http://dx.doi.org/10.4314/ajtcam.v11i5.10

INTEREST IN AND WILLINGNESS TO USE COMPLEMENTARY, ALTERNATIVE AND TRADITIONAL MEDICINE AMONG ACADEMIC AND ADMINISTRATIVE UNIVERSITY STAFF IN BLOEMFONTEIN, SOUTH AFRICA

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Abstract

Background: Healthcare systems worldwide are changing and the use of complementary, alternative and traditional medicine (CAM) form part of this transformation. South Africa has a large number of CAM practitioners, but they are not included in the official healthcare system. The aim of this study was to determine the perception and usage of CAM among the academic and administrative staff of the University of the Free State (UFS) in Bloemfontein, South Africa.
Methods: A questionnaire was compiled and sent electronically to all the academic and administrative staff of the UFS who had a university email address, to be completed online.
Results The response rate was 5.5%, with most of the respondents from the Faculty of Health Sciences. The respondents (n=165) were mainly women of 41–60 years of age with more than one tertiary qualification. Most of the respondents were in good health and considered CAM as moderately helpful and mostly safe. Most of the CAM recommendations were not from a medical physician. The respondents wanted alternatives to certain medications, such as antibiotics. They also had good previous experience with CAM and felt that conventional treatment was not always effective to treat their problems. They identified a need for CAM in the health system.
Conclusion: The study has limitations due to the data collection method and the low response rate. The results showed that the respondents favored a more integrated healthcare system including different CAM therapies, and that conventional doctors should be better informed about these therapies and its uses.

Keywords: perceptions; usage; complementary medicine; alternative medicine; traditional medicine; university staff.

Introduction

Healthcare systems in developed countries are changing and the use of complementary and alternative medicine (CAM) is a part of this transformation (Spence & Ribeaux, 2004). Defining CAM is difficult, because the field is very broad and constantly changing. The National Center for Complementary and Alternative Medicine (NCCAM, 2013) defines CAM as "a group of diverse medical and healthcare systems, practices, and products that are not generally considered part of conventional medicine. The boundaries between CAM and conventional medicine are not absolute, and specific CAM practices may, over time, become widely accepted."

Complementary medicine refers to the use of CAM together with conventional medicine, while alternative medicine refers to the use of CAM instead of conventional medicine (NCCAM), 2007). Traditional medicine (TM), according to the World Health Organization (WHO, 2013), refers to "the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, used in the maintenance of health and in the prevention, diagnosis, improvement or treatment of physical and mental illness. Traditional medicine covers a wide variety of therapies and practices which vary from country to country and region to region. In some countries, it is referred to as 'alternative' or 'complementary' medicine (CAM)" (WHO, 2002, 2013).

Up to 80% of the African population use some form of traditional medicine (TM) (Nyika, 2009), and due to historical circumstances and cultural beliefs, populations in Latin America, Asia and China continue to use TM. The popularity of CAM in developed countries is also becoming more and more prominent, with 48% of individuals in Australia showing interest in CAM, 70% in Canada, 42% in USA, 38% in Belgium and 75% in France (Spence & Ribeaux, 2004; WHO, 2002). In this article, the term CAM has been used for both CAM and TM.

According to the Department of Health (Health Systems Trust SA, 2007), South Africa has 185 500 traditional medicine practitioners, 68 000 full-time herbalists and 3 600 complementary medicine practitioners, compared to 34 000 doctors (including 7 000 general practitioners in private practice), 11 000 pharmacists, 100 000 professional nurses, 84 000 staff nurses and auxiliaries. They all fall under the Department of Health in one of the following divisions: Health Professions Council, Dental Technicians Council, Nursing Council, Pharmacy Council, Allied Health Professions Council and the Traditional Healers Council. With proposals and legislation as presented in the SA Health Review of 2007, it is possible that non-conventional medicine will be included in future SA healthcare systems. (Health Systems Trust SA, 2007).

The aim of this study was to explore the perception and usage of CAM among the academic and administrative staff of the University of the Free State (UFS) in Bloemfontein, South Africa.

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Methods

A questionnaire was compiled by combining multiple choice questionnaires developed by Frenkel et al. (2008) and Smith et al. (2008), as well as information from "Health and Healthcare in South Africa"(Van Rensburg, 2010) used to address South African needs with regard to CAM.

A pilot study was done where the questionnaire was randomly sent to 10 persons on the email list of the UFS. They were asked for comments, uncertainties and recommendations to the questions. Their comments were evaluated and included in the final questionnaire. The questionnaire was then sent by email to all the academic and administrative staff of the UFS who had a university email address to be completed online. No cleaners, messengers and students were included in the survey. The questionnaire was available in both formal languages used at the UFS, namely English and Afrikaans. If requested, a paper copy could be provided. Members of staff were requested to complete the questionnaire within two weeks after receiving it. Participation in the study was voluntary and anonymous. Approval to conduct the research was granted by the Ethics Committee of the Faculty of Health Sciences and University management, with the reference number of ETOVS NR 86/2010.

Results and Discussion

Although email is widely used by the staff to spread information and notifications, we had a very poor response to our questionnaire – only 5.5% of staff responded, with another 3% who opened the questionnaire but did not complete it. On average, previous surveys conducted by the University among members of staff rendered a return rate of 18% [personal communication, UFS Information Technology and Communication (ITC) staff]. Furthermore, due to technical reasons, a follow-up email to non-responders requesting participation could not be distributed. The list of staff to which the email was sent was incomplete, as an update of all staff information had been launched during the study period. We were not informed about this and had to use the incomplete staff list, resulting in only 2 990 members of staff having been used instead of the almost 5 4000 staff members listed on the new email list. The results that are presented in this article are therefore rather a description of the respondents' views and do not represent the view of all staff of the UFS, neither does it represent the recent composition of the UFS staff.

The questionnaire was sent out to all the listed email addresses by UFS ITC Department, coming to 2 990 persons. In this group, 460 (15.4%) individuals were Black (2.2% responded), 104 (3.5%) Coloured, i.e. of mixed ancestry (1.5% responded), 36 (1.2%) Indian (2.8% responded), and 2 383 (79.7%) White (5.4% responded). For seven persons (0.2%), no information on race was provided. With regard to gender, 1 570 (52.5%) were female (7.4% responded) and 1 420 (47.5%) male (3.5% responded). The median age of the recipients was 47 years, ranging between 25 and 73 years of age.

Demographic data of all the respondents

Demographic data were obtained to compile a profile of the respondents. These results are presented in Table 1. Most of the respondents were White (92.1%), women (70.3%) and Afrikaans-speaking (75.2%). Of the White respondents (both men and women), only 48.7% used CAM, while 70% of the few Black respondents and 100% of the few Coloured respondents used CAM. The English-speaking respondents were more open to CAM usage (59.4%) than the Afrikaