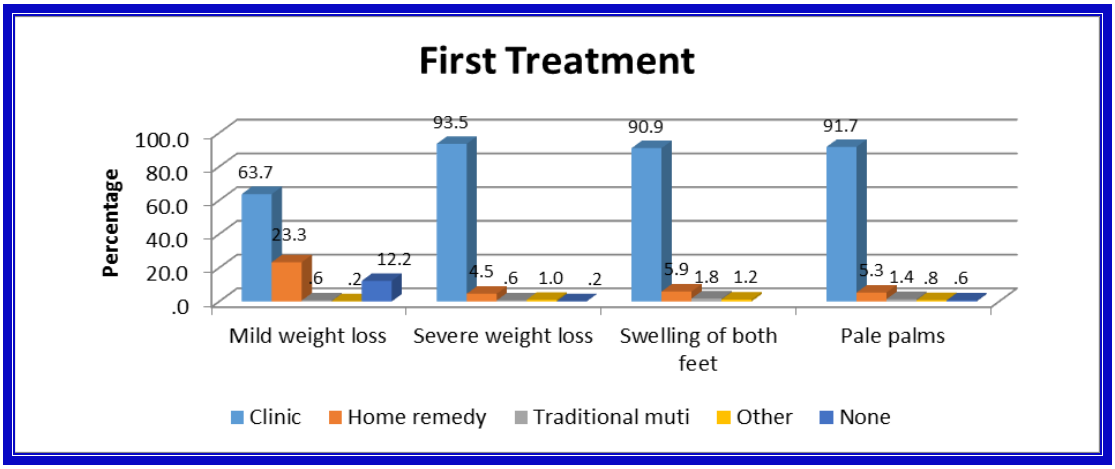

Figure 4.18: The first treatment sought for Malnutrition and Anaemia.

4.11.5. Time taken to seek care for Malnutrition and Anaemia

Figure 4.19 indicates the time taken to seek care for malnutrition and anaemia. Almost half of the respondents 46.5% (n=236) would seek care between 2-3 days, 43.2% (n=219) would seek care witin 1 day of onset, 6.9% (n=35) between 4-5 days, while 3.2% (n=16) would seek care after 5 days. 0.2% (n=1) would not seek care (p<.0005).

Figure 4.19: The time taken to seek care for Malnutrition and Anaemia

4.12. HIV INFECTION - TESTING

A significant portion 81.5% (n=413) indicated their child had been tested for HIV while 17.4% (n=88) revealed their children were not tested for HIV (p<.0005).

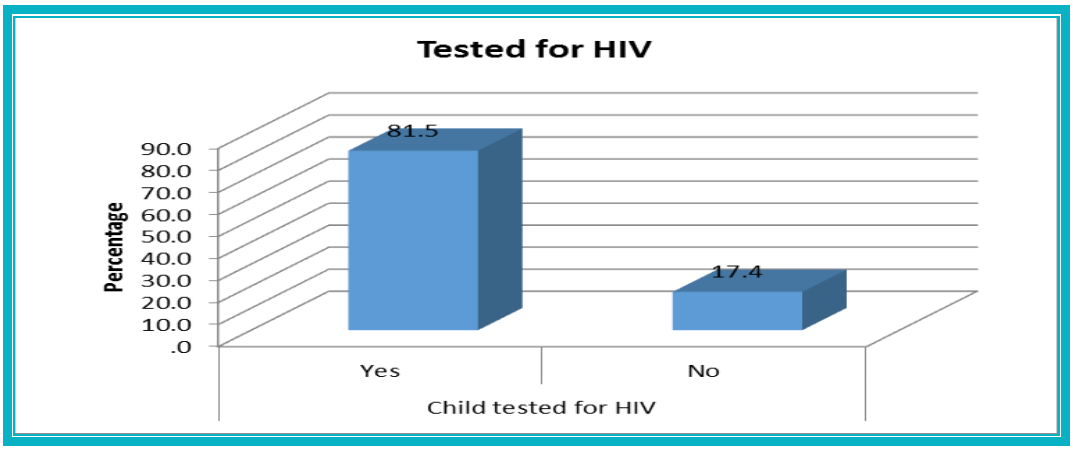

Figure 4.20: Children tested for HIV.

4.12.1. HIV infection treatment

When asked about the treatment choices for HIV infection, a significant majority 96.4% (n=489) would seek clinic care, 0.6% (n=3) would use home remedy, 0.4% (n=2) selected other and specified doctor and hospital. 0.2% (n=2) would use traditional medicine, 0.2% (n=1) would not seek any care (p<.0005).

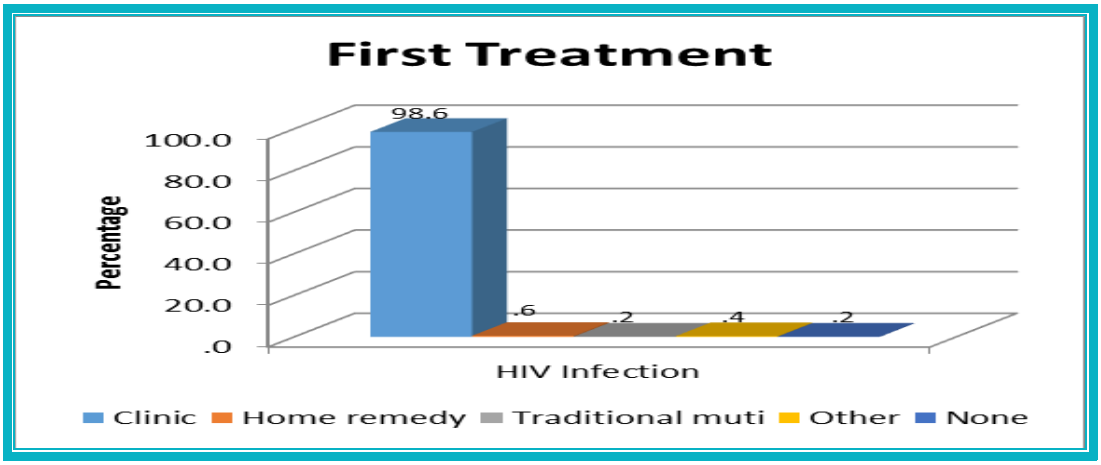

Figure 4.21: Choices for HIV infection treatment

4.11. TUBERCULOSIS (TB)

4.12.1. Cough for more than seven days

The majority of respondents 94.5% (n=479) revealed that they would seek clinic care if their child had a cough for more than seven days, 3.7% (n=19) home remedy, 0.4% (n=2) selected other and stipulated doctor, general practitioner. 0.4% (n=2) would not seek any care, while 0.2% (n=1) would use traditional medicine (p<.0005).

Table 4.29: The treatment choice for cough persisting for more than seven days

	Treatment choice	Frequency	Percent
	Clinic	479	94.5
	Home remedy	19	3.7
	Traditional muti	1	.2
	Other	2	.4
	None	2	.4
	Total	503	99.2
Total		507	100.0

4.12.2. Fever for 14 days or more

Majority of the respondents 97.2% (n=493) stipulated that they would seek clinic care for if their child had fever for 14 days or more, 1.2% (n=6) would use home remedy, 0.8% (n=4) chose other and specified doctor, general practitioner, hospital. 0.2% (n=1) would use traditional medicine. Table 4.30 depicts the care for children with fever for more than 14 days (p<.0005).

Table 4.30: Treatment chosen for fever for 14 days or more

	Treatment choice	Frequency	Percentage
	Clinic	493	97.2
	Home remedy	6	1.2
	Traditional muti	1	.2
	Other	4	.8
	Total	504	99.4
Total		507	100.0

4.12.3. Child is tired all the time

Table 4.31 reflects the care for children who are tired all the time. Majority 82.8% (n=420) of respondents selected clinic care as the first line of treatment if their child was tired all the time, 13.8% (n=70) home remedy, 1.4% (n=7) would use traditional medicine while 1% (n=5) would not seek any care. 0.6% (n=3) chose other and stipulated doctor, general practitioner (p<.0005).

Table 4.31: Treatment choice if the child is tired all the time

	Treatment choice	Frequency	Percentage
	Clinic	420	82.8
	Home remedy	70	13.8
	Traditional muti	7	1.4
	Other	3	.6
	None	5	1.0
	Total	505	99.6
Total		507	100.0

4.12.4. Losing weight

Majority of the respondents, 88.8% (n=450) indicated they would seek clinic care if their child was losing weight, 9.7% (n=49) chose to use home remedy, 0.4% selected other and stipulated general practitioner and hospital. 0.2% (n=1) revealed they would use traditional medicine (p<.0005).

Table 4.32: The choice of treatment if the child is losing weight

	Treatment choice	Frequency	Percentage
	Clinic	450	88.8
	Home remedy	49	9.7
	Traditional muti	1	.2
	Other	2	.4
	None	2	.4
	Total	504	99.4
Total		507	100.0

4.12.5. Has been in contact with a person who has TB

If their child had been in contact with a person who has TB, a significantly large number of respondents 96.4% (n=489) reflected they would seek clinic treatment, 2.2% (n=11) home remedy, 0.4% selected other and specified doctor, hospital. 0.2% (n=1) revealed they would use traditional medicine. (p=<.0005). Table 4.33 stipulates the care for children who have been in contact with a person who has TB.

Table 4.33: The choice of treatment if the child has been in contact with a person who has TB

	Treatment choice	Frequency	Percentage
	Clinic	489	96.4
	Home remedy	11	2.2
	Traditional muti	1	.2
	Other	2	.4
	Total	503	99.2
Total		507	100.0

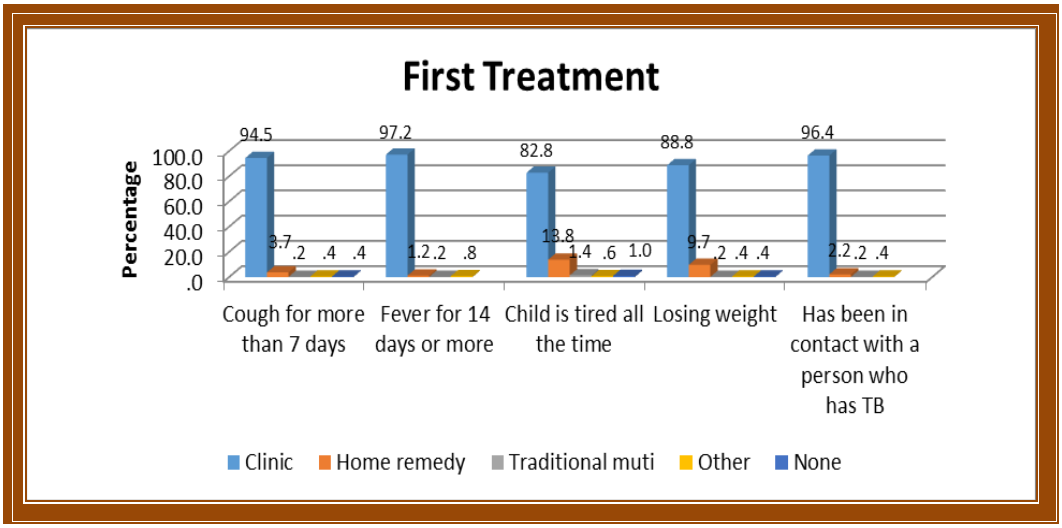

Figure 4.22: The first treatment sought for Tuberculosis

4.13. PREFERRED METHOD OF TREATMENT

When asked about the preferred method of teatment, 51.7% (n=262) selected western only, 40.9% (n=205) indicated preference of both traditional and western medicine, 5.9% (n=30) stipulated traditional only, while 0.8% (n=4) selected other and specified home remedy, western and home (p<.0005).

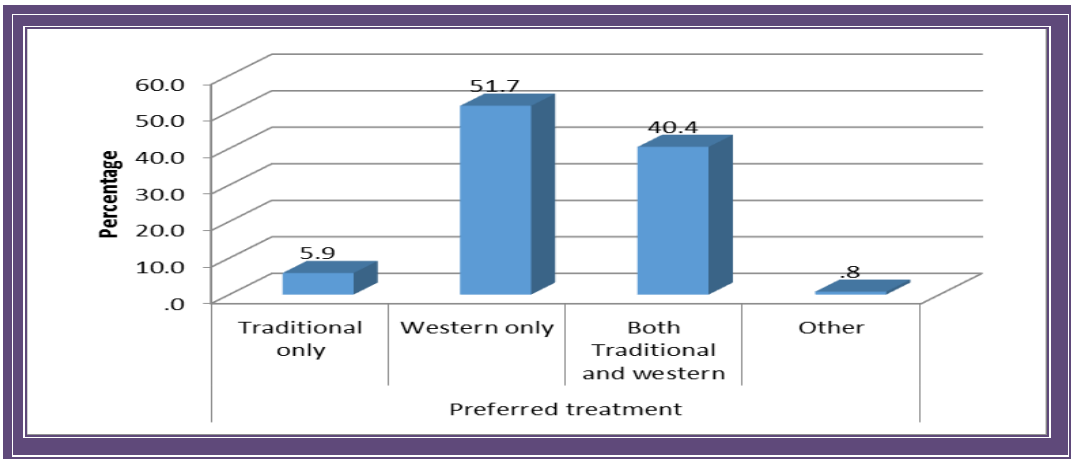

Figure 4.23: The preferred methods of treatment.

4.13.1 CHILD BECOMES SICKER WHILE ON CLINIC TREATMENT

When respondents were asked what they would do if their child was on clinic treatment and became more sick, 49.9% (n=253) indicated they would stop the medication, while 44% (n=223) indicated they would not stop the medication. 94.5% (n=479) revealed they would go back to the clinic while 4.1% (n=21) would not go back to the clinic. 48.5% (n=248) would not continue with medication, while 45.2% (n=229) would continue until the medication is finished. 81% (n=413) stipulated they would not go to the traditional healer if their child gets sicker while 12.4% (n=63) indicated they would go to the traditional healer. 1% (n=) chose other as an option and stipulated they would use home remedy, go to hospital, pray. Figure 4.24 depicts the choices for children who become sicker while on clinic treatment.

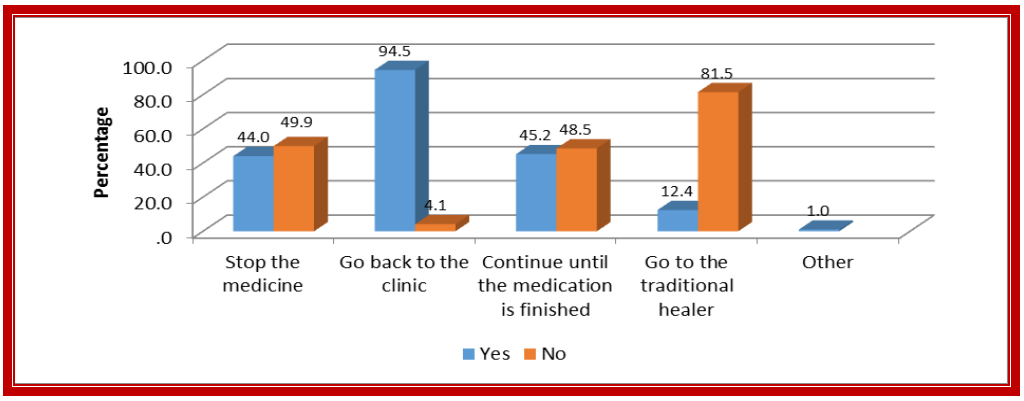

Figure 4.24: The action taken if the child becomes sicker while on clinic treatment

4.14. TRADITIONAL MEDICINE USE AND AVAILABILITY

A one-sample t-test to test whether the average agreement score shows significant agreement or disagreement was used.

Table 4.34: Traditional medicine use and availability

	Test Value = 3					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
15.1 I have always used traditional medicine	-25.377	502	.000	-1.038	-1.12	-.96
15.2 My child could not be cured at the clinic	-19.782	490	.000	-.857	-.94	-.77
15.3 There are no clinics close to my home	-25.206	494	.000	-1.004	-1.08	-.93
15.4 Western medicines are too expensive	-3.753	502	.000	-.207	-.32	-.10
15.5 I prefer to use herbs/ home medication that I / elders at home prepare	-9.820	504	.000	-.483	-.58	-.39
15.6 Traditional medicine is effective for my child	-8.339	504	.000	-.428	-.53	-.33
15.7 Western medicine does not always help make my child better	-3.556	506	.000	-.191	-.30	-.09
15.8 Western medicine has too many side effects	-2.232	502	.026	-.125	-.24	-.01
15.9 It is easier to communicate with a traditional healer	-5.063	499	.000	-.278	-.39	-.17
15.10 Family and friends encourage me to go to a traditional healer	-6.170	500	.000	-.341	-.45	-.23
15.11 Natural medicine is better	.109	499	.913	.006	-.10	.11

Table 4.34 describes traditional medicine use and the availability thereof. There is significant disagreement that traditional medicine is always used (t(502)=-25.377, p<.0005), the child could not be cured at the clinic (t(490) =-19.782, p<.0005), there are no clinics close to home also yielded significant disagreement, (t(494)=-25.206, p<.0005). There was significant disagreement with western medicine is too expensive, (t(502)=-3.753,p<.0005). I prefer to use herbs/ home medication that I / elders prepare at home generated significant disagreement (t(504)=-9.820, p<.0005), traditional medicine is effective for my child reflected significant disagreement (t(504)=-8.339, p<.0005). Significant disagreement also arose from western medicine does not always make the child better (t(506)=-3.556, p<.0005), western medicine has too many side- effects, (t(502)=-2.232, p=.026). Strong disagreement also arose from it is easier to communicate with a traditional healer (t(499)=-5.063, p<.0005). Family and friends encourage me to go to a traditional healer also yielded strong disagreement (t(500)=-6.170, p<.0005). There was significant agreement that natural medicine is better (t (499) =.109, p=.913).

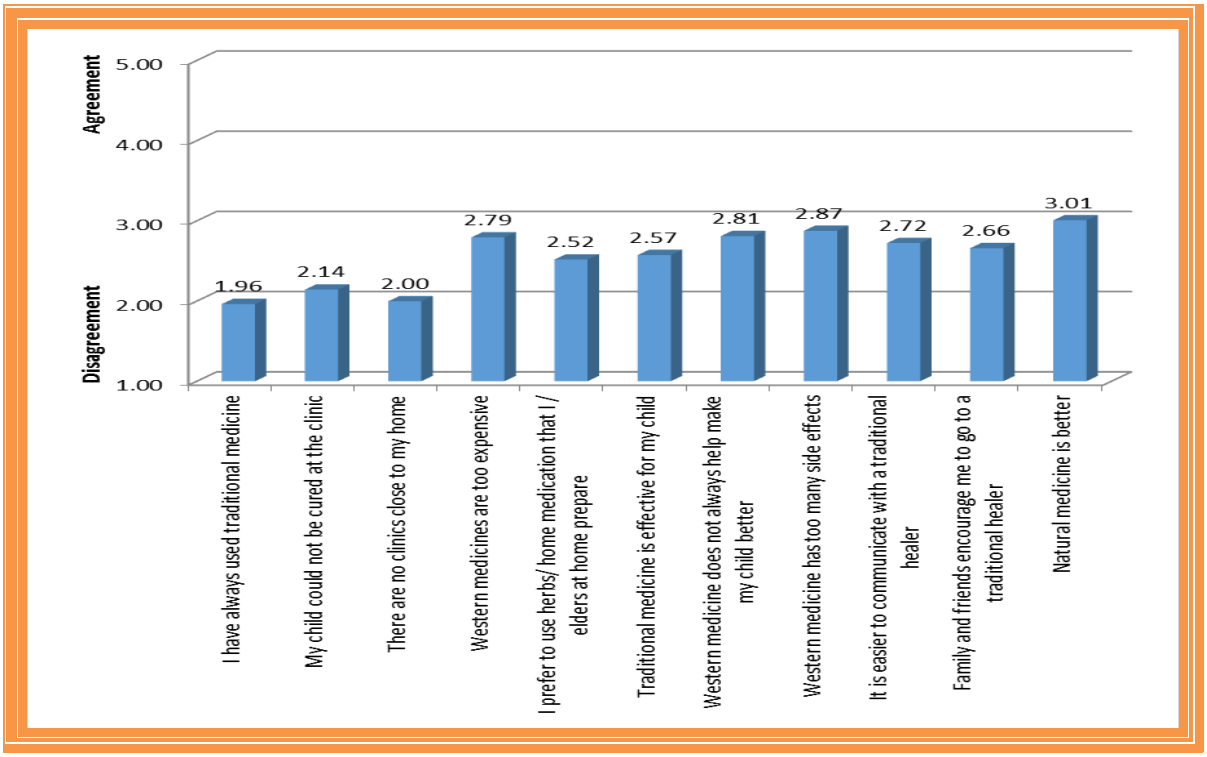

Figure 4.25: Traditional medicine use and availability as reflected by the respondents.

4.15. Discussion of traditional medicine use between caregivers and health care professionals

In figure 4.26, respondents were asked whether they would disclose the use of traditional medicine if asked by a doctor or nurse, the majority 75.7% (n=384) indicated they would disclose, 13.8% (n=70) reflected maybe, while 10.1% (n=51) would not disclose, (p<.0005).

Respondents were asked if the child was to get sicker with traditional medicine whether they would stop the administration, majority 80.9% (n=410) indicated they would stop the administration, 10.7% (n=54) selected maybe,

and 8.1% (n=41) specified they would not stop giving the traditional medicine, (p<.0005).

When asked whether they would comply with a doctor or clinic nurse asking them to stop the use of traditional medicine while the child is on western medicine, a total of 99% (n=502) caregivers answered this question and 79.5% (n=403) stipulated they would comply,12.2% indicated they may, whereas 7.3% (n=37) indicated they would not comply, (p<.0005).

When asked whether they were happy to discuss the use of traditional medicine with a doctor or nurse 71.8% (n=364) who indicated yes, 15.4% (n=78) stipulated they were not happy, and 12.4% (n=63) indicated maybe (p<.0005).

When asked if they would give both traditional medicine together with western medicine, just over half of the respondents, 52.9% (n=268) indicated that they would not give both medicines together, 28.6% (n=145) specified they would give both together, and 17.4% (n=88) specified that maybe they would give both together, (p<.0005).

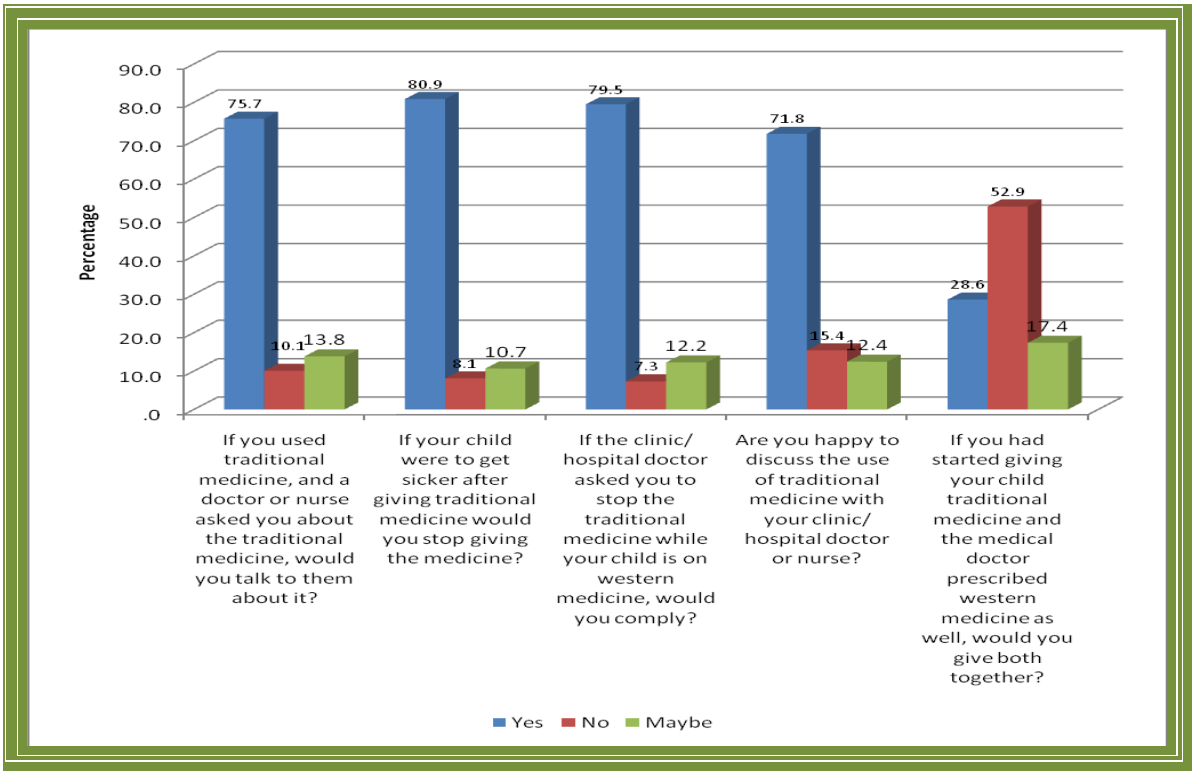

Figure 4.26: The discussion of traditional medicine use between caregivers and health care professionals

4.16. Reasons for not disclosing use of traditional medicine

Figure 4.27 illustrates a few reasons for caregivers not wanting to disclose the use of traditional medicine for their sick children. When asked about fear, just over half of the respondents, 66.9% (n=339) stipulated that they would be fearful to disclose while 31.2% (n=158) would not be fearful (p<.0005).

Respondents were also asked whether they felt the health care professionals would not understand, majority 71.6% (n=363) indicating yes staff would not understand, while 23.9% (n=121) stipulated no to this question (p<.0005).

The relevance of traditional medicine in relation to western medicine was questioned 75.1% (n=381) revealed they do not find traditional medicine

relevant to western medicine whereas 21.5% (n=109) specified that there is a relevance (p<.0005).

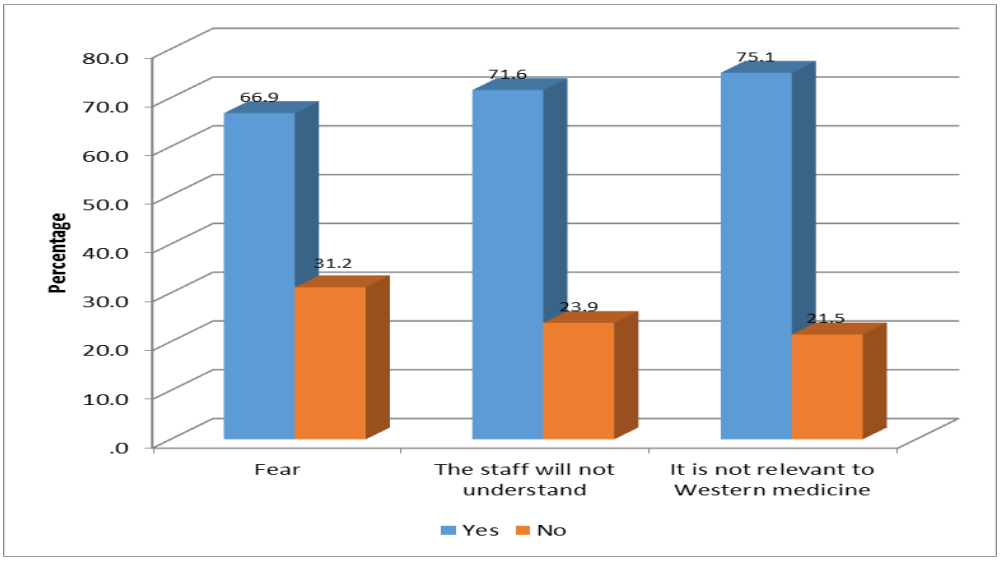

Figure 4.27: The reasons for non-disclosure of traditional medicine use

Table 4.35: Indicates the comparison of the relationship between closest care provider and the treatment consider safest

			3. What treatment do you consider to be the safest in treating your sick child?			
			Clinic	Traditional healer	Home remedy	Total
Closest care provider	Clinic	Count	465	4	19	488
		Expected Count	463.5	4.9	19.6	488.0
		% within Closest care provider	95.3%	.8%	3.9%	100.0%
		Std. Residual	.1	-.4	-.1	
	Traditional healer	Count	8	1	1	10
		Expected Count	9.5	.1	.4	10.0
		% within Closest care provider	80.0%	10.0%	10.0%	100.0%
		Std. Residual	-.5	2.8	.9	
Total		Count	473	5	20	498
		Expected Count	473.0	5.0	20.0	498.0
		% within Closest care provider	95.0%	1.0%	4.0%	100.0 %

The relationship which exists between question 3- in section B pertaining to the closest care provider, question 13 in section B relating to the treatment preferred for use in a sick child ,was compared with question 3 in section A concerning the treatment considered to be the safest to use. There exists a significant relationship between closest care provider and the treatment they consider safest for their child (Fisher's = 7.021, p=.038). A significant difference exists of those whose closest provider is a traditional healer whom they believe are the safest carer for their child. There is a significant relationship between closest care provider and their preferred treatment (Fisher's = 15.210, p<.0005). More expected of those whose closest provider

is a traditional healer prefer traditional treatment alone or traditional and Western treatment combined.

4.17. CONCLUSION

Data generated from the data collection tool was analysed and presented in this chapter. For each of the questions the frequencies and percentages were described. Graphs were also used to depict the data analysed. The implications of the study findings are discussed in greater details chapter 5.

CHAPTER 5

DISCUSSION AND CONCLUSION

5.1 INTRODUCTION

Traditional medicine is widely used in South Africa, Luyck *et al* (2005: 39) and globally (Ekor 2013: 177). Although there are benefits as indicated by Aworinde & Erinoso (2015: 9), there remains a high risk when used in children and could result in serious illness or even death (Nyika 2007: 33). The results of this study are discussed in this chapter and are guided by the study objectives and findings from the questionnaires answered by caregivers with children under the age of five years.

5.2. OVERVIEW OF RESEARCH DISCUSSION

This analysis was conducted to satisfy the objectives of this study as stated in chapter one. The objectives of this study were:

1. The first line of treatment given to sick children by caregivers.
2. The health care seeking behaviour of caregivers for their sick children.
3. The health interventions after the first line of health care seeking.

5.3. THE FIRST LINE OF TREATMENT GIVEN TO SICK CHILDREN BY CAREGIVERS.

This study found that most of the respondents indicated they would seek care from a clinic first, for all the childhood illnesses mentioned in the data

collection tool. However there remains some who revealed that they would use home remedies, traditional medicine or not seek care at all. The care seeking behaviour of these caregivers are in keeping with the findings of Webair & Ghouth (2014: 587-588) who indicated that caregivers perceiving an illness as “not for medical intervention” was the main reason for a delay in seeking appropriate health care for sick children. Childhood illnesses have been known to be treated by means other than conventional treatment and this has been highlighted in Table 2.1 which addresses childhood illnesses treated with traditional medicines.

5.4. THE HEALTH CARE SEEKING BEHAVIOUR OF CAREGIVERS FOR THEIR SICK CHILDREN

When analysing the time taken to seek care for their sick children, it was of significance to note that in most instances there was a delay in seeking health care. Table 5.1 summarises how long the caregiver will wait before seeking care for the sick child. One of the factors to consider when analysing this delay (2 days or more), is what does the caregiver do for the child prior to seeking care?

Table 5.1: Indicates the time taken to seek care for sick children

Childhood illness	1 day	2 days and more	No treatment
General danger signs	62.9%	36.5%	-
Cough	43.6%	56.1%	-
Fever	49.3%	50.3%	-
Rash/ fever	48.3%	50.7%	0.2%
Ear problems	59.8%	39.7%	0.2%
Weight loss	43.2%	56.6%	0.2%

Sharkey *et al* (2012: 114), indicated that hospital based audits on child mortality rates suggest that many sick children are presented late to seek medical attention especially in under resourced places. When caregivers of sick children eventually seek health care either at local clinics or hospitals, there is a lack of a detailed assessment of traditional medicine use in the sick child, and care planning is done without consideration of the traditional medicine or home remedies being used. This could result in the caregiver continuing to administer traditional medicine in conjunction with conventional treatment and the effects on the renal system and the liver could be detrimental to the sick child. Blanke *et al* (2008: 38) found that seeking traditional medicine first, caused a delay in seeking timeous health care. This is in keeping with the delay in seeking health care found in this study.

5.5. THE HEALTH INTERVENTIONS AFTER THE FIRST LINE OF HEALTH CARE SEEKING.

When caregivers were asked what they would do should their child's condition deteriorates further while on clinic treatment, most respondents indicated they would either continue until the medication is finished or go back to the clinic. However there were those who reflected that they would stop the medication, and go to the traditional healer. Caregivers were also asked about the treatment they considered to be the safest for the sick children and it is interesting to note that there is a significant relationship between closest care provider and the treatment they consider safest for their child (Fisher's = 7.021, p=.038). More than expected of those whose closest provider is a

traditional healer believe that traditional healers are the safest carer for their child. There is a significant relationship between closest care provider and their preferred treatment (Fisher's = 15.210, p<.0005). More than expected of those whose closest provider is a traditional healer prefer traditional treatment alone or traditional and Western treatment combined.

So although most caregivers indicated the clinic is closest to home, it did not mean that this was their preferred method of treatment, it is actually traditional medicine or a combination of both traditional and western medicine. It is important to view these findings in relation to the findings of Towns *et al* (2014) who indicated that the childhood illnesses which posed the greatest concern to the WHO include diarrhoea, respiratory conditions and malaria are in some instances being treated by using remedies made from plants, and these herbal medicines which were self- administered was shown to have been preferred as compared to seeking medical care.

5.6. THE CONCURRENT USE OF TRADITIONAL MEDICINE WITH CONVENTIONAL MEDICINE

The concurrent use of traditional medicine with conventional medicine poses a great threat to the lives of patients if healthcare professionals do not identify the use of traditional medicine before prescribing conventional treatment, the use of traditional mixtures may at some level expose the patient to toxins however when combined with other chemicals it can be fatal (Nyika 2007: 33). In this study caregivers were asked if they would administer traditional medicine concurrently with conventional medicine, and although the majority

indicated they would not, 28.5% indicated they would actually administer both together, and 17.4% reflected that maybe they would. This finding is of great concern since Blanke *et al* (2008: 38), found that children who were given traditional medicine before admission to hospital were more likely to die, more so in children who were younger. The concern that arises is also justified by the findings of Adams *et al* (2013: 228) who stated that considering the high rate of concurrent use of complementary and conventional medication, in conjunction to the omission to disclose, there remains an urgent need to include in history taking the use alternative medicine when routinely assessing any sick child. Although the lack of discussion between health care professional and caregivers has been described in previous studies for over 10 years, there still remains place for health care assessment of sick children to improve (Adams *et al* 2013: 228).

5.7. DISCUSSION OF TRADITIONAL MEDICINE USE BETWEEN CAREGIVERS AND HEALTH CARE PROFESSIONALS

There is evidence to greatly suspect the probability of herbal medicine usage in a sick child prior to seeking healthcare and therefore the need for a more comprehensive healthcare system (Towns *et al* 2014). It was also highlighted that although there was a high prevalence of traditional medicine use, health care professionals and parents did not discuss this during the assessment of sick children (Vlieger *et al* 2011: 629). In this study caregivers were asked whether they would discuss the use of traditional medicine if the nurse or doctor enquired about it, and 75.7% indicated they would disclose if they were

asked. This finding is pertinent and is in keeping with the findings of Oshikoya *et al* (2008) where none of the parents in their study had disclosed the use of traditional medicine to the doctor, however 85% of parents would have disclosed this information if they were asked by the examining health care professionals.

This study also found that 79.5% of the caregivers would comply if the attending health care professional asked them to stop the use of traditional medicine while the child is on conventional medicine. Some of the caregivers opted not to disclose the use of traditional medicine to health care professionals with some the reasons being fear, the staff would not understand and that traditional medicine is irrelevant to western medicine. This was also found in a study by Adams *et al* (2013: 228), where although the use of complementary medication is so prevalent among children; there are very few caregivers who actually disclose the use to the attending health care professionals. Some of the reasons for non- disclosure included the concern of a negative response from the health care professional, the physician did not need to know and also that the health care professional did not ask about alternative medication (Adams *et al* 2013: 228). The value of enquiring about the use of traditional medicine in sick children cannot be over-emphasised as Marais *et al* (2015: 1), highlighted that health care professionals are to blame for not always asking their patients about traditional medicine use; as the lack thereof could result in drug –herb interactions, potential treatment failure, and even death.

5.8. RECOMMENDATIONS

5.8.1. On Nursing Research

The findings of this study has contributed to the knowledge we have on the assessment of sick children under the age of five years in relation to the possible use of traditional medicine prior to seeking medical care. The information generated from this study was predominantly from caregivers living in an urban setting. There is a need however, for more research into the use of traditional medicine for sick children living in rural areas.

5.8.2. On assessment of sick children under the age of five years

The pertinent findings of this study that impact on the assessment of sick children under the age of five years were;

- Some caregivers would administer traditional medicine concurrently with conventional medicine.
- A significant percentage of caregivers would disclose the use of traditional medicine for their sick children if they were asked about it by a nurse.
- A significant percentage of caregivers indicated that if they were asked by a nurse, to discontinue the administration of traditional medicine while conventional medicine is being given to their sick children, they would comply.

The current assessment tool for children under the age of five years, does not guide the health care professional to take any history pertaining to the use of traditional medicine; therefore the affected child is not identified and referred to hospital sooner. The resultant effect is often rapid deterioration in the child's condition which may become difficult or impossible to reverse. Hospital based care does not include the possibility of ongoing use of traditional medicine while the child is on western medicine, this can further impact on the risk of renal and hepatic impairment. In view of these findings, the IMCI assessment tool should make provision for compulsory history taking on the use of traditional medicine when a child is being assessed for any of the childhood illness depicted in the guidelines. In consideration of the potential complications that can arise from traditional medicine use, IMCI should also make provision for the health care professional to classify the child who has taken traditional medicine preferably as a danger sign or as "Red" requiring urgent attention and referral to hospital, since there is a potential threat to life. Incorporation of compulsory history taking pertaining to the use of traditional medicine into the IMCI tool will also improve the skills of nurses who assess sick children since it is used to teach in various nursing curricula.

5.8.3. On child mortality

The concurrent use of traditional medicine with conventional medicine appears to be prevalent, and maybe a contributing factor to child mortality. Caregivers should be cautioned by health care professionals against the use

of both traditional and conventional medicine concurrently, in a manner that is non- judgemental and caring to promote compliance by caregivers. Education of the potential risk associated with the use of both traditional and conventional medicine together should be compulsory at every level of caring for sick children.

5.9. LIMITATIONS

The waiting time for children to be examined is short at Gateway Clinic as well as POPD; as a result it was difficult for the researcher to access caregivers since completing the questionnaire would take an average of 30 minutes. Sometimes caregivers were in a hurry to consult with the health care provider and this prevented them from wanting to answer the questionnaire.

5.10. CONCLUSION

This study does not by any means imply that traditional medicine is entirely harmful to children, but does intend to highlight the need for safety surrounding its use especially in young children. The researcher is aware that traditional medicines have and always will be an integral part as an alternative health care system. It is important however that various aspects which include safe sourcing of ingredients, hygiene in the preparation of concoctions, calculation of doses according to child's age and weight are but a few needs that are to be considered. It is vital that sick children be assessed and cared for holistically.

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Integrated Management of Childhood Illnesses 2013.

ANNEXURE-A

Institutional Research Ethics Committee
Faculty of Health Sciences
Room MS 49, Mansfield School Site
Gate 8, Ritson Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2900
Fax: 031 373 2407
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

5 November 2015

IREC Reference Number: **REC 100/15**

Mrs S Pillay
664 A Stella Road
Queensburgh
4093

Dear Mrs Pillay

The use of traditional medicine by caregivers for children under the age of five years as health seeking behaviour

The Institutional Research Ethics Committee acknowledges receipt of your notification regarding the piloting of your data collection tool.

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.

Yours Sincerely,

[redacted]

Professor J K Adam
Chairperson: IREC

DUT DURBAN UNIVERSITY OF TECHNOLOGY
2015 -11- 05
INSTITUTIONAL RESEARCH ETHICS COMMITTEE
P O BOX 1334 DURBAN 4000 SOUTH AFRICA

ANNEXURE B

Appendix B: Permission letter to the KZN Department of Health

664AStella Road
Queensburgh
Durban
4093

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

Dear Sir

Re: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am presently registered for a Master's Degree at the Durban University of Technology in the Department of Nursing. My student no. is (21449552). The proposed title of my study is **"The use of traditional medicine by caregivers for children under the age of five years as health seeking behaviour."** I hereby request permission to conduct the study at the R.K.Khan Hospital Gateway clinic and Paediatric Out- Patient Department.

Data will be collected by means of a questionnaire that will be given to caregivers with sick children under the age of five years. Participation is voluntary, and informed consent will be obtained from all participants. Confidentiality will be maintained at all times. Please find attached a copy of my research proposal.

Sincerely

[redacted]

Mrs SPillay (Researcher)
Telephone: 084 4451872
Email:Shanitha.pillay@kznhealth.gov.za

[redacted]

Dr. P. Basson (Supervisor)
Telephone: 031-373 2687
Email: petrob@dut.ac.za

ANNEXUREC

health
Department
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 251/15
NHRD: KZ_2015RP20_86
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Mrs S. Pillay
Email: Shanitha.Pillay@kznhealth.gov.za

Subject: Approval of a Research Proposal

1. The research proposal titled 'The use of traditional medicine by caregivers for children under the age of five years as health care seeking behaviour' was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at RK Khan Hospital.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

[redacted]

Dr E Lutge
Chairperson, Health Research Committee
Date: 25/09/15

ANNEXURE D

Permission letter to R.K.Khan Hospital CEO

664AStella Road
Queensburgh
Durban
4093

Dr P. Subban

R.K.K.han Hospital

Private Bag X004

Chatsworth

4093

Dear Sir

Re: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am presently registered for a Masters Degree at the Durban University of Technology in the Department of Nursing. My student no. is (21449552). The proposed title of my study is **"The use of traditional medicine by caregivers for children under the age of five years as health seeking behaviour"**

I hereby request permission to conduct the study at the R.K.Khan Hospital Gateway clinic and Paediatric Out- Patient Department.

Data will be collected by means of a questionnaire that will be given to caregivers with sick children under the age of five years. Participation is voluntary, and informed consent will be obtained from all participants. Confidentiality will be maintained at all times. Please find attached a copy of my research proposal.

Sincerely

[redacted]

Mrs S Pillay (Researcher)
Telephone: 084 4451872
Email:Shanitha.pillay@kznhealth.gov.za

[redacted]

Dr. P. Basson (Supervisor)
Telephone: 031-373 2687
Email: petrob@dut.ac.za

Permission letter to R.K.Khan Hospital Nursing Service Manager

664AStella Road
Queensburgh
Durban
4093

Mrs. N.F. Ngidi

R.K.K.han Hospital

Private Bag X004

Chatsworth

4093

Dear Madam

Re: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am presently registered for a Masters Degree at the Durban University of Technology in the Department of Nursing. My student no. is (21449552). The proposed title of my study is **"The use of traditional medicine by caregivers for children under the age of five years as health seeking behaviour"**

I hereby request permission to conduct the study at the R.K.Khan Hospital Gateway clinic and Paediatric Out- Patient Department.

Data will be collected by means of a questionnaire that will be given to caregivers with sick children under the age of five years. Participation is voluntary, and informed consent will be obtained from all participants. Confidentiality will be maintained at all times. Please find attached a copy of my research proposal.

Sincerely

[redacted]

Mrs S Pillay (Researcher)
Telephone: 084 4451872
Email:Shanitha.pillay@kznhealth.gov.za

[redacted]

Dr. P. Basson (Supervisor)
Telephone: 031-373 2687
Email: petrob@dut.ac.za

ANNEXURE E

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

R.K.KHAN HOSPITAL/ETHEKWINI
DISTRICT
OFFICE OF THE CEO
PRIVATE BAG X004
CHATSWORTH
4030

Tel.: 031-4596001
Fax. No. 031-401 1247
Email: reena.ramcharan@kznhealth.gov.za
www.kznhealth.gov.za

ENQUIRIES: DR P.S. SUBBAN

11 September 2015

Mrs S. Pillay
Durban University of Technology

Dear Mrs Pillay

RE: PERMISSION TO CONDUCT RESEARCH : THE USE OF TRADITIONAL MEDICINE BY CAREGIVERS FOR CHILDREN UNDER THE AGE OF FIVE YEARS AS HEALTH SEEKING BEHAVIOUR

Permission is granted to conduct your research at this institution.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Institution with regards to this research.
2. Please ensure this office is informed before you commence your research.
3. You will be expected to provide feedback on your findings to this institution.
4. Kindly liaise with Mrs F.G. Ngidi, the Nursing Manager on Ext 6384.

Yours faithfully

[redacted]

HOSPITAL CEO

ANNEXURE F

LETTER OF INFORMATION

Dear Participant

Thank you for agreeing to be a part of this study by sharing your valuable contributions.

Title of the Research Study: The use of traditional medicine by caregivers for children under the age of five years as health seeking behaviour.

Principal Investigator/s/researcher: Mrs. Shanitha Pillay (BACur)

Co-Investigator/s/supervisor/s: Dr. P. Basson (PhD - Senior lecturer)

Brief Introduction and Purpose of the Study: This study intends to look at the use of traditional medicine by caregivers to treat sick children under the age of five years. The use of traditional medicine in children under the age of five is not fully considered when health workers examine sick children. Therefore the researcher wants to determine if this can help to improve the care given to sick children by health care facilities. A study will be done by using a structured questionnaire which will be handed out to caregivers attending a primary health care clinic seeking health care for their sick children and caregivers of children attending the Paediatric Out – Patient Department at R.K.Khan hospital. The researcher will not ask the child accompanying you any questions, the child's privacy will be protected at all times.

Outline of the Procedures: Data will be collected using a structured questionnaire that will be handed to caregivers of children under the age of five, attending the Gateway clinic and POPD at R.K.Khan hospital.

Risks or Discomforts to the Participant: This study will not impose any risk or discomfort to the participants.

Benefits: the study will assist in holistic assessment and care planning for sick children.

Reason/s why the Participant May Be Withdrawn from the Study: Participants may withdraw from the study at any time with no penalties.

Remuneration: There will be no remuneration.

Costs of the Study: The researcher will not bear any costs in this study.

Confidentiality: Will be maintained by the use of codes to protect the identity of participants. The master list of participants, codes and records will be kept under lock and key for a period of 5 years then destroyed by shredding. Research data on electronic devices will be deleted.

Research-related Injury: none

Persons to Contact in the Event of Any Problems or Queries:

Please contact the researcher Mrs. Pillay (tel no. 0844451872), my supervisor -Dr. Basson (tel no.031-3732602) or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F.Otieno on 031 373 2382 or dvctip@dut.ac.za.

