Patients' experiences of homoeopathic care rendered at a primary health care facility in the eThekwini district

Phindile Simphiwe Gift Khumalo

Dissertation submitted in fulfilment of the requirements for the Degree in Masters of Technology in Homeopathy in the Faculty of Health Sciences at the Durban University of Technology

Supervisor: Dr CM Hall

Co-supervisor: Prof MN Sibiya

Date: March 2015

Declaration

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is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources).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

_____ _____

Signature of student Date

Approved for final submission

_____ _____

Dr CM Hall Date
M Tech: Homeopathy

_____ _____

Prof MN Sibiya Date
RN, RM, D Tech: Nursing

Abstract

Introduction

In South Africa homoeopathy is relatively unfamiliar, even though it has been in existence with formal qualification from 1989 at the Durban University of Technology, (formerly Durban Institute of Technology and Techikon Natal) as well as the University of Johannesburg formerly Wits Technikon). A large portion of the South African public is unclear with regards to homoeopathic understanding and homoeopathic medicine use. South African studies exploring the perception of homoeopathy have revealed that there is a degree of ignorance or misinterpretation of homeopathy.

The objectives of this study were to expand the database of knowledge regarding the patients' experiences of homoeopathy, by investigating their experiences of homoeopathic care rendered at a PHC facility in the eThekwini district, namely, the Redhill homoeopathic clinic. This study was guided by the following grand tour question: What are the experiences of patients of homoeopathic care rendered at a primary healthcare clinic in the eThekwini District?

Aim of the study

The aim of this study was to determine the experiences of patients receiving homoeopathic care rendered at a primary healthcare facility in the eThekwini district.

Methodology

A qualitative, explorative, descriptive and contextual design was employed. Qualitative research in this study was considered the most appropriate method to gain an in-depth understanding of the patients' experiences of homoeopathic care. Convenience sampling was used to recruit a minimum of 10 potential research participants from patients receiving homoeopathic care at the Redhill homoeopathic clinic, but the sample size was only determined once data saturation was obtained. The study population were patients who were visiting the Redhill homoeopathic clinic for the second time or more and those who had utilized homoeopathic remedies. The data was collected and analysed using Tesch's eight-step procedure.

Results

Results from this study showed that the study group had knowledge of homoeopathy and that there is growth in the knowledge of homoeopathy as compared to previous studies. The researcher observed that Indian participants had a better understanding of homoeopathy than African participants. Participants showed great confidence in homoeopathy and most of them revealed a high level of satisfaction with the homoeopathic treatment and were very happy with the service delivery. Results showed that there had been an improvement of the patients' ailments since the commencement of homoeopathic treatment.

Dedication

I dedicate this dissertation to God Almighty. I am really grateful for his mercy towards me and for making it possible for me to finish this work on time. I understand that it wasn't because of my power nor of my knowledge but it was by his spirit. I can do all things through Christ who strengthens me and if God is for me who can be against me.

I dedicate this to my parents Mrs Sayinile Mirriam and Mr Ntotho Paul Khumalo. Thank you for raising me well and instilling principles and good values to be the person that I am today. Thank you for all the hard work and sacrifices that you have made to make everything possible for me. Thank you mom for your endless prayers that kept me strong and going through my journey. I am grateful for your support, motivation, wise words and most of all your unconditional love.

Acknowledgements

To Professor M.N. Sibiya I really do not know where to start thanking you, I am really grateful for all the hard work you've put into this study, for all the sacrifices that you have made to see me finishing this work. Thank you Prof. Sibiya for your endless support, motivation and encouragement and most of all thank you for believing in me and that is one of the things that kept me motivated for I knew that you were always there to help me and to give me guidance. Thank you for always availing yourself in order to see me accomplishing my Masters. May God bless you and give you more wisdom, thank you Sotobe.

To Dr C. Hall thank you for all your help and support during this study and throughout the course. Thank you for encouraging me and having faith in me, that really means a lot to me. May the good Lord bless you.

To Dr Nienaber thank you for allowing me to conduct this study at the Redhill homoeopathic clinic. Thank you for your patience, support and guidance.

To my sisters; Sindi, Nontobeko, Nontokozo and Zandile I thank God for giving me such sisters. Thank you for being a greatest support system. Thank you for taking care of me as your younger sister and providing for me with all the necessities that I needed throughout my educational journey. You've always been there for me and you've never complained and you guys always went all out in order for me to be a better person one day. Thank you for your prayers, love and support.

To my one and only brother Adv. Wiseman Xolani Khumalo, thank you for all that you've done for me in supporting my dream. You've been my source of strength and there are a lots of things that you've sacrificed for all you wanted was the best in me. Today you are reaping what you've sown my brother and if it wasn't for you I wouldn't be where I am today. Thank you for having faith in me and for your tremendous support through all the hardships that I've

encountered in this journey – you never gave up on me. Thank you for loving me and guiding me.

To my nephews Fisokuhle and Akhani, and my nieces Sphesihle, Yamantungwa and Thandokuhle. Thank you for making me laugh, putting a smile on my face and planting joy in me during stressful times.

To all my friends I just want to thank you for being always supportive. Thank you Euvette Taylor for being the best study mate – you have played a big role in my studies. Thank you Nondumiso, Nokuthula, Adhieman, Nokwe, Nonhle, Myalowenkosi and Minenhle, to mention only a few.

To Dr Ashley Ross, Dr Madu Maharaj, Dr David Naude, Dr Jabulile Ngobese and Dr Ingrid Couchman for all your support, guidance and wisdom through the years of my studies, it is highly appreciated.

Table of Contents

List of tables

Appendices

Glossary of terms

Access: Gaining entry into the health care system and obtaining the necessary assistance.

Allied Health Professions Council of South Africa: is a statutory council for Natural Health, responsible for the promotion and protection of the health of the population of South Africa and will affect this by regulating and setting standards for the profession of homoeopathy, under Act 63 of 1982.

Complementary and alternative medicine: this is a term used for medical product and practices that are not part of standard care, for example acupuncture, chiropractic and homoeopathy.

Health care providers: are all categories of the multidisciplinary team working in the PHC clinic.

Holistic approach: this is when you treat a patient considering the mental, emotional and physical aspect.

Patient: any individual who enters the health care facility seeking any health assistance. The term 'patient' is used interchangeable with the concept 'client'

Primary health care facilities/clinics: are first levels health care institutions that render basic medical care.

Primary health care: is health care at a basic rather than specialized level for people making an initial approach to a doctor or nurse for treatment.

Repertory: An index of the homoeopathic materia medica by symptom. A list of remedies is indicated for each symptom.

Simillimum: The single remedy which best matches the symptoms of the patient

World Health Organisation: A United Nations agency to coordinate international health activities and to help governments improve health services

List of acronyms

Acronym	Full term
AHPCSA	Allied Health Professional Council of South Africa
AIDS	Acquired immune deficiency syndrome
ARVs	Antiretrovirals
CAM	Complementary and Alternative Medicine
CHCs	Community Health Centres
DUT	Durban University of Technology
GHH	Glasgow Homoeopathic Hospital
GPs	General Practitioners
HIV	Human immunodeficiency virus
KZN	KwaZulu-Natal
NHI	National Health Insurance
NHS	National Health System
PHC	Primary Health Care
STI	Sexually transmitted infection
UCT	University of Cape Town
UK	United Kingdom
UKZN	University of KwaZulu-Natal
UNHC	Ukuba Nesibindi Homoeopathic Clinic
WHO	World Health Organization

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND INFORMATION

According to the World Health Organization (WHO) homoeopathy is the fastest developing and the second largest system of medicine in the world. By the year 2017 homoeopathy will be equal to the combined medical systems that make up the rest of alternative health care market, if it continues to grow at its current rate of 20% to 25% per annum (Ottermann 2010). In most parts of the world homoeopathy is not considered as a health care modality even though it is becoming recognised as a primary health care (PHC) choice (Innocent 2010).

All the studies on the perception of homoeopathy in South Africa conducted so far have found that the group least knowledgeable about homoeopathy is the African group (Moys 1998). There is no study that has focused on this group and explored their experiences of homoeopathic care.

The Durban University of Technology's (DUT), Department of Homoeopathy has been instrumental in starting three homoeopathic community clinics namely, Kenneth Gardens, Redhill, and Ukuba Nesibindi Homeopathic Clinic (UNHC). These clinics provides Primary Health Care (PHC) and homoeopathic treatment at no cost to the members of the public that are dependent on public healthcare facilities.

1.2 PROBLEM STATEMENT

Homoeopathy in South Africa is relatively unknown, although it has been in existence with formal qualification from 1989 at the DUT (formerly Durban Institute of Technology and Techikon Natal) as well as the University of Johannesburg, (formerly Wits Technikon) (Von Bardeleben 2009). A large portion of the South African public is uncertain regarding the understanding of homoeopathy and the use of homoeopathic medicines (Paruk 2006).

Perception studies that have been conducted in South Africa so far have showed that there is a degree of ignorance or misunderstanding of homeopathy (Small 2004; Maharaj 2005; Macquet 2007).

The lack of extensive data regarding public perceptions of homoeopathy in South Africa means that homoeopaths have much work to do in the research field to investigate the level of knowledge of homoeopathy amongst the population of South Africa. Through further research, marketing strategies can be formulated to create greater awareness of homoeopathy amongst the general public (Harriphershard 2009).

Homoeopathy is presently not included formally within the public PHC sector in South Africa even though it could supposedly serve to enhance the health sector and thus advance access to healthcare (Smillie 2010). Complementary and Alternative Medicine (CAM) is not covered by the national insurance systems in Austria (Frass *et al.* 2012).

According to Kautzky and Tollman (2008) within the PHC sector in South Africa there has been a shortage resulting in medical personnel being unable to cope with the current demands. The situation needs more effort in addressing the challenges in inventive health system design within today's rigid PHC system. Smillie (2010) stated that the inclusion of homoeopathy at the current PHC clinics would be advantageous to the current healthcare system

Smillie (2010) conducted a retrospective clinical audit at the UNHC whose purpose was to determine the patient demographic and disease prevalence profile as well as identifying and describing the major medicines prescribed. Smillie (2010) further recommended that there be a study which will formally measure patient benefit in response to the treatment in a form of patient benefit survey.

1.3 PURPOSE OF THE STUDY

The purpose of this study was to broaden the database of knowledge regarding patients' experiences of homoeopathy by investigating their experiences of homoeopathic care rendered at a PHC clinic in eThekwini.

1.4 OBJECTIVES OF THE STUDY

This study seeks to answer the following questions:

1.4.1 Grand tour question

- What are the experiences of patients of homoeopathic care rendered at a PHC clinic in eThekwini?

1.4.2 Probing questions

- What is your knowledge of homoeopathy?
- What is your reason for accessing homoeopathy?
- How do you feel about homoeopathic treatment?
- How would you describe the service delivery of the homoeopaths?

1.5 SIGNIFICANCE OF THE STUDY

This study may assist in describing the role of homoeopathic care in a primary healthcare setting. The increased demand for homoeopathic care may give an opportunity for homoeopathy to be recognised by the government and may be included in the National Health Insurance (NHI) scheme. This study would be beneficial to the homoeopathic field as it enhances the knowledge of patients' experiences of homoeopathy, which has never been done before locally. This study will provide the necessary information that will be useful in improving service delivery, which would expectedly heighten the awareness of homoeopathy. This study can provide baseline information for experiences of

patients of homoeopathic care since such study hasn't been explored in South Africa to this date.

South African surveys exploring the perception of homoeopathy have included all racial groups; all the studies have found that the African racial group had the least knowledge about homoeopathy.

1.6 LIMITATIONS

Only the patients from the Redhill clinic were included in the study. Only the patients who were visiting the clinic for the second time and more were included in the study. The respondents were those who were available at the clinic during the time of the study and who wanted to be part of the study and the patients who were not available were not included in the study, therefore the results obtained are not necessarily representative of the population as a whole.

1.7 OUTLINE OF THE DISSERTATION

Chapter 1: Introduction and background to the study.

Chapter 2: Literature Review. This will include the eight variables that were identified in the literature viz. Laws and principles of homoeopathy, homoeopathy in the PHC, the South African PHC, homoeopathic PHC clinics, local surveys on perceptions of homoeopathy and international surveys on perceptions of homoeopathy.

Chapter 3: Research methodology.

Chapter 4: Presentation of results.

Chapter 5: Discussion of results.

Chapter 6: Conclusion and recommendations that can be drawn from this study The list of references and appendices follow this chapter.

1.8 CONCLUSION

The data obtained from this study may be used to provide a future homoeopathic education to the public. The data obtained from this study may also be used as motivation to consider the integration of homoeopathy into PHC in South Africa. Such a proposal would be aimed at closing the gaps that are caused by the shortage of doctors and other medical professionals in PHC.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Homoeopathy is a medical method that respects the knowledge of the body. It is a method that uses medicines that arouse the body's own immune and defence systems to initiate the healing process. It is a system of medicine that is extensively recognized to be harmless. Therefore, it can be hypothetically very effective in treating new types of ailments that are affecting us now and will possibly affect us in future. As a primary-contact consultant, a homeopath brings about all aspects of patient healthcare, diagnosis, cure and management, together with referrals and communication with other healthcare professions and organizations (Homoeopathic Association of South Africa 2007).

This chapter will present only the selected literature to give background to the study. Strauss and Corbin (1990) articulate that a selected literature review is conducted to help “the researcher view the research situation with some background in the technical reading”. This chapter starts by reviewing the laws and principles of homoeopathy. The subsequent headings include homoeopathy in primary health care, South African primary health care, the proposed national health insurance scheme, homoeopathic primary health care clinics, Redhill clinic, local surveys on the perceptions and attitudes towards homoeopathy and international surveys on the attitudes and perception of homoeopathy.

2.2 THE LAWS AND PRINCIPLES OF HOMOEOPATHY

Homoeopathy is legally acknowledged as a PHC profession in South Africa and is controlled by a constitutional body, The Allied Health Professions Council of South Africa (AHPCSA). Despite this, homoeopathy is not officially included in the public healthcare sector and has been established almost exclusively in the private sector.

Samuel Hahnemann is the German physician who founded and established homoeopathy in the late 18th century (de Schepper 2001). This is a system of medicine which treats disease by remedies prescribed in minute doses, which when given to a healthy individual would develop symptoms like those of disease. Dr. Samuel Hahnemann who introduced homoeopathy gives the basic rules of homoeopathic practices (Chauhan and Gupta 2007).

The following are the cardinal principles:

a. Law of similia – the symptoms experienced by the sick are not the disease, but are a reaction of the body's defense mechanism. The choice of remedy is based on the principle of "similia similibus curentur." The drug must have ability to produce most similar symptoms of the disease to be cured in a healthy person.

b. Law of simplex – only one single, simple medicinal substance is to be administered in a given case at a time, which is called a simillimum.

c. Law of minimum – reduction of the drug dose by succession of trituration at every step of dilution employing an inert medium like alcohol or lactose (Chauhan and Gupta 2007).

Homoeopathic remedies aid the body to heal itself, by stimulating the body's own energy or vital force (Bloch and Lewis 2003).

2.3 HOMOEOPATHY IN PRIMARY HEALTHCARE

Homoeopathy is currently not included legitimately within the public primary healthcare sector in South Africa although it could hypothetically aid to enhance this health sector and consequently advance access to healthcare (Smillie 2010). In all the regions of the developing world complementary medicine has retained its reputation. It usage is rapidly growing in industrialised countries; about two thirds of the world's population depend entirely on traditional medicinal therapies, the WHO has declared its purpose to encourage CAM therapies including homoeopathy worldwide (WHO Media Centre 2006).

Homeopathy is one of the fastest growing medical modalities in the world today. In spite of this growing interest much confusion still exists regarding the true origins, scientific validity, applicability and efficacy of homeopathy. Even in this day and age of effective mass communication, internet, journals, etc., misconceptions about the basis, fundamental principles and philosophy of homeopathy exist which tend to equate homeopathy with eastern philosophy, “natural and traditional medicine such as herbalism and the likes” (Prinsloo 2011a).

McIntosh (2008 cited in Smillie 2010: 9). states that patients are often turned away due to the shortage of doctors in the public healthcare system of South Africa, Furthermore for various reasons many peripheral clinics in rural areas have limited pharmaceuticals. Most of the patients treated by McIntosh presented with ailments which had not been resolved by allopathic medicine and the developments that occurred as a result of homoeopathic treatment gained the confidence of patients and the local nurses alike. McIntosh states that homoeopathy has the ability to work well in a free community clinic site, as it is inexpensive and often does not require to be used long-term. Homoeopathy may thus contribute significantly to such conditions.

Almost 20 years ago the WHO projected that in several countries 80% or most people living in rural areas are cared for by traditional practitioners and birth attendants. Only a few people have regular access to dependable modern medical services. Hence equity and coverage of primary health care are the implications of formalising the traditional sector. The Commonwealth Working Group on Traditional and Complementary Health Systems was established to promote and integrate traditional health systems and complementary medicine into national health care (Bodeker 2001).

