A survey study on the Mmotong community's knowledge and attitudes towards collaboration between Traditional and Western-trained mental health care practitioners

by

LERATO HILDAH MATLEBJOANE

DISSERTATION

SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in

Psychology

in the

FACULTY OF HUMANITIES

(School of Social Sciences)

Department of Psychology

at the

UNIVERSITY OF LIMPOPO

Supervisor: Dr M Makgahlela

Co-supervisor: Dr JP Mokwena

2022

Declaration of originality

I, Lerato Hildah Matlebjoane, declare that "**A survey study on the Mmotong community's knowledge and attitudes towards collaboration between Traditional and Western-trained mental health care practitioners"** submitted to the University of Limpopo as fulfilment for Master of Arts Degree in Psychology, has not been previously submitted by me for a degree at any other university, that it is my work in design and accomplishment, and that all the material contained therein has been duly acknowledged.

…….. ……

Lerato Hildah Matlebjoane Date

Dedication

In loving memory of my aunt, Matiane Theresia Manamela, who always wanted the best for me. I believe that this dissertation would have made her even prouder of me. She will forever remain in my heart.

Acknowledgements

Firstly, I would like to thank the Almighty God. For his grace is sufficient for me. For it is by His grace that I have been able to carry out this profound project. He has provided and seen to it that I complete the project. Hallelujah!

“Motho ke motho ka batho”

I have received different forms of help and support in the completion of this research. I would like to thank the following people who contributed and offered assistance in the completion of this research project:

- My supervisor, Dr M Makgahlela for his never-ending support, guidance, determination and patience with me - even when I was dragging my feet. He has never given up on me, he continued to push me to achieve my ultimate goal. I truly appreciate the great role he has played in assisting me to complete this dissertation.
- Dr JP Mokwena, my co-supervisor, for his continuous support and patience when I was dragging my feet. I appreciate his guidance and helping source a statistician (Mr Peter Mpekgwana) to assistant with data analysis and many other aspects.
- My mother, Asnath Mmaphuti Matlebjoane. I thank her for her never-ending support, understanding and devotion in helping me reach for my dream. Never had she complained when I continuously asked her to help, financially or to babysit my son while I ran to meetings or did data collecting. I am forever indebted to her.
- My little sister, Tshimollo “Alpha” Matlebjoane. I appreciate her help in collecting data, in the blazing sun.
- My peer and former colleague, Treasure Mokalapa-Manyatsa, for her continuous help, when things were blurry.
- My friends, their help and support have helped me reach this point.
- To the leaders and members of the Mmotong community, I thank them for welcoming me into their homes, trusting me to keep anonymity with their inputs.

May your cups run over, always.

Abstract

Globally, mental disorders are a growing public health problem. The World Health Organisation has urged member states to prioritise efforts to address the growing pandemic of mental illness. One strategy identified by WHO is the promotion of the use of traditional medicines. Similarly, a collaboration between Western and Traditional health care practitioners has been identified as another strategy that could help bridge the gap of shortages of mental health care providers and the cost of professional mental health care services. The present study investigated the Mmotong community's knowledge of mental disorders and attitudes towards collaboration between Traditional healers and Western-trained practitioners in the treatment of mental disorders. A quantitative study was conducted, with a sample of 200 participants (Female = 131; Male = 69; in the age range of 18 years and older). Participants were selected using convenience sampling. Data was collected using a questionnaire and analysed using the SPSS to draw out the descriptive statistics.

A majority (59%) of participants were found to possess knowledge of mental disorders. Attitudinally, most participants favoured Western-oriented mental health care services in terms of effectiveness. Despite this finding, a majority (69%) endorsed the need for collaboration between the two healthcare systems. A gender analysis revealed that more females (71.8%) than males (63.8%) favoured collaboration. While analysed by age, those 18-37 years (63.5%), 38-57 years (75.5%) and over the age of 58 years (75.5%) favoured the collaboration respectively. The present study findings show that in this community, the majority of members possess knowledge of mental illness. The community also favours the collaboration between traditional and medically oriented health care providers in mental health care. The study is concluded by making recommendations to the government, Traditional healers, and Western-oriented health practitioners to work towards the harnessing of collaboration of the two healthcare systems.

Keywords: Collaboration, Mental illness, Traditional, Western

List of Abbreviations and Acronyms

Abbreviations	Acronyms
ANC:	African National Congress
HPCSA:	Health Profession Council of South Africa
STATS SA:	Statistics South Africa
TREC:	Turfloop Research Ethical Clearance
THPs:	Traditional Health Practitioners
WHO:	World Health Organisation
WTHPs:	Western-trained Health Practitioners

TABLE OF CONTENTS

Declaration of originality……i

Dedication……...ii

Acknowledgements……iii

Abstract……iv

List of Abbreviations and acronyms ……v

TABLES ..... **viii**

CHAPTER 1 ..... **1**

BACKGROUND OF THE STUDY **1**

1.1. Introduction **1**

1.2. Research problem **2**

1.3. Aim of the study **3**

1.4. Objectives of the study **3**

1.5. Operational definitions **4**

1.5.1. Attitudes **4**

1.5.2. Traditional healers **4**

1.5.3. Collaboration **4**

1.6. Significance of the study **4**

1.7. Summary **5**

CHAPTER 2 ..... **6**

LITERATURE REVIEW **6**

2.1. Introduction **6**

2.2. Mental health care service delivery **6**

2.2.1. Diviners **8**

2.2.2. Herbalists **8**

2.2.3. Western-trained mental health care practitioners **8**

2.3. Knowledge of mental disorders **9**

2.4. The collaboration between Traditional health care practitioners and Western-trained mental health care practitioners **10**

2.5. Attitudes towards Traditional medicine and Traditional health care practitioners **12**

2.6. Attitudes towards Western medicine and Western mental health care practitioners **15**

2.7. Attitudes towards mental health disorders 16
2.8. Theoretical framework: Sociocultural theory 18
2.8.1. Introduction 18
2.8.2. Sociocultural theory 18
2.9. Summary 20
CHAPTER 3 21
METHODOLOGY 21
3.1. Introduction 21
3.3. Research design 22
3.4. Area and study participants 22
3.5. Sampling 22
3.6. Data collection instrument 23
3.7. Procedure 23
3.8. Data analysis 24
3.9. Reliability and validity 25
3.10. Ethical considerations 25
3.10.1. Ethical clearance to conduct the study 25
3.10.2. Informed consent 25
3.10.3. Confidentiality and anonymity 26
3.10.4. Avoidance of harm to participants 26
3.11 Summary 26
CHAPTER 4 27
RESULTS 27
4.1. Introduction 27
4.2. Demographic characteristics of the participants 27
4.3. Summary 33
CHAPTER 5 35
DISCUSSION OF RESULTS 35
5.1. Introduction 35
5.2. Mental health knowledge and health-seeking pathways 35
5.3. Attitude towards the collaboration of Traditional health practitioners and Western health practitioners in mental health care 37
5.4. Implications of the study findings 38
5.4.1. Implications for research 38
5.4.2. Implications for policy 39

5.4.3. Implications for practice 39
5.5 Study limitations 39
5.6. Conclusion 40
REFERENCES 41
APPENDICES 51
Appendix 1A: Data collection tool: English version 51
Appendix 1B: Data collection tool: Sepedi version 54
Appendix 2 A: Consent form: English version 57
Appendix 2B: Consent form: Sepedi version 58
Appendix 3: Turfloop Research Ethical Clearance (TREC) 59
Appendix 4: Letter to the Mmotong head of council 60

TABLES

Table 1: Demographic profile of participants.....27
Table 2: Personal experience of mental illness and health-seeking pathways.....28
Table 3: Descriptive statistics of participants' overall scores on knowledge and attitudes towards collaboration.....29
Table 4: Knowledge and attitudes towards collaboration based on age.....31
Table 5: Knowledge and attitudes of mental illness based on gender.....33

CHAPTER 1

BACKGROUND OF THE STUDY

1.1. Introduction

People's perceptions and attitudes towards coping with health or ill-health, often influence their health-seeking pathways (Ramgoon et al., 2011). In Africa, two health care systems are utilised, that is, Western medicine and Traditional medicine (Campbell-Hall et al., 2010) and seemingly, in South Africa, the two systems are used side-by-side (Kahn & Kelly, 2001; Meissner, 2004; Van Rooyen et al., 2017). However, Traditional medicine is most favoured and utilised by people in rural areas to address their physical and mental healthcare needs (Meissner, 2004). Reasons for this preference are that Traditional healers are more freely available and affordable (Hillenbrand, 2006; Meissner, 2004). Their approach to mental health care is holistic and in line with the local inhabitants' cultural beliefs (Galabuzi et al., 2010). It is for these reasons, amongst others, that their collaboration in the mainstream health care system has continued to be advocated for by various stakeholders (Department of Health, 2013). This is despite some reluctance and antagonism by some Western-trained health care practitioners (Sorsdahl et al., 2010).

Collaboration of the two systems in mental and physical health care has been identified as necessary as it could enhance admission to health care for the majority of the populace (WHO, 2002). Hence, several calls to facilitate such a collaboration or synergy have been made, including empirical research involving all role-players, being professionals, policy makers, Traditional healers, and community members at large (WHO, 2002; Van Rooyen et al., 2017). The World Health Organization (WHO) has long observed that mental disorders cost national economies billions of dollars, in terms of expenditure, due to loss of productivity. Simultaneously, Western-oriented global health care systems are not coping to cater for the mentally ill (WHO, 2003). In retrospect, a review of the literature (Campbell-Hall et al., 2010; Sorketti et al., 2010; Sorsdahl et al., 2010) on collaboration efforts suggests that most empirical studies about such efforts have largely documented the attitudes and perceptions of professionals while neglecting those of patients and communities. To exemplify and support this study, one study of psychiatric nurses reported that patients who were already consulting with Traditional healers believed that a combination of the two

systems would yield results that are more positive for them (Kahn & Kelly, 2001). Although these were the patients' opinions reported by psychiatric nurses, generally studies on patients and communities about collaboration efforts are lacking, especially in the South African context. Similarly, studies conducted elsewhere on community members reveal mixed attitudes and perceptions towards the collaboration of the two systems (Gulati et al., 2014; Lingeswaran, 2010). This cannot be assumed applicable in the South African context, thus the present study seeks to explore community attitudes towards the collaboration of the two systems in mental health care in a rural South African community.

1.2. Research problem

Globally and in South Africa, the formal collaboration of the Traditional and Western-oriented medical health care systems is envisaged to have the potential to assist in curbing the growing pandemic of mental and health-related disorders. Both the long-promulgated WHO Traditional Medicine Strategy 2002-2005 (WHO, 2002) and The National Mental Health Policy Framework and Strategic Plan 2013-2020 (Department of Health, 2013) are in favour of such a collaboration. The latter policy further recognises the need for collaboration between sectors in the socio-economic, political and health spheres to promote the mental wellbeing of the nation. More so, it is estimated that about 80% of South Africans rely on Traditional medicine (Sobiecki, 2014). Fostering collaboration between the two systems could greatly benefit mental health care users (Hillenbrand, 2006). The Department of Health (1996) Article 11 of the National Drug policy also advocates for such collaboration (Hlabano, 2013). The Traditional Health Practitioners Act (Act 22 of 2007) is responsible for the training and registering of Traditional healers (Hlabano, 2013). The Act also favours the collaboration between the two health care systems.

Unfortunately, despite policies being put in place to harness such collaboration, there are several attitudes and perceptions, which seem to negatively affect this imperative (Kahn & Kelly, 2001). Studies conducted with Western-trained mental health care practitioners and Traditional healers seem to suggest that there is a negative attitude towards such collaboration. This is largely due to the different philosophies founding the two health care systems. For instance, Campbell-Hall et al. (2010) found that Western-trained mental health care practitioners react negatively towards Traditional

health practitioners because they believe that Traditional health practitioners are not educated. In contrast, Traditional practitioners believe that Western-trained doctors undermine their work and do not view them as effective, discouraging people from using Traditional medicine, thus they are not amenable to working with them (Sorsdahl et al., 2010). Meissner (2004) also discovered that Traditional health practitioners fear that their knowledge and skills will be exploited if they were to work with Western health practitioners. It was found that most Traditional healers were open to working with Western-trained doctors in treating mental disorders despite the negative attitudes of Western health practitioners towards Traditional medicine (Sorsdahl et al., 2010)

In the mix of all these conflicting attitudes from practitioners, the voices of the users of the two healthcare systems are largely undocumented or neglected. Kahn and Kelly (2001) noted this view by stating that an omission in empirical studies echoes the voices of the general community members and policymakers and to some extent the patients themselves (Kahn & Kelly, 2001). A problem arising from this omission could result in poor policy formulation and implementation regarding the collaboration. It is therefore vital to know what the community thinks and feels about the collaboration of these two systems. The current study seeks to establish community members' knowledge and attitudes towards the collaboration of the two health care systems in a rural setting.

1.3. Aim of the study

The study aims to investigate the Mmotong community's knowledge and attitudes towards the collaboration of Traditional and Western-trained practitioners in mental health care.

1.4. Objectives of the study

The following are study objectives:

- To determine the Mmotong community's knowledge regarding Traditional healers and Western-trained practitioners in mental health care.
- To ascertain the Mmotong community's attitude towards Traditional healers and Western-trained practitioners in mental health care.

- To describe the Mmotong community's attitude towards the collaboration between Traditional healers and Western-trained professionals in mental health care practice.

1.5. Operational definitions

1.5.1. Attitudes

According to Bohner and Dickel (2011) attitude refers to enduring feelings, beliefs and behavioural tendencies concerning socially important objects or groups. In this study, the attitude would refer to how community members feel and think about the collaboration between Traditional and Western-trained mental health care practitioners.

1.5.2. Traditional healers

A Traditional healer is an individual known by the community in which they live as a skilled individual providing primary health care. Such people make use of animals, plants and mineral-based substances along with approaches founded on the social, cultural and religious background, including key knowledge, beliefs and attitudes for the physical, mental and social well-being of the community (Semenya & Potgieter, 2014). This definition was adopted in this study.

1.5.3. Collaboration

Mashek (2016) defines collaboration as a platform where two or more people show public enthusiasm and commitment to learning from each other and becoming better at what they do collectively. In the context of this study, collaboration would imply a commitment of both the Traditional and Western practitioners towards improving the mental health of the user.

1.6. Significance of the study

The study will give insights into the Mmotong community's knowledge and attitudes towards collaboration between Traditional and Western-trained mental health care practitioners. It could also shed light on the community's views on the collaboration of the two health care systems, and on how policymakers could support such a collaboration. The study will contribute towards the realisation of the National Mental Health Policy Framework and Strategic Plan 2013-2020 that seeks to endorse,

recognise and integrate the service of Traditional healers in the mainstream health care system. The study is similarly important for policymakers as it would give them insight into rural community's attitudes towards this initiative, guiding some of the policy decisions about mental health care in the country.

1.7. Summary

Chapter one provides the background to the study, including, the research problem, aim and objectives of the study, as well as the significance of the study. The background of the study provided the basis for the importance of the current study. The aims and objectives of the study were addressed. The significance of the study outlined how the study is important in creating awareness amongst policymakers of the community's attitudes towards the merging of the two healthcare systems, and ultimately, the possible reception of this initiative by the general populace of the country.

In chapter two, relevant literature relating to the study is reviewed, as well as relatable theory discussed. In chapter three, the methodology that was followed is detailed. Chapter four presents the findings of the study and lastly, in chapter five, the research findings are discussed.

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

People's views differ on certain topics; the issue of Traditional and Western healthcare systems is certainly no different. Attitudes vary across different age groups, races, gender and geographic locations. This chapter gives a literature review on mental disorders, knowledge and attitudes towards mental disorders and health care practitioners. It also gives an overview of collaboration between Traditional and Western-trained mental health care practitioners. The chapter also provides an overview of the theory that is relative to the formation and spreading of attitudes, as well as the collaboration between the two healthcare systems.

2.2. Mental health care service delivery

Every culture has disease theory systems that incorporate attributed notions to describe the causes of illnesses (Chipfakacha, 1994). In the African context, illness is thought to be the result of witchcraft, contact with impure objects or neglect of the ancestors (van Niekerk, 2014). As per Mabunda (2001), disease and illness are shared in all human societies. Nevertheless, the nature of diseases that transpire, their diagnosis, as well as treatment, rest on how people view them. According to him, these views differ from society to society. To effectively recognise the aspects of mental illness, a person has to recognize the cosmopolitan norms that form the perceptions of the cultural principles of people, mainly concerning the notions of cause and effect**.**

From a traditional African perspective disease causality, including mental disorders, is explained as all-encompassing, taking into consideration both the biopsychosocial, spiritual and supernatural factors (Sorsdahl et al., 2009). It is for this particular reason that Traditional healers continue to be used side-by-side with Western orientated health care systems (Van Rooyen et al., 2017). Ghana, like South Africa, can be described as having two parallel health care systems, being the Western health care system and the Traditional health care system (Yaro, 2016). Both systems have remained dominant sources of health care providers over the years. Traditional medicine remains a popular healthcare choice due to its appeal to the socio-cultural beliefs and values of the population (Hillenbrand, 2006). Traditional medicine is also

used because it is cheaper and is usually situated near the patients' residence, as opposed to Western medical facilities that are not as close to the patients (Mokgobi, 2012).

Traditional medicine is used mostly by people living in poverty. This is not surprising, considering that the country is still developing and most of the African population is unemployed. Most people's well-being would be negatively affected if the Traditional health care systems were to be phased out (Mokgobi, 2012). In South Africa, Traditional medicine is believed to be used more than Western medicine (Sobiecki, 2014). This is not surprising, considering that 18 964 mental health practitioners are registered with the Health Profession Council of South Africa (HPCSA, 2018). South Africa is estimated to have about 22 psychiatric hospitals and 36 psychiatric wards within general hospitals (Tromp et al., 2014). This is not enough to meet the mental healthcare needs of about 56,52 million South Africans (Stats SA, 2017) because it places a tremendous burden on the Western-trained mental health practitioners, with one practitioner estimated to serve 2 980 people.

Mental health services are provided largely at primary, secondary and tertiary levels in South Africa. Primary care is concerned about the management of people with more serious mental disorders such as bipolar mood disorder and schizophrenia. It also focuses on symptom management through the facility of follow-up medication. After patients are stabilised, they are released and sent to primary care clinics, which they are expected to join to obtain medication and undergo regular observation of their mental health status. Secondary care is involved with psychotropic medication, generally accessible in a general hospital for internal psychiatric units and external health facilities. Tertiary care is the rotating access pattern of care, in which mental health patients who are cleared from tertiary facilities are re-admitted frequently as a result of insufficient care in the community (Lund et al., 2012). Supplementary programmes are presented as fragments of mental health care that incorporate therapies, which deal with the delivery of applied backing and guidance. Psychiatric restoration aims to aid people with mental illness to nurture the social, emotional and intellectual skills that are required to live, learn and work in the community with minimal professional support. The initial tactic is individual-centred and focuses on evolving the patient's skills in relating to the stressful environment. The second strategy is

ecological and focused on developing environmental alternatives to lessen the potential stressor (Rossler, 2006).

The Western approach to illness is grounded on the philosophies of technology, science and clinical scrutiny and the environment. Diseases are repeatedly allied with the physical body. The Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases, (ICD-l0) are used as devices for diagnosing and treating disorders.

Traditional health practitioners play a significant role in teaching about Traditional culture, cosmology and spirituality (Mokgobi, 2012). The Traditional healthcare system includes various healthcare providers, including diviners and herbalists.

2.2.1. Diviners

Diviners use bones and ancestral spirits to diagnose and dispense medication for different physiological, psychiatric and spiritual conditions (Mokgobi, 2012). Diviners are Traditional healers who have been called to the profession and have been through Traditional training and possess divination and medicinal knowledge to deal with various health and psycho-spiritual matters (Green & Makhubu, 1984). Diviners may diagnose a mental illness as the patient's calling by the ancestors and that patient would need diviner training (Zabow, 2006).

2.2.2. Herbalists

In contrast, herbalists are Traditional healers who possess great medicinal knowledge often gained over time, working closer with diviners. Herbalists work more like pharmacists by providing patients with a variety of herbal products (Zabow, 2006). Unlike diviners, herbalists do not use divination, but they make a diagnosis based on physical or mental symptoms (Green & Makhubu, 1984).

2.2.3. Western-trained mental health care practitioners

Practitioners who use Western medicine and/or provide counselling for people who suffer from mental disorders or substance abuse problems (Rehagen, 2015). Their diagnosis and management of mental disorders are often guided by the bio psychosocial model of disease causality explanations (Sorsdahl et al., 2009). In South Africa, Western mental healthcare practitioners are guided by the Health Professions

Council of South Africa, and they should be registered with the council before they can practice (HPCSA, 2018). This system usually consists of psychiatric hospitals, psychiatric wards in a general hospital, psychiatric nurses, clinical psychologists as well as psychiatrists.

2.3. Knowledge of mental disorders

“Mental health literacy” is a term that has been coined by Jorm, (2011) referring to the knowledge and beliefs about mental disorders which help their detection, management or prevention. Mental health literacy is comprised of: (i) the skill to identify precise disorders or different kinds of mental anguish; (ii) information and views about risk factors and origins; (iii) information and views about self-help interventions; (iv) information and views about available professional assistance; (v) attitudes which simplify acknowledgement and fitting help-seeking and (vi) information of how to pursue mental health information. Mental health literacy influences people’s symptom management actions (Jorm, 2011). Farrer et al. (2008) found that younger people possessed more knowledge of mental disorders than older people did.

Jorm (2011) also conducted a study and found that many people fail to know specific disorders or different types of psychological distress. While younger people were able to identify specific mental disorders more so than older people could. This was based on a study by Farrer et al. (2008). Knowledge and attitudes are important in growing the public’s awareness of mental health problems (Puspitasari, 2020). People hold different attitudes and knowledge of mental health. In countries such as Saudi Arabia, it was revealed that mental health perceptions are highly mixed and that knowledge is deficient (Abolfotouh et al., 2019). Disinformation of mental health literacy, such as the failure to use accurate psychiatric labels and a deficiency of information of symptomatology may cause problems of communication (Jorm, 2011).

People in Western countries usually believe depression and schizophrenia are caused by their social environment, particularly, recent stressors (Jorm, 2011). It was also discovered that the public believes environmental factors are more important than biological factors. However, relatives of people with schizophrenia perceived biological factors are more important (Jorm, 2011). Supernatural happenings such as witchcraft and being possessed by evil spirits are understood as reasons for mental disorders in non-Western cultures (Jorm, 2011).

Media and social media are the main channels through which people obtain knowledge about mental disorders (Farrer et al., 2008; Jorm, 2011; Puspitasari, 2020). How the media depicts mental health disorders influence people's attitudes towards mental health disorders and their formation of knowledge of such disorders (Jorm, 2011).

2.4. The collaboration between Traditional health care practitioners and Western-trained mental health care practitioners

Before the inception of the democratic government of South Africa in 1994, the African National Congress (ANC) proposed its health plan. It suggested the incorporation of Traditional health practitioners as a vital standard part of health care in South Africa. It maintained that clients would be given the right to see a practitioner of their choice for their health care and that regulations would be altered to simplify the measured practice of Traditional practitioners (Summerton, 2006). The South African government holds the responsibility of fostering the health care needs of all South Africans in a non-biased manner (Summerton, 2006).

The relationship between Western medicine and native procedures of care has commonly been tense, categorised by a belief that the two systems would be unable to operate together as a result of their utterly dissimilar identifications of mental illness (Calabrese, 2013; Mashabela et al., 2016). Also, it has been broadly thought that patients' use of Traditional healers merely mirrored the deficiency of a substitute. However, new research proves that they are continuously used even though psychiatric medication and facilities are easily accessible and it is now recognised that the demand for healers is rooted in their capability to comprehend a patient's illness experience inside their cultural framework (Burns, 2015; Heaton, 2013; Read, 2012). This is mostly true of mental illness, where social and cultural factors play a prominent role. As the extensive practice of consulting Traditional healers displays no intention of decreasing, it appears reasonable to rationalise the attempts of formal and informal providers to fashion a mental healthcare model that signifies patient health-seeking pathways (Green & Colucci, 2020)

In societies that comprise the two health care systems, the Western health care system is, habitually more often than not, the certified and viewed greater of the two systems (Summerton, 2006). In a study conducted by Sorsdahl et al. (2010) the

Western approach is perceived to be greater than the Traditional methods. -Despite the negative attitudes of Western-trained doctors towards Traditional medicine, the healers were open to working with the doctors in treating mental disorders. Many of the Traditional healers had expressed how Western-trained doctors undermine their medicine and how they discourage people from using Traditional medicine. It is conveyed that Western-trained mental health care practitioners ignored Traditional health care practitioners while not overlooking that in some cases some biomedical practitioners work with traditional healers informally (van Niekerk, 2014).

Western health practitioners' critical interpretation of Traditional medicine is founded on ideas that Traditional health practitioners are a threat to their patients' health (Mashabela et al., 2016). The reservation that Western practitioners have towards Traditional healing and practitioners results from ignorance regarding Traditional theories of disease and health, the mysticism surrounding Traditional medicines and detrimental Traditional healing practices and medicines (Summerton, 2006). According to Traditional healers, Western-trained doctors refuse to work with them as they do not see them as competent and respected health professionals (Sorsdahl et al., 2010). Western-trained doctors receive little or negative feedback from community members in countries like Ghana (Galabuzi et al., 2010). Generally, the two health-care systems are characterised by tension, mistrust and conflict owing it to epistemological and paradigmatic differences. This on its own creates a challenge for the two systems to work towards a common goal, and which ultimately will hinder collaboration (Moshabela et al., 2016).

Kajawu (2017) concluded that supernatural and psycho-social factors play a key role in people's quest for aid for mental health complications from indigenous healers, which is another reason why Traditional healers should collaborate with Western-trained mental health workers. The collaboration between Traditional and Western-trained mental health workers could increase the number of people seeking help as Chikomo (2011) had established. In Chikomo's study, it was recommended that rehabilitation for mental health patients ought to focus on supernatural and psycho-social factors in addition to what is normally treated in Western medicine.

Zabow (2006) reported that a considerable amount of African psychiatric patients pursue treatment from native healers although they also visit psychiatric clinics. This

was found in both rural and urban areas. Zabow (2006) also believes that the use of THP's in the urban areas of South Africa for the treatment of mental illnesses is brought on by the belief that mental illnesses are caused by witchcraft (Mokgobi, 2012) and therefore, Traditional health practitioners can treat them. Even though they believe mental illnesses are caused by bewitchment, they still consult with Western-trained mental health practitioners and this simultaneous consultation vouches for the collaboration between the two health systems. Western mental health facilities are believed to help with symptom control and medication, but they cannot help relieve the fear of bewitchment that is usually found in patients of Traditional health practitioners (Zabow, 2006).

Patients are believed to possess the power to choose the treatment services that they want and therefore, the collaboration would be able to offer them that choice (van Niekerk, 2014). Collaboration could help in the standardisation of medication and the Western-trained mental health care practitioners can learn cultural aspects and the use of herbs of Traditional healing (Habtom, 2018). Even though Western medicine is effective in the treatment of many illnesses, Traditional medicine is believed to be superior to Western medicine for treating psychiatric conditions (Mokgobi, 2012).