General: Potential participants must be assured that participation is voluntary and the approximate number of participants to be included should be disclosed. A copy of the information letter should

be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population e.g. isiZulu.

ANNEXURE G

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Shanitha Pillay (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: 100/15
- 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, Shanitha Pillay (name of researcher) 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

ANNEXURE H

Incwadi yokwazisa ngocwaningo

Siyabingelela koyingxenye yocwaningo

Siyakubonga ngokuba yingxenye, nangeqhaza olibambile kuloucwaningo

Isihloko socwaningo: Ukusetshenziswa kwe mithi yendabuko ngabanakekela abantwana abaneminyaka engaphansi kwemihlanu ngenjongo yokubalapha.

Ohola Ucwaningo ngu: Mrs S. Pillay (BA Cur)

Ebambisene no : Dr. P. Bason

ISINGENISO KANYE NENHLOSO YOCWANINGO:

Lolucwaningo luhlose ukubheka ukusenthenziswa kwemithi yendabuko ngabanakekela abantwana ukwelapha abagulayo abaneminyaka engaphansi kwemihlanu.

Ukusetshenziswa kwemithi yendabuko akubhekelwa ngokwanele lapho abezempilo behlola abantwana abagulayo abaneminyaka engaphansi kwemihlanu.

Ngalokho umcwaningi uhlose ukwenza inhlolovo ukuthi lokhu kungasiza kanjani ukwenza ngcono ukunakekelwa kwabantwana abagulayo ezikhungweni zezempilo.

Lolucwaningo luzosebenzisa imibuzo ehleliwe ezonikezwa labo abayingxenye yocwaningo, okungabanakekela abantwana abahambela izikhungo zokuqala zezempilo (Primary Health Care Clinic) ukuzolapha izingane ezigulayo, Kanye nalabo abahambela igumbi Labantwana abagulayo kodwa bengalalisiwe (Paediatric Outpatient Department) esibhedlela R K Khan.

Umcwaningi angeke abuze imibuzo enganeni ephelezelwe, ilungelo lengane lokuhlonishwa liyonakekelwa ngezikhathi zonke.

Ukuhleleka kocwaningo : Imininingwane iyotholakala ngokusebenzisa imibuzo ehleliwe eyonikelzwa abanakekela abantwana engaphansi kwemihlanu abahamele umtholampilo ozimele ngaphakathi esibhedlela (Gateway clinic) Kanye nalabo ababamele igumbi lezingane ezingalalisiwe esibhedlela(POPD) e R K Khan

Ingozi nokuhlukumezeka koyingxenye yocwaningo: Lolucwaningo alunayo ingozi noma ukuhlukumezeka kulabo abayingxenye yocwaningo.

Inzuzo: Ucwaningo luzosiza ngokuthi ingane ihlolwe ngokuphelele,futhi kuhlelelwe kahle ukunakekela izingane ezigulayo.

Isizathu sokungaqhubeki nokuba yingxenye yocwaningo: Abayingxenye yocwaningo bangahoxa noma yinini ngaphandle kokuhlawuliswa.

Yocwasningo: Angeke kube khona nkokhelo yokuba yingxene yocwasningo.

Izindleko: Akukho zindleko azobhekana nazo ngokbayingxenye yocwaningo

Ilungelo lokungadalulwa: Kuyosethsenziswa amakhodi noma izinombolo ukuvikela lelilungelo.

Uhla lwabayingxenye yocwaningo, amakhodi, nemininingwane yonke yocwaningo iyo valelwa futhi kukhiywe lapho ikhona kuze kuphele iminyaka emihlanu bese icucuzwe iphele nya.

Imininingwane ekuma (computer) nayo iyoshatshalaliswa.

Ukulimala koyingxenye yocwaningo: Akukho ukulimala angahlangabezana nakho oyingxenye yocwaningo

Ongathintana nabo uma kunesehlo, inking noma imibuzo: Imibuzo yakho yibhekise kumcwaningi

Nkosikazi Pillay kulenombolo 0844451872, nabambisene naye u Dr. Basson kulenombolo

031 3732602 noma kwi Institutional Research Ethics Administrator kulenombolo 031 3732900

Izikhalazo zingabikwa kwiDVC:TIP, Prof F. Otieno ku 031 3732382 noma dvctip@dut.ac.za

Isiniseko (Pledge)` : Njengoba uyingxenye yalolucwaningo , qiniseka ukuthi lokhu ukwenza ngaphandle kwengcindezi.

ANNEXURE I

IMVUME

Isivumelwano sokuba yingxenye yocwningo:

- Ggiyaqiniseka ukuthi ngazisiwe ngumcwaningi (Mrs Pillay), ngesimo , nokuziphatha Kanye nobungozi kwalolucwaningo, olugunyazwe yi Research Ethics Clearance Number: 100/ 15.
- Ngifundile futhi ngaqonda imininingwane yocwaningo kwincwadi eshicilelwe ngocwaningo (Participant Information Letter) enginikwe yona.
- Ngiqwashisiwe ngemiphumela yocwaningo mayelana nemininingwane yami ngokobulili, iminyaka yami , usuku lwami lokuzalwa, igama elifingqiwe lami, nesigulo sami ukuthi kuyovikeleka uma sekubikwa ngocwaningo.
- Ngokubonelela izidingo zocwaningo, ngiyavuma ukuba imininingwane etholakale ngalolucwaningo ishicilelwe kwi computer.
- Ngingahoxa kulolucwaningo nangasiphi isikhathi ngaphandle kokohlawuliswa.
- Ngibe nethuba elanele lokubuza imibuzo, ngakho ngiyazibandakanya nalolucwaningo ngaphandle kokuphoqwa.
- Ngiyaqonda ukuthi okunye okubalulekile, nokusha okungithintayo okungavela ngesikhathi socwaningo ngiyokwaziswa ngako.

_____	_____	_____	_____
Igama eliphelele loyingxenye yocwaningo / Isithupha	Usuku	Isikhathi	Sayina / Isithupha

Mina Shanitha Pillay (Umcwaningi) , ngiyaqiniseka ukuthi lozibandakanya nalocwaningo uchazelwe konke mayelana nokuziphatha kanye nobungozi balolucwaningo

_____	_____	_____	_____
Igama eliphelele lomcwaningi	Usuku	Isikhathi	Sayina / Isithupha

_____	_____	_____	_____
Igama aphelele ofakazayo	Usuku	Isikhathi	Sayina/ Isithupha

_____	_____	_____	_____
Igama eliphelele logada ingane	Usuku	Isikhathi	Sayina/ Isithupha

ANNEXURE J

RE: : SHANITA PILLAY

STUDENT NO : **21449552**

QUALIFICATION: M TECH NURSING

SUBJECT : EDITING OF DISSERTATION

TITLE : "The use of Traditional Medicine by caregivers for children under the age of five years as health seeking behaviour"

DATE : 5 DECEMBER 2016

This serves to confirm that I had edited the grammar in respect of

the above mentioned dissertation.

Thank you

[redacted]

N.GOVENDER(MRS)

ANNEXURE K

CAREGIVER QUESTIONNAIRE

SECTION A – DEMOGRAPHIC DATA

(Tick the appropriate option)

1. How old are you?

18 to 25 years	
26 to 35 years	
Over 35 years	

2. What type of area do you live in? **(Select ONE option only)**

Urban (Town)	
Rural (Farm)	

3. Are you working?

Yes	
No	

4. Which care provider is closest to your home?

Clinic	
Traditional Healer	
Other **(Please specify)** _____ _____	

SECTION B

(Tick the appropriate option)

1. How are you related to this child?

Mother	
Father	
Other: please specify _____	

2. How old is your child?

Under 2 months old	
Older than 2 months but less than 1 year	
Older than 1 year but less than 5 years	

3. What treatment do you consider to be the safest in treating your sick child? **(You may select ONLY ONE OPTION)**

Clinic treatment	
Traditional medicine	
Home remedies	
Other: please specify _____	

4. General Danger Signs

4.1 What type of treatment would you **first** give your child should he/she have the following illnesses? **(You may select ONLY ONE OPTION for each illness.)**

ILLNESS	CLINIC TREATMENT	HOME TREATMENT	TRADITIONAL MEDICINE (MUTI)	OTHER (PLEASE SPECIFY)	NONE
4.1.1 CONVULSIONS (fits)					
4.1.2 LETHARGY (floppy)					
4.1.3 VOMIT EVERYTHING					

4.2 If your child had any of the above mentioned signs, how long after the onset will you seek help? **(You may select ONLY ONE OPTION.)**

1 day	
2 to 3 days	
4 to 5 days	
More than 5 days	
I will not seek help	

5. Cough

5.1 What type of treatment would you **first** give your child should they have the following illnesses? **(You may select ONLY ONE OPTION for each illness.) Answer all the questions, please.**

ILLNESS	CLINIC TREATMENT	HOME TREATMENT	TRADITIONAL MEDICINE (MUTI)	OTHER (PLEASE SPECIFY)	NONE
5.1.1 Dry cough					
5.1.2 Cough with chest in- drawing					
5.1.3 Fast breathing					
5.1.4 Noisy breathing					
5.1.5 Wet cough					

5.2 I f your child has a cough, how long after onset will you seek help? **(You may select ONLY ONE OPTION.)**

1 day	
2 to 3 days	
4 to 5 days	
More than 5 days	
I will not seek help	

6. Diarrhoea and vomiting

6.1 What type of treatment would you **first** give your child should they have the following illnesses? **(You may select ONLY ONE OPTION for each illness.) Answer all the questions, please.**