Bodeker (2001) states that complementary medicine is now acknowledged and complementary medicine is regularly used by half the population of industrialised countries. The predictors of the use of complementary medicine are higher education, higher income, and poor health. The growth in consumer demand and availability of services for complementary medicine

has outpaced the development of policy by governments and health professions. There has been a policy matter entailing the integration of complementary medicine into the national health services by the Western governments. This issue has been long addressed in many developing countries. Their experience institutes a valuable, although mainly unexplored, pool of policy data (Bodeker 2001).

Over 10 years ago in Tuscany, Italy, Complementary Medicine was included into the Regional Health System. A regional survey, promoted by the Health Regional Agency in 2003, noted a great interest of the use of CAM by paediatricians and family doctors. In 1994 the Tuscan Network of Integrative Medicine Health which involves co-operation between the region of Tuscany, Cuba, Western Sahara, Senegal and Serbia. The network was launched it was offering acupuncture, herbal medicine and homeopathy amongst other services in the framework of natural and orthodox medicine at over 75 sites (Rossi *et al.* 2010) .

Several social and health institutions have contributed to different cooperation projects. The results of these activities have generally been evaluated very positively by the participants, and offer possible solutions to problems of sustainability of public health systems in developing countries. Complementary and traditional medicine can represent a useful and sustainable resource in different fields of health care including chronic disease, physiological delivery, allergies, tumours, pre- and post-operative rehabilitation, epidemics, paediatrics, third age care, dentistry, veterinary medicine. Their inclusion in the public health system must go hand in hand with an adequate process of scientific evaluation to control the efficacy, safety and quality of the health services and products by means of case/control observational studies, as well as randomized, blinded clinical trials. Initiatives and actions are aimed at achieving inclusion of complementary and traditional medicine in the public healthcare systems and the introduction of these disciplines into healthcare planning, in the programmes of public health structures, and specific regional and/or national standards (Rossi *et al*. 2010).

The law regulating the use of complementary medicine by physicians, dentists, veterinarians and pharmacists was permitted by the Regional Council of Tuscany in February 2007. The experience of incorporating non-orthodox medicine in Tuscany's healthcare programmes is a vital reference point on a national level; user satisfaction has been achieved and been mostly well-received. It has also assisted to create a positive relationship with the organisations and scientific societies of the sector and has gained the gratitude of the region's medical and academic circles. For the first time public sector homeopathic clinics have also been set up. Projects supporting the development of natural and homeopathic medicine in the southern countries of the world were financed by the Tuscan government (Rossi, *et al.* 2008).

Rossi *et al.* (2008) stated that the 2008 WHO Report recognized traditional medicine as one of the resources of primary healthcare services that could contribute to improved health results. Drug consumption can be reduced by rational and appropriate use of complementary and traditional medicine and therefore public healthcare costs. Furthermore, these therapies can aid to diminish the side-effects of artificial drugs globally. The manufacture and use of traditional remedies can foster the growth of local economies, accumulating value to important parts of indigenous cultures and making economic activities optimising local resources (Rossi *et al*. 2008).

A resolution that is relevant to homeopathy and other therapies in the field of CAM was adopted by the 62nd World Health Assembly of the WHO in May 2009. It was noted that many governments have made a progress to include Traditional Medicine, as well as CAM, into their national health systems (NHS), and that progress in this field has been attained by a number of Member States through implementation of the WHO traditional medicine strategy 2002-2005. The Alma Ata Declaration, supported by WHO and UNICEF, strongly demanded that the global community's support the inclusion of scientifically authenticated traditional medicine and of complementary medicine into the NHS (Rossi *et al.* 2010).

Complementary and traditional medicine can represent a beneficial and maintainable resource in various fields of health care. Inclusion in the public health system must go hand in hand with scientific assessment. The intervention programmes currently operating seem to have finally become aware of the fact that health promotion cannot be limited to medical action only, but should also be considered as a multi-sectoral approach (Rossi *et al.* 2010).

Sociological research has not been as established on homeopathy as on acupuncture, however, it is obvious that this therapy has reached higher status within Western mainstream healthcare. In the UK the Faculty of Homeopathy*,* a professional body for medical doctors and other mainstream health-care professionals, accredits postgraduate training courses in this therapy which are restricted to those professionals. Furthermore, more hospitals provide homeopathic treatments on the NHS and in 2006 homeopathic over-the-counter remedies for some conditions were made available to the public (Samarasekera 2007).

Outside Europe, in Brazil, homeopathy has been integrated in the same way as acupuncture, having been a medical speciality since 1980 (Almeida 2012).In Brazil homeopathy has enjoyed government approval since the 19th century; it is incorporated into its public health system, and continues to be very popular. In fact, Brazilian investigators were experimenting with homeoprophylaxis for meningococcal disease, with outstanding results, as far back as 1974, and more recently have had the same results against dengue fever (Milgrom, Ringo, Wehrstein 2012). In the UK it is estimated that about 5.75 million people a year seek treatment from a CAM consultant and approximately one in four members of the public would like to access complementary medicine on the NHS. In 2000, a House of Lords Select Committee report on CAM listed homeopathy as a group one therapy, along with osteopathy, chiropractic, acupuncture and herbal medicine. Therapies having their own diagnostic approach and treatment methods are part of group one. Homeopathy is well-developed in the UK, having been obtainable

through the NHS since its commencement in 1948. In addition to the five NHS funded homeopathic hospitals (in Bristol, Glasgow, Liverpool, London and Tunbridge Wells), over 400 general practitioners (GPs) use homeopathy in their everyday practice and the Society of Homeopaths, the largest body representing professional homeopaths in the UK, has 1500 registered members. However, compared with European countries the UK's homeopaths are a relatively untapped resource. One reason for this could be the misconception that homeopathy lacks a scientific evidence base (Roberts 2008).

Roberts (2008) stated that full incorporation of homeopathy into primary care would esteem and preserve patient choice, advance patient security and lead to the best possible clinical results. With full communication amongst orthodox and CAM physicians, the most suitable treatment can be selected depending on the case whether it is an orthodox drug, homeopathic medicine or some other involvement and patient security can be sustained. Only qualified and registered homeopaths should receive referrals for homoeopathic treatment. Recorded members of the Society of Homeopaths have met required standards of education, are fully covered and have accepted to abide by a strict code of ethics and practice.

Rossi *et al*. (2008) stated that one of the Committee's first decisions was a survey to evaluate the demand for non-orthodox medicine in Tuscany. As part of this project, a survey was conducted on the opinions of family doctors and paediatricians in Tuscany in 2003. Of the 2228 responding doctors and paediatricians (of approximately 3500 in total), 15.2% practised non-orthodox medicine, 57.8% recommend them to their own patients, 11% have specific training, while 29.2% would like to have training in non-orthodox medicine. 65.7% were in favour of teaching non-conventional medicine at university and 23.7% have used non-conventional medicine to treat their own ailments, compared to the average of 20% for all Tuscan citizens.

Rossi *et al.* (2014) conducted a study to explore patients repeatedly treated by the homoeopathic clinic of the Campo di Marte Hospital,Lucca to evaluate

their socio-demographic features, including the distribution of the different diagnoses and follow-up clinical outcomes attained over twelve years of clinical practice in the public health system in the Tuscany Region. The data that was collected stated that there were 2592 consecutive patient consultations and 6812 first and follow-up visits at the homoeopathic clinic of Campo di Marte Provincial hospital between September 1998 and December 2010. In 2010 there were a total of 29918 visits to the complementary medicine public services, mostly accessed by older people, and women were most likely to be users than men.

The homoeopathic clinic of Lucca was funded by the Tuscany Region and was established in 1998 as part of a trial study which was intended to assess the chances of including complementary medicine into the public health care system. This hospital became a reference centre for homoeopathy in 2002, then in November 2003 a women's homoeopathic clinic was opened in the same hospital and in October 2010 an out-patient clinic for complementary medicine and nutrition in oncology was opened in the district of Lucca in collaboration with the oncological department of Lucca (Rossi *et al*.2014).

Dr X. Zhang referred to the incorporation of homoeopathy into the national health systems of various countries in 1994, at a congress of the International Homeopathic Medical Organization. These countries include Germany, India, Mexico, Pakistan, Sri Lanka, and the United Kingdom. Dr Zhang noted that in homoeopathy the medical substance is extremely diluted and there is no doubt about the safety of this medical system. Yet there is still great concern about the clinical effectiveness. In modern medical terms the mechanism of homoeopathy has not yet been established (Poitevin 1999). According to Prasad (2007) India is arguably unique in the degree to which it has acknowledged homoeopathy as an authentic system of medicine. In spite of originating in Germany, the Indian government has given it the status of a national medical system.

General practice has been recognized as one branch of medicine where CAM is making its existence felt. However, incorporation and acceptance by

general practitioners (GPs) is not even across all CAM therapies, and homeopathy appears to be among the least supported CAM as reported by Australian GPs. A national study of Australian GPs found that less than 1% of GPs had practised homeopathy in the past 12 months, though 3% had received homeopathy as part of their own treatment. GPs in this previous study were more motivated to refer for homeopathic treatment than practice it, with 10% referring at least monthly. Another national study in 1997 instituted that 20% of GPs had referred a patient for homeopathic treatment in the past 12 months. However, referral did not necessarily suggest support, as only 9% of GPs in this Australian study stated that they would actively encourage a patient to use homeopathic medicines (Wardle, Adams and Sibbritt 2013).

Additionally, there seems to be little support for the integration of homeopathy into Australian general practice, with only one-quarter of GPs suggesting that homeopathy should be practised by medical doctors and only one-third supporting subsidies from medically trained practitioners providing homoeopathy. Low levels of support for homeopathic integration are coupled with prevailing perceptions amongst Australian GPs that homeopathy is ineffective, with national studies demonstrating that 50-82% of the GP population believe homeopathy is ineffective (Wardle, Adams and Sibbritt 2013). The views on homeopathy in general practice outside of Australia also show mixed results. It has been asserted that one-in-eight GPs in New Zealand use or refer to homeopathy in practice, and studies of patients attending conventional general health services indicate homeopathic utilisation of 27-65%. British studies suggest that 49% of Scottish GP practices and 21% of English GP practices have prescribed homeopathic remedies. However, higher homeopathic use in these countries has led to high-profile calls for medical practitioners to cease supporting, practising or referring to homeopathy calls promoted by medical associations and printed in the major medical journals (Wardle, Adams and Sibbritt 2013).

2.4 PRIMARY HEALTH CARE IN SOUTH AFRICA

Public healthcare is vital care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community and country so they can manage to maintain their health at every stage of their development and wellbeing (WHO 1978). The health care personnel of the Primary Health Care team are those who have first communication with the patient. In every country there are different health care personnel that make up the PHC team, which is under constant change. In most countries nurses, family doctors or general practitioners make up the PHC team (Pillay 2013).

The PHC system in South Africa is based on principles that are advocated by the WHO. The WHO describes the healthcare system as a system that provides all people with Primary Health Care benefits at an affordable cost (De Haan, Dennill and Vasuthevan 2005). According to the WHO (1978) the Alma Ata Declaration VII, PHC is involved in addressing the following:

- Reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
- Addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
- Includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
- Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works,

communications and other sectors and demands the coordinated efforts of all those sectors;

- Requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
- Should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
- Relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

According to Kautzky and Tollman (2008) there is a shortage of staff within the primary healthcare sector in South Africa resulting in medical staffs being incapable to cope with the current demands; the situation needs more effort in addressing the challenges in innovative health system design within today's rigid primary healthcare system.

In South Africa more than 60% of health care institutions struggled to fill existing vacant posts as reported by WHO in 2003, with more than 4000 vacancies for general practitioners and 32 000 vacancies for nurses all over the provinces. The serious lack of trained health labourers, and the inability to fill important posts, institutes an important obstacle to attain provisions for district-based health services in South Africa currently. The uneven distribution of health personnel and resources across public and private sectors endures as a seminal obstacle to health systems growth and the adequate service delivery (Kautzky and Tollman 2008).

Daviaud and Chopra (2008) conducted a study whose aim was to quantify staff requirements in PHC facilities in South Africa through an adaptation of the WHO workload indicator of staff needs tool. Findings revealed that there is either a lack of doctors visiting clinics or too few doctors to cover the opening times of community health centres (CHCs) across all the districts. Overall there is only 7% of the required number of doctors. There is 94% of the needed number of qualified nurses but with wide differences amongst districts, with a few districts having excesses while most have lacks. The quantity of enrolled nurses is 60% of what it should be. There are 17% of enrolled nurse assistants. There is wide variation in recruitment levels between facilities leading to incompetent professional staff (Daviaud and Chopra 2008).

The crucial challenges that have been identified for the South African health system in rural areas, is inadequate numbers and poor distribution of health personnel. The PHC core package for South Africa defines clinics, satellites and mobile clinics as being nurse-based, with infrequent sessions by doctors, and community health centres as being referral centres, necessitating doctors on site (Daviaud and Chopra 2008).

There is an increase in demand of health care systems due to the rise of patients with chronic illnesses, in turn, creating significant burden on the under staffed PHC clinics and the Department of Health (Kautzky and Tollman 2008).

Tanser, Gijsbertsen and Herbst (2006) investigated the accessibility and utilization of PHC in rural South Africa. It was revealed that physical access to health care affects a large range of health outcomes. To get to the nearest PHC clinic many patients travel long distances. The average travelling time to the nearest clinic is 81 minutes when using public transport (buses and taxis), and sometimes walking a great distance it takes one hour or longer to attend to the nearest clinic. The long waiting periods for patients is caused by the high number of patients visiting PHC clinics which are under staffed.

Wilkinson *et al.* (2001) conducted a study to investigate the effects of removing user fees on attendance for curative and preventive primary health care services in rural South Africa. It was said that in many developing countries user fees are used to recover costs and discourage pointless attendance at PHC. In South Africa, user fees for children aged less than 6 years and pregnant women were removed in 1994, and all user fees at all PHC clinics were stopped in 1997. The purpose of these policy changes was to advance access to health services for previously underprivileged communities. The effects of these changes were investigated on clinic turnout patterns in Hlabisa health district.

According to Wilkinson *et al.* (2001) average quarterly new registrations and total attendances for preventive services (antenatal care, immunization, growth monitoring) and curative services (treatment of diseases) at a mobile PHC unit were studied from 1992 to 1998. Regression investigation was commenced to assess whether trends were statistically significant. There was a constant increase in new registrations (P = 0.0001) and total attendances (P = 0.0001) for curative services, and a fall in new registrations (P= 0.01) and total attendances for immunization and growth monitoring (P = 0.0002) over the study period.

The increase in demand for curative services commenced at the time of the first policy change. The reductions in antenatal registrations (P = 0.07) and attendances (P = 0.09) were not statistically significant. The number of new registrations for immunization and growth monitoring increased following the first policy change but declined thereafter. The second policy change did not influence the underlying trends as there was no evidence found. The access to curative services improved after the removal of user fees, but this may have happened at the expense of some preventive services. In order to ensure that objectives are being met the governments should remain vigilant about the effects of new health policies (Wilkinson *et al*. 2001).

2.5 THE PROPOSED NATIONAL HEALTH INSURANCE

The NHI scheme will ensure that everyone has access to suitable, efficient and quality health services. It will be phased-in over a period of 14 years. This will involve major changes in the service delivery structures, administrative and controlling systems. The NHI is proposed to bring reform that will improve service delivery. It will encourage fairness and efficiency so as to ensure that all South Africans have access to reasonable, quality healthcare services irrespective of their socio-economic status (National Health Insurance 2011).

The NHI is proposed to ensure that all South African citizens and authorized residents will benefit from healthcare support on a reasonable and maintainable basis. The NHI will provide coverage to the whole population and decrease the burden carried by individuals of paying straight out of pocket for healthcare services. This model of delivering health and healthcare services to the population is well recognized, described and extensively promoted by the WHO as worldwide coverage (National Health Insurance 2011).

The NHI scheme will be guided by the following principles (The National Department of Health: National Health Insurance 2011):

a) **The Right to Access** – Section 27 of the Bill of Rights of the Constitution states that everyone has a right of access to health care services including reproductive health care and that the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of these rights. The reform of healthcare is an important step towards the realisation of these rights and the key aspect of this is that access to health services must be free at the point of use and that people will benefit according to their health profile.

b) **Social Solidarity** – this refers to the creation of financial risk protection for the entire population that ensures sufficient cross-subsidisation between the rich and the poor, and the healthy and sick. Such a system allows for the spreading of health costs over a person's lifecycle: paying contributions when

one is young and healthy and drawing on them in the event of illness later in life.

c) **Effectiveness** – this will be achieved through evidence based interventions, strengthened management systems and better performance of the healthcare system that will contribute to positive health outcomes and overall improved life expectancy for the entire population.

d) **Appropriateness** – this refers to the adoption of new and innovative health service delivery models that take account of the local context and acceptability and tailored to respond to local needs. The health services delivery model will be based on a properly structured referral system rendered via a re-engineered PHC model.

e) **Equity** – this refers to the health system that ensures that those with the greatest health need are provided with timely access to health services. It should be free from any barriers and any inequalities in the system should be minimised. Equity in the health system should lead to expansion of access to quality health services by vulnerable groups and in underserved areas.

f) **Affordability** – this means that services will be procured at reasonable costs that recognise health as not just an ordinary commodity of trade but as a public good.

g) **Efficiency** – this will be ensured through creating administrative structures that minimize or eliminate duplication across the national, provincial and district spheres. The key will be to ensure that minimal resources are spent on the administrative structures of the National Health Insurance and that value-for-money is achieved in the translation of resources into actual health service delivery.

According to Sekhejane (2013) the public has lost faith in the health-care system of South Africa and its service providers, particularly in those working for the state. The NHI policy emphases predominantly on the creation of an extraordinary health-care system; nevertheless, it does not address the

behavioural problems and the lack of efficient, trained and professional health-care workers. Most small community clinics and public hospitals, mainly in the rural or semi-urbanised areas, are operated by health-care labours that possess neither skills nor a professional code of practice. The National Health Insurance (2011) stated that NHS has countless challenges, amongst these being the worsening multiply burden of disease and deficiency of key human resources. The public sector has underachieving institutions that have been attributed to poor management, underfunding, and deteriorating infrastructure

Most low-income citizens are dissatisfied by the quality of service they receive from these facilities, mainly owing to the negligent attitude of the staff. There is little chance that those who are on private medical aid schemes will abandon private hospitals, and therefore, it is unrealistic for the planners of the NHI to suppose that the private sector will suffer long-term effects from the implementation of the NHI (Sekhejane 2013). Sekhejane (2013) states that according to a report by Matsoso and Fryatt, the implementation is progressing positively in many areas. However, there are considerable issues that require serious attention, particularly the financing and service delivery aspects, and thus require thoughtful management.

There currently appears to be no plan to cover homoeopathy or homoeopaths under the NHI. The justification at present for such is that only evidence based therapies are currently being considered (Gower 2012 cited in Pillay 2013: 12). CAM is not covered by national insurance systems, and users pay almost all costs out of pocket. This willingness to pay reflects the public's general acceptance of CAM and also suggests that CAM therapies have benefits that outweigh their costs (Frass *et al.* 2012).

In South Africa with our ever-changing health care system (the proposed NHI which is presently under evaluation), it is important that all health care professionals are aware of alternate therapies, such as homoeopathy, as an additional option for their patients (Pillay 2013).

2.6 HOMOEOPATHIC PRIMARY HEALTH CARE CLINICS

According to Smillie (2010), the DUT community clinics at Redhill, Warwick Junction and Kenneth Gardens provide PHC services to some communities of KwaZulu Natal province. Some of the common conditions treated at the clinics are: colds and influenza, hypertension, diabetes melliatus type II, arthritis, headaches, allergies, asthma, menopause and dermatological problems.

The Redhill Clinic was established in the period of 2005-2006; it is based in an established community and has been well received by the public. The fifth year homoeopathic students provide treatment, free of charge to patients under the supervision of a qualified homoeopathic practitioner (Pillay 2013). The DUT Department of Homoeopathy, in partnership with the UKZN Community Development Department established the Kenneth Gardens community homoeopathic clinic in 2012which offers the services of 4th and 5th year student homoeopaths with supervision by a qualified Homoeopath (Erwin, Marks and Couchman 2012). The clinic operates from the Kenneth Gardens Community Hall and is available once a week, every Wednesday, between 9am-12am. An informal case study of Kenneth Gardens and its recently established homoeopathy clinic indicates a high level of responsiveness which the clinic has received from the community (Erwin, Marks and Couchman 2012).

The UNHC offers homoeopathic treatment free of charge to the local community and is operated by 4th and 5th year homoeopathic students, under the supervision of qualified homoeopathic clinicians. UNHC runs from two rooms with an adjacent dispensary on the 3rd floor in the UNHC LifeLine House. The clinic room has two examination beds and a small section where consultations take place. An English/Zulu interpreter is provided when needed, but most of the students are now isiZulu speaking so this is generally not a problem. When the clinic opened in 2004 it was only operational on Wednesdays and Fridays. However, since 2007, due to an increase in patient numbers and demand for the clinic's services, the clinic included an additional consultation day and currently operates on Mondays, Wednesdays, and

Fridays from 1:00pm to 4:00pm (Smillie 2010). Results of a clinical audit of UNHC showed that there had been a significant increase in patient numbers at the clinic since its establishment in 2004 (Smillie 2010).

2.7 THE REDHILL HOMOEOPATHIC CLINIC

When interviewed on 13 August 2014, Nienaber (head clinician at Redhill Homoeopathic Clinic) stated that the Redhill homoeopathic clinic was established in 2004 by Dr Hayley Reader. Medication and consultation was charged at R60. Dr Nienaber became the head of Redhill homoeopathic clinic and no fees were charged for both consultation and medication. In 2008 the clinic was operational on Tuesdays, Dr Nienaber was alternating with other homoeopaths in conducting consultations.

The Department of Homoeopathy from DUT was approached by the Redhill Homoeopathic Clinic in 2009 to utilise the clinic as a satellite clinic. From 2010 DUT utilised the clinic as one of their satellite clinics and it was operated by Dr Botha until June 2013. A number of conditions were treated and it was noticed that patients' were content about services that were provided to them. Several patients' esteemed the manner in which they were treated and that they received emotional treatment which is not offered by the main Redhill clinic (Nienaber 2014).

According to Nienaber (2014) homoeopathic medicine is different because it focuses on the mental, emotional and physical aspects and patients get educated about the medication they are receiving. Patients with chronic diseases are given more time. It was noticed that the clinic is attended by more females than males and that more patients were Indians followed by Africans. The conditions that are treated the most at the Redhill homoeopathic clinic are upper respiratory tract infections, dermatological conditions, digestive complaints and secondary infections due to HIV and depression. The clinic operates on every second Friday of the month from 8:30 am t0 12:00pm, this is due to inadequate rooms at the clinic.

The Redhill Homoeopathic clinic which was the clinical site of investigation of this study is operated by fifth year homoeopathic students under the supervision of a qualified homoeopathic practitioner (Dr Nienaber at present) where they offer PHC services. The clinic forms part of clinical homoeopathic training. The clinic also operates on referral basis from the nursing sister (Pillay 2013).

2.8 THE REDHILL PHC CLINIC

When interviewed on 14 August 2014, Xulu (nursing sister at Redhill clinic) stated that Redhill clinic is situated in the eThekwini district. This particular clinic is unique in that it serves an impoverished community where most of the people live in shack houses and some in reconstruction and development programme houses (RDP) and are reliant on public healthcare. The clinic is owned by the eThekwini municipality, this clinic is different from the other clinics in that its offers maternal women's health, youth services, child health services, curative services, treats communicable and non-communicable diseases.

When interviewed on 14 August 2014, Xulu (nursing sister) stated that the clinic is operational six days a week, it operates from 7:30 am to 16:00 pm. On Mondays chronic cases are reviewed and immunisation is conducted. On Tuesdays the clinic offers youth and child health services which are conducted by social workers, maternal woman's health is conducted on Wednesdays. Patients' living with Human Immune Virus (HIV) collect antiretroviral (ARVS) and geriatrics are also seen on Thursdays. On every second Friday of the month optometrists alternates with homoeopaths to consults with their patient's. Saturdays are for emergency cases.

2.9 LOCAL SURVEYS ON PERCEPTIONS OF HOMOEOPATHY

Homoeopathy is acknowledged as being the fastest developing medical modality in the world, the awareness of homoeopathy is changing and there is a growing interest to learn more about homoeopathy. In South Africa the homoeopathic sector has been growing gradually (Prinsloo 2011b).

Perception studies conducted so far in South Africa have discovered that there is a degree of unawareness or misinterpretation of homeopathy, and that varied views on its application and effectiveness exist among the general public. The lack of wide-ranging data regarding public perceptions of homeopathy in South Africa means that homeopaths have great work to do in the research field to explore the level of knowledge of homeopathy amongst the population of South Africa. Through further research, advertising approaches can be formulated to create greater consciousness of homeopathy among the general public (Harripershard 2009).

Small (2004) conducted a survey to determine the perceptions of homoeopathy amongst Grade 12 learners in Durban metropolitan area, South Africa. The data gathered showed that 76% of the respondents had never heard of homoeopathy before, and more than 80% of those respondents showed an interest in learning more about homoeopathy (Small 2004).

Paruk (2006) conducted a survey to determine the perception that exists amongst pregnant women towards the use of homoeopathy during pregnancy. The results showed a great lack of knowledge about homoeopathy not being sought as a form of treatment during pregnancy. It was concluded that if homoeopathy was more publicly known, it would be used as treatment in the future (Paruk 2006).

Singh, Raidoo and Harries (2004) conducted a study on the prevalence, and pattern of usage of complementary and alternative medicine (CAM) amongst an Indian community in Chatsworth, South Africa. The study consisted of 200 one-on-one interviews with residents. Singh, Raidoo and Harries (2004) found that during 2000-2001, 38.5% of the respondents had complementary and

alternative medicine with herbal/natural remedies and spiritual therapies. Half of the CAM users used allopathic medicine concurrently with their CAM, 37.6% of the respondents said they used allopathic medicine which had not cure them but had improved their conditions, 14.3% respondents preferred allopathic medicine, 32.5% of respondents preferred to use both and 51.9% preferred CAM. The results from this study conducted in Chatsworth, South Africa were similar to the findings found in studies conducted across the world and emphasise the need for CAM to be integrated with allopathic medicine (Singh, Raidoo and Harries 2004). There are numerous studies that reflect an interest in complementary therapies, with an estimated 45% of the general population in the United State of America using complementary therapies (Pillay 2013).

A study conducted by Maharajh in 2005 had a total of 484 questionnaires that were distributed and a total of 155 responses were returned. A total of 97 GPs and 58 pharmacists responded. The percentage return of questionnaires was 32,02%. The response rate was 26,22% for GPs and 50.87% for pharmacists respectively. Most pharmacists (46,6%) and GPs (41,2%) were uncomfortable with homoeopathy but found it to be effective for some patients. Many of the pharmacists (36,2%) and GPs (42.3%) perceived that they were not informed enough to comment. Less than 5.2% of all respondents perceived that homoeopathy was quackery and that it does more harm than good.

Only 12.1% of pharmacists and 12.4% of GPs perceived homoeopathy to be an excellent mode of treatment. Sixty eight point four percent of pharmacists and 79.8% of GPs perceived that co-operation amongst the pharmacists; GPs and homoeopaths would be beneficial to all. It was found that there is limited communication and co-operation between pharmacists, GPs and homoeopaths. Secondly there seems to be a lack of knowledge on the nature of homoeopathic training that is available in South Africa. It was concluded that GPs and pharmacists know very little detail about homoeopathy and homoeopathic training, and it can be assumed that this lack of knowledge is a

possible reason for the poor communication and co-operation that currently exists between these practitioners and homoeopaths (Maharaj 2005).

In 2007, Thorvaldsen conducted a survey to determine the perceptions of 3rd year medical students at the University of Cape Town (UCT) and the University of KwaZulu-Natal (UKZN) towards homoeopathy. Three hundred and forty seven questionnaires were distributed and 181 returned. A total of 50% of questionnaires from KZN and 45% from Cape Town were returned. It was deduced that 96% of respondents had heard of homoeopathy, 21% were knowledgeable about it, 4% of respondents had never heard of it; 68% of respondents indicated an interest in learning more about homoeopathy and 92% of respondents felt that it is important for a medical doctor to know about the complementary forms of treatment. Seventy nine percent of respondents said that improved communication between homoeopaths and conventional medical practitioners is important (Thorvaldsen 2007).

Naicker (2008) conducted a survey to determine the perceptions of medical specialists and interactions with homoeopathy. The data gathered during this study showed that 70.7% of medical specialists had heard of homoeopathy but had no contact with it. Seventy six point seven percent of medical specialists had perceived homoeopathy could be used in conjunction with conventional medicine, with 8% of medical specialists referring patients to a homoeopath. Overall, the study showed there is limited knowledge that medical specialists have of homoeopathy, yet the perception of homoeopathy was favourable.

Allopi (2008) conducted a survey to determine the perception of nurses in the eThekwini region towards homoeopathy. This study revealed that there is a lack of knowledge of homoeopathy amongst nurses. From the data received it was perceived that holistic medicine would have a role to play in a hospital setting (Allopi 2008).

2.10 INTERNATIONAL SURVEYS ON PERCEPTIONS OF HOMOEOPATHY AND COMPLEMENTARY AND ALTERNATIVE MEDICINE

International research conducted at Glasgow Homoeopathic Hospital (GHH) was conducted to determine patients' views on the consultation. It was indicated that patients placed great value on the holistic approach taken by doctors (Mercer and Reilly 2004). They acknowledged that the time made available for consultation, the empathy of the doctor with the patient, discussion and shared decision-making between patient and doctor, and the on-going therapeutic doctor-patient relationship were sought-after factors of care at the hospital (Mercer and Reilly 2004).

Within the developed world a recent phenomenon has been the rapid rise in the demand for and use of complementary therapies. Almost a third of the UK population have seen a complementary therapist and 74% think that complementary therapies should be made accessible on the NHS. Complementary therapies is used by most patients together with, or following, conventional treatment, and reasons for their use often seems to relate to a longing for holistic, patient-centred care. In mainstream medicine patient-centred care has also become a major focus and is being assessed and promoted within general practice specifically. However, much remains to be learnt and attention is gradually being paid to patient's opinions. High levels of patient satisfaction with apparently good clinical outcomes across a range of chronic diseases have been shown by an integrated NHS unit of complementary and orthodox care (Mercer and Reilly 2004).

In Cuba, health co-operations with the Tuscany Region have been central to the incorporation of homoeopathy into the public health system of the country (Rossi *et al.* 2010). This partnership and incorporation has presented a possible solution to the problem that a developing country, such as Cuba, faces in providing maintainable healthcare systems (Rossi *et al.* 2010).

Research study was done in Italy, to assess any changes in patients that were presumably due to homoeopathic treatment. The aim of the study was to

evaluate the efficacy of homoeopathy in PHC by attaining how patients felt one year after getting homoeopathic treatment. From June 1995 to May 1997 about 609 patients on their first visit to a homoeopathic clinic received a telephone call one year later in which they were asked to rate their general health compared with one year ago. Results showed that out of a total of 648 patients for whom cards were made out, telephone interviews were obtained with 609 (94%). Thirty five point nine percent females were 31 - 45 years old and 81.8% of them had a high level of education (Attena *et al* 2000).

With regards to the patient's choice of homoeopathy, most (87.5%) had been recommended by relations and friends. Data obtained from the telephone interview revealed that 82.8% of the subjects had followed therapy correctly and 83.9% of patients were satisfied with the medical care received. With regards to the patients' evaluation of the effects of the homoeopathic treatment one year after the first examination, 36.9% rated their health to be much better now than one year previously, before the homoeopathic treatment (scored as 'marked improvement'), 36.6% stated that they felt somewhat better ('moderate improvement'), while 22.5% reported their health to be about the same ('no improvement'). Moreover, four patients had a moderate and two a marked, worsening. They did not evaluate the self-reported health status of those who did not start therapy. The improvement was independent of education level and was significantly higher in females (Attena *et al*. 2000).

Marian *et al.,* (2008) conducted a study to investigate the patient perception and satisfaction of adverse effects in homoeopathy compared to conventional care in a PHC setting. The results showed that there was higher satisfaction in the homoeopathic group in primary care setting and homoeopathic treatment was perceived low risk therapy with fewer adverse effects. Milgrom, Ringo and Wehrstein (2012) stated that the government of Switzerland affirmed the cost effectiveness of several forms of CAM as equal to allopathic medicine, homeopathy was excepted from the other CAM because it had lower costs than allopathic Medicine.

A study that was conducted in India explored the utilization of homoeopathy both in rural and urban areas, the aim of the study was to find out the reasons of preferences as well as cost of treatment. Results showed that the reasons for utilization of homoeopathic treatment were no side effects (31%), cheap (30%), effective (25%) and doctors are easily available (11%). The reasons for not utilizing homoeopathy were slow progress (28%), no faith (12%) and no availability of medicine (5%). About 11.94% of urban respondents preferred homoeopathy 11.29% of rural respondents (Singh, Yadav and Pandey 2005).

Avina and Schneiderman (1978) conducted interviews with 100 homeopathic patients in the San Francisco Bay Area. The interviews were aimed at investigating the reasons why patients choose homoeopathy. The results revealed that most subjects provided more than one explanation for seeking homeopathic care, some positively directed towards their expectations, others obviously in reaction to unhappy experiences with conventional medical care. Patients (81%) commented on dissatisfaction with one or more aspect of conventional care, 55% had a belief that conventional treatment was failing, 55% were dissatisfied with medication side effects, 21% were dissatisfied with lack of preventive medicine and nutritional orientation and 20% were dissatisfied with the lack of health care education. It was apparent that only a small number of patients (19%) claim that they were using homeopathy because it was consistent with belief or principle.

A much larger number of patients described dissatisfaction with one or more aspects of conventional health care. Three patients stated that they chose to go to homeopaths when their conventional physicians had recommended surgical operation. Several questions in the interview were designed to probe attitudes with regard to the use of health care providers for specific medical situations. Although 78% of the subjects said that they would use or recommend conventional physicians for emergencies, acute illnesses and orthopaedic problems, 16% said they would not recommend such physicians for any reason. The demographics of the study showed that most of the

patients who were seeking homoeopathy were young, white and well-educated, and had white-collar jobs. The results also showed that the reasons patients seeks homoeopathy were relief of problem without traditional medication (83%), improved health education (33%), improved health maintenance and disease prevention (21%), improved dietary consultation (19%) and treatment consistent with personal principles and beliefs (19%) (Avina *et al*. 1978).

A study to assess the attitudes of physicians at an academic medical centre toward CAM was conducted in the Mayo Clinic in Rochester, United States of America (USA). A total of 660 physicians were emailed a web-based 14 point survey and were asked about their attitudes towards CAM in general and their knowledge regarding specific CAM therapies. Two hundred and thirty three physicians responded to the survey, 76% had never referred a patient to a CAM practitioner. However, 44% stated that if CAM practitioners were available at their institution they would refer their patients. Integrating CAM therapies would have a positive effect on patient satisfaction was a thought that was stated by 57% of medical specialists, and 48% believed that more patients would be attracted when CAM is offered. Most of the physicians were not comfortable in counselling their patients about CAM treatments but agreed that some CAM therapies hold promise for the treatment of symptoms or diseases. The study highlights the need for educational involvements and the significance of providing physicians ready access to evidence-based data regarding CAM (Wahner-Roedler *et al.* 2006).

Hsu *et al.* (2011) conducted a study to determine the acceptance of patients and clinicians to the inclusion of other healing options in primary care. The study used focus groups, four groups of PHC patients (44 patients) and three groups of clinicians (32 clinicians) from an integrated medical system. Both groups were open to including a broader range of healing options (51 options including homoeopathy) in primary care. Some evidence on the effectiveness of the treatments was wanted by the patients, many of who believed that a significant form of proof was a clinician's private and practical experience. The

lack of information about many of the alternative therapies was the clinicians' main concern and they were unaware of authentic local practitioners to whom they could refer their patients to. It was concluded that the integration of other healing options would be feasible and desirable.

Furlow *et al.* (2008) conducted a study which was aimed at investigating physicians and patients attitudes towards CAM in obstetrics and gynaecology. The results showed that physicians appeared to have a more positive attitude towards CAM as compared to general obstetrics/gynaecology patients. Most physicians indicated that clinical care should integrate the best conventional and CAM practices (73.8%), whereas only 40.8% of patients agreed with this statement ($p < .05$, 95% confidence interval [0.27, 0.39]). Similarly, more than half of the physician respondents indicated that CAM includes areas and methods from which conventional medicine could benefit (73.2%), that CAM approaches hold promise for treatment of symptoms, conditions and diseases (59.3%), that health professionals should be able to advise their patients about commonly used CAM methods (68%), and that knowledge about CAM is important to them as patients (54.9%). Less than 50% of patients agreed with each of these statements ($p <.05$ for all statements). Although both physicians and patients disagreed with the statements: while a few CAM approaches may have limited health benefits, they have no true impact on treatment of symptoms, conditions and/or diseases, or CAM is a threat to public health, a higher proportion of physicians disagreed with these statements ($p <.05$, confidence intervals [0.13, 0.26] and [0.17, 0.30] respectively).

Sharples, van Haselen and Fisher (2003) conducted a study at the Royal London Homoeopathic Hospital to examine patients' reasons for seeking CAM in the NHS, including the nature and duration of the patient's main health problem, the impact of CAM on this, satisfaction with clinical care, and usage of conventional prescription medication.

The results revealed that about 506 were returned and 499 were analysed. Patients' most frequent reasons for seeking CAM were that other treatment

had not helped, and concerns about or experience of adverse treatment reactions. Two hundred and ninety-seven patients (63%) had had their main problem for more than 5 years. Musculoskeletal system problems were the most frequent diagnostic group (*n* = 151, 32%). Satisfaction with clinical care was high (443/490: 90%). Three hundred and eighty patients (81%) indicated their main problem had improved very much, moderately or slightly. Of the 262 patients who had been taking prescription medicines when they first attended, 76 (29%) had stopped, and 84 (32%) had reduced their intake. It was concluded that the results suggest that orthodox medicine is not meeting the needs of some patients and that CAM may wholly or partly substitute for conventional medicines. Most patients indicated their problem had improved with CAM (Sharples, van Haselen and Fisher 2003).

Frenkel *et al.* (2008) conducted a study to evaluate the perspectives of patients attending a family medical clinic towards the incorporation of CAM into primary care. A questionnaire was given out to 502 patients attending the family medicine clinic, with 66% of patients who have used CAM during that year. The majority (55.4%) of patients suggested that they would like CAM therapies to be incorporated into their PHC clinic. It was concluded that patients are wishing for their family physicians to be more involved in giving and supervising CAM treatments.

Riley *et al*. in 2001 conducted a study that was an international multi-centre observational study in a real world medical setting which compared the effectiveness of homoeopathy with conventional medicine, with 30 investigators with conventional medical licences in six clinics in four countries. They treated 500 patients with at least one of the three following complaints (1) upper respiratory tract complaints including allergies; (2) lower respiratory tract complaints including allergies; or (3) ear complaints. A total of 456 patient visits with 281 patients received homoeopathy and 175 patients received conventional medicine were compared. Regarding the response to treatment defined as cured or major improvement after 14 days, the response to treatment for homoeopathy was 82.6% and for conventional medicine it

was 68%. Patients that had an adverse reaction to treatment were 22.3% for patients using conventional medicine compared to only 7.8% for patients using homoeopathy. The majority (65.1%) of patients using conventional medicine were completely satisfied compared to the 79% of patients using homoeopathy who were completely satisfied. This study was conducted in Glasgow (Riley *et al*. 2001).

2.11 CONCLUSION

In conclusion, the literature survey has revealed that locally there is a lack of knowledge about homoeopathy. The above studies have explored perceptions and attitudes of the public and health care professionals towards homoeopathy and the usage of homoeopathy but do not address the question of what are the experiences of the patients receiving the homoeopathic services with regard to their care? Therefore, this study was seeking to understand the in-depth experiences of patients at a homoeopathic clinic in the eThekwini area.

According to the literature presented above it is apparent that many questions are still not answered about what are the patient's experiences and benefits with regards to homoeopathic care. Therefore, this study bridges the gap in the knowledge and the questions that are still unanswered. The literature review show the growth and popularity of CAM among the population worldwide, it also reveals that there is a great demand for CAM to be integrated into Primary Health Care. However, most of the studies conducted locally and internationally shows a lack of knowledge of homoeopathy and other CAM therapies.

Studies conducted internationally support the integration of homoeopathy and other CAM therapies into the PHC; this is because there have been positive results from these therapies. To the researcher's knowledge locally there are few studies that addresses homoeopathy being integrated into PHC.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

A qualitative study design is used to answer research questions as it is well-suited to attaining patient perception and experience, of treatment and care, within a healthcare system (Holloway and Wheeler 2010). A qualitative study establishes a pattern or theory of the phenomenon under study and is useful in acquiring knowledge and insight in an area of interest about which little is known (Creswell 1994; Patton 1987). Qualitative research focuses on the subjective experiences of a social reality; it is an inductive and exploratory method which assimilates and analyses contextual data from participants and is able to uncover meaning from the insider perspective (Holloway and Wheeler 2010).

3.2 RESEARCH DESIGN

A qualitative, explorative, descriptive and contextual design was employed (Holloway and Wheeler 2010; Polit and Beck 2012). Qualitative research in the field of healthcare is a process of enquiry into how people make sense of their experiences and suffering, it is useful in attaining perspectives on care and treatment within a healthcare system (Holloway and Wheeler 2010). Qualitative research in this study was considered the most appropriate method to gain an in-depth understanding of the patients' experiences of homoeopathic care.

3.3 SETTING

The study took place at the Redhill Clinic which is located between Tweed and Effingham road in the eThekwini district, KZN.

3.4 SAMPLING PROCESS

Convenience sampling was used to recruit a minimum of 10 potential research participants from patients receiving homoeopathic care at the Redhill Clinic (Padgett, 2012). Sampling is a process of selecting cases to represent the entire population so that inferences about the population can be made (Polit & Beck 2012: 275). In this study convenience sampling was done. Convenience sampling is one in which the researcher uses any subjects that are available (Naude, 2012). The sample size was defined during the course of the study and it was dependent on data saturation (Holloway and Wheeler 2010).

3.4.1 Inclusion criteria

- Patients of Redhills who utilized the services of the DUT homoeopathic clinic.
- Patients who had one or more follow-up consultations.
- Patients of 18 years or older.

3.4.2 Exclusion criteria

- Patients who were visiting the clinic for the first time.
- Patients who were under the age of 18

3.5 DATA COLLECTION PROCESS

Patients were approached by the researcher, informed of the study being conducted and offered the opportunity to voluntarily take part in the research. Interviews took place at the convenience of the participant which was either before or after their visit to the clinic. Interviews were conducted in a quiet and private environment where the participants were feeling comfortable and free to discuss relevant topics without distraction or coercion.

Prior to the interview, participants who were willing and who met the inclusion criteria received a Letter of information (Appendices C and D), and were

required to provide written informed consent (Appendices E and F). Each interview took approximately 20-30 minutes. The researcher conducted the interviews using the interview guide (Appendices G and H) the interviews were conducted in English and isiZulu which ensured each participant the freedom to express themselves fully and adequately in the interview. The researcher conducted and facilitated the interviews. The interviews were captured by audio-recordings in order to accurately preserve the participant's words.

Observational data was collected by the researcher on an on-going basis, this included the non-verbal behaviour of interviewees. This data was useful in enhancing the understanding of the participants' experience beyond verbal explanation and was recorded in the form of field-notes by the researcher soon after the interview (Padgett 2012).

Data collection continued until data saturation was achieved. Saturation is said to take place when each category is conceptually dense, when variations in data are identifiable and explainable, and when no new data relevant to the existing categories emerges during collection (Polit and Beck 2012).

3.6 PILOT STUDY

A pilot study was conducted to test the interview questions in order to check if patients will understand the questions. The pilot study was conducted at the Red hill Homoeopathic Clinic before the study commenced using five patients that were randomly selected. Those participants were not used for the main study.

3.7 DATA ANALYSIS

In order to identify the emerging themes, the researcher personally analysed data under the guidance of the supervisor who is an expert in qualitative research. Tesch's eight-step procedure of data analysis was applied (Tesch, cited in Cresswell, 2009) as follows:

- Interviews were transcribed verbatim and analysed by the researcher.

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

3.8 RESEARCH RIGOUR AND TRUSTWORTHINESS

Lincoln and Guba (1985) suggest four criteria for developing the trustworthiness of a qualitative inquiry. To ensure trustworthiness in this study, the following criteria were used.

3.8.1 Credibility

In order to ensure credibility of the study, the researcher discussed the research process and the findings with the co-supervisor who is qualified and competent in the field and gave insight into factors about which the researcher may be concerned. The researcher used field notes and tape recorder to collect data, the data was transcribed and the researcher made sure that the transcribed notes were a true reflection of the participants' experiences.

3.8.2 Dependability

An audit trail was maintained through safe keeping of raw data of each interview for future reference.

3.8.3 Confirmability

Following the transcription of the voice-recorded interviews, each participant was given an opportunity to review the notes to confirm if they were a true reflection of his/her views regarding their experiences. Voice recordings were made so as to reflect the participant's voice (Graneheim and Lundman 2004).

3.8.4 Transferability

To facilitate transferability the researcher gave a clear and distinct description of the context, selection of participants, data collection and the process of data analysis.

3.9 ETHICAL CONSIDERATIONS

Approval was obtained from the Institutional Research Ethics Committee at DUT, IREC reference number: Rec 69/14 . Permission to conduct the study was obtained from the Manager of Red hill homoeopathic clinic (Appendix A). The study was explained in an information letter (Appendices C and D). Each participant gave written consent (Appendices E and F). During data collection, participants were given numbers that only the researcher had access to. These numbers represented their personal details and no names were mentioned at any point. Confidentiality was maintained, there was no coercion.

Three basic ethical principles were adhered to at all times namely, the principles of respect for persons, beneficence and justice. Respect for persons refers to respecting their autonomy and that if they have reduced autonomy, respect that they entitled to protection. Beneficence refers to doing no harm and to giving consideration to the potential benefits and/or risks that the individual may encounter as a result of this research. The researcher looked for ways to maximize any possible benefits that the research may embody for research participants while still upholding the principle of justice. Of utmost importance was the maintenance of the safety and confidentiality of

all the participants, both in the data analysis and discussion and dissemination of findings (Polit and Beck 2012).

3.10 CONCLUSION

The purpose of this chapter was to describe the research methodology of this study, explain the sample selection, describe the procedure used in collecting the data, and provide an explanation of the data analysis procedures used to analyse the data. The results that were obtained from the data collected will appear in Chapter 4 and be discussed in Chapter 5.

CHAPTER 4: PRESENTATION OF THE RESULTS

4.1 INTRODUCTION

The findings presented in this chapter resulted from the data obtained during observations that were made at the Redhill Clinic and the results of the interviews with the patients attending the Redhill Clinic. Theories can't be made with actual occurrences or activities as observed or reported; that is raw data. The occurrences, events, happenings are taken as, or analysed as, potential pointers of phenomena, which are thereby given conceptual labels (Strauss and Corbin, 1990). Therefore, in analysis the first step is conceptualising data. Strauss and Corbin further state that once the particular phenomena in the data have been identified, the researcher can then begin to group concepts around them to decrease the number of units to work with. These authors refer to the process of grouping concepts that seem to apply to the same phenomena, as grouping (Strauss and Corbin 1990). Henceforth, presentation of the results of the data in this study is therefore organized under the main themes and subthemes (Sibiya 2009).

The analysis of data was completed using Tesch's eight-step procedure. Data analysis began by transcribing the interviews. The researcher read the transcript and compared them with the audio-taped interviews. The researcher read the transcript for the second time to identify the underlying meaning. The researcher selected the most interesting and informative interviews and notes were made in the margins of the transcribed interviews, the process was repeated for the rest of the interviews. Similar topics were clustered together under topics, from the topics, the researcher formed themes and sub-themes. An experienced person in the field of qualitative research analyzed the data separately and then identified themes that were discussed with the researcher. The results were obtained by following a convenience sampling method. Patients attending the Redhill homoeopathic clinic were approached by the researcher to be part of the qualitative study. The results are outlined in

a manner which indicates how the objectives of the study were achieved. The outline is as follows: (a) Demographic data. (b) knowledge of homoeopathy, (c) service delivery, (d) feedback on service delivery, (e) reasons for accessing homoeopathy, (f) expectations, and (g) improvements.

The main objective of the analysis was to describe the patients' experiences of homoeopathic care rendered at a PHC facility in the eThekwini district.

4.2 DEMOGRAPHIC DATA

4.2.1 Gender

The study revealed that majority of patients during the study period were females and there were few male patients.

4.2.2 Age group

During the study period patients' who attended the clinic were between the ages of 35- 65 years.

4.2.3 Race

There was an equal amount of Indian and African patients who were interviewed for the study. The clinic was not visited by white and coloured patients. There were 4 interviews that were conducted in isiZulu and 6 in English and all the 10 interviews were included for analysis of data.

4.3 MAJOR THEMES

After analysing data the following six themes were recognized.

Theme 1: The knowledge of homoeopathy.
Theme 2: Service delivery.
Theme 3: Feedback to service delivery.
Theme 4: Reason for accessing homoeopathy.
Theme 5: Expectations.
Theme 6: Improvements

These six themes and their sub-themes are presented in Table 4.1.

Table 4.1: Overview of the themes and the sub-themes

THEMES AND SUB-THEMES	
THEME 1	Knowledge of homoeopathy
Sub-theme 1.1	Understanding of homoeopathy.
Sub-theme 1.2	How participant got know/exposed to homoeopathy.
THEME 2	Service delivery
Sub-theme 2.1	The hospitality of doctors.
Sub-theme 2.2	Treatment procedure.
THEME 3	Feedback to service delivery
Sub-theme 3.1	Participants likes about homoeopathy and the Redhill homoeopathic clinic.
Sub-theme 3.2	Participants dislikes about homoeopathy and the Redhill homoeopathic clinic.
THEME 4	Reason for accessing homoeopathy
Sub-theme 4.1	Dissatisfaction with other streams of medicine.
Sub-theme 4.2	Contentment and the positive results with homoeopathy.
Sub-theme 4.3	Ailments
THEME 5	Expectations
Sub-theme 5.1	Preconceived ideas
THEME 6	Improvements
Su-theme 6.1	Spread the knowledge of homoeopathy.
Sub-theme 6.2	Participants felt that the time the doctors spend at the clinic is too little.

4.4 PRESENTATION OF THEMES AND SUB-THEMES

The results of this study are presented along the themes and sub-themes that were derived from the analysis of interviews. The six themes that emerged out of this study are presented in Table 4.1. Related direct quotes are provided to support relevant results.