2.5. Attitudes towards Traditional medicine and Traditional health care practitioners

Rauwolfia Serpentina is a traditional herbal remedy identified to have antipsychotic effects (Jorm, 2011). Kajawu (2017) believes that African traditional medicine, which is known as 'Hun'anga' in the Shona language, could encourage patients to consider mental health treatment as the WHO (2015) revealed that 90% of people with mental disorders do not seek treatment. This belief comes from the notion that a vast majority of the population prefers Traditional medicine over biomedicine (Hillenbrand, 2006). Natural remedies like vitamins and herbs are regarded more positively by the public than Western medicines (Jorm, 2011). In a study by Ramgoon et al. (2011) on psychologists, it seemed that Traditional healers afforded a culture-sensitive intervention since they shared the same cultural background as their clients. This was believed to have an encouraging outcome on compliance.

Hillenbrand (2006); Kajawu (2017) and Xin et al. (2020) found that Traditional medicines for mental disorders are mostly preferred because they are cheaper and

easier to access. Ethiopia also uses different traditional sources of help, including herbalists, for a range of mental health problems (Jorm, 2011), which they prefer above Western medical help. This is also common in Asian countries such as Pakistan. Kajawu (2017) further documented that Traditional medicine is more preferred as it communicated on cultural and spiritual matters, and because it is holistic, that is, it considers a person's body, mind and spirit that biomedicine does not offer. Ameade et al. (2015) have found that even developed countries, such as the United States of America (USA) use traditional medicine. Ameade and his colleagues went on to estimate that 20% of the USA population use herbs in addition to orthodox medicines without their doctors' knowledge. It is believed that developed countries think that herbs are natural and are therefore safer than orthodox medicine. Traditional healers do not stress the q"one size fits all" method to their clients. In every case, each treatment plan is tailor-made to incorporate each patient's cultural beliefs and practices (Mokgobi, 2006).

The power of the Traditional healing system lies in the fact that it shares the belief system and worldview of the people who trust and use it (Summerton, 2006). It is the patients who keep Traditional health care practitioners and medicine in competition with Western medicine because it works with their cultural norms and values. Traditional healers are believed to understand culture, witchcraft and other underlying supernatural causes. Traditional healers are preferred by most people (Summerton, 2006). In Sudan, people see Traditional healers as true representatives of spiritual power (Sorketti et al., 2010).

In an Indian study, Schoonover et al. (2014) discovered that people who were from rural areas preferred Traditional healers over Western mental health care practitioners who were preferred by the people from the cities. The study also went on to reveal that even people who never had mental health issues also preferred Traditional healers for mental health care. Even though a substantial number of people preferred Traditional healers, other respondents reported Traditional healers as "cheats" and unhelpful (Schoonover et al., 2014). The high use of Traditional medicine in developing countries may be ascribed to (i) its historic availability and low cost in contrast to Western medicine, and (ii) it is strongly rooted within the broader belief systems (WHO, 2002). In a South African study, it was reported that traditional causes for mental illnesses include bewitchment, failure to perform a traditional ritual as expected by the

ancestors, stepping over a dangerous track and evil spirits to name a few (Zabow, 2006). A great percentage of South Africans, both urban and rural, possess solid traditional cultural beliefs and acts, which impact their responses to illness (Summerton, 2006). According to Jorm (2011), a person's belief system determines their views of health, illness and disease.

Traditional healers embrace an honoured and authoritative status in Southern African societies. They function as a physician, counsellor, psychiatrist and priest (Mufamadi & Sodi, 2010). Individuals consult with Traditional healers for issues ranging from social problems to great medical illnesses. They have roles to represent in constructing the health system of South Africa. South Africa is a country that has countless needs and minimal resources. Traditional healers can play a vital and clear part in aiding communities to enhance their quality of life, including their health (Truter, 2007). Moletsane (2004) posits that treatment differs between cultures and that diverse cultures have diverse practices of treating their patients. He also maintained that in some cultures a lot of people have confidence in pursuing treatment from Traditional healers or their religious leaders. Amid African traditional healers, rituals are connected to the conservation of well-being in the community as a whole. The healers use numerous methods to find out the grounds of the various conditions that their clients present them with. Diagnostic procedures might differ resulting from issues such as the healer's fondness and the nature of the preparation that the healer received (Ngoma et al., 2003).

In South Africa, Mokgobi (2012) researched health care practitioners' attitudes, knowledge, opinions and experiences with Traditional healers, and he found that psychiatric nurses and psychiatrists possessed more optimistic opinions, positive attitudes and more information as well as preparedness to work with Traditional health practitioners than general nurses and doctors. He further reported that psychiatric and general nurses had more knowledge with Traditional healing than physicians and psychiatrists did. Contrariwise, in Zimbabwe, Western-trained practitioners are mistrustful of traditional health practices due to a lack of knowledge. Trials for the active incorporation of Traditional healing services into official community mental health care include the dissimilar methods and nosological standpoints of Traditional healing and recognized community mental health services (Yaro, 2016).

2.6. Attitudes towards Western medicine and Western mental health care practitioners

Negative attitudes towards Western medicine in the treatment of mental disorders has been reported to be perpetuated by the knowledge that psychotropic medicine has side effects, such as dependency and lethargy, as well as the belief that these kinds of treatments only deal with symptoms and not causes (Jorm, 2011). An Australian study on electroconvulsive therapy (ECT) had also been viewed under a negative lens by the public. It was believed to do more harm than good (Jorm, 2011). Farrer et al. (2008) also found that different age groups have different attitudes towards the Western mental health care system as they found that older people were less likely to recommend psychiatrists or counsellors and psychologists for the treatment of depression in comparison to younger age groups.

There is a tendency for Traditional health practitioners not to believe in the efficacy of the psychotropic medication. This perception was usually related to the thought that Western medication works slowly and that the causal factor was not spoken about when patients' symptoms worsened upon ceasing medication (Green & Colucci, 2020). This undesirable perception of medications could result in complications in the joint management of clients since Traditional health practitioners' philosophies are that mental illness is a disease that can be cured, instead of a chronic disorder. This might result in them encouraging patients to cease the use of medication when symptoms have lessened (Green & Colucci, 2020).

Negative attitudes towards Western medication and mental disorders have, therefore, led to a stigmatisation of mental disorders (Ta et al., 2018). This stigmatisation does not only affect people and their relatives with mental disorders but also spreads out to psychiatric hospitals, psychopharmacology, psychiatrists and mental health care staff (Ta et al., 2018). In a study conducted in India by Gulati et al. (2014), it was revealed that medical students and interns in medical schools were less encouraged by peers and family members from studying and specialising in psychiatry due to the stigmatisation of mental disorders.

Mungee et al. (2016) had also discovered that medical students thought that psychiatrists are valued less in society in comparison to other medical doctors. In the same research, it was discovered that doctors considering psychiatry as a career

option were perceived by their peers as odd and eccentric. The dislike for psychiatrists leads to a substantial burden and is negatively affecting the mental health care system, weakening the help-seeking efforts of patients and their treatment options as well as hindering recruitment of young psychiatrists among medical graduates (Ta et al., 2018).

It was established that even physicians within the Western medical system seemed to be slightly uneasy with psychiatry, as they are likely to view psychiatry as lacking a confidently scientific basis that is untainted due to its propensity to diagnosing and treating mental disorders (Sartorius et al., 2010). It is safe to say that the 'battle' about the knowledge of illness does not seem to be merely between the Western medical model and Traditional healing, but also exists within the wider Western medical model itself, whereby psychiatry is sometimes seen as being inferior (Sartorius et al., 2010) to the other disciplines. The Western medical model tends to treat the mind, body and soul as different entities; therefore, the link between them vanishes. This is opposed to Traditional healing, which treats illnesses from a holistic approach. This tendency could hinder the reception of the Western medical model (Mokgobi, 2012).

Contrary to other Indian studies, Schoonover et al. (2014) had found that a significant number of people who had consulted with both Traditional healers and psychiatrists, preferred psychiatrists over Traditional healers. Those who had previously exhibited psychiatric symptoms reported considerable improvement after being treated with Western medicine.

2.7. Attitudes towards mental health disorders

Asian countries such as India and Vietnam have stigmatised mental disorders (Ta et al., 2018). A strong social stigma is linked to mental health disorders even though countless people have mental disorders. The stigmatisation has also led to a reduction in the number of people seeking mental health care services (Farrer et al., 2008; Nsereko et al., 2011). Individuals suffering from mental health problems can experience judgement in all areas of their lives (Puspitasari, 2020). Puspitasari (2020) has revealed that stigma is likely to result in discrimination against people with mental

disorders, thus preventing them from achieving two important life goals: job prospects and the opportunity to live safely while independent.

Mental disorders experienced by people are usually underrated because of the stigma to the community. People with mental disorders are isolated and do not want to search for treatment. The stigmatisation of mental disorders also expands to help-seeking pathways. Participants in a UK study reported being embarrassed to consult with a general practitioner because they believed the general practitioner would view them as neurotic or unbalanced (Jorm, 2011). In India, patients have been reported to present their distress in somatic instead of psychological terms (Jorm, 2011).

There are different attitudes towards mental illnesses amongst cultures and those cultural influences do not only form attitudes and perceptions concerning the mentally ill but also influence how patients are diagnosed, prevention and treatment methods applied and so forth (Subudhi, 2014). A great number of South Africans, both urban and rural, possess firm traditional cultural beliefs and practices, which influence the way they react to mental illness (Summerton, 2006). They attribute mental illness to bad luck, witchcraft or punishment from their ancestors (Nsereko et al., 2011). Social costs of mental illness are comprised of disordered families, discrimination, stigma, and loss of future prospects, marginalisation and reduced quality of life (Lund, 2012). The disgrace associated with mental disorders may hinder help-seeking pathways.

Stigmatising views described in South Africa comprise views that individuals with mental disorders are bewitched, mad, lazy, insane, weak, and not able to think or do anything. The results of those erroneous views are that people who have been branded as having mental illnesses are mocked, feared or abused. Many individuals have also been deserted, isolated, excluded by family and peers, abused or excepted from basic rights and engagement in social activities. Stigma can thus act as a blockade to receiving education, suitable housing, employment and other desires (Lund, 2012). The stigmatisation of mental disorders has led to the reluctance to discuss mental disorders with friends and relatives, as reported in a German study (Jorm, 2011) while physical disorders are discussed without hesitation.

Subudhi (2014) has documented how in his country, India, mental health practices are entirely controlled by diverse cultures. He further went on to say that India has not given status to mental health services and there is an insufficiency of mental health

professionals; which generates additional favourable circumstances for culture to dominate mental health practices. Mental illness is seen as a disgrace, taboo or humiliation in India. He believes it is essential to create knowledge amongst people and encourage them to pursue contemporary mental health services.

2.8. Theoretical framework: Sociocultural theory

2.8.1. Introduction

The present study uses sociocultural theory to support the research. Its use is appropriate concerning the study as it gives insight into how the Mmotong community's attitudes toward the collaboration between Traditional and Western health care practitioners in the treatment of mental disorders are formed and how they are likely to spread from the older generation to the younger generation.

2.8.2. Sociocultural theory

The Sociocultural Theory is a theory proposed by Lev Vygotsky in 1934 (Scott & Palincsar, 2013). It is a theory that focuses on the significant contributions that society makes to personal development. It also maintains that people's behaviour and attitudes are influenced by their interactions with others. According to Vygotsky, knowledge is circulated between people and the environments in which they live (Mucherah & Owino, 2016). The knowledge that the Mmotong community members have is spread and shared within the Mmotong community. The sociocultural theory emphasizes the interaction between evolving people and the culture in which they live. The Sociocultural theory emphasises how the gaining of behaviours is shaped by cultural beliefs and attitudes, including adult and peer influences. Rendering to sociocultural theory, upon the birth of a child, they have important biological limitations on their mind; it is the culture that offers the likelihood for learning, and because of that, children start using the capabilities of their mind to adjust to their culture (Choudhry et al., 2016).

Vygotsky formulated the theory by focusing on the sociocultural, psychosocial and historical impacts on an individual's development by highlighting how a person's mental and educational development are connected to the social, cultural and historical context in which they are based (Panhwar et al., 2016). As a whole, culture is a learned process that changes over time and consists of tangible and intangible

behaviours. Cultural traits and norms shape people's normative behaviour practices and beliefs, influences their thinking process and define the everyday activities of their specific group (Subudhi, 2014)

According to Zea and Bowleg (2016) parents, caregivers, peers, and the culture at large are liable for developing higher-order functions by transferring norms, values and morals to their offspring. With regards to this study, the elders who hold knowledge on the consultation with Traditional health practitioners and Western-trained mental healthcare practitioners, could influence their children on the collaboration of the two systems as well as provide knowledge on the two systems. Children are easily influenced, more so by their parents. Depending on what they have been told regarding the two systems, children could hold positive or negative attitudes towards the collaboration of the two systems, towards the Traditional and the Western health practitioners.

The sociocultural theory stresses that peoples culture influences and shape their development and it is not the people shaping their culture. Since the Mmotong community is rural, their cultural influences could hinder or foster the collaboration of the two systems in the treatment of mental disorders. Therefore, cultural factors play a role in the formation of people's attitudes (Panhwar et al., 2016). The social-cultural perspective focuses on society as a whole given that what affects a small portion of the society always affects the whole society.

The theory suggests that human learning is largely a social process, so the Mmotong community members co-create knowledge through interactions with the social and internal world (Panhwar et al., 2016). The theory explains how involvement in social interactions and culturally prepared activities impact psychological development. Therefore, given the present study, this means that the Mmotong community members would learn to hold certain views regarding collaboration between Traditional and Western-trained mental health care practitioners largely as a product of socially interacting with others. Community members influence each other, including one another's decision making, and how they will interact with other people in the future (Scott & Palincsar, 2013). People model themselves to the outer world by familiarizing themselves with the meaning of the factors recognized in social undertakings (Panhwar et al., 2016).