ILLNESS	CLINIC TREATMENT	HOME TREATMENT	TRADITIONAL MEDICINE (MUTI)	OTHER (PLEASE SPECIFY)	NONE
6.1.1 Watery stools					
6.1.2 Blood in stools					
6.1.3 Sunken eyes					
6.1.4 Not able to drink anything					
6.1.5 Sunken fontanelle (soft spot on head)					

6.2 If your child has diarrhoea, how long after onset will you seek help? **(You may select ONLY ONE OPTION.)**

1 to 3 day	
4 to 6 days	
7 to 14 days	
More than 14 days	
I will not seek help	

7. Fever

7.1 What type of treatment would you **first** give your child should they have the following illnesses? **(You may select ONLY ONE OPTION for each illness.) Answer all the questions, please.**

ILLNESS	CLINIC TREATMENT	HOME TREATMENT	TRADITIONAL MEDICINE (MUTI)	OTHER (PLEASE SPECIFY)	NONE
7.1.1 Feels hot to touch					
7.1.2 Has stiff neck					
7.1.3 Bulging fontanelle (soft spot on head that is bulging)					

7.2 If your child has fever, how long after onset will you seek help? **(You may select ONLY ONE OPTION.)**

1 day	
2 to 3 days	
4 to 5 days	
More than 5 days	
I will not seek help	

8. Measles or Rash

8.1 What type of treatment would you **first** give your child should they have the following illnesses? **(You may select ONLY ONE OPTION for each illness.) Answer all the questions, please.**

ILLNESS	CLINIC TREATMENT	HOME TREATMENT	TRADITIONAL MEDICINE (MUTI)	OTHER (PLEASE SPECIFY)	NONE
8.1.1 Rash on body and feels hot to touch					
8.1.2 Red eyes					
8.1.3 Mouth sores/ whitish spots in mouth					

8.2 If your child has a rash and fever, how long after onset will you seek help? **(You may select ONLY ONE OPTION.)**

1 day	
2 to 3 days	
4 to 5 days	
More than 5 days	
I will not seek any help	

9. Ear problem

9.1 What type of treatment would you **first** give your child should they have the following illnesses? **(You may select ONLY ONE OPTION for each illness.) Answer all the questions, please.**

ILLNESS	CLINIC TREATMENT	HOME TREATMENT	TRADITIONAL MEDICINE (MUTI)	OTHER (PLEASE SPECIFY)	NONE
9.1.1 Ear pain					
9.1.2 Ear discharge					
9.1.3 Child wakes up at night with ear pain					
9.1.4 Has swelling behind ear					

9.2 If your child has an ear problem, how long after onset will you seek help? **(You may select ONLY ONE OPTION.)**

1 day	
2 to 3 days	
4 to 5 days	
More than 5 days	
I will not seek any help	

10. Malnutrition and Anaemia

10.1 What type of treatment would you **first** give your child should they have the following illnesses? **(You may select ONLY ONE OPTION for each illness.) Answer all the questions, please.**

ILLNESS	CLINIC TREATMENT	HOME TREATMENT	TRADITIONAL MEDICINE (MUTI)	OTHER (PLEASE SPECIFY)	NONE
10.1.1 Mild weight loss					
10.1.2 Severe weight loss					
10.1.3 Swelling of both feet					
10.1.4 Pale palms					

10.2 If your child has a problem of losing weight, how long after onset will you seek help? **(You may select ONLY ONE OPTION.)**

1 day	
2 to 3 days	
4 to 5 days	
More than 5 days	
I will not seek any help	

11. HIV Infection

11.1 Has your child been tested for HIV Infection?

Yes	
No	

11.2 What type of treatment would you **first** give your child should they have the following illness? **(You may select ONLY ONE OPTION.)**

ILLNESS	CLINIC TREATMENT	HOME TREATMENT	TRADITIONAL MEDICINE (MUTI)	OTHER (PLEASE SPECIFY)	NONE
11.2.1 HIV Infection					

12. Tuberculosis

12.1 What type of treatment would you **first** give your child should they have the following illnesses? **(You may select ONLY ONE OPTION for each illness.) Answer all the questions, please.**

ILLNESS	CLINIC TREATMENT	HOME TREATMENT	TRADITIONAL MEDICINE (MUTI)	OTHER (PLEASE SPECIFY)	NONE
12.1.1 Cough for more than 7 days					
12.1.2 Fever for 14 days or more					
12.1.3 Child is tired all the time					
12.1.4 Losing weight					
12.1.5 Has been in contact with a person who has TB					

13. Which of the following method/s of treatment do you prefer to use when your child is sick? **(You may select ONLY ONE OPTION)**

Traditional only	
Western only	
Both Traditional and Western	
Other **(please specify)**_____	

14. If your child became sicker while on clinic medicine, what would you do? **(Answer all the questions)**

	YES	NO
14.1 Stop the medicine		
14.2 Go back to the clinic		
14.3 Continue until the medication is finished		
14.4 Go to the traditional healer		
14.5 Other **(please specify)** _____		

15. Indicate your level of agreement that the following are reasons why you would choose to take your child to a traditional healer/ use traditional medicine: **(Answer all the questions)**

	Strongly disagree	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
15.1 I have always used traditional medicine					
15.2 My child could not be cured at the clinic					
15.3 There are no clinics close to my home					
15.4 Western medicines are too expensive					
15.5 I prefer to use herbs/ home medication that I / elders at home prepare					
15.6 Traditional medicine is effective for my child					
15.7 Western medicine does not always help make my child better					
15.8 Western medicine has too many side effects					
15.9 It is easier to communicate with a traditional healer					
15.10 Family and friends encourage me to go to a traditional healer					
15.11 Natural medicine is better					

PLEASE TICK THE APPROPRIATE COLUMN. ANSWER ALL THE QUESTIONS.

	YES	NO	MAYBE
16. If you used traditional medicine, and a doctor or nurse asked you about the traditional medicine, would you talk to them about it?			
17. If your child were to get sicker after giving traditional medicine would you stop giving the medicine?			
18. If the clinic/ hospital doctor asked you to stop the traditional medicine while your child is on western medicine, would you comply?			
19. Are you happy to discuss the use of traditional medicine with your clinic/ hospital doctor or nurse?			
20. If you had started giving your child traditional medicine and the medical doctor prescribed western medicine as well, would you give both together?			

21. Indicate whether the following are reasons why you would not tell the clinic doctor or nurse about using traditional medicine:

	Yes	No
21.1 Fear		
21.2 The staff will not understand		
21.3 It is not relevant to Western medicine		

ANNEXURE L

IMIBUZO YONAKEKELA INGANE

ISIGABA A – IMININGWANE YAKHO

1. Uneminyaka emingakhi? **(Khombisa okuqondene)**

18 - 25	
26- 35	
35 Nangaphezulu	

2. Uhlala endaweni enjani? **(khombisa okuyikona)**

Esilungwini	
Emakhaya	

3. Kungabe uyasebenza? **(Khombisa okuqondene)**

Yebo	
Qha	

4. Yiluphi usizo lwezempilo oluseduze nawe? **(Khombisa)**

Umtholampilo	
Umlaphi wendaduko	
Olunye usizo**(Cacisa/ Chaza)** **_____** **_____**	

ISIGABA B

1. Uhlobene kanjani nalomntwana? **(Khombisa okuqondene)**

Umama	
Ubaba	
Obunye ubuhlobo (Cacisa) _____	

2.Ungakanani umntwana wakho? **(Khombisa okuqondene)**

Ngaphansi kwezinyanga ezimbili	
Ngaphezu kwezinyanga ezimbili kodwa ngaphansi konyaka	
Ngaphezu konyaka kodwa ngaphansi kwemihlanu	

3. Yimuphi umuthi ongathi uphephe kakhulu ? **(khombisa ngokukhetha owodwa kwelandelayo)**

Umuthi wasemtholampilo	
Umuthi wesintu	
Amakhambi asekhaya	
Eminye imithi: Cacisa/ Chaza _____	

4. Izimpawu zobungozi

4.1 Yimuphi umuthi ongawusebenzisa kuqala uma ingane yakho inezifo ezilandelayo? **(Khetha ube munye kwelandelayo.)**

ILLNESS	Umuthi wasemthola mpilo	Amakhambi asekhaya	Umuthi womlaphi wendabuko	Eminye imithi (cacisa/ Chaza)	Awukho engingawu sebenzisa
4.1.1 Isithuthwana (ukudlikiza)					
4.1.2 Ukuyetha (ukukhathala kakhulu)					
4.1.3 Ephalaza/ ebuyisa konke akudlile					

4.2Uma ingane inezifo ezibalwe ngenhla, ungamusa nini ukuthi athole usizo? **(Khetha okukodwa.)**

Ngosuku lokuqala egula	
Ngolwesibili kuya kolwesithathu	
Ngolwesine kiya kolwesihlanu	
Ngemuve kwezinsuku ezinhlanu	
Angilifuni usizo	

5. Ukukhwehlela

5.1 Yimuphi umuthi ongawunikeza kuqala uma ingane yakho inokukhwehlela okulandelayo? **(Ungakhetha okukodwa.) Phendula yonke ibibuzo, uyacelwa.**

IISIFO	OWASEMTHOLAMPILO	AMAKHAMBI ASEKHAYA	OWESINTU	OMUNYE (WUCHAZE)	AWUKHO
5.1.1Okomile					
5.1.2Okubaqaza isifuba					
5.1.3 Okunokuphefumula ngokushesha					
5.1.4Okunokuphefumula okunomsindo					
5.1.5 Okunezikhwehlela					

5.2 Uma ingane yakho ikhwehlela, ulufuna nini usizo **(Ungakhetha kube kunye kokulandelayo.)**

Ngosuku- 1	
Ngosuku 2 - 3	
Ngosuku 4 to 5	
Ngaphezu kwezi 5	
Angiludingi usizo	

6. Isihudo nokuphalaza/ ukubuyisa

6.1Yimuphi umuthi ongawunikeza ingane yakho kuqala, uma inalesihudo?
(Ungakhetha okukodwa.) Phendula yonke imibuzo, uyacelwa.