4.4.1 Knowledge of homoeopathy

The majority of the participants had a reasonable understanding of homoeopathy. During observations, the researcher noted that most of the patients who had more knowledge about homoeopathy were Indian and a very few Africans. There were very few participants who had no idea and others who knew a little about homoeopathy However, they expressed different views regarding their knowledge. The researcher noted that the participants used different aspect to explain their knowledge of homoeopathy. These aspects include: their understanding of homoeopathy, how do homoeopaths work and what is homoeopathy about. The following excerpts from the interviews with participants support this theme:

> "…When I am sick I go to the homoeopathic clinic to get pills, which make me feel better and strengthened. Their pills are helping". (Participant 1).

> "…I know that they are doctors" (Participant 6).

> "…It is where they help children and people with problems" (Participant 5).

> "…I don't have that much of knowledge, what I know is that they are doctors who helps in all the problems you have with regards to diseases." (Participant8).

> "…They are healers whom I heard about them from the security at the gate." (Participants 3).

> "…I know that it is the kind of medicine that uses herbs that are not mixed with chemicals" (Participant 9).

> "…It is mostly herbal and it is not made of chemicals. They supply patients with their own medication made at the clinic." (Participant 8).

> "…It is natural and has no side effects." (Participant 7).

> "…They treat patients using herbs and with substances that are not chemicals." (Participant 2).

"…I don't have much knowledge but I know that they use herbs, natural herbs." (Participant 4).

"…I noticed that homoeopathy was helping me with different kinds of specific medication to specific ailments. Its takes care not only of the specific part of the body but holistic approach. Consider the body as a whole. What I know is that it is mainly plants that medication is derived from; I'm not that knowledgeable about the medication but I know that it doesn't contain lots of drugs. Many people go for natural, drug free and side effects free medication like homoeopathy". (Participant 10).

The researcher noted that most patients who came to the Redhill homoeopathic clinic never heard about homoeopathy before up until they came to the clinic. Most of the participants who knew about homoeopathy got the knowledge through word of mouth. Some of the participants heard about homoeopathy from the security lady who works at the clinic and some heard from the nurses who work at the clinic. The participants knew about homoeopathy because of the Redhill clinic. The following extracts are presentation of some of the responses from the participants with regard to how they knew about homoeopathy:

"…I got the information about homoeopathy from the newspaper." (Participant 2).

"…I heard about homoeopathy from one of the nurses who work at the clinic." (Participant 6).

"…I was told by the security." (Participant 1).

"…These are healers I heard about from the security." (Participant 3).

"…My friends told me about homoeopathy and they recommended it because they found it to be benefiting." (Participant 10).

"…I was referred by one of the staff members." (Participant 4).

"…The security told me about homoeopathy." (Participant 7).

4.4.2 Service delivery

All the participants that were interviewed had good things to say about the service that they receive from the Redhill homoeopathic clinic, most of the participants spoke about how well they were treated including the time doctors spend on them and the care that is given to them. Most of the interviewees gave an insight into how they felt about the way they were treated (hospitality). The following quotes from the interviews with participants support this theme:

> "…I like their service delivery, its 1st grade. If you enter into their consultation room, you explain what your main complaint is. They give you full attention, thoroughly examine you and they take their time when they are treating you. They don't care whether you dirty or clean." (Participant 1).

> "…Their service is of a 1st grade; these doctors are people who can communicate well. You can talk to them about every problem you have, they are free. If you are sick you are able to tell them about each and every detail of your sickness. They like their work and they know how to treat a person they treat us good." (Participant 2).

> "…They are good people. They care and they listen." (Participant 9).

> "…The way they treat us, shows that they have a passion of what they are doing. If you have a problem they leave everything that they are doing and give you attention, which makes me very happy." (Participant 5).

> "…It is very well, I'm very happy with the service. I have got no problem it is excellent they give me good advice and I feel comfortable around them." (Participant 3).

> "…They are nice doctors who are willing to help and willing to listen to your complaints. They made time and looked for what they can make for my ailments." (Participant 8).

"…Their service delivery is excellent because they consider patient's problems, they are sympathetic and attentive. They spend lots of time giving attention to patients." (Participant 10).

"…The service is good because they cured me. I never had the pain again." (Participant 4).

4.4.3 Feedback to service delivery

Service delivery is defined as an organised system of labour and material aids used to supply the needs of the public (Reverso dictionary for mobile 2014). The patients attending the Redhill homoeopathic clinic gave the feedback on the services they received from the homoeopaths. The researcher formulated the following sub-themes which are likes and dislike. This includes likes and dislikes about homoeopathic medication, service, doctors and the consultations. The following passages from the interviews with participants support this theme:

"…I like everything about them, they treated me well and they are helping me with everything that I need. I am not complaining." (Participant 1).

"…I liked that homoeopathy treat naturally it does not use chemicals." (Participant 8).

"…I like the Redhill homoeopathic clinic because it helps us. Their treatment is acting fast even my husband is taking the homoeopathic drops for asthma. After taking the drops his asthma becomes better. I also like that it uses natural methods." (Participant 2).

"…There is nothing that I don't like, I like the way they work it is fast." (Participant 7).

"…I don't want to lie they know how to examine everything in children. I like that they always find other wrong things through their thorough examination." (Participant 5).

"…There's nothing that I don't like, there's always a person to help with communication, who interprets for you when you can't address other things in English. They are very helpful." (Participant 6).

"…I like that they are helping us nutrition wise by giving us nutritional advice and give us vitamins to improve our health." (Participant 10).

"…I like the way they treat patients, their friendliness showed that they care. I liked the gentle palpation and their full involvement with patients it made me feel relaxed. I like the way they treat and like their medication because it is taken hourly and I'm not a person who likes medication so with homoeopathic medication it's easy to take because you take it hourly." (Participant 4).

"…I liked the consultation It was good I could stop anywhere I could, the doctors are quite understanding, I enjoyed it. The consultation was good I did not feel pressurised in a way that I wasn't forced to say much and it was the first time telling people about my emotions. The thing that I didn't like was that there were too many people in the consultation room when I was talking about my emotions." (Participant 3).

"…I don't like that the doctors spend little time at the clinic; they come once a week only for four hours." (Participant 9).

4.4.4 Reason for accessing homoeopathy

Patients highlighted their reasons for accessing homoeopathy, during data collection the researcher noted that most patients go to the Redhill homoeopathic clinic for different reasons. It emerged that the reasons for accessing homoeopathy was dissatisfaction with other streams of medicine, ailments and contentment with homoeopathic treatment. Some of the participants mentioned that they were dissatisfied with the mainstream medicine and they decided to give homoeopathy a try and use it as an alternative therapy. However, most patients seemed to be pleased with the

homoeopathic treatment gave positive feedback. This is indicated in the following quotes from the interviewees 'statements:

"…I came for infertility, I tried other methods and I was given fertility tablets which were not successful. I had an option to try alternative therapy which is homoeopathy." (Participant 3).

"…I had a pain on my lower left abdomen which was not resolved by panado and brufen. I took brufen and panado but I didn't feel better and the pain became worse. One of the staff members assisted me to go see the homoeopaths. I felt better after they treated me, until today I don't have the pain." (Participant 4).

"…I had an eye problem that has been there for years. My eyes would suddenly turn red, excoriate and be painful; I would put medication and I would not feel better. I went to the Red hill Homoeopathic Clinic for consultation and I was given medication. I used their medication within half an hour my eyes became clear and cool. These doctors are very helpful I feel much better from what I was. They are very helpful people and their medication is very powerful and strong, it is healing medication." (Participant 6).

"…I am an arthritis and spondylitis patient; since I started coming to the clinic I have seen a change. I feel the difference and their medication work on you." (Participant 8).

"…I've been coming for about a year and a half, I had sinus, digestion and joint problems. I have found a lots of relieve and that is the reason why I keep coming back." (Participant 10).

"…I had a leg pain; the pills helped me. They gave me good treatment and they take their time they do not hurry. I've been coming to this clinic for more than 3 years and I prefer the homoeopathic clinic than the mainstream clinic." (Participant 1).

"…I have diabetes; I came to get help from the homoeopathic clinic. I've been coming to the clinic for a year and I have seen a difference that is why I keep on coming back. I feel better and I am recovering." (Participant 9).

"…The reason I accessed homoeopathy was that the method of medicine that is used was not working for me. With homoeopathic medication I drink now and get healed now." (Participant 2).

4.4.5 Expectations

Some of the patients reported that what they were expecting did not happen but to some their expectations were met. From the data source it emerged that all the participants had preconceived ideas about their first consultation with the homoeopathic doctors. Some of the patients had positive expectations and some were expecting the worst to happen during their first consultation. Most of the participants that were expecting the worst were proven wrong. As it is shown in the following extracts from the interviewees' statements:

"…My expectations were to get a relief and the homoeopaths covered quite a large percentage, they met about 75% of that but there is still room for improvement." (Participant 10).

"…I was expecting the usual medication I thought I was going to be given what I am used to but they gave me drops which is something that I am not used to. I was surprised when they gave me drops and I took them because they were for free." (Participant 3).

"…my child, I want to tell you a secret that what doctors will give you will first make you worse; you must not stop taking it. It will eventually help you. The drops helped me and I still want more of them." (Participant 7).

"…I was expecting good treatment; I found that they are very friendly people and open people. I didn't feel shy when I was with them. I had hoped that I would be healed from the problem I had for years and indeed I

was healed. I believe that there's nothing that helps a person besides telling yourself in your mind that you will get help." (Participant 6).

"…I was expecting not to be treated well because it was my first time meeting those doctors. I never had hoped that their medication would help me and work but my knees became much better after taking their medication." (Participant 2).

"…I never expected to be examined I thought they were going to ask the problem I was presenting with and then check me but I was examined I was put on the bed, they palpated and then they looked for a lots of things not only just the pain I was complaining about. They did a full examination." (Participant 4).

"…I wasn't sure of what to expect. I didn't know that my childhood history will come up and that if the body and emotions are not in tune healing it might take time for an individual to be healed. I did not expect to be asked about my emotions. I wasn't expecting the medication I was given, I would have thought I was going to receive herbs or some aromatherapy oils; I was so surprised when I received the powders." (Participant 8).

4.4.6 Improvement of service delivery

Some of the participants had a few suggestions on how the service delivery of the Redhill homoeopathic clinic can be improved:

"..I wish the doctors could come every day." (Participant 3).

"…There needs to be someone who will explain because most are English speaking people. There are words that you can't explain in English therefore an interpreter is needed so that I will be heard." (Participant 6).

"…I would like patients to be referred to hospital and get referral letters from the homoeopathic clinic." (Participant 7).

"…I wish the knowledge about homoeopathy could be spread to many places and many people cannot reach the clinic therefore, there must be

pamphlets that will explain in details on what is homoeopathy and what is it about. These pamphlets must be handed out here at this clinic." (Participant 9).

In this chapter, the researcher was capable of analysing the information that was derived from the interviews with the selected participants so that certain themes could be identified. Table 4.1 provides a summary of themes and sub-themes. The overall themes that emerged from the interviews were knowledge of homoeopathy, service delivery, and feedback on service delivery, reason for accessing homoeopathy, expectations and improvements. Chapter 5 will elaborate further by discussing these findings.

CHAPTER 5: DISCUSSION OF THE RESULTS

5.1 INTRODUCTION.

In the previous chapter, the research results were presented and this chapter focuses on the discussion of the results. The discussion of the results is guided by the research question described in the first chapter as well as by the themes that emerged from the analysis of the interviews.

5.2 OVERVIEW OF THE RESEARCH DISCUSSION

The main objective of the study was to describe the patients' experiences of homoeopathic care rendered at a primary health care facility in the eThekwini district. In this study six major themes were identified, namely:
Theme 1: The knowledge of homoeopathy.
Theme 2: Service delivery.
Theme 3: Feedback to service delivery.
Theme 4: Reason for accessing homoeopathy.
Theme 5: Expectations.
Theme 6: Improvements

These themes and their sub-themes are interpreted below and validated by means of relevant literature to support the interpretation of the findings.

5.3 KNOWLEDGE OF HOMEOPATHY

Findings from this study revealed that majority of the participants had a better understanding of homoeopathy. During observations, the researcher noted that Indian patients had more knowledge about homoeopathy compared to African patients'. There were very few participants who completely had no idea about homoeopathy.

Prinsloo (2011b) states that homoeopathy is known as being the fastest developing medical modality in the world, the awareness of homoeopathy is

changing and there is a growing request to learn more about homoeopathy. Naicker (2008) conducted a survey to determine the perceptions of medical specialists and interactions with homoeopathy. The data gathered during this study showed that 70.7% of medical specialists having heard of homoeopathy but had no contact with it. Seventy six point seven percent of medical specialists presumed that homoeopathy could be used concurrently with conventional medicine, with 8% of medical specialists referring patients to a homoeopath. The perception of homoeopathy was favourable yet the study showed there is limited knowledge that medical specialists have about homoeopathy.

Paruk (2006) carried out a survey to determine the perception that exists amongst pregnant women regarding the use of homoeopathy during pregnancy. The results revealed a great lack of knowledge about homoeopathy not being required as a form of treatment during pregnancy. Harripershard (2009) articulated that perception studies conducted so far in South Africa have discovered that there is a degree of unawareness or misinterpretation of homeopathy, and that varied views on its application and effectiveness exist among the general public.

Allopi (2008) conducted a survey to determine the perception of nurses in the eThekwini region towards homoeopathy. This study revealed that the nurses lack knowledge of homoeopathy. From the data received it was perceived that in a hospital setting integrative medicine could have a role to play.

Zanini *et al*. (2007) conducted a survey to assess the knowledge of oncology nurses regarding complementary and alternate therapies. Due to the increase of use of complementary and alternate therapies by the public, and because nurses play a key role in healthcare as primary care providers, it is likely that they would be asked by their patients about other therapies. The survey was handed out to 270 registered nurses, with a return rate of 57.4%. Ninety four of the nurses perceived that they had knowledge about complementary and alternate therapies. Two-thirds of these nurses said that they had gained their information from books, other common sources of information came from

other healthcare workers, the internet, workshops and seminars and only 17% said their primary source of knowledge on complementary and alternate therapies came from their formal nursing education. A total of 71.6% of nurses encountered patients using complementary and alternate therapies, with 47.1% of patients asking about information on the therapies. It was concluded that nurses do not have sufficient knowledge to give their patients in order for the patients to make an informed decision.

Findings from this study revealed that most patients who came to the Redhill homoeopathic clinic never heard about homoeopathy before until they came to the Redhill clinic. Most of the participants who knew about homoeopathy got that knowledge through word of mouth. Some of the participants heard about homoeopathy from the security lady who works at the clinic and some heard from the nurses who works at the clinic.

A study conducted by Thorvaldsen (2007) to determine the perceptions of 3rd year medical students at the UCT and the UKZN towards homoeopathy. It was found that 96% of respondents had heard of homoeopathy, 21% were knowledgeable about it, 4% of respondents have never heard of it, 68% of respondents indicated an interest in learning more about homoeopathy and 92% of respondents felt that it is important for a medical doctor to know about the complementary forms of treatment. The majority (79%) of respondents said that it is important to improve communication between homoeopaths and conventional medical practitioners (Thorvaldsen, 2007). A study conducted by Lee *et al.* (2002) found that respondents recognized 231 kinds of CAM treatments and approximately half of CAM consumers showed that they would recommend CAM to others.

Small (2004) conducted a survey to determine the perceptions of homoeopathy amongst Grade 12 learners in Durban, South Africa. The data gathered found that 76% of the respondents had never heard of homoeopathy before, and more than 80% of those respondents displayed an interest in learning more about homoeopathy.

In 2009, Von Bardeleben conducted a survey to determine the perceptions of homoeopathy amongst parents of children aged 3 to 7 years old at pre-primary schools in the Pinetown district. Fifty six point one percent of the respondents had heard of homoeopathy before and 22.7% of the respondents had taken their children to a homoeopath with 48.6% of the parents being satisfied with the homoeopathic treatment their child had received. Almost two thirds (65.6%) of the respondents thought homoeopathy should be made available in clinics and hospitals. The survey concluded that even though more than half the respondents were aware of homoeopathy, their levels of knowledge of homoeopathy were poor (Von Bardeleben 2009).

Data achieved from the telephone interview conducted by Attena *et al.* (2000) presented that with respects to the patient's choice of homoeopathy approximately 87.5% had been suggested by relatives and associates.

5.4 SERVICE DELIVERY AND FEED BACK REGARDING SERVICE DELIVERY

All the participants that were interviewed had good things to say about the services that they are receiving from the Redhill homoeopathic clinic. According to Frass *et al.* (2012) there has been minor investigation of the homeopathic profession in Australia and of homeopathic training by medical practitioners, and the effect of homeopathy on PHC remains unknown.

Frass *et al.* (2012) articulate that even though these figures have been growing in the current years, the debate about the clinical effectiveness of alternative therapies has been debated amongst many medical specialists. Nevertheless, the approach of the overall inhabitants toward CAM is mostly positive even though there are few scientific documents that are available for this discipline. The implication of these figures implies that CAM is drawing extra attention within the Healthcare (Frass *et al.* 2012).

The outcomes of adding homoeopathy into public health system have generally been evaluated very positively by the participants and offer possible solutions to difficulties of sustainability of the public health systems in the

developing republics (Rossi *et al.* 2010). International research conducted at Glasgow Homoeopathic Hospital (GHH) was conducted to determine the patient's views on the consultation. It was indicated that patients placed great value on the holistic approach taken by doctors (Mercer and Reilly 2004). They acknowledged that the time made available for consultation, the empathy of the doctor with the patient, discussion and shared decision-making between patient and doctor, and the on-going therapeutic doctor-patient relationship were desirable factors of care at the hospital (Mercer and Reilly 2004). According to Mercer, Reilly and Watt (2002) patients attending the GHH reported great levels of satisfaction and seemingly good clinical results across a range of long-lasting diseases.

Mercer, Reilly and Watt (2002) conducted a study to demonstrate the significance of sympathy in enablement in the sample studied. The described difference in enablement empathy accounted for 66% nearly two and a half times the significance of the doctor's own perception of the relationship and nine times more important than the patient's prospects before consulting the doctor. Even though there is substantiation that empathy may be lacking in contemporary medicine, it seems to be an abandoned area of research.

The GHH is significant in permitting patients to express their story in detail and creating a rapport, and that following consultations are more reliant on the on-going development and deepening of an empathetic and therapeutic relationship. Alternatively, the absence of a clear relationship with length of consultation could basically be a reflection of the study size. The results suggested that empathy and constant therapeutic alliance are key constituents of patient enablement at the GHH. The relevance of these findings to the primary care setting needs to be established and work on this is currently underway (Mercer Reilly and Watt 2002).

Furthermore, there seems to be slight support for the incorporation of homeopathy into Australian general practice, with only one-quarter of general practitioners proposing that homeopathy should be practised by medical doctors and only one-third supporting subsidies from Medicare for medically

trained practitioners providing homeopathy. Low levels of support for homeopathic integration are coupled with prevailing perceptions amongst Australian GPs that homeopathy is ineffective; with national studies demonstrating that 50-82% of the GP population believe that homeopathy is ineffective. The heterogeneity of GP views on homeopathy is further complicated by debate amongst GPs who doubt the scientific validity of homeopathy, yet may still acknowledge homeopathy as a potentially therapeutically effective treatment due to its enhanced non-specific, or placebo, effects (Wardle, Adams and Sibbritt 2013).

Guthlin, Lange and Walach (2004) conducted a study to measure the effects of acupuncture and homoeopathy in general practice. After the treatment patients were required to rate the progress of how their complaints developed. Over follow-up time, results revealed that 39% of homoeopathy patients felt very much better and 38% felt somewhat better, 17% thought the symptoms were unchanged, and only 2% reported a deterioration of symptoms. Patients and doctors were requested to report side effects to the treatment. The maximum rate was given by homoeopathy patients at 7%. It was said that at times homoeopathy produces symptoms of initial aggravation, when therapy is going to work well. Five percent of the acupuncture patients felt some side effects to the treatment. Advance investigation showed that these were minor reactions like needle sensation.

5.5 REASONS FOR ACCESSING HOMOEOPATHY

The results revealed that most patients go to the Redhill homoeopathic clinic for different reasons. It emerged that the reasons for accessing homoeopathy was dissatisfaction with other streams of medicine, ailments and satisfaction with homoeopathic treatment. Furthermore, most patients seemed to be pleased with the homoeopathic treatment hence they gave positive feedback.

CAM consumption is multifaceted and includes old-fashioned methods of treatment. Patients utilize CAM because they feel the need for holistic method of treatment which focuses on treating the whole being: mind, soul and body.

CAM incorporation in treatment resolutions would decrease dissatisfaction with current therapies. Further investigation would support the advance incorporation of CAM into orthodox medicine, as the benefits of these treatments are frequently recognized and distributed in scientific journals. For instance, a study published in the previous year presented a substantial decrease in blood pressure and heart rate after deep tissue massage. Hence, further training about CAM is required to make students of the following age group of physicians, to meet the necessities of their patients (Frass *et al.* 2012).

Marian *et al.* (2008) conducted a study to investigate the patient perception and satisfaction of side effects in homoeopathy compared to orthodox care in a PHC setting, and found that there was greater satisfaction in the homoeopathic group in the PHC setting and homoeopathic treatment was perceived low risk therapy with fewer side effects.

Sharples, van Haselen and Fisher (2003) conducted a study at the Royal London Homoeopathic Hospital to study patients' reasons for seeking CAM in the NHS, including the nature and duration of the patient's main health problem, the impact of CAM on this, satisfaction with clinical care, and usage of conventional prescription medication.

The results showed that the most frequent reasons for patients to seek CAM were that they did not get help from other medical methods, and worries about side effects of the treatment. About 297 patients (63%) had had their main problem for more than five years. Clinical care satisfaction was high (443/490: 90%). The main problems of about 380 patients (81%) had improved very much, moderately or slightly. Of the 262 patients who had been taking prescription medicines when they first attended, 76 (29%) had stopped taking medication, and 84 (32%) had decreased their intake. The results obtained from the study suggested that some needs of patients were not met by conventional medicine and that CAM may wholly or partly substitute for conventional medicines. CAM improved most patients' problems. The age

group for this study was from 18 to 65 years (Sharples, van Haselen and Fisher 2003).

Avina and Schneiderman (1978) conducted interviews in the San Francisco Bay area with 100 homeopathic patients. The purpose of the interviews was to investigate the reasons why patients choose homoeopathy. The majority of the participants provided more than one explanation for seeking homeopathic care; some positively directed towards their expectations; others obviously in reaction to unhappy experiences with orthodox medical care. The findings of the study revealed that 81% of patients were dissatisfied with one or more aspect of conventional care, 55% had a belief that conventional treatment was failing, 55% was dissatisfied with side effects of the medication, 21% was dissatisfied consequent from deficiency of preventive medicine and nutritional orientation. Due to the lack of health care education 20% of the participants were dissatisfied. It was apparent that only a small number of patients (19%) claim that they were using homeopathy because it was consistent with belief or principle.

Dissatisfaction with one or more aspects of conventional health care was described by a much larger number of patients. Three patients indicated that they chose to go to homeopaths when their orthodox physicians had suggested surgical operation. With regard to the use of health care providers for specific medical situations several questions in the interview were designed to probe attitudes. Although 78% of the subjects said that they would use or recommend conventional physicians for emergencies, acute illnesses and orthopaedic problems, 16% said they would not recommend such physicians for any reason (Avina and Schneiderman 1978).

This is predominantly unfortunate that being dissatisfied with other therapeutic methods has resulted into a greater number of patients coming to see CAM therapists. What was derived from the data is that in general patients are very fulfilled, not only with the treatment, but also with the effectiveness of the treatment. This fulfilment is not only perceived in self-report matters, but is also replicated in the consistent and well-validated scale SF-36, which is

known to be very robust and does not simply overvalue change (Güthlin, Lange and Walach 2004).

A study that was conducted in India explored the utilization of homoeopathy both in rural and urban areas, the aim of the study was to find out the reasons of preferences as well as cost of treatment. Results showed that the reasons for utilization of homoeopathic treatment were no side effects (31%), cheap (30%), effective (25%) and doctors are easily available (11%). The reasons for not utilizing homoeopathy were slow progress (28%), no faith (12%) and no availability of medicine (5%). About 11.94% preferred homoeopathy in urban areas and 11.29% in rural areas (Singh, Yadav and Pandey 2005).

The charges of the alternative therapies existing within the assessment phase are unambiguous. Neither homoeopaths nor acupuncturists apply expensive technical products. They do not order a great number of diagnostics, and the amounts of consultations taken to accomplish the results are modest. Regularly 10 acupuncture and 2 to 3 homoeopathic consultations were needed to attain the effects with stability over four years, which interprets to approximately €300 per patient, with no secret charges for costly drugs (Guthlin, Lange and Walach 2004).

International research conducted at GHH was conducted to determine the patient's views on the consultation. It was indicated that patients placed great value on the holistic approach taken by doctors (Mercer and Reilly 2004). They acknowledged that the time made available for consultation, the empathy of the doctor with the patient, discussion and shared decision-making between patient and doctor, and the on-going therapeutic doctor-patient relationship were desirable factors of care at the hospital (Mercer and Reilly 2004).

The greater use of a CAM therapy is associated to a wellness and health protective lifestyle, absence of doctors, no usage of recommended medicines and vitamins over the past week; no medicinal management concerning rheumatism, heart disorders, allergic coryza or other allergies as well as

mental breakdown or depression over the past 12 months. It was also reported that there has been no physical or psychological problem since over 12 months. No headache, facial pain, fatigue over the past 4 weeks, complete discontinuing of influenza vaccination, a good up to very good self-reported health status. In general users of a CAM therapist seem to be in a better health than users preferring a physician as their CAM provider (Frass *et al.* 2012*)*.

Guthlin, Lange and Walach (2004) articulate that most of the patients needed help for chronic problems, which were not responding to orthodox treatments, and therefore by default unlikely to relapse back to normal. The documented development is also unlikely to be due to simultaneous conventional or other treatments. The documented practice of other medical treatments is related rather to routine visits and decreased slightly. This is also true for the intake of painkillers and other pills.

Most doctors used complementary therapies for patients with long-lasting disease. Nineteen doctors used complementary treatments for those with psychosomatic disorders; 17 doctors used complementary treatment for those with minor illnesses such as occasional headache and 14 doctors used complementary therapies to relieve patients with terminal illnesses. For 84.2% of doctors who used complementary medicine in their practice prior therapeutic success was a reason for the use of these treatments. Sixteen viewed failure of orthodox medicine and positive experiences with complementary medicine as a reason, 50.0% used such treatments because of the scarcity of adverse reactions and 34.2% because of patients' requests (Frass *et al*. 2012).

The five most prevalent system disorders encountered at UNHC infectious illnesses were the most common along with cardiovascular, dermatological, psychological and musculoskeletal disorders. Of the infectious illnesses (29% of all illness treated at UNHC), cold and flu accounted for 8%, HIV/AIDS 6%, and sexually transmitted infections 4%. In the cardiovascular system one of the major diagnosed disorders was hypertension (13%). Frequently this was

diagnosed incidentally on a routine blood pressure assessment which is carried out on all patients seen at UNHC (Smillie 2010).

In the study conducted by Avina and Schneiderman (1978) most of the patients who were seeking homoeopathy were young, white and well-educated, and had white-collar jobs. The results revealed that 83% of patients were seeking homoeopathy to find relief of problem without allopathic medication. The other reasons for seeking homoeopathy was that 33% of patients wanted to improve their health education, 21% need an improved health maintenance and disease prevention, 19% wanted to improve their dietary consultation and 19% was seeking homoeopathy because their treatment is consistent with personal values and principles.

The medical conditions treated with CAM were investigated by various researchers which found that the top five medical conditions for which CAM was used most often were back pain or back problems, depression, insomnia or trouble sleeping, severe headache or migraine, and stomach or intestinal illness (Frass *et al*. 2012).

The most regularly self-reported symptoms and grievances had to do with the respiratory system (16%) and skin problems (19%). A lesser amount complained of back pain (7%) and headaches (10%). Of the homoeopathy patients, 65% identified that they had taken orthodox treatment and 29% had consulted more than four physicians previously. Nineteen percent of the patients had had homoeopathic treatment for the reported symptoms before. Treatment inspiration was given as being the low perceived effectiveness of other treatments (70%) and compensation by the insurance company (73%). Less prominent reasons were the side effects of other treatments (60%) and the need to be treated with homoeopathy (56%) (Guthlin, Lange and Walach 2004).

5.6 EXPECTATIONS

Some of the patients reported that what they were expecting did not happen but to some their expectations were met. From the data source it emerged that all the participants had preconceived ideas about their first consultation with the homoeopathic doctors. Some of the patients had positive expectations and some were expecting the worst to happen during their first consultation. Most of the participants that were expecting the worst were proven wrong.

Positive or negative health effects may be associated to the patients' expectations and to the setting where treatment is applied. Therapeutic benefits are activated by the supposed specific effects of the treatment in general practice, by the patients' and doctors' expectations and the non-specific effects of the therapeutic ritual, to name but a few factors (Guthlin, Lange and Walach 2004).

5.7 IMPROVEMENTS

Certain participants had a few suggestions on how the service delivery of the Redhill homoeopathic clinic could be improved. The participants requested that the doctors should come every day since they only come every second Friday. Others suggested that there needs to be an isiZulu interpreter who will close the communication gap because most of the homoeopathic doctors were English speaking people. Patients felt that there were words that they could not express in English therefore an interpreter is needed so that all the details of the case are taken into consideration and nothing is left unsaid.

Furthermore, it was suggested that patients should be referred to hospitals and get referral letters from the homoeopathic clinic. One of the patient’s major concerns was that there is a lack of the knowledge of homoeopathy and about the Redhill homoeopathic clinic. Hence, they suggested that the knowledge of homoeopathy should be spread to many places as they felt that

many people cannot reach the clinic and they do not know about homoeopathy in general. Therefore, it was further recommended that there must be pamphlets explaining in details on the knowledge of homoeopathy and about the homoeopathic clinic.

The Board of Greater Glasgow National Health Services noted the progress on the review of homoeopathy services. The NHS Greater Glasgow operated an initiative to report the prolonged outpatient waiting times and advance access to the services. Discharged patients or patients who have completed their treatment were returned to their GP, referring consultant or discharged with no further medical follow-up. This initiative was repeated during 2003/2004 resulting in a further reduction of the waiting list. There has been a growth of 922 new patients in 03/04 representing a 90% rise. This trend places interest in the rise in demand for outpatient Homoeopathy services (Glasgow Board Meeting 2004).

The improved homoeopathic service could harvest greater access to shorter waiting times, faster access to homoeopathic guidance and treatment, specialist adviser view, better choice for patients with option of day or evening clinics, acute inpatient care provided in acute hospital with appropriate back up. The new model could confirm that suitable care is delivered for patients referred to GHH. At the same time, it will decrease the existing extreme waiting times for the service and reach the 26-week objective and sustain better-quality access (Glasgow Board Meeting 2004).

In the UK homoeopathic services are provided on an outpatient basis, the necessity for patients to stay in hospital having been overcome. This demonstrates that homoeopathic care can be delivered in a different way and that the model of care in Glasgow may be less well developed than homoeopathic services provided in other centres. This initial review has also concluded that a redesign of the current service could deliver shorter waiting times, quicker access to homoeopathic advice and treatment, specialist consultant opinion and better choice for patients with option of day or evening clinics. The overall referral rate to the outpatient service has risen

substantially over recent years, peaking at 200 new outpatient referrals per month with the number of referrals received exceeding available appointments by 100% (Glasgow Board Meeting 2004).

This study revealed that the Redhill homoeopathic clinic has grown significantly and that shows that there is a great demand for homoeopathic treatment in the PHC. The level of this significant growth is indicative of the clinic's success and the positive effect of the service rendered. Each and every modality has a role to play in the treatment of various ailments and the researcher believes that homoeopathy has a big role to play in the PHC and it has an ability to close the gaps that the South African PHC is currently facing.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The results of this qualitative study provided data on the experiences of patients attending the Redhill homoeopathic clinic in the EThekwini Municipality District. Their knowledge of homoeopathy, expectations of homoeopathy, their experience in PHC and their views on homoeopathic service delivery were assessed. The study designated that the study group had knowledge of homoeopathy and it has shown that there is growth in the knowledge of homoeopathy as compared to the previous studies that were conducted. The researcher observed that most of the participants who had a better understanding of homoeopathy were Indians and there was a lack of the knowledge of homoeopathy in the African participants.

Participants showed a high level of confidence towards homoeopathy, and majority of them were satisfied with homoeopathic treatment and were very pleased with the service delivery. Results revealed that patients' ailments improved ever since the commencement of homoeopathic treatment.

The findings represents individuals who participated in the study, and not the entire patients' of Redhill homoeopathic clinic. Therefore, generalisation of findings and assumptions concerning the patients' experiences towards the homoeopathic care rendered at Redhill homoeopathic clinic is not possible.

6.2 LIMITATIONS

The results of this study are limited in that convenience sampling was used and the study was conducted in one of the homoeopathic satellite clinics. Therefore, the results cannot be generalized to different satellite clinics. Patients from the Redhill homoeopathic clinic were included in the study and those who were visiting the clinic for the second time and more were also included in the study.

The respondents were those who were available at the clinic during the time of the study and who wanted to be part of the study. Patients who were not available were not included in the study. The findings of this qualitative, explorative, descriptive and contextual study although not generalizable, it may provide further information on the experiences of patients attending homoeopathic primary care clinic. The findings of the study obtained are not necessarily representative of the population as a whole.

6.3 RECOMMENDATIONS

Based on the outcomes of the study, the following recommendations were established with special reference to the knowledge of homoeopathy, service delivery patient's experiences with regard to the homoeopathic treatment and further research:

- There must not be many student doctors in one room during case taking for patients feel under pressure and they feel that there is no privacy.
- The working hours should increase at least by an hour or add one more day in a week, because the time spent at the clinic is sometimes not enough but that is usually dependent on how many patients are there on that particular day.
- Computer software is needed to quicken the process of prescribing, which will reduce the waiting time of patients.