This theory helps in understanding and describing how the Mmotong holds some attitudes towards the collaboration of Traditional and Western-trained mental health care practitioners. According to the sociocultural theory, attitudes towards collaboration between Traditional and Western-trained mental health are easily spread from one person to the other because of the daily interactions taking place (Scott & Palincsar, 2013). If some community members hold negative views on collaboration between the systems they are likely to influence the views of other people and vice versa.

2.9. Summary

The chapter gave an outline of the literature that has been reviewed to support the study. The main focus is knowledge of mental health disorders and attitudes towards mental disorders, locally and internationally. Attitudes towards Traditional healers, Western-trained practitioners and mental disorders. The merging of the two systems as well as the relative theory. The Socio-Cultural theory is more suitable as it provides more understanding of how attitudes are formed and maintained.

CHAPTER 3

METHODOLOGY

3.1. Introduction

Positivism is frequently referred to as the scientific method, and it is constructed on the rationalistic, empiricist philosophy (Mackenzie & Knipe, 2006). In an attempt to test a theory or describe an experience, empiricist researchers adopt a value-free or objective attitude while using methods such as observations and measurements (e.g., experiments, tests and scales). Studies taken under the empiricist paradigm are quantitative (Mackenzie & Knipe, 2006), as opposed to the recently proposed philosophy, i.e. post-positivism which is flexible and accommodating to the use of mixed methods. Empiricism is a theory that maintains that knowledge stems from experience; experience from our senses (seeing, hearing, tasting, feeling, smelling), observation and experimentation (Ryan, 2018).

Interpretivism, on the other hand, seeks to understand and describe the world of human experience from the vantage point of those being studied, therefore, reality has different representations (Ryan, 2018). Humans are studied bearing in mind their characteristics and involvement in the social and cultural worlds (Wahyuni, 2012). It derives motive from meanings and motives behind people's actions such as their interactions and behaviours with others. Interpretivists maintain that cultures can be understood by studying people's ideas, meanings and cognitive functions.

The empiricist approach was chosen because it maintains the separation of the researcher from what is being researched while using a quantitative methodology (Wahyuni, 2012). The quantitative methodology primarily seeks to test hypotheses, look for cause and effect and make predictions (Apuke, 2017; Creswell & Creswell, 2018). It involves the process of collecting data using statistical techniques to analyse it and present it in numerical data (Apuke, 2017). The numerical data can then be analysed using statistical techniques to answer questions like what, who, when, how, where, how much (Apuke, 2017). With this methodology often variables can be measured, usually on instruments, in which numbered data can be analysed using statistical procedures.

3.3. Research design

Research design is the overall strategy which researchers use to conduct research, involving the integration of various components, coherently and logically, to address the research problem (Sileyew, 2019). It is a detailed section of what is included in the research framework and sets parameters of what will and will not be included in the research (Sileyew, 2019) The present study adopted the descriptive cross-sectional design. Descriptive cross-sectional studies are observational, meaning that researchers use the design to describe characteristics that are present in a community (Setia, 2016). In this case, the researcher sought to survey the attitudes of Mmotong community members towards the collaboration of the two health systems. The design involves collecting data at one point in time from the target population (Creswell & Creswell, 2018; Zangirolami-Raimundo et al., 2018). Descriptive studies use questionnaires designed to measure the characteristics of the population with statistical precision. Descriptive surveys help with evaluations from a sample that can be attributed to the entire population with a degree of confidence (Sukamolson, 2007). The weakness of cross-sectional studies is that they do not find the difference between cause and effect since they are conducted once off (Setia, 2016; Zangirolami-Raimundo et al., 2018).

3.4. Area and study participants

The study was conducted at the Mmotong rural community in the Capricorn district of Limpopo Province, South Africa. Limpopo Province has an estimated population of 5 797 300 people, which accounts for 10% of the South African population (Stats SA, 2018). The Mmotong community is rural, with an estimated population of 825 per the 2011 census (Stats SA, 2018). The village is estimated to be comprised of 207 households with males (392) outnumbered by females (433) (Stats SA, 2018). 100% of the community is Black, with 99% of the community members speaking Sepedi (Stats SA, 2018). The target population of the study was both males and females, 18 years and older.

3.5. Sampling

A convenience sampling strategy was adopted to sample participants from the Mmotong community. Convenience sampling is a no probability sampling technique whereby not all participants in a population have an equal chance of being selected,

meaning that the researcher chose which subjects to be included in the study (Creswell & Creswell, 2018). Participants who met the criteria (18 years and older, residents of Mmotong village) were selected based on their availability and willingness to participate in the study and also because they were easy to access at the time of data collection (Etikan et al., 2016). The sample size was determined using the Krejcie and Morgans, (1970) table. Since the Mmotong population was estimated at *N=825* (Stats SA, 2018), the sample size was estimated to be 265 participants as per the size determination table. Convenience sampling involves a selection of sampling units based on their availability and convenience (Creswell & Creswell, 2018; Etikan et al., 2016). The researcher started collecting data at the first house from where the Mmotong village starts, selecting any willing and qualifying participants to participate in the study.

3.6. Data collection instrument

Data was collected by compiling a survey questionnaire (see appendix 1A and 1B). A survey questionnaire is a research apparatus comprising of a series of questions and other prompts to collect information from respondents (Krueger & Casey, 2014). For quality control, the questionnaire was first forwarded to a language expert, to ensure that the test items are easy to read, and secondly, for the translation of the questionnaire into the Sepedi language. This helped to ensure that no potential participant was excluded based on language. The questionnaire had to be piloted first with 20 participants. Based on the pilot results, the questionnaire was then revised from 15 questions to 9, to eliminate redundant items. The final questionnaire was adjusted accordingly before official data collection could commence.

3.7. Procedure

The aim and objectives of the study were explained to the participants and those that agreed to take part in the study signed informed consent forms (see appendix 2A and 2B). The participants were assured that anonymity and confidentiality would be preserved and some opted to use pseudo names while others had no problem writing their real names. Participants were made aware that their participation in the study was voluntary and they were allowed to withdraw participation at any time without facing penalties.

The questionnaires were available both in English and Sepedi languages. The researcher sat with the participants while they were completing the questionnaire and assisted the participants if they needed clarity on any questions. Fifty-three questionnaires were answered in Sepedi while another 147 were answered in English. On average it took about 5 minutes for participants to complete the questionnaire. Participants were encouraged to be truthful in answering the questions. The questionnaires were collected immediately after participants had completed them.

3.8. Data analysis

The data were analysed using the Statistical Package for the Social Sciences (SPSS), Version 26, which is a software package used in the statistical analysis of data. The data collected was also analysed using descriptive statistics which summarises the data coherently and concisely. This is used to describe the relationship between variables and are performed by analysing one variable at a time (Kaur et al., 2018). In this case, variables of interest were participant knowledge and attitudes towards the collaboration of Traditional health practitioners and Western-trained health practitioners. The variables were also analysed based on the contrast of age and gender. The data or information received from the study was then converted into graphical representation such as tables and graphs (Corder & Foreman, 2014). The data were categorised into age, gender, educational level and religious orientation. Educational level was closed-ended while gender was in a form of binary and closed-ended responses. Religious orientation responses were non-binary and open-ended in which participants could write different religious orientation that was not included in the options. Age responses were in the form of intervals of 10, starting from 18 years, for example, age categories were from people in the age range of 18 to 27 years old, people in the age range of 28 to 37 years old, people in the age range of 38 to 47 years old, people in the age range of 48 to 57 years old, people in the age range 58 to 67 years old and people aged 68 and older.

Chi-Square tests were conducted to calculate the relationship between variables such as age and gender with the knowledge and attitude of participants towards the collaboration of the two systems. Cross tabulation was used. The totals mean standard deviation, minimum and maximum scores and modes were calculated.

3.9. Reliability and validity

Reliability is considered to be the accuracy of an instrument employed to measure consistently on repeated occasions (Heale & Twycross, 2015). Joppe (2000) defines reliability as the degree to which results are constant over time. In contrast, study validity determines whether the research accurately measures what is planned to be measured or how accurate the research results are (Heale & Twycross, 2015; & Joppe, 2000). To satisfy study validity and reliability, amongst other observances, the instrument used was piloted. For data analysis, the services of a professional statistician were sought in the process, the statistician helped calculate Cronbach's alpha for internal consistency. The Cronbach's alpha value of the questionnaire for the current study was 0.80. A language expert was employed to ensure the correct use of terms.

3.10. Ethical considerations

3.10.1. Ethical clearance to conduct the study

Ethical clearance to collect data and conduct the study was sought and obtained from the University of Limpopo's Turfloop Research Ethics Committee (TREC) (see Appendix 3). Furthermore, gatekeeper permission was also sought from the Mmotong community's Head of Council (See Appendix 4).

3.10.2. Informed consent

The aim, objectives, participant's role and all other information about the study were explained by the researcher to the participants before participation in the study. The researcher also informed the participants that they have a right to cease their participation in the study at any time without facing any undesirable outcomes. Generally, the participants were informed about the nature of the study, their rights and responsibilities and their intentional participation in the study. This enabled the participants to be in a position to give informed permission (see Appendix 2A and 2B) before participating in the study. Informed consent was given through participants signing the informed consent form (Terre Blanche et al, 2009).

3.10.3. Confidentiality and anonymity

The respondents were guaranteed confidentiality and anonymity. No personal information such as identity number or physical address of any participant was intentionally collected. If, some personal information (such as real names) was mentioned at any stage, the researcher altered such information through the use of pseudonyms. The researcher also enlightened the participants on the limitations that are rooted in the confidentiality agreement (Terre Blanche et al., 2009). The confidential data is kept in a secure locker to which only the researcher has access. Upon completion of the research, the stored data will be effectively destroyed through the use of a shredder.

3.10.4. Avoidance of harm to participants

This sort of study poses a low risk to the participants; therefore, it was envisaged that no harm would ensue in the process of conducting the study (Dixon & Quirke, 2018). Nonetheless, none of the participants reported any sort of harm during or after the study was conducted.

3.11 Summary

In this chapter, the empiricist philosophy which undergirds the study methodology, i.e., the quantitative descriptive cross-sectional design was elaborated. Subsequently, methods for sampling (convenience sampling strategy), data collection (survey questionnaire) and data analysis (SPSS) were elaborated. Ethical issues central to the study were also discussed. The next chapter will focus on the presentation of the study findings.

CHAPTER 4

RESULTS

4.1. Introduction

The present chapter presents the findings of the study. Firstly, findings on participant demographic variables are presented, followed by participants' knowledge of mental health and diagnosis of mental disorders. Subsequently, descriptive findings on their attitudes towards Traditional health practitioners and Western health practitioners are also presented. Towards the end, descriptive findings of participants' attitudes towards the merging of the two health care systems in the treatment of mental disorders are presented. To conclude the chapter, a summary of the results is given.

4.2. Demographic characteristics of the participants

The study consisted of 200 participants, both male (N=69) and female (N=131) (see table 1). Participant age distribution ranged from persons aged between 18 and older, with a majority aged between 18 to 27 years of age, followed by persons aged between 28 to 37 years of age and persons aged between 38 to 47 years respectively.

Table 1: Demographic profile of participants

Characteristics	Category	Frequency	Percentage
Age	18-27	61	30.5
	28-37	43	21.5
	38-47	36	18.0
	48-57	20	10.0
	58-67	22	11.0
	68 & above	18	9.0
Gender	Female	131	65.5
	Male	69	34.5
Marital status	Married	65	32.5
	Single	109	54.5
	Divorced	14	7.0
	Widowed	12	6.0

Level of education	No formal education	19	9.5
	Primary school	24	12.0
	Secondary school	93	46.5
	Tertiary	64	32.0

Most participants were single (54.5%) followed by those who were married (32.5%). Furthermore, most had a High school education (46.5%). In terms of religious orientation distributions, most participants were following the Pentecostal (33.0%), Missionary (30.5%) and African Traditional (17.5%) dogmas respectively.

Table 2: Personal experience of mental illness and health-seeking pathways

Question	**Frequency**
Do you know of any mental disorders?	YES: 118 (59%) NO 82 (41%)
Have you ever been diagnosed with a mental disorder?	YES: 17 (8.5%) NO: 183 (91.5%)
If yes, where do you consult if you need treatment for mental disorders?	TRAD 5(2.5%) WEST 7(3.5%) BOTH 5(2.5%) N/A 183(91.5%)
Do you have a family member who has a mental disorder?	YES 44 (22.0%) NO 156 (78.0%)
If yes, where do they consult for their mental health care provisions?	TRAD 12(6%) WEST 22(11%) BOTH 10(5%) N/A 156 (78%)

Key: TRAD= Traditional health care practitioners

WEST= Western-trained health care practitioners

N/A= not applicable

Table 2 illustrates the frequencies of participants in terms of their basic knowledge of mental illness and health-seeking pathways. A majority (59%) of participants were found to possess knowledge of mental disorders. The majority (about 183), have never been diagnosed with a mental condition nor used (91.5%) some kind of mental illness treatment. Similarly, their relatives were not diagnosed (78.0%) nor put on some form of mental illness treatment before. On mental health-seeking path-ways, participants who admitted a positive diagnosis of mental disorders (8.5%) or that of a relative (22.0%) were found to be relying solely on Western medicine (14.5%) compared to 8.5% which used Traditional medicine alone and those who combined (7.5%) both forms of treatments.

Table 3: Descriptive statistics of participants' overall scores on knowledge and attitudes towards collaboration

Question	YES	NO
There is a difference between Traditional healers and Western-trained practitioners	92 (46%)	108 (54%)
People with mental disorders need to be treated by both Western and Traditional practitioners	138 (69%)	62 (31%)
Traditional healers need to work together with Western-trained practitioners to manage mental disorders	140 (70%)	60 (30%)
People with mental illness recover without treatment	29 (14.5%)	171 (85.5%)
THP can heal mental illnesses effectively	100 (50%)	100 (50%)
WTHP can heal mental illnesses effectively	129 (64.5%)	71 (35.5%)
I support the collaboration of Traditional healers and Western mental health practitioners	138 (69%)	72 (36%)
Some mental disorders cannot be treated using Western medicine	131 (65.5%)	69 (34.5%)

Key: THP= Traditional Health Practitioners

WTHP= *Western-trained Health Practitioners*

On knowledge and collaboration, the findings revealed that a majority of study participants perceived no difference between THP and WTHP (54%) and understood that people with mental illness needed treatment to recover (85.5%). These participants believed there is a similarity between Traditional and Western-trained health care practitioners. They consulted with both health care practitioners because they are aware there is a need to seek treatment for mental disorders.

Interestingly, the study displayed that most participants viewed WTHP more favourably in terms of effectiveness (64.5%) of managing mental illness cases. This vote of confidence in Western-trained healthcare practitioners in the treatment of mental disorders could imply that most participants would opt for the Western route in terms of mental health care. And it could also be an indicator that WTHP is more popular in the treatment of mental disorders.

Despite favouring WTHP, most participants felt that some mental conditions needed either Traditional medicine (70%) or Western medicine (65.5%) to be treated successfully. When it comes to the need for the two categories of healers to work together, a majority of participants (69%) supported their collaboration in treating mental illness. Their belief in the effectiveness of Western medicine as well as in Traditional medicine for the treatment of mental disorders could imply that participants would support the merging of the two systems, particularly because there is little difference (4.5%) in terms of effectiveness between Western and Traditional medicine. Traditional and Western-trained health care practitioners should work together to manage and treat mental disorders, the people are vouching for the collaboration.

Table 4: Knowledge and attitudes towards collaboration based on age

	Category 1 (18 – 37)	**Category 2** (38 – 57)	**Category 3** (above 57)
There is a difference between Traditional healers and Western-trained practitioners	YES 42 (40.4%) NO 62 (59.6%)	24 (42.9%) 32 (57.1%)	26 (65.0%) 14 (35.0%)

People with mental disorders need to be treated by both Western and Traditional medicines	YES 66 (63.5%) NO 38 (36.5%)	42 (75%) 14 (25%)	30 (75%) 6 (25%)
Traditional healers need to work together with Western trained practitioners to manage mental disorders	YES 66 (63.5%) NO 38 (36.5%)	43 (78.8%) 13 (23.2%)	31 (77.5%) 9 (22.5)
People with mental illness recover without treatment	YES 18 (17.3%) NO 86 (82.7%)	9 (16.1%) 47 (83.9%)	2 (5.0%) 38 (95.0%)
THP can heal mental illnesses effectively	YES 46 (44.2%) NO 58 (55.8%)	29 (51.8%) 27 (48.2%)	25 (62.5%) 15 (37.5%)
WTHP can heal mental illnesses effectively	YES 67(64.4%) NO 37(35.6%)	36 (64.3%) 20 (35.7%)	26 (65.0%) 14 (35.0%)
I support the collaboration of Traditional healers and Western mental health practitioners	YES 66 (63.5%) NO 36 (36.5%)	42 (75.5%) 14(25.0%)	30 (75.5%) 10 (25.5%)
There are some mental disorders that cannot be treated using Western medicine	YES 64 (61.5%) NO 40 (38.5%)	38 (67.9%) 18 (32.1%)	29 (72.5%) 11 (27.5%)
There are some mental disorders that cannot be treated using Traditional medicine	YES 72 (69.2%) NO 32 (30.8%)	41 (73.2%) 15 (26.8%)	27 (67.5%) 13 (32.5%)

Key: THP= Traditional Health Practitioners

WTHP= Western-trained Health Practitioners

A majority (65.0%) of participants within age category 3 (>57) believed that there was a difference between Traditional and Western-trained health care practitioners. This

finding could mean that most older people (>57) have consulted with both Traditional and Western health practitioners hence they know that there is a difference between the two health systems. This could also mean that the younger participants have never consulted with both Traditional and Western-trained practitioners. The same age group in category 3 also showed an affinity for Western-trained practitioners to treat mental illnesses effectively. Although not significantly different, all participants across all age categories were in favour of collaboration between Traditional health practitioners and Western-trained health care practitioners. This finding suggests that people from different age groups are in support of collaboration between the two health systems and that they should collaborate in the treatment of mental disorders. The collaboration between Traditional and Western-trained healthcare practitioners could make more people seek treatment for their mental health needs.

Table 5: Knowledge and attitudes of mental illness based on gender

	Male	Female
There is a difference between Traditional healers and Western health practitioners	YES 13 (18.8%) NO 56(81.2%)	16 (12.2%) 115 (87.8%)
People with mental disorders can recover without treatment	YES 38 (55.1%) NO 31 (44.9%)	91 (69.5%) 40 (30.5%)
Traditional healers can treat all mental illnesses effectively	YES 33 (47.8%) NO 36 (52.2%	67 (51.1%) 64 (48.9%)
There are some mental disorders that cannot be treated using Traditional medicine	YES 47(68.1%) NO 22(31.9%)	93 (71%) 38 (29%)
There are some mental disorders that cannot be treated using Western medicine	YES 50 (72.5%) NO 19 (27.5%)	81 (61.8%) 50 (38.2%)
Western-trained health practitioners can treat any mental disorder effectively	YES 38 (55.1%) NO 31 (44.9%)	91 (69.5%) 40 (30.5%)

Traditional healers and Western mental health professionals need to work together to manage mental disorders	YES 47 (68.1%) NO 22 (31.9%)	93 (71%) 38 (29%)
People with mental disorders need to be treated by both Western and Traditional Medicine	YES 46 (66.7%) NO 23 (33.3%)	92 (70.2%) 39 (29.8%)
I support the collaboration of Traditional healers and Western mental health practitioners	YES 44 (63.8%) NO 25 (36.2%)	94 (71.8%) 37(28.2%)

More than eighty percent of males and females believe that there is a difference between Traditional health practitioners and Western-trained healthcare practitioners. Also, the females believed that people with mental illness can heal without treatment. This finding implies that more females do not believe that people need to consult for their mental health provisions. This means that females may not take mental disorders as seriously as somatic diseases.

Females also supported the collaboration of Traditional health practitioners and Western-trained health care practitioners. The support from females implies that females are open to and keen on the collaboration of the two health care systems collaborating in the treatment of mental disorders.

4.3. Summary

This chapter presented the research findings. In the main, a majority (59%) of participants were found to possess knowledge of mental disorders. With management, some participants relied solely on Western services, followed by those using Traditional services and another smaller number combining both services. Although participants favoured Western-oriented mental health care services, in their majority

they endorsed the need for collaboration of both health care systems in mental health care management.

CHAPTER 5

DISCUSSION OF RESULTS

5.1. Introduction

The previous chapter presented study findings. In this chapter, a discussion of the findings is offered. The discussion will be oriented by the study objectives while also contrasted and integrated with past empirical research and theory.

5.2. Mental health knowledge and health-seeking pathways

Knowledge and awareness of mental health problems promote early identification and management of it (Farrer et al., 2008). To this end, Jorm (2011) and Farrer et al. (2008) found that communities which possessed mental health knowledge or mental health literacy are better able to recognise, manage and prevent mental health problems as early as possible. In this study, it was established that about 59% of the Mmotong community members possessed some knowledge of mental disorders. Similar to past studies, Gamm et al. (2010) found that rural community members had some knowledge of mental disorders, although, like in this study (about 40%); a sizeable number lacked in-depth knowledge. It, therefore, becomes important for communities to lobby those with some mental health knowledge to act as agents of mental health literacy in their respective communities. The sociocultural theory suggests that knowledge can be circulated between people and the environments in which they live (Mucherah & Owino, 2016). This is further supported by Jorm (2011) saying that personal experiences and evidence from family and friends may be the tool by which people obtain information and beliefs regarding mental health. Mental health literacy is spread from one generation to the other and those holding more knowledge and positive attitudes towards mental disorders are in a better position to influence and educate those having little or no knowledge about mental disorders (Scott & Palincsar, 2013). Generally, this finding implies that for improved mental health care and prevention more efforts are needed to consolidate the community's mental health care literacy.

One other finding in this study was that a majority of community members who were diagnosed with some form of mental illness were using Western medicine followed by Traditional medicine. Another portion was using a combination of both forms of

treatment simultaneously. This finding suggests that in this community, although a majority of people suffering from mental illness would be disposed to using Western forms of treatments, there's another part of the population that would either use Western medicine in conjunction with Traditional medicine or the latter alone. Some scholars have argued that the preference for Western medicine might be because the Western health care system is perceived to be greater or superior to the Traditional health care system (Summerton, 2006). Despite the supposed preference, in this community, both forms of treatments may need to be availed and promoted, with capacitating preference a bit slanted towards the treatment of choice preferred by a majority of the population, i.e., Western medicine (van Niekerk, 2014; Eggertson, 2015). Availing both forms of treatments would help align the services with the community's established mental health-seeking pathways. This is vital because patients are the major stakeholders in mental health care, and they know when and where to seek mental health care in times of need.

More than 50% of the female participants and a little under 50% of the male participants believed that Traditional health practitioners can treat mental disorders effectively. This suggests that the community members had faith in the ability of Traditional health practitioners to treat mental disorders effectively. This is backed by a study by Nemutandani et al. (2016) who found that Traditional health practitioners play a vital role in the country's health system and that they are the patients' preferred health providers. Although past studies seem to suggest that a larger portion of people in rural African communities use Traditional medicine (Hillenbrand, 2006), the present study seems to suggest otherwise. This is further supported by the findings documented by Oyebode et al. (2016) that there is a decrease in the utilization of Traditional medicine for mental disorders and also by Kabir et al. (2004) who found that participants preferred Western medicine for the treatment of mental disorders. The reason for the decline in the uptake of Traditional medicine for mental disorders in these communities remains undocumented therefore it calls for further research investigations.

Reasons supplied for the continued use of Traditional medicine for mental health care are varied, ranging from issues of cost, long queues, poor working conditions and shortages of health professionals, belief system influences and gender and age variables (Hillenbrand, 2006; Kabir et al., 2004; Kajawu, 2017; Nemutandani et al.,

2016; & Nsereko et al., 2011). In this study, the majority of elderly people had faith that Traditional health practitioners can treat mental disorders effectively. As Xin et al. (2020) found that the use of Traditional medicine was associated mostly with older people.

Community attitude and beliefs play a role in determining mental help-seeking behaviour and successful treatment of the mentally ill (Kabir et al., 2004). Kabir and his colleagues also found that different beliefs in the cause of mental disorders play a role in the help-seeking behaviour of community members. Buchwald et al. (2000) also found that the use of Traditional medicine was strongly affiliated with culture. Read (2019) found that in Ghana, patients with mental disorders such as schizophrenia are treated harshly, with shackles and chains, mainly because it is believed to be caused by possession of evil spirits or witchcraft. This is in line with the Sociocultural theory which suggests that cultural beliefs and norms will always shape people's thinking and response or how they deal with issues of health and ill-health (Subudhi, 2014).

5.3. Attitude towards the collaboration of Traditional health practitioners and Western health practitioners in mental health care

The study revealed community members' positive attitude towards the collaboration of Traditional healers and Western-oriented mental health practitioners in the treatment of mental disorders. Most studies documented on collaboration attitudes have focused on health practitioners themselves, and rarely on health care users.

Given the former, Traditional health care practitioners were found to be open to working with Western-trained healthcare practitioners (Sorsdahl et al., 2010), whereas the professionals are not in favour of such a collaboration. The present study brings in the third leg to the collaboration debate, i.e., health care users seem to be in favour of a collaboration of both systems in mental health care. This, of course, is despite some studies (Mashabela et al., 2016; Sorsdahl et al., 2010; Summerton, 2006) having established that there's some lack of trust and enthusiasm between the practitioners themselves. Notwithstanding this potential hindrance, as per van Niekerk (2014) and van der Watt et al. (2018)'s assertions, it is the community that wields the power to decide which treatment services they want to utilise. Nemutandani et al. (2016) have suggested that the belief and reliance on the Traditional health system or simultaneous use of the existing health care systems by the indigenous communities highlight the

diverse processes of mental health-seeking pathways in South Africa. It is therefore the government's responsibility to exercise its prerogative to see to it that the two health care systems work collaboratively while efforts to develop, capacitate and regulate them are also put in place for the benefit of its multicultural citizens (Habtom, 2018).

Although previous studies have suggested that the elderly group seem to favour the collaboration imperative, in this study even younger populations (in the age groups of 18 to 37; 38 to 57; and older than 57-year-olds) supported the need for collaboration in the management of mental disorders. It should not be overlooked that a fraction of the youth population least favoured collaboration between the African and Western approaches. This finding supports previous studies which also found that people from different age groups sought treatment from both health care systems because they viewed Traditional medicine as being as effective as Western medicine (van der Watt et al., 2018; Xin et al., 2020). The possible reason for less favour in the youth population could be the lack of confidence in the efficacy of Western-trained health practitioners more than in the efficacy of Traditional health practitioners in the treatment of mental disorders. Farrer (2008) found that younger people were willing to recommend a counsellor for the treatment of depression while older people were not.