ISIFO	UMUTHI WOMTHOLA MPILO	AMAKHAMBI ASEKHAYA	UMUTHI WESINTU	EMINYE (CACISA)	AWUKHO
6.1.1 Esikhipha amanzi					
6.1.2 Esikhipha igazi					
6.1.3 Esenza izigobhe					
6.1.4 esenza kungagwinyeki lutho					
6.1.5 Esishinisa ukhakhayi					

6.2 Uma ingane yakho inesihudo ulufuna emva kwezinsuku ezingakanani usizo?
(Ungakhetha okukodwa kokulandelayo.) Ngosuku

1 - 3	
4 - 6	
7 - 14	
Ngaphezu 14	
Angilifuni usizo	

7. IMFIVA (UKUSHISA KAKHULU KOMZIMBA)

7.1 Yimuphi umuthi ongawunika kuqala , uma ingane yakho inemfiva? **(Ungakhetha okukodwa kokulandelayo.) Phendula yonke imibuzo, Uyacelwa.**

ISIFO	UMUTHI WASEMTHOLAMPILO	AMAKHAMBI ASEKHAYA	UMUTHI WESINTU/(WENDABUKO	EMINYE IMITHI(CACISA)	AWUKHO ENGINGA WUSEBENZISA
7.1.1 Ishisa kakhulu					
7.1.2 Iqine intamo					
7.1.3 Ivuvukele ukhakhayi					

7.2 Uma ingane yakho inemfiva ulufuna ngemva kwezinsuku ezingakhi usizo?
(Khetha okukodwa kokulandelayo.)

1	
2 - 3	
4 - 5	
6	
Angilifuni usizo	

8. Isimungumungwana / Ukuqubuka

8.1 Yimuphi umuthi ongawunika kuqala uma ungane yakho inesimungumungwana?
(Ungakhetha kube kunye kokulandelayo.) Phendula yonke imibuzo, Uyacelwa.

IISIFO	UMUTHI WOMTHOLAMPILO	AMAKHAMBI ASEKHAYA	UMUTHI WESINTU/ WENDABUKO	EMINYE(CACISA)	AWUKHO ENGINGA WUSEBENZISA
8.1.1 ukuqubuka nokushisa komzimba					
8.1.2 Amehlo abomvu					
8.1.3 Izilonda emlonyeni					

8.2 Uma ingane yakho iqubuka noma ishisa ulufuna emva kwezinsuku ezingakhi usizo? **(Ungakhetha okukodwa kokulandelayo.)**

1	
2 -3	
4 - 5	
Ngaphezu 5	
Angilufuni usizo	

9. Inkinga yendlebe

9.1 Yimuphi umuthi ongawunikeza kuqala , uma ingane yakho iguliswa yindlebe ? **(Ungakhetha okukodwa kokulandelayo.) Phendula yonke imibuzo , uyacelwa.**

ISIFO	UMUTHI WOMTHOLAMPILO	AMAKHAMBI ASEKHAYA	UMUTHI WESINTU/ WENDABUKO	EMINYE(CACISA)	AWUKHO ENGINGA WUSEBENZISA
9.1.1 Ubuhlungu bendlebe					
9.1.2 Ukuvuza kwendlebe					
9.1.3 ubuhlungu obuyivusa ebusuku ingane					
9.1.4 Ukuvuvuka emva kwendlebe					

9.2 Uma ingane yakho inenkinga yendlebe ungalufuna emva kwezinsuku ezingakhi usizo? **(Ungakhetha okukodwa kokulandelayo.)**

1	
2 - 3	
4 - 5	
Ngaphezu 5	
Ngeke ngilifune usizo	

10. Ukungondleki nokushoda kwegazi

10.1Yimuphi umuthi ongawunika kuqala, una ingane yakho inezimpawu ezilandelayo? **(Ungaqoka okukodwa.) Phendula yonke imibuzo, Uyacelwa.**

ILLNESS	UMUTHI WOMTHOLAMPILO	AMAKHAMBI ASEKHAYA	UMUTHI WESINTU/ WENDABUKO	EMINYE(CACISA)	AWUKHO ENGINGA WUSEBENZISA
10.1.1 Ukuncipha komzimba					
10.1.2 Ukuncipha okukhulu komzimba					
10.1.3 Ukuvuvuka kwezinyawo zombili					
10.1.4 Inkomba yokushoda kwegazi ezandleni					

10.2 Uma ingane yakho yehlelwa isisindo ungalufuna emva kwezinsuku ezingakhi usizo? **(Ungakhetha kube kunye.)**

1	
2 - 3	
4 -5	
Ngaphezu 6	
Ngeke ngilifune usizo	

11. Isandulela ngculazi

11.1 Uke wahlolelwa isandulele ngculazi umntwana wakho? **(Khombisa okuyikona)**

Yebo	
Qha	

11.2Yimuphi umuthi ongawunika kuqala uma ingane yakho itho la isandulela ngculazi? **(Ungaqoka okukodwa okuqondene.)**

ISIFO	UMUTHI WASEMTHOLAMPILO	AMAKHAMBI ASEKHAYA	UMUTHI WOMLAPHI WENDABUKO	OMUNYE (SICELA UCACISE)	AWUKHO ENGINGA WUSEBENZISA
11.2.1 Isandulela ngculazi					

12. ISIFO SOFUBA

12.1 Yimuphi umuthi ongawunikeza kuqala uma ingane yakho inesifuba? **(Ungakhetha kube kunye kokulandelayo.) Phendula yonke imibuzo, Uyacelwa.**

ISIFO	UMUTHI WOMTHOLAMPILO	AMAKHAMBI ASEKHAYA	UMUTHI WESINTU	OMUNYE (CACISA)	NONE
12.1.1 Ukukhwehlela ngaphezu kwezinsuku ezingu 7					
12.1.2 Ukushisa komzima ngaphezu kezinsuku ezingu 14					
12.1.3 Ingane ikhathala ngasosonke isikhathi					
12.1.4 Yehlelwa isisindo					
12.1.5 Isondelane nomuntu onesifuba					

13. Kwizindlela zokulashwa ezilandelayo . iyiphi oyikhethayo? **(Ungakhetha kube kunye)**

Eyesintu kuphela	
Eyesilungu kuphela	
Zombili, yesintu neyesilungu	
Ezinye **(cacisa/ chaza)**_____	

14. Uma ingane yakho isebenzisa umuthi wasemtholampilo kodwa igule kakhulu kunakuqala, ungenzenjani? **(Phendula yonke imibuzo)**

	YEBO	QHA
14.1 Ngiyayeka ukumphuzisa umuthi		
14.2 Ngibuyela emtholampilo		
14.3 Ngiqhubeka nokumphuzisa umuthi uze upele		
14.4 Ngiyakumlaphi wendabuko		
14.5 Okunye **(cacisa/ chaza) _____**		

15. Khombisa izinga lokuvumelana kwakho nezizathu ezilandelayo zokuyisa ingane yakho kumlaphi wendabuko noma ukusebenzisa umuthi wesintu: **(Phendula yonke imibuzo)**

	Ngiphika kakhulu	Ngiyapki ka	Angivumi futhi angiphiki	Ngiyavuma	Ngiyavuma kakhulu
15.1 Selokhu kwathi nhlo ngisebenzisa umuthi wesintu					
15.2 Ingane yami ibingasizakali					
15.3 Bowungekho oseduze umtholampilo					
15.4 Imithi yesilungu iyadula kakhulu					
15.5 Ngikhetha ukusebenzisa amakhambi enziwa abantu abadala ekhaya					
15.6 Umuthi wesintu ushaya emhloleni kumntwana wami					
15.7 Umuthi wesilungu ubuye ungamsizi umntwana wami					
15.8 Umuthi wesilungu unezinto eziningi ezingathandeki					

15.9 Sikhuluma kahle sizwane nomlaphi wendabuko					
15.10 Umndeni nabangani bangikhuthaza ukuya kumlaphi wendabuko					
15.11 Umuthi wemvelo ungcono					

KHOMBISA OKUYIKHO. PHENDULA YONKE IMIBUZO.

	YEBO	QHA	MHLAMBE
16. Uma usebenzisa umuthi wesintu unesi noma udokotela ekubuza , ungabatshela yini ngawo?			
17. Uma ingane yakho igula kakhulu ngemva kokuphuza umuthi wesintu, ungama ukumphuzisa na?			
18. Uma abezempilo, udokotela noma umhlengikazi ethi yeka ukunika umuthi wesintu, uma usebenzisa owesilungu. Ungenzenjalo na ?			
19. Ukhululekile ukuxoxisana ngemithi yesintu nabezempilo , odokotela nabahlengikazi ezibhedlela nasemakiliniki?			
20. Uma unukeza ingane yakho imithi yesintu , udokotela akunike eyesilungu, ungayisebenzisa yonke kanyakanya na?			

21. Izizathu ezilandelayo zingenza ukuba ungasho emtholampilo noma kudokotela ukuthi usebenzisa umuthi wesintu:

	Yebo	Qha
21.1 Ukwesaba		
21.2 Ngeke baluqonde		
21.3 Akuqondene nomuthi wesilungu		