- Preferable an isiZulu interpreter is required for most of the patients who are attending the clinic are isiZulu and isiXhosa speaking patients and most of them are not fluent in English. That will enable patients to express themselves freely without any hindrances.

- There must be awareness of homoeopathy; to accomplish that there must be pamphlets that are explaining about homoeopathy in details including the scope of practice of homoeopaths. This pamphlet has to be available at the Redhill clinic to all patients who are attending the clinic.

- The Redhill clinic staff should be educated about homoeopathy as it is one of the modalities that are offered at the Redhill clinic. According to Pillay (2013) in order for homoeopathy to become more widely accepted into the health sector of the area, there needs to be more education regarding the practices and training of homoeopathy made available to the nurses, and to the public in general.

- This study was limited to the eThekwini Municipality District. A larger study would be suitable in order to obtain a wider perspective and a broader understanding of patients receiving homoeopathic services at a PHC. It is suggested that surveys be conducted in other areas of South Africa.

- This study was conducted in a qualitative paradigm; an additional quantitative study which aims to determine the patient's experiences towards homoeopathic care rendered at a PHC would be necessary because it will cover a larger sample size as compared to this qualitative study which was directed by data saturation. Future studies should include a larger sample size which would gather a broader perspective. Future studies should attempt to determine the homoeopathic services rendered at a PHC compared to services rendered at a private practice.

- It is recommended that a similar study should be conducted but it has to target only the African population because the results of this study showed that there is still lack of the knowledge of homoeopathy in the African population.

REFERENCES

Allopi, K. 2008. A survey to determine the perceptions of nurses in the eThekwini region towards homoeopathy. M Tech: Homeopathy. Durban University of Technology.

Almeida, J. 2012. The differential incorporation of CAM into the medical establishment: the case of acupuncture and homeopathy in Portugal. *Health Sociology Review* (online), 21(1): 5-22. Available: http://www.tandfonline.com/doi/abs/10.5172/hesr.2012.21.15#/doi/abs/10.5172/hesr.2012.21.15 (Accessed 03 March 2014).

Attena, F., Del Giudice, N. Verrengia, N. and Granito, C. 2000. Homoeopathy in primary care: self-reported change in health status. *Complementary Therapies in Medicine* (online), 8(1): 21-25. Available: http://www.ncbi.nlm.nih.gov/m/pubmed/10812756/ (Accessed 10 March 2014).

Avina, R. L. and Schneiderman, L. J. 1978. Why patients choose homeopathy. *The western journal of medicine* (online), 128(4): 366-369. Available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1238132/ (Accessed 19 January 2014).

Bloch, R. and Lewis, B. 2003. *Homoeopathy for the home.* Cape Town, South Africa: Struik Publishers.

Bodeker, G. 2001. Lessons on integration from the developing world's experience. *Biomedical Journal* (online), 322(7279): 164-167. Available http://www.ncbi.nlm.nih.gov/pubmed/11159579.

Chauhan, V. K. and Gupta, M. 2007. *Homoeopathic principles and practice of medicine: homoeopathic fundaments*. Mumbai, India: B. Jain Publishers.

Cresswell, J. W. 2009. 3rd ed. *Research design: qualitative, quantitative and mixed methods approaches*. Los Angeles, CA: Sage.

Creswell, J. W. 1994. *Research design: qualitative and quantitative approaches.* London: Sage.

Daviaud, E. and Chopra, M. 2008. How much is not enough? Human resources requirements for primary health care: a case study from South Africa. *Bulletin of the World Health Organization,* 86(1): 46-51.

De Haan, M. Dennill, K. and Vasuthevan, S. 2005. *The Health of Southern Africa*. 9th ed. Cape Town: Juta.

De Schepper, L. 2001. *Hahnemann revisited.* United States of America Sant Fe, NM: Full of Life Publishers.

Erwin, K., Marks, M and Couchman, I. 2012. Embedding homoeopathic solution to health problems in a municipal housing estate in Durban: a case study of Kenneth Gardens (online), available http://www.kennethgardens.co.za/wp-content/uploads/2013/04/Kenneth-Gargens-Annual-Report-2013 (Accessed 19 January 2014).

Frass, M., Strassl, R. P., Friehs, H., Mullner, M., Kundi, M. and Kaye, A. D. 2012. Use and acceptance of complementary and alternative medicine among the general population and medical personnel: a systematic review. *The Ochsner Journal,* 12(1): 45-56.

Frenkel, M., Ben-Arye, E., Carlson, C. and Sierpina, V. 2008. Integrating complementary and alternative medicine into conventional primary care: the patient perspective. *Explore (New York, NY)* (online), 4(3): 178-86. Available: http://www.ncbi.nlm.nih.gov/pubmed/18466848/ (Accessed 30 May 2014).

Furlow, M.L., Patel, D.A., Sen, A. and Liu, J.R. 2008. Physician and patient attitudes towards complementary and alternative medicine in obstetrics and gynaecology. *Bio Medical Central Complementary and Alternative Medicine* 8: 35 (online). Available: http://www.biomedcentral.com/1472-6882/8/35 (Accessed 02 February 2014).

Granheim, U.H. and Landman, B. 2004. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24: 105-112.

Greater Glasgow National Health Services Board Meeting. 2004. Homoeopathic Inpatient Services: Update (online). Available: http://www.nhsggc.org.uk/,,/nhs=board/- (13 March 2015).

Guthlin, C., Lange, O. and Walach, H. 2004. Measuring the effects of acupuncture and homoeopathy in general practice: an uncontrolled prospective documentation approach (online). *BMC Public Health,* 4(6). Available: http://www.biomedcentral.com/1471-2458/4/6 (Accessed 02 March 2015).

Harripershard, S. 2009. A survey to determine the perceptions of parents in the central Durban area towards paediatric homeopathy. M. Tech: Homoeopathy. Durban University of Technology.

Holloway, I. and Wheeler, S. 2010. *Qualitative research in nursing and healthcare.* 3rd Ed. Chichester, West Sussex, UK: John Wiley & Sons Ltd.

Homoeopathic Association of South Africa. 2007. (online) Available: http://www.hsa.org.za (Accessed December 2013).

Hsu, C. Cherkin, D. C. Hoffmeyer, S. Sherman, K. J. and Philips, W. R. 2011. Patient and clinician openness to including a broader range of healing options in primary care. *Annals of Family Medicine* (online), 9(5): 477-453. Available: http://www.annfammed.org/content9/5/447/suppl/DC2 (Accessed 30 May 2013).

Innocent, M. 2010. Why people are choosing homoeopathy as their primary health care? (online). Available: http://www.ezinearticles.com/?Why-More-People-Are-Choosing-Homeopathy-As-Primary-Health-Care.php (Accessed 25 May 2014).

Kautzky, K. and Tollman, S. M. 2008. A perspective on primary health care in South Africa. In: Barron P, Roma-Reardon J, editors. South African health review. Durban: Health Systems Trust.(online). Available: http://reference.sabinet.co.za/sa-epublication-article/healthr-2008-a5 (Accessed 10 April 2014).

Lamula, S.B. 2009. The perception of homoeopathy amongst African adults resident in Mnambithi municipality (KwaZulu-Natal, South Africa). M. Tech: Homoeopathy. Durban University of Technology.

Lee, S., Khang, Y., Lee, M. and Kang, W. 2002. Knowledge of, attitudes toward, and experience of complementary and alternative medicine in western medicine and oriental medicine trained physicians in Korea. *American journal of public health*, 92(12): 1994-2000.

Lincoln Y. S. and Guba, E. G. 1985. *Naturalistic enquiry*. London: Sage.

Macquet, T. 2007. The perceptions and awareness of homoeopathy and the Homoeopathic Day Clinic (H.D.C) amongst students at the Durban University of Technology (DUT). M. Tech: Homoeopathy dissertation. Durban University of Technology.

Maharaj, D. 2005. A survey to determine the perceptions of general practitioners and pharmacists in the greater Durban region towards homoeopathy. M. Tech: Homoeopathy dissertation. Durban Institute of Technology.

Marian, F., Joost, K., Saini, K. D., Von Ammon, K. Thurneysen, A and Busato, A. 2008. Patient satisfaction and side effects in primary care: an observational study comparing homoeopathy and conventional medicine. (online). *BMC Complementary and Alternative Medicine*, 8(52). Available: http://www.biomedcentral.com/1472-6882/8/52 (Accessed 10 March 2014).

Mercer, S. W., Reilly, D. and Watt, G. C. M. 2002. The importance of empathy in the enablement of patients attending the Glasgow Homoeopathic Hospital.

(online). *British Journal of General Practice*, 52: 901-905. Available: http://ncni.nlm.nih.gov/.../PMC1314441/ (Accessed 05 May 2014).

Mercer, S.W., Reilly D. 2004. A qualitative study of patient's views on the consultation at the Glasgow Homoeopathic Hospital, an NHS integrative complementary and orthodox medical care unit. *Patient Education and Counselling*, 53(1): 13-18.

Milgrom, L. R., Ringo, M. R. and Wehrstein, K. M. 2012. Emerging economies need for cheap, efficient health care makes western anti-homeopathy rhetoric irrelevant: observations from the Canadian Homeopathy Conference, October 2011. *The Journal of Alternative and Complementary Medicine,* 18(7): 723-726.

Moys, E. R. 1998. The perceptions of affluent White and Indian communities in the greater Durban area towards homoeopathy. M. Tech: Homoeopathy dissertation. Technikon Natal, Durban.

Naicker, S. 2008. A survey of medical specialist's perceptions and interactions with Homoeopathy. M. Tech: Homoeopathy. Durban University of Technology.

National Health Insurance in South Africa. 2011. Policy Paper (online). Available: http://www.info.gov.za/ (Accessed 15 May 2014).

Naude, D. 2012. Research methodology, lecture notes distributed in the Department of Homoeopathy. Durban University of Technology..

Ottermann, B. 2010. Homoeopathy – a gift or con? (online). Available: http://www.health24.com/natural/General/17-2892,59066.asp (Accessed 6 February 2014).

Padgett, D. 2012. *Qualitative and mixed methods in public health*. Thousand Oaks, CA: Sage Publishers.

Paruk, F. 2006. A survey to determine the perceptions that exist amongst pregnant adults towards the use of homoeopathy during pregnancy. M Tech: Homeopathy mini-dissertation. Durban University of Technology.

Patton, M. Q. 1987. *How to use qualitative methods in evaluation.* Thousand Oaks, CA: Sage publications.

Pillay, S. 2013. A study on the knowledge, attitudes and perceptions of primary healthcare nurses in the eThekwini municipality district with regards to the inclusion of homoeopathy in the primary healthcare. M. Tech: Homeopathy mini-dissertation. Durban University of Technology.

Polit, D. F. and Beck, C. T. 2012. *Nursing research: generating and assessing evidence for nursing practice.* 9th ed. Philadelphia: Wolters Kluwer Health / Lippincott Williams and Wilkins.

Poitevin, B. 1999. Integrating homoeopathy in health systems (online). *Bulletin of the World Health Organization,* 77(2). Available: http://www.cdrwww.who.int (Accessed 29 April 2014).

Prasad, R. 2007. Homoeopathy booming in India. *Lancet (online)*, 370 (9600): 1679-80. Available: http://www.thelancet.com [Accessed 20 February 2014]

Prinsloo, J. P. 2011a Homoeopathy in perspective (online). Available: http://www.biocura.co.za/homeopathy.html (Accessed 1 March 2014).

Prinsloo, J. P. 2011b. Legal legislation of homoeopathy (online). Available: http://www.biocura.co.za (Accessed March 1, 2014).

Reverso Dictionary for Mobile. 2014. Service delivery (Online), Available: http://www.mobile-dictionary.reversp.net/english-defination/service%20delivery%20in%20public%20health

Riley, D., Fischer, M., Singh, B., Haidvogl, M. and Heger, M. 2001. Homoeopathy and conventional medicine: an outcomes study comparing effectiveness in a primary setting. *The Journal of Alternative and Complementary Medicine*, 7(2): 149-159.

Roberts, R. 2008. Integrating homoeopathy into primary care *National Health Executive Journal* (online). Available at: http://www.dcscience.net (Accessed 03 February 2014).

Rossi, E., Baccetti, S., Firenzuoli, F. and Belvedere, K. 2008. Homeopathy and complementary medicine in Tuscany, Italy: integration in the public health system. *Homoeopathy* (online), 97(2): 70-75 Available: http://www.sciencedirect.com (Accessed 20 January 2014).

Rossi, E., Di Stefano, M., Baccetti, S., Firenzuoli, F., Verdone, M., Facchini, M., Stambolovich, V., Vina, M. P. and Clades, M. J. 2010. International cooperation in support of homoeopathy and complementary medicine in developing countries: the Tuscan experience*. Homoeopathy* (online), 99(4): 278–283. Available: http://www.sciencedirect.com/science/article/pii/S1475491610000871#. (Accessed 6 February 2014).

Rossi, E., Picchi, M., Bartoli, P., Panozzo, M., Di Stefano, M., Puglia, M. and Da Frè, M. 2014. Homoeopathy in the public health system: outcome data from the Homoeopathic Clinic of the Campo di Marte Hospital, Lucca, Italy. *European Journal of Integrative Medicine* (online), 6(2014): 39-47. Available at: http:// www.sciencedirect.com (Accessed 1 March 2014).

Samarasekera, U. 2007. Pressure grows against homoeopathy in the UK. *The Lancet* (online)*,* 370: 1677-1678. Available: http://www.thelancet.com/journals/lancet/articles/PIIS0140-6736(07)61708-5/abstract (Accessed 3March 2015).

Sekhejane, P. R. 2013. South African National Health Insurance (NHI) Policy: prospects and challenges for its efficient implementation. Africa Institute of South Africa (online). Available: http://www.dspace.africaportal.org (Accessed 7 May 2014).

Sharples, F. M. C., van Haselen, R. and Fisher, P. 2003. NHS patients' perspective on complementary medicine: a survey. *Complementary Therapies in Medicine* (online)*,* 11(4):243-248. Available at: http://www.sciencedirect.com./science.article.pii/S0965229903001079 (Accessed 19 January 2014).

Sibiya, M. N. 2009. A model for the integration of primary health care services in KwaZulu-Natal, South Africa. D. Tech: Nursing: Durban University of Technology.

Singh, P., Yadav, R. J. and Pandey, A. 2005. Utilization of indigenous systems of medicine and homoeopathy. *Indian journal of medical research* (online), 122(2): 137-42. Available: http://www.ncbi.nlm.nih.gov/m/pubmed/16177471/ (Accessed 10 March 2014).

Singh, V., Raidoo, D. M. and Harries, C. 2004. The prevalence, patterns of usage and people's attitudes towards complementary and alternative medicine (CAM) amongst the Indian community in Chatsworth, South Africa. *BMC Complementary and Alternative Medicine* (online), 4:3. Doi:10.1186/1472-6882-4-3

Small, D. 2004. The perceptions of homoeopathy amongst grade 12 learners in Durban, South Africa. M. Tech: Homoeopathy dissertation. Durban Institute of Technology.

Smillie, T. 2010. A clinical audit of the Durban University of Technology Homoeopathic satellite clinic established at Ukuba Nesibindi. M. Tech: Homeopathy. Durban University of Technology.

Strauss, A. and Corbin, J. 1990. Basics of qualitative research: grounded theory procedures and techniques. Thousand Oaks, CA: Sage Publications

Tanser, F., Gijsbertsenb, B. and Herbst, K. 2006. Modelling and understanding primary health care accessibility and utilization in rural South Africa: an exploration using a geographical information system. *Social Science and Medicine* (online), 63(93): 691-705. Available: http://www.elsevier.com/locate/socscimed (Accessed 05 May 2014).

Thorvaldsen, S. 2007. A survey to determine the perceptions of 3rd year medical students at the University of Cape Town and the University of

KwaZulu-Natal towards homoeopathy. M. Tech. Thesis. Durban University of Technology.

Von Bardeleben, C. L. 2009. A survey on the perception of homoeopathy amongst parents of children aged 3-7 years old at pre-primary school in Pinetown District. M. Tech: Homoeopathy. Durban University of Technology.

Wahner-Roedler, D. L., Vincent, A., Ekin, P. L., Loehier, L. L., Cha, S. S. and Bauer, B. A. 2006. Physicians' attitudes toward complementary and alternative medicine and their knowledge of specific therapies: a survey at an academic medical centre (online). Available: http://www.ecam.oxfordjournals.org (Accessed: March 6, 2014).

Wardle, J., Adams, J. and Sibbritt, D. 2013. Homeopathy in rural Australian primary health care: a survey of general practitioner referral and practice in rural and regional New South Wales, Australia. *Homoeopathy* (online), 102(3): 199-206.

Wilkinson, D., Gouws, E., Sach, M., Salim, S. and Karim, A. 2001. Effect of removing user fees on attendance for curative and preventive primary health care services in rural South Africa. *Bulletin of the World Health Organization* (online), 79: 665-671.