The finding on collaboration attitudes implies that Traditional and Western-trained health care practitioners should be encouraged to work together for the benefit of the mental health care users. Chikomo (2011) shares the same sentiment in highlighting that the collaboration between Traditional and Western-trained mental health workers could increase the number of people seeking mental help in the coming years leading to people receiving the help that they need. The collaboration imperative could therefore come in handy to resolve issues of mental health care costs, lack of human and material resources and, user culture centred services. This could lead to cost-effective and accessible mental health care services for users.

5.4. Implications of the study findings

5.4.1. Implications for research

Research on the attitudes of community members regarding the collaboration of Traditional and Western-trained healthcare practitioners in the treatment of mental disorders is inadequate. Most studies were focused on the attitudes of health care

practitioners themselves while overlooking health care users. There is therefore a need for more research to be conducted on the attitudes of patients regarding the collaboration of the two systems. More research, especially in rural communities, is needed because it cannot be concluded based on this finding that everyone will have a positive attitude and support the collaboration imperative. As more evidence is gathered, it will help inform the nature and extent of how the collaboration should be fashioned.

5.4.2. Implications for policy

The present study supports both the WHO's Traditional Medicine Strategy 2002-2005 and South African National Mental Health Policy Framework and Strategic Plan 2013-2020 which both supports the collaboration between Traditional and Western-trained health care practitioners. Collaboration between the two systems could help increase the number of mental health professionals to meet the health care needs of patients, which currently is a global crisis. There is a need for continued calls and implementation efforts both internationally and nationally, towards the collaboration between the mainstream and Traditional health care systems.

5.4.3. Implications for practice

The study exposed the need for Traditional health practitioners and Western-trained health practitioners to work together in managing mental disorders as a majority of participants supported the collaboration of the two health systems. This suggests that practitioners need to work towards achieving this imperative. Fostering collaboration to align it to patient heath seeking pathways could resolve some mental health management challenges such as non-adherence of patients to treatment, fear of stigma when seen to be using either of the two systems, costs of managing mental illness and so forth. It is therefore incumbent on national governments to see to it that the two systems are capacitated, supported and regulated while their collaboration is fostered.

5.5 Study limitations

The following are limitations to the study:

- The study included only 200 participants from a small village in Polokwane, whose input cannot be used to conclude that collaboration between Traditional

Health Practitioners and Western-trained Health Practitioners will be accepted by a majority of the South African populace.

- It was initially envisaged to have 265 participants included in the study as per the sampling frame needs, however, due to the national lockdown announced by the President in March 2020, data collection had to cease and at that time the researcher had only collected data from 200 participants.
- Because the current study was more descriptive quantitative, an inferential quantitative approach and mixed-method studies could be done in the future.
- This study relied upon self-reporting on the questionnaire, thus, some participants may have provided inaccurate responses.

5.6. Conclusion

The present study established the Mmotong community's knowledge of mental illness and attitudes towards collaboration between Traditional and Western-trained Health Practitioners in mental health care. In the main, the community was found to possess mental illness knowledge. Both systems of mental illness management were being utilised by affected community members. Most community members were using Western-oriented mental health care services. Despite the community favouring Western-oriented services, the community had a positive attitude towards the collaboration of both the Traditional and professional mental health care services. The study is concluded by recommending to the government to harness efforts towards the working together of Traditional and Western-oriented health care practitioners in the management of mental illness. This could be one way of aligning mental health care services with users' worldviews. It could assist in addressing mental health care service issues such as non-adherence to treatment, shortages of professional human resources and the costs of mental health. It is therefore recommended to the government and all stakeholders to work towards the collaboration imperative.

REFERENCES

Abolfotouh, M. A., Almutairi, A. F., Almutairi, Z., Salam, M., Alhashem, A., Adlan, A. A., & Modayfer, O. (2019). Attitudes toward mental illness, mentally ill persons, and help-seeking among the Saudi public and sociodemographic correlates. *Psychology Research and Behavior Management, 12,* 45-54. http://doi.org/10.2147/PRBM.S191676

Ameade, E. P. K., Amalba, A., Helegbe, S. K., & Mohammed, B. S. (2015). Herbal medicine: a survey on the knowledge and attitude of medical students in Tamale, Ghana. *Peak Journal of Medicinal Plant Research, 3*(1), 1-8.

Apuke, O. D. (2017). Quantitative research methods: A synopsis approach. *Arabian Journal of Business and Management Review (Kuwait Chapter), 6*(10), 40-47. http://doi.org/10.12816/0040336

Bohner, G., & Dickel, N. (2011). Attitudes and attitude change. *Annual Review of Psychology*, 62(1), 391-417. https://doi.org/10.1146/annurev.psych.121208.131609

Buchwald, D., Beals, J., & Manson, S. M. (2000). Use of Traditional health practices among Native Americans in a primary care setting. *Medical Care, 38*(12), 1191-1199. https://www.jstor.org/stable/3767997

Burns, J. K. (2015). Traditional and religious healers in the pathway to care for people with mental disorders in Africa: A systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology, 50*(6), 867–877

Butcher, J. N., Hooley, J. M., & Minneke, S. (2015). *Abnormal Psychology.* (16th ed.). Pearson Education, Inc.

Calabrese, J. D. (2013). *A different medicine: Postcolonial Healing in the Native American church*. Oxford University Press.

Campbell-Hall, V., Peterson, I., Bhana, A., Mjadu, S., Hosegood, V., & Flisher, A. J. (2010). Collaboration between Traditional practitioners and primary health care staff in South Africa: Developing a workable partnership for community mental health services. *Transcultural Psychiatry*, *47*(4), 610-328. http://doi.org/10.1177/1363461510383459

Chikomo, J. G. (2011). *Knowledge and Attitudes of the Kinondoni Community towards Mental disorder.* (Master's thesis). Stellenbosch University, Stellenbosch. Retrieved from http://hdl.handle.net/10019.1/6562

Chipfakacha, V. (1994). The role of culture in primary health care*. African Medical Journal*, *84*(12), 860-861.

Choudhry, F. R., Mani, V., Ming, L. C., & Khan T. M. (2016). Beliefs and perception about mental health issues: a meta-synthesis. *Neuropsychiatric Disease and Treatment. 12*, 2807–2818.

Corder, G. W, & Foreman, D.I. (2014). *Non-parametric statistic: A step by step approach*. (2nd ed.), New York: Wiley.

Cresswell, J. W., & Cresswell, J. D. (2018). Research Design. (5th ed.). Sage Publications

Department of Health. (2013). *National Mental Health Policy Framework and Strategic Plan 2013-2020*. Pretoria: Department of Health.

Dixon, S. & Quirke, L. (2018). What's the harm? The coverage of ethics and harm avoidance in research methods textbooks**.** *Teaching Sociology*, *46*(1), 12 –24. http://doi.org/10.1177/0092055X17711230

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of Convenience Sampling and Purposive Sampling. *American Journal of Theoretical and Applied Statistics, 5*(1), 1-4. http://doi.org/10.11648/j.ajtas.20160501.11

Farrer, L., Leach, L., Griffiths, K. M., Christensen, H., & Jorm, A. F. (2008). Age differences in mental health literacy. *BMC Public Health, 8,* 125. http://doi.org/10.1186/1471-2458-8-125

Gaebel, W., Zäske, H., Cleveland, H. R., Zielasek, J., Stuart, H., Arboleda-Florez, J., Akiyama, T., Gureje, O., Jorge, M. R., Kastrup, M., Suzuki, Y., Tasman. A., & Sartorius, N. (2011). Measuring the stigma of psychiatry and psychiatrists: development of a questionnaire. *European Archives of Psychiatry and Clinical Neuroscience*, *261*, 119–123. http://dx.doi.org/10.1007/s00406-011-0252-0.

Gaebel, W., Zäske, H., Zielasek, J., Cleveland, H. R., Samjeske, K., Stuart, H., Arboleda-Florez, J., Akiyama, T., Baumann, A. E., Gureje, O., Jorge, M. R., Kastrup, M., Suzuki, Y., Tasman. A., Fidalgo, T. M., Jarema, M., Johnson, S. B., Kola, L., Krupchanka, D., … Sartorius, N. (2014). Stigmatization of psychiatrists and general practitioners: results of an international survey. *European Archives of Psychiatry and Clinical Neuroscience*, *265*(3), 189–197. http://doi.org/10.1007/s00406-014-0530-8

Galabuzi, C., Agea, J. G., Fungo, B. L. & Kamoga, R. M. N. (2010). Traditional medicine as an alternative form of a health care system: A preliminary case study of Nangabo Sub-country, Central Uganda. *African Journal of Traditional, Complementary and Alternative Medicine,* 7(1), 11-16. http://hdl.handle.net/10570/1530

Gamm, L., Stone, S., & Pittman, S. (2010). Mental health and mental disorders- a rural challenge: literature review. *Rural Healthy People*, *2,* 97-114

Green, E.C., & Makhubu, l. (1984). Traditional healers in Swaziland: towards improved cooperation between the Traditional and modern health sector. *Social Science Medicine*, *18*(12), 1071-1079. https://www.ncbi.nlm.nih.gov/pubmed/6463675

Green, B., & Colucci, E. (2020). Traditional healers' and biomedical practitioners' perceptions of collaborative mental healthcare in low- and middle-income countries: A systematic review. *Transcultural Psychiatry, 57*(1), 94–107. http://doi.org/10.1177/1363461519894396

Gulati, P., Das, S., & Chavan, B.S. (2014). Impact of psychiatry training on attitude of medical students toward mental disorder and psychiatry. *Indian Journal of Psychiatry, 56*(3), 271-277. http://dx.doi.org/10.4103/0019-5545.140640

Gureje, O., Nortje, G., Makanjuola, V., Oladeji, B. D., Seedat, S., & Jenkins, R. (2015). The role of global Traditional and complementary systems of medicine in the treatment of mental health disorders. *The Lancet Psychiatry*, *2*(2), 168-177. https://dx.doi.org/10.1016%2FS2215-0366(15)00013-9

Habtom, G.K. (2018). Perceptions and attitudes of modern and traditional medical practitioners about traditional medical practice in Eritrea. *International Journal of*

Complementary & Alternative Medicine, 11 (1), 6–19. DOI:10.15406/ijcam.2018.11.0034

Heale, R., & Twycross, A. (2015). Validity and reliability in quantitative studies. Evidence-Based Nursing, 18(3), 66-67, doi: 10.1136/eb-2015-102129

Health Professions Council of South Africa. (2018). *Mental health professionals' statistical figures*. Health Professions Council of South Africa.

Heaton, P. C., Tundia, N. L., & Lunder, H. R. (2013). US emergency departments visits resulting from poor medication adherence: 2005=07. *Journal of the American Pharmacists Association, 53* (5), 513-519. https://doi.org/10.1331/JAPhA.2013.12213

Hillenbrand, E. (2006). Improving Traditional-conventional medicine collaboration: perspectives from Cameroonian Traditional practitioners. *Nordic Journal of African Studies*,*15*(1), 1–15. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKEwi4n8PF4bHeAhVQXRoKHaskA-YQFjAAegQICRAC&url=https%3A%2F%2Fpdfs.semanticscholar.org%2F0811%2Feb98336797050115b3956f99504ce492f1a3.pdf&usg=AOvVaw1khadj4FnVCFjC1bXYFs83

Joppe, M. (2000). The Research Process. http://www.ryerson.ca/~mjoppe/rp.htm

Jorm, A. F. (2011). Mental health literacy: Public knowledge and beliefs about mental disorders. *The British Journal of Psychiatry. 2000, 177,* 396-401*. http://bjp.rcpsych.org/*

Kabir, M., Iliyasu, Z., Abubakar, I. S., & Aliyu, M. H. (2004). Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria. *BMC International Health and Human Rights, 4*, 3. http://doi.org10.1186/1472-698X-4-3

Kahn, M. S., & Kelly, K. J. (2001). Cultural tensions in psychiatric nursing: Managing the interface between Western mental health care and Xhosa Traditional healing in South Africa. *Transcultural Psychiatry*. *38*(1), 35-50 http://journals.sagepub.com/doi/pdf/10.1177/136346150103800104.

Kajawu, L. (2017, September 8). Traditional vs contemporary medicine in mental disorder. *AFRICAN Independent*. https://www.africanindy.com/news/Traditional-vs-contemporary-medicine-in-mental-illness 11117897

Kaur, P., Stoltzfus, J., & Yellapu, V. (2018). Descriptive statistics. *International Journal of Academic Medicine*, 4(1), 60-63. doi:10.4103/IJAM_7_18

Krueger, R. A., & Casey, M. A. (2014). *Focus groups: A practical guide for applied research*. (5th ed.), Sage publications.

Lingeswaran, A., 2010. Psychiatric curriculum and its impact on the attitude of Indian undergraduate medical students and interns. *Indian Journal of Psychological Medicine*. *32*, 119–127. http://dx.doi.org/10.4103/0253-7176.78509

Lund, C., Petersen, I., Kleintjes, S., & Bhana, A. (2012). Mental health services in South Africa. Taking stock. *African Journal of Psychiatry*, *15*(6), 402-405. http://dx.doi.org/10.4314/ajpsy.v15i6.48

Mabunda, M. M. (2001). Perceptions of disease, illness, and healing among selected black communities in the Northern Province, South Africa. *South Africa Journal of Ethnology*, 24(1), 11-16.

Mackenzie, N. & Knipe, S. (2006). Research dilemmas: Paradigms, methods and methodology. *Issues in Educational Research, 16*(2), 193–205.

Malone, H., Nicholl, H., & Tracey, C. (2014). Awareness and minimisation of systematic bias in research. *British Journal of Nursing*. *23(*5), 279-282. https://doi.org/10.12968/bjon.2014.23.5.279

Mashabela, M., Zuma, T., & Gaede, B. (2016). Bridging the gap between biomedical and Traditional health practitioners in South Africa. *SAHR. 8*, 83- 92

Mashek, D. (2016 February 22). Collaboration: It's Not What You Think. *Psychology Today*. https://www.psychologytoday.com/us/blog/relationships-intimate-and-more/201602/collaboration-its-not-what-you-think

Meissner, O. (2004). The healer as part of the primary healthcare team? *South African Medical Journal, 94*(11), 901-902. http://www.ncbi.nlm.nih.gov/m/pubmed/15587451

Mokgobi, M. G. (2012). *Views on Traditional healing: Implications for integration of Traditional healing and Western medicine in South Africa.* [Unpublished doctoral dissertation]. University of South Africa.

Moletsane, M.K. (2004). *The efficacy of the Rorschach among black learners in South Africa*. Pretoria: University of Pretoria.

Mucherah, W., Owino, E. (2016) Using the Sociocultural Theory to Explain the Perceptions of Homosexuality among Kenyan and U.S. University Students. *Journal of black sexuality and relationships*. 2(3). http://doi.org10.1353/bsr.2016.0026

Mufamadi, J., & Sodi T. (2010). Notions of mental illness by Vhavenda Traditional healers in Limpopo province. *South Africa. African Journal of Indigenous Knowledge Systems, 9*(2), 253-264.

Mungee, A., Zieger, A., Schomerus, G., Ta, T. M. T., Dettling, M., Angermeyer, M. C., & Hahn, E. (2016). Attitudes towards psychiatrists: A comparison between two metropolitan cities in India. *Asian Journal of Psychiatry. 22*, 140-144. http://doi.org/10.1016/j.ajp.2016.06.014

Nemutandani, S., M., Hendricks, S., J., & Mulaudzi, M. F. (2016). Perceptions and experiences of allopathic health practitioners on collaboration with Traditional health practitioners in post-apartheid South Africa. *African Journal of Primary Health Care and Family Medicine, 8(*2), 1-8. http://dx.doi.org/10.4102/phcfm.v8i2.1007

Ngoma, M. C., Prince, M., & Mann, A. (2003). Common mental disorders among those attending primary health clinics and traditional healers in urban Tanzania. *British Journal of Psychiatry*, 183, 349-355.

Nsereko, J. R., Kizza, D., Kigozi, F., Ssebunnya, J., Ndyanabangi, S., Flisher, A. J., & Cooper, S. (2011). Stakeholder's perceptions of help-seeking behaviour among people with mental health problems in Uganda*. International Journal of Mental Health Systems, 5,* 5. http://www.ijmhs.com/content/5/1/5

Oyebode, O., Kandala, N. B., Chilton, P. J., & Lilford, R. J. (2016). Use of Traditional medicine in middle-income countries: a WHO-SAGE study. *Health Policy and Planning,* 1–8. http://dx. doi.org/ 10.1093/heapol/czw022

Panhwar, A. H., Ansari, H., & Ansari S. (2016). Sociocultural Theory and its Role in the Development of Language Pedagogy*. Advances in Language and Literary Studies, 7*(6), 183-188. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKEwjvudWF6LHeAhVix4UKHfxTAjMQFjAAegQICRAB&url=http%3A%2F%2Fwww.journals.aiac.org.au%2Findex.php%2Falls%2Farticle%2Fview%2F2914&usg=AOvVaw27oSgqrF40PN1c117P93nd

Puspitasari, I. M., Garnisa, I. T., Sinuraya, R. K., & Witriani, W. (2020). Perceptions, knowledge, and attitude toward mental health disorders and their treatment among students in an indonesian university. *Psychology Research and Behavior Management. 13,* 845- 854. https://www.dovepress.com/

Ramgoon, S., Dalasile, N. Q., Paruk, Z., & Patel, C. J. (2011). An exploratory study of trainee and registered psychologists' perceptions about indigenous healing systems. *South African Journal of Psychology*, *41*(1), 90-100. https://doi.org/10.1177/008124631104100110

Read, U. (2012). 'I want the one that will heal me completely so it won't come back again': The limits of antipsychotic medication in rural Ghana. *Transcultural Psychiatry, 49*(3-4), 438-460.

Read, U. (2019). Rights as relationships: collaborating with faith healers in community mental health in Ghana. *Cultural Medicine and Psychiatry*, *43*, 613–635. https://doi.org/10.1007/s11013-019-09648-3

Rehagen, T. (2015). Psychologist or Psychiatrist: Which Is Right for You? *WebMD*. https://www.webmd.com/mental-health/features/psychologist-or-psychiatrist-which-for-you#1

Rossler, W. (2006). Psychiatric rehabilitation today: An overview. *World Psychiatry, 5*(3), 151-157.

Ryan, G. (2018). Introduction to positivism, interpretivism and critical theory. *Nurse Researcher,* 25(4), 14-20. Doi:10.7748/nr.2018.e1466

Sartorius, N., Gaebel, W., Cleveland, H-R., Stuart, H., Akiyama, T., Arboleda-Florez, J., Baumann, A.E., Gureje, O., Jorge, M.R., Kastrup, M., Suzuki, Y., & Tasman, A. (2010). WPA guidance on how to combat stigmatization of psychiatry and psychiatrists. *World Psychiatry, 9,* 131-144.

Schoonover, J., Lipkin, S., Javid, M., Rosen, A., Solanki, M., Shah, S., & Katz. C.L. (2014). Perceptions of Traditional healing for mental illness in rural Gujarat. *Annals of Global Health*, *80*(2), 96-102. https://doi.org/10.1016/j.aogh.2014.04.13

Scott, S., & Palincsar, A. (2013). *Sociocultural Theory.* http://www.education.com/reference/article/sociocultural-theory

Semenya, S. S., & Potgieter, M.J. (2014). Bapedi Traditional healers in the Limpopo Province, South Africa: Their socio-cultural profile. *Journal of Ethnobiology and Ethnomedicine*. *10*(4), 2-12. https://doi.org/10.1186/1746-4269-10-4

Setia, M. S. (2016). Methodology Series Module 3: Cross-sectional Studies. Indi*an Journal of Dermatology, 61(*3), 261–264. https://doi.org/10.4103/00195154.182410

Sileyew, K. J. (2019). Research design and methodology. http://dx.doi.org/10.5772//intechopen.85731.

Sobiecki, J. (2014). The intersection of culture and science in South African traditional medicine. Indo-Pacific Journal of Phenomenology, 14(1),1-10. https://doi.org/10.2989/IPJP.2014.14.1.6.1238

Sorketti, E. A. (2009) Sudan's national mental health programme and burden of mental disorder. *International Psychiatry*, *6*(1), 16–18. http://dx.doi.org/10.1192/S1749367600000254

Sorketti, E. A., Zuraida, N. Z., & Habil, M. H. (2010), Collaboration between Traditional healers and psychiatrists in Sudan. *International Psychiatry*, *7*(3), 71-74. http://doi.org/10.1192/S1749367600005907

Sorsdahl, K., Stein, D. J. & Flisher, A. J., (2010) Traditional Healer Attitudes and Beliefs Regarding Referral of the Mentally Ill to Western Doctors in South Africa.

Transcultural Psychiatry, 47(4), 591-609. http://doi.org/pdf/10.1177/1363461510383330

Sorsdahl, K., Stein, D.J., Grimsrud, A., Seedat, S., Flisher, A. J., Williams, D.R., & Myer, L. (2009). Traditional healers in the treatment of common mental disorders in South Africa. *The Journal of Nervous and Mental Disease, 197*(6), 434–441. http://doi.org/10.1097/NMD.0b013e3181a61dbc

Statistics South Africa (2018). *Mid-year population estimates 2018*. Pretoria: Statistics South Africa. Retrieved from http: www.statssa.gov.za/?m=2018

Subudhi, C. (2014). Social work practice in mental health: cross-cultural perspectives. *Culture and Mental Illness*. http://doi.org/10.13140/2.1.1117.4724

Sukamolson, S. (2007). *Fundamentals of quantitative research*. Language Institute, Chulalongkorn University.

Summerton, J. (2006). Western health practitioners' view about African traditional health practitioners' treatment and care of people living with HIV and AIDS. *Curationis*. *29*(3), 15-23.

Ta, T. M. T., Boge, K., Cao, T. D., Schomerus, G., Nguyen, T. D., Dettling, M., …Hahn, E. (2018). Public attitudes towards psychiatrists in the metropolitan area of Hanoi, Vietnam. *Asian Journal of Psychiatry, 32*, 44–49. http://doi.org/10.1016/j.ajp.2017.11.031

Terre Blanche, M.T., Durrheim, K., & Painter, D. (2009*). Research in practice: Applied methods for social sciences*. University of Cape Town Press.

Tromp, B., Dolley, C., Laganparsad, M., & Goveneder, S. (2014). *Sunday Times investigation on mental health in South Africa*. Retrieved 30 September 2014

Truter, I. (2007). African traditional healers: Cultural and religious beliefs intertwined in a holistic way. *SA Pharmaceutical Journal, 74* (8), 56–60.

Van der Watt, A. S. J., van der Water, T., Nortje, G., Oladeji, B. D., Seedat, S., Gureje, O., & Partnership for Mental Health Development in Sub-Saharan Africa (PaM-D) research team. (2018). The perceived effectiveness of Traditional and faith healing in the treatment of mental illness: a systematic review of qualitative studies. *Social Psychiatry and Psychiatric Epidemiology, 53,* 555-556

Van Niekerk, M. (2014). Perceptions of the Traditional Health Practitioner's role in the management of mental health care users and occupation: a pilot study. *SA Journal of Occupational Therapy, 44,* 20-24.

Van Rooyen, M. R., Pretorius, B., Tembani, M. M., & Ten Ham-Baloyi, W. (2017). Evidence-based recommendations to facilitate professional collaboration between allopathic and Traditional health practitioners. *Health SA Gesondheid* 22, 291-299. https://doi.org/10.1016/j.hsag.2017.05.001

Wahyuni, D. (2012). The research design maze: Understanding paradigms, cases, methods and methodologies.

World Health Organisation. (2015). *WHO comprehensive mental health action plan 2013–2020.* Geneva: WHO http://www.who.int/mental_health/action_plan_2013/en/

Xin, B., Mu,S., Tan, T., Yeung, A., Gu, D., & Feng, Q. (2020). Belief in and use of Traditional Chinese medicine in Shanghai older adults: a cross-sectional study. *BMC Complementary Medicine and Therapies, 20*, 128. https://doi.org/10.1186/s12906-020-02910-x

Yaro, B. P. (2016). *Perspectives of different stakeholders about mental health care services provided by Traditional healers in Ghana and the possibility of the integration of Traditional medicine into mental health care.* (Master's thesis). Stellenbosch University, Stellenbosch. https://scholar.sun.ac.za

Zabow, T. (2006). Traditional healers and mental health in South Africa. *International Psychiatry, 4* (4), 81-83.

Zangirolami-Raimundo, J., Echeimberg, J. O., & Leone, C. (2018). Research methodology topics: Cross-sectional studies. *Journal of Human Growth and Development. 28*(3), 356-360. http://dx.doi.org/10.7322/jhgd.152198

Zea, M.C & Bowleg, L. (2016). The final frontier-transitions and sustainability: from mentored to independent research. *AIDS and Behaviour*, *20*(2), 311-317. https://doi.org/10.1007/s10461-016-1368-z

APPENDICES

Appendix 1A: Data collection tool: English version

Demographic information

1.1 Age

18-27 ☐ 28-37 yrs. ☐ 38-47yrs. ☐

48-57 yrs. ☐ 58-67yrs. ☐ 68yrs & above ☐

1.2. Gender:

Male ☐ Female ☐

1.3. Marital status:

Married ☐ Single ☐ Divorced ☐ Widowed ☐

1.4. Educational level:

No education ☐ Primary school ☐ High school ☐

Tertiary ☐

1.5 Religious orientation

Pentecostal churches ☐ Missionary churches ☐

African traditional religion ☐ African independent churches ☐

Other, specify ……

2. Research questions

Mental disorder has been defined as a group of symptoms that co-occur in an individual and cause disturbance in a person's behaviour, emotion regulation or cognitive functioning (Butcher et al., 2015)

Do you know of any mental disorders?

Yes ☐ No ☐

Have you been diagnosed with a mental disorder?

Yes ☐ No ☐

If yes, where do you consult if you need treatment for mental disorders?

Traditional healers ☐

Western-oriented mental health care practitioners ☐

Both ☐

Other, specify …….

Do you have a family member who has a mental disorder?

Yes ☐ No ☐

If yes, where do they consult for their mental health care provisions?

Traditional healers ☐

Western-oriented mental health care practitioners ☐

Both ☐

Other, specify …….

3. Knowledge and attitude items (English version)

Please, read each of the statements in the questionnaire and, if you agree or disagree with each of the statements, indicate your answer by ticking the corresponding box.

Items	Yes	No
1. People with mental disorders can recover without any medication.		
2. Traditional healers can treat any mental disorder effectively		
3. Western-trained health practitioners can treat any mental disorder effectively		
4. There are some mental disorders that cannot be treated by using Traditional medicine.		
5. There are some mental disorders that cannot be treated by using Western medicine		
6. People with mental disorders need to be treated by both Western and Traditional medicines.		
7. Traditional healers and Western mental health professionals need to work together to manage mental disorders.		
8. I support the collaboration of Traditional healers and Western mental health practitioners.		
9. There is no difference between Traditional and Western health practitioners.		

Appendix 1B: Data collection tool: Sepedi version

1.1 Mengwaga:

18-27 ☐ 28-37☐ 38-47 ☐ 48-57☐

58-67 ☐ 68 le go ya godimo ☐

1.2 Bong:

Monna ☐ Mosadi ☐

1.3 Seemo sa lenyalo:

Nyetši/nyetšwi ☐ Aseke nyale/nyalwe ☐ Thlalane le molekani ☐

Hlokofaletšwi ke molekani ☐

1.4 Seemo sa thuto:

Akena thuto ☐ Ke nale thuto ya sekolo sa praemari ☐ Ke nale thuto ya sekolo sa sekontari ☐

Ke nale thuto ya ka godimo ga sekontari ☐

2. Dipotšišo tsa nyakišišo

Malwetji a monagano a hlalositšwe bjalo ka dika tšeo di tšwelelago mmogo ka gare ga monagano wa motho gomme di hlola hlakahlakano ka gare go maitshwaro, maikutlo le mogopolo wa motho.