WHO: World Health Organisation. 1978. Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. (online). Available: http://www.who.int/publications/almaata_declaration_en.pdf (Accessed 10 June 2014).

WHO: World Health Organization Media Centre (online). 2006. Available: http://www.theholisticcare.com (Accessed October 20 2013).

Zanini, A., Quattrin, R., Goi, D., Frassinelli, B., Panriti, M., Carpanelli, I. and Brusaferro, S. 2007. Italian oncology nurses knowledge of complementary and alternate therapies: national survey. *Journal of advanced nursing,* 62(4): 451-456.

APPENDICES

Appendix A: Permission letter to the Manager: Redhill Homoeopathic Clinic

1757 Richards Bay

Piet Retief

2380

The Manager

Redhill Homeopathic Clinic

Redhill

Dear Dr Nienaber

I am presently registered for a Masters Degree at the Durban University of Technology in the Department of Homoeopathy. The proposed title of my study is *'Patients' experiences of homoeopathic care rendered at a primary health care facility in the eThekwini district'*. I hereby request permission to conduct the study at the Rehill Homeopathic Clinic.

The purpose of this study will be to explore and describe the experiences of patients receiving the homoeopathic services at the Redhill Homoeopathic Clinic with regard to their care in order to improve the quality of services provided by the Department of Homeopathy. 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 the summary of the research proposal for perusal.

Sincerely

……..

Ms PSG Khumalo (Researcher) Telephone: 078 505 4713

Email: pkhumalo93@yahoo.com

……..

Dr C Hall (Supervisor) Telephone: 031-373 2514

Email: corneh@dut.ac.za

……..

Prof MN Sibiya (Co-supervisor) Telephone: 031-373 2606

Email: nokuthulas@dut.ac.za

Appendix B: Approval letter from the Manager: Redhill Homoeopathic Clinic

The Manager

Redhill Homeopathic Clinic

Redhill

1757 Richards Bay

Piet Retief

2380

Dear Phindile

RE: PERMISSION LETTER TO CONDUCT A STUDY AT REDHILL HOMOEOPATHIC CLINIC.

This letter is confirmation that you are granted permission to conduct your research at Redhill clinic.

Kind Regards

Dr Silvana Nienaber

Appendix C: Letter of information (English)

Title of the Research Study: Patients' experiences of homoeopathic care rendered at a primary health care facility in the eThekwini District.

Principal Investigator/s/researcher: Ms PSG Khumalo, B Tech: Homeopathy

Co-Investigator/s/supervisor/s: Dr C. Hall, M. Tech: Homoeopathy and Prof M.N. Sibiya, D. Tech: Nursing

Brief Introduction and Purpose of the Study: Homoeopathy in South Africa is legally recognized as a primary healthcare profession. The professionals are regulated by a statutory body; the Allied Health Professional Council of South Africa. Homoeopathy is not part of the public healthcare sector; local research has shown that homoeopathy is a valuable form of medicine in the public healthcare setting however, no research has been done to find out what the patients think about this form of medicine. We are doing a research study of homoeopathy patients at the Redhill Clinic. The reason for this study is to learn about patient experiences at the clinic, we also want to find out what the patients think and how they feel about the medication and the care they receive at the clinic.

Outline of the Procedures: We are asking that you take part in a 30 minutes interview. The interview will take place in the clinic. Patients will be interviewed in Zulu/ English depending on their language preference. The interview is informal, like a conversation. We will talk about your thoughts and experiences of the homoeopathic clinic at this clinic. With your permission, we would like to audio tape the interview; the recordings are only going to be used for the research purposes.

Risks or Discomforts to the Participant: There are no risks involved when participating in this study.

Benefits: The information that you will share with us during the interview, will contribute towards improving the care that you receive from this clinic.

Reason/s why the Participant May Be Withdrawn from the Study: The researcher may stop you from taking part in the study at any time if she believes it is in your best interest or if the study stopped. Also participants may choose to withdraw from the study at any time during the interview process with no adverse consequences for these participants.

Remuneration: Participants will not be remunerated for taking part in the study.

Costs of the Study: There is no cost involved for participants taking part in the study.

Confidentiality: Your personal details will not be disclosed at any stage of the study. The interview documents and audio recordings will be kept secure by the researcher for the duration of the research and then stored in a locked office of research study personnel at Durban University of Technology, Homoeopathy department and destroyed within 5 years. Only people involved in the research will be able to access this information. None of the information you give me will be shared with providers at the clinic, your family members or anyone else outside of this research project, your name will not be used in any written reports or articles that result from this project.

Research-related Injury: Due to the nature of the research there is no anticipated risk for injury related to research. No compensation will be made for such claims.

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

Please contact the researcher Phindile Khumalo (cell no. 078 5054 713), my supervisor Dr C. Hall (Tel no. 031-373 2514) and Prof M.N. Sibiya (Tel no.031-373 2606) 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

Appendix D: Incwadi yolwazi

Isihloko socwaningo: Patients' experiences of homoeopathic care rendered at a health care facility in the eThekwini District.

Umcwaningi: Phindile Khumalo. B.Tech: Homoeopathy

Abaqondisi bocwaningo: Dkt C.Hall. M. Tech: Homoeopathy kanye no Solwazi M.N. Sibiya. D. Tech: Nursing.

Isingeniso nenhloso yocwaningo: Ihomoeopathy eNingizimu Afrika ngokomthetho ithathwa njengomsebenzi ohamba phambili kwezempilo. Abasebenzi baphethwe inhlangano; i-Allied Health Professional Council of South Afrika. I-homoeopathy ayisiyo inxenye yomkhakha wezempilo zomphakathi; ucwaningo lwakuleli luveze ukuthi iwuhlobo lokulapha esigcawini sokwelapha somphakathi, alukho ucwaningo oseluke lwenziwa lwathola okucatshangwa abantu ngaloluhlobo lokwelapha.

Senza isifundo socwaningo lwabasebenzisa i-homoeopathy kumtholampilo wase-Redhill. Inhloso yalolu cwaningo ukuthola ngokuphatheka kwabasebenzisa umtholampilo, sifuna futhi ukuthola ukuthi abasebenzisa umtholampilo bacabangani nokuthi bazizwa kanjani ngemithi nokunakekelwa abakumtholampilo.

Indlela okuzosetshenzwa ngayo: Sicela ukuthi ubambe iqhaza ngokuphendula imibuzo ethatha imizuzu eyi- 30. Lokhu kuphendula imibuzo kuzokwenzeka e-clinic. Ukuba yinxenye yalolu cwaningo kufanele kube ukuthi usufike ukuthola usizo nge-homoeopathy kabili noma ngaphezulu e-Redhill Kumele ubeneminyaka eyi-18 ubudala noma ube umbheki osemthethweni womuntu oze emtholampilo. Abantu abeze emtholampilo bazobuzwa ngeSizulu noma ngesiNgisi kuya ngokuthi bancamela luphi ulimi.

Ukubuzwa kwemibuzo kungokukhululekile, njengengxoxo. Sizokhuluma ngemicabango yakho nokuphatheka kwakho nge-homoeopathy kumtholampilo wase Redhill ngemvume yakho, singathanda ukuqopha inkulumo yokubuzwa imibuzo, okuqoshiwe kuzosetshenziselwa izinhloso

zocwaningo. Uma ukhetha ukuba yingxenye yocwaningo ungaqhubeka uze emtholampilo ukuzothola usizo, ayikho imininingwane osinikayona uphendula imibuzo ezonikwa noma imuphi wabahlinzeki emtholampilo, uvumelekile futhi ukuthi ungabi ingxenye yocwaningo. Uma ukhetha ukuba yingxenye ocwaningweni uzonikezwa elakho iphepha lalencwadi ukuthi uligcine.

Izingcuphe noma ukungaphatheki kahle kozoba yinxenye: Izingcuphe zokuba yingxenye kulolu cwaningo zincane. Uma ungathola umbuzo unzima ukuwuphendulo noma ungazizwa kahle ngokuwuphendula, nginga (a) chaza (b) thatha ikhefu (c) yeka. Uma ukhetha ukuyeka, singaqhubeka ngelinye ilanga noma ungayeka ukuba inxenye yocwaningo. Likhona ithuba ukuthi imininingwane ingaputshuka. Ingcuphe yalokho iphansi kakhulu kanti sizokwenza yonke imizamo ukukuvikela kule ngcuphe.

Okuhlomulwayo: Ulwazi ozosinika lona kulolucwaningo, luzongeza ekunyuseni amazing empatho eniyithola kulomtholampilo.

Isi/zizathuthu ezingenza oyinxenye akhishwe cwaningweni: Owenza ucwaningo angakumisa ekubambeni iqhaza ocwaningeni uma akholwa ukuthi akulungele noma ucwaningo lumiswa. Kanti nababambe iqhaza bengakhetha ukuhoxa ocwaningweni nganoma isiphi isikhathi ngokuqhubeka kokubuzwa imibuzo ngaphandle kokuthi kube nenkinga kulabo ababambe iqhaza.

Inkokhelo: Ababambe iqhaza angeke bahole ngokuhlanganyela kulolucwaningo.

Imfihlo: Imfihlo yababambe iqhaza kulolucwaningo ivikelekile. Lokhu kusho ukuthi amagama ababambe iqhaza angeke akhishwe ngendlela engahlanganiswa nobambe iqhaza. Kuzobe kunenombolo esikhundleni segama lakho ephepheni lenhlolovo. Zonke inzinhlolovo, amaphepha ocwaningo nokuqoshiwe kuzogcinwa kuphephile ngocwaningayo ngokuqhubeka kocwaningo bese kugcinwe ehhovisi elikhiywayo abasebenzi bocwaningo e-Durban University of Technology, emnyangweni we-Homoeopathy kungakapheli iminyaka eyisihlanu. Abantu abathintene nocwaningo kuphela abazokwazi ukuthola lolu lwazi.

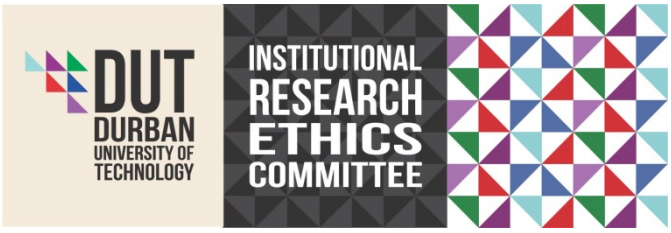
Alikho kulolu lwazi olizonikezwa abasemtholampilo, amalunga omndeni wakho noma ubani omunye ongaphandle kwalomsebenzi wocwaningo, igama lakho ngeke libhalwe kunoma iyiphi imibiko noma izahluko ezizophuma kulolu cwaningo

Ngenxa yesimo salolucwaningo azikho izingozi ezingabakhona, akukho nokunxephezelwa okuzobakhona.

Ukulimala okuhlobene nocwaningo: Ngenxa yendlela ucwaningo oluyiyo abukho ubungozi bokulimala obuhlobene nocwaningo. Asikho isinxephezelo esingafunwa ngalokho.

Abantu ongaxhumana nabo uma kuvela inkinga noma unombuzo: Sicela uxhumane nomcwaningi; Phindile Khumalo (inombolo yocingo 078 5054 713), abaqondisi; Dkt. C.Hall (inombolo yocingo 031-373 2514) Kanye no Solwazi MN Sibiya (031-373 2606) noma Institution Research Ethics administrator 031-373 2900. Izikhalazo zingabikwa ku DVC: TIP, Prof F. Otieno 031-373 2382 noma dvctip@dut.ac.za

Appendix E: Consent in English



Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, _____ (Phindile Khumalo), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: REC 69/1
- 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, _____ (Phindile Khumalo) 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 Time

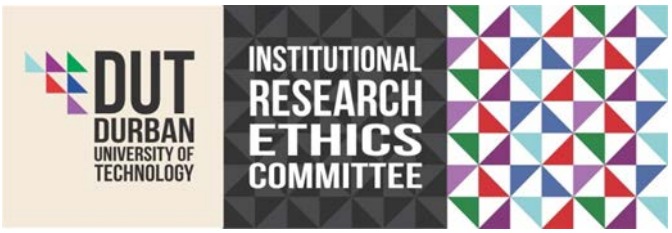
_____

Signature

_____ _____

Full Name of Witness (If applicable) Date Signature

Appendix F: Consent in isiZulu



Appendix E: Isivumelwano

Isivumelwano sokuba yinxenye yocwaningo

- Nginesiqiniseko sokuthi umcwaningi _____ uPhindile Khumalo ungazisile ngendlela ucwaningo oluzohamba ngayo, isimo kanye nobungozi balolucwaningo – Research Ethic Clearance Number: Rec 69/14
- Ngitholile, ngafunda futhi ngaqonda ulwazi olubhalwe ngaphezulu oluchaza kabanzi ngalolucwaningo.
- Ngiyazi ukuthi imiphumela yalolucwaningo, ebandakanya imininingwane yami, ubulili, iminyaka, usukulwami lokuzalwa, iziqalo zamagama kanye nokugula kwami angeke kuvezwe kwimiphumela yalolocwaningo.
- Ngokubheka izinto ezidingwa yilolucwaningo, ngiyavuma ukuthi ulwazi oluzotholakala umakwenziwa lolucwaningo lucubungulwe ngengqondomshini ngumcwaningi.
- Ngingayeka ukubayinxenye yalolucwaningo noma inini, ngingasavumi ukubayinxenye.
- Ngilitholile ithuba elanele lokubuza imibuzo futhi ngilungele ukuba yinxenye yalolucwaningo.
- Ngiyaqonda ukuthi ulwazi olusha oluzotholakala ngizonikezwa ngokuba ngibeyinxenye yalolucwaningo.
-

_____ _____

Igama usuku isikhathi uphawu lwesivumelwano

Mina _____u(Phindile Khumalo) ngiyaqinisekisa ukuthi ngiludlulsile ulwazi olugcwele ngendlela ucwaningo oluzohamba ngayo, isimo kanye nobungozi balolucwaningo.

_____ _____ _____

Igama lomcwaningi usuku uphawu lwesivumelwano

_____ _____ _____

Igama lofakazi usuku uphawu lwesivumelwano

_____ _____ _____

Igama lomzali usuku uphawu lwesivumelwano

Appendix G: Interview guide

Grand tour question

What are your experiences regarding the homeopathic care at this clinic?

Probing questions

Additional questions based on the responses of the participants including the following:

1. What is your knowledge of homoeopathy?
2. What is your reason for accessing homoeopathy?
3. How do you feel about homoeopathic treatment?
4. How would you describe the service delivery of the homoeopaths?
5. What were you expecting from your consultation at this clinic?
6. Were your expectations met? If not why? Is yes, in what way?
7. What did you like/dislike about your consultation/treatment?

Appendix H: Imibuzo yenhlolovo

Umbuzo ngqangi

Phawula ngethuba osuke wabanalo ngokusebenza kwehomoeopathy kulomtholampilo.

Imibuzo

Imibuzo ezokwengezwa ngokuphendula kwababamba iqhaza ilena elandelayo:

1. Iluphi ulwazi onalo nge homoeopathy?
2. Isiphi isizathu esibangela ukuba usebenzise I homoeopathy?
3. Ingabe uzizwa unjani emvakokusebenzisa imithi yehomoeopathy?
4. Ungayichaza kanjani impatho yodokotela behomoeopathy?
5. Ingabe yikuphi obowukulindele ngokuza kulomtholampilo?
6. Ingabe obukulindele kwenzekile? Uma kungenzekanga kungani? Uma kwenzekile, kwenzeke ngayiphi indlela?
7. Ingabe yini oyithandile/ongayithandanga ngokuza kulomtholampilo/ nangemithi?

Appendix I: Ethics Clearance Certificate

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

17 November 2014

IREC Reference Number: **REC 69/14**

Ms P S G Khumalo
1757 Richards Bay
Piet Retief
2380

Dear Ms Khumalo

Patients' experiences of homoeopathic care rendered at a primary health care facility in the eThekwini district

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

Please note that you may now proceed with research on the proposed project.

Kindly ensure that participants used for the pilot study are not part of the main study.

Yours Sincerely,

[redacted]

Professor J K Adam
Chairperson: IREC

Appendix J: Editing certificate

DR RICHARD STEELE
BA, HDE, MTech(Hom)
HOMEOPATH and EDUCATOR
Registration No. A07309 HM
Practice No. 0807524
Part-time lecturer, Dept of Homeopathy, DUT
Freelance academic editor

110 Cato Road
Glenwood, Durban 4001
031-201-6508/082-928-6208
Fax 031-201-4989
Postal: P.O. Box 30043, Mayville 4058
Email: rsteele@telkomsa.net

EDITING CERTIFICATE

Re: **Phindile Simphiwe Gift Khumalo**

Patients' experiences of homoeopathic care rendered at a primary health care facility in the eThekwini district

I confirm that I have edited this dissertation and the references for clarity, language and layout. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at UCT was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University of Technology). In my capacity as a part-time lecturer in the Department of Homoeopathy I have supervised numerous Master's degree dissertations.

Dr Richard Steele
30 March 2015
electronic