2.1 Na go nale bolwetji bja monagano bjo o bo tsebago?

Ee ☐ Aowa ☐

2.2 Na o lwala bolwetji bja monagano?

Ee ☐ Aowa ☐

2.3 Ge ele gore karabo ya gago ke ee, na oya kae go humana kalafo?

Ngaka ya setšo ☐ Ngaka ya sekgowa ☐

Ngaka ya Sekgowa gammogo le ngaka ya setšo ☐

Go gongwe, fahlela…….

2.4 Ka gae go nale yo a lwalago bolwetji bja monagano?

Ee ☐ Aowa ☐

Ge ele gore Karabo ya gago ebile ee, na ba humana kalafo kae?

Ngaka ya setšo ☐ Ngaka ya sekgowa ☐

Ngaka ya Sekgowa gammogo le ngaka ya setšo ☐

Go gongwe, fahlela…….

3. Knowledge and attitude items (Sepedi version)

Ka kgopelo, bala lefoko le lengwe le lelengwe, ge odumela goba oganana le lona, bontšha karabo ya gago ka go thala mothaladi go lebana le lepokisi lago išetsana le karabo ya gago.

	Ee	**Aowa**
1. Balwetši ba monagano baka fola ntle le kalafo.		

2. Dingaka tsa setšo dika alafa bolwetši bjo bongwe le bjo bongwe bja monagano.		
3. Kalafo ya sekgowa e kgona go fodisa malwetsi a monagano		
4. Go nale malwetsi a mangwe a monagano ga a foli ka kalafo ya setso		
5. Go nale malwetsi a mangwe a monagano ga a foli ka kalafo ya sekgowa		
6. Balwetši bja monagano ba swanetši go alafa ke dingaka tša setšo le tša sekgowa.		
7. Dingaka tša setšo le tša sekgowa di swanetši go šumišana mmogo go laola malwetši a monagano.		
8. Ke thekga šumišano mmogo ya dingaka tša setšo le tša sekgowa go alafa malwetši a monagano.		
9. Gagona phapano magareng ga dinyaka tša setšo le dingaka tša sekgowa.		

Appendix 2 A: Consent form: English version

I, …… hereby agree to participate in a Master's research project that focuses on the Mmotong community's attitudes towards the collaboration of Traditional healers and Western-trained mental healthcare practitioners.

The purpose of this study has been fully explained to me. Furthermore, I understand that I am participating freely and without being forced in any way to do so. I also understand that I can terminate my participation in this study at any point should I wish to do so, and that this decision will not affect me negatively in any way. I understand that the researcher would try as much as possible to keep any personal information that could be linked to me confidential.

I understand that this is a research project, whose purpose is not necessarily to benefit me personally. I understand that my details as they appear in this consent form will not be linked to the interview schedule and that my answers will remain confidential.

_____ _____

Signature Date

Appendix 2B: Consent form: Sepedi version

Nna,…… ke dumelela go tšea karolo ka gare go nyakišišo ya Masters yeo e le lebelelago botsebi le maitshwaro a badudi ba Mmotong mabapi le tšhomišanommogo ya dingaka tša setšo le dingaka tja sekgowa kago alafa malwetši a megopolo.

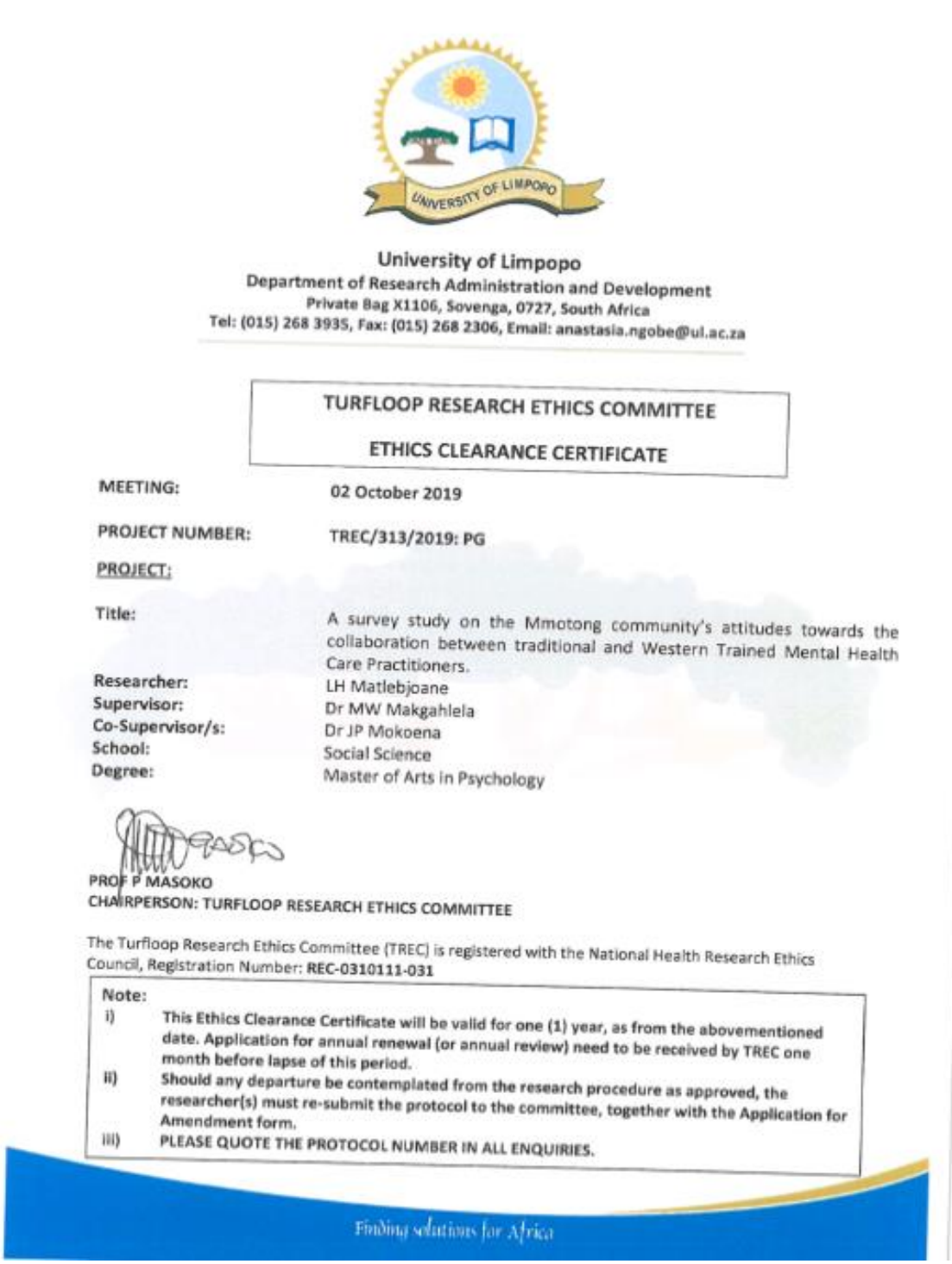
Kgwekgwe ya nyakišišo ye e hlalositšwe ka botlalo. Ebile, ke a kwešiša gore ke tšea karolo ke lokolegile kesa gapeletšwi. Ke kwešiša gape gore ke nale maloka a go ka ikgogela morago nako enngwe le enngwe ebile se se kase ntlišetje ditlamorago tše mpe. Ke a kwešiša gore monyakišiši otla leka ka maatla kamoka go tšhireletša tshedimušo yaka ebile le ditaba kamoka tše eleng gore tshedimušo ya gona etlaba ya sephiri, etla šireletšwa.

Ke a dumela gore nyakišišo ye mošomo wa yona ase go kgola nna ka senna. Ke a kwešiša gore tshedimušo yaka kage e tšwelela mo letlakaleng le e ka se be ya hlakantšhwa le diputšišo tšeo ke tlago di araba, di tla dula ele sephiri.

_____ _____

Signature Letsatsikgwedi

Appendix 3: Turfloop Research Ethical Clearance (TREC)



University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING:	02 October 2019
PROJECT NUMBER:	TREC/313/2019: PG
PROJECT:	
Title:	A survey study on the Mmotong community's attitudes towards the collaboration between traditional and Western Trained Mental Health Care Practitioners.
Researcher:	LH Matlebjoane
Supervisor:	Dr MW Makgahlela
Co-Supervisor/s:	Dr JP Mokoena
School:	Social Science
Degree:	Master of Arts in Psychology

PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:

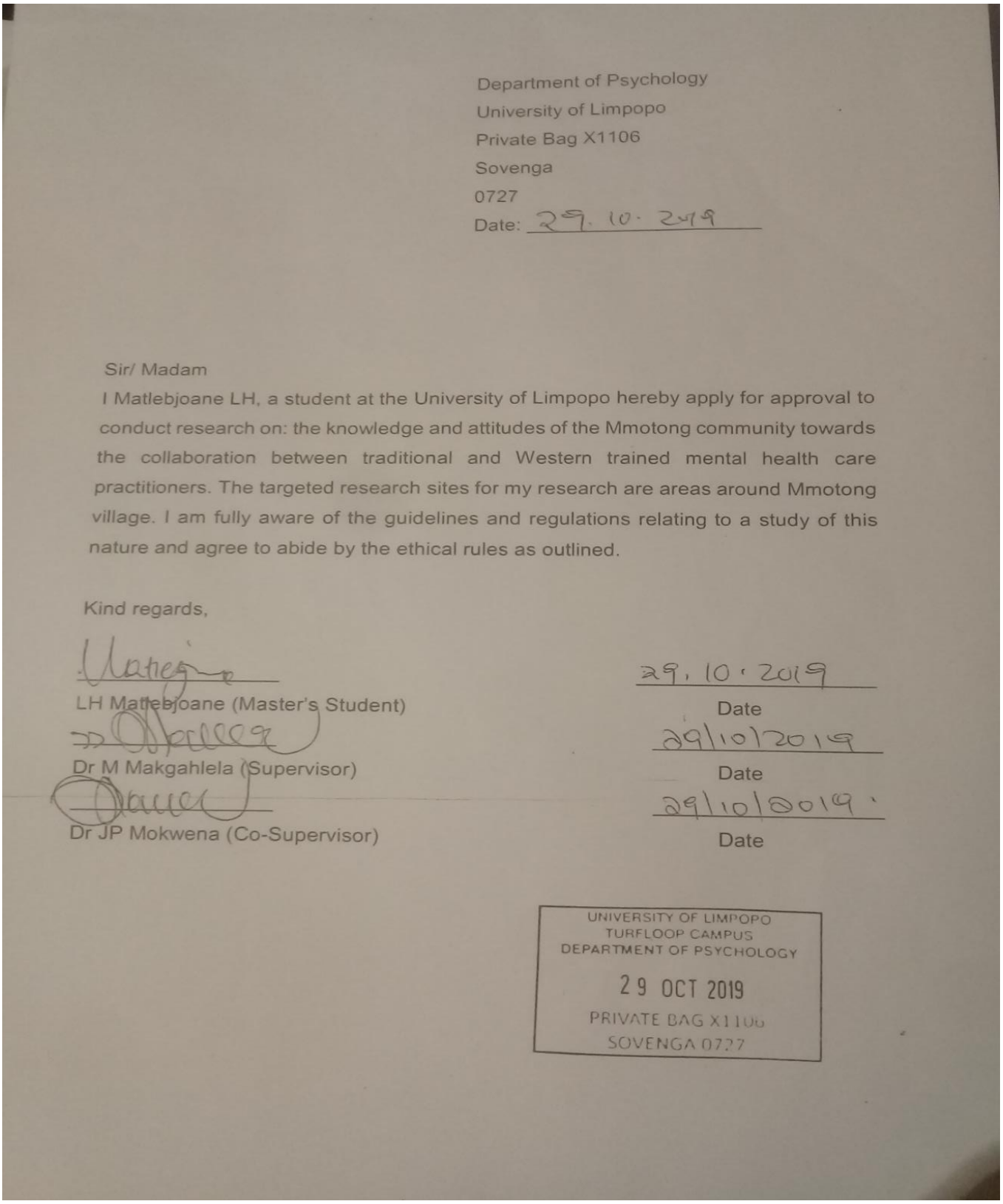
i) **This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.**

ii) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.**

iii) **PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**

Finding solutions for Africa

Appendix 4: Letter to the Mmotong head of council



Department of Psychology
University of Limpopo
Private Bag X1106
Sovenga
0727
Date: 29. 10. 2019

Sir/ Madam

I Matlebjoane LH, a student at the University of Limpopo hereby apply for approval to conduct research on: the knowledge and attitudes of the Mmotong community towards the collaboration between traditional and Western trained mental health care practitioners. The targeted research sites for my research are areas around Mmotong village. I am fully aware of the guidelines and regulations relating to a study of this nature and agree to abide by the ethical rules as outlined.

Kind regards,

LH Matlebjoane (Master's Student) — 29. 10. 2019 — Date

Dr M Makgahlela (Supervisor) — 29/10/2019 — Date

Dr JP Mokwena (Co-Supervisor) — 29/10/2019 — Date

UNIVERSITY OF LIMPOPO
TURFLOOP CAMPUS
DEPARTMENT OF PSYCHOLOGY
29 OCT 2019
PRIVATE BAG X1106
SOVENGA 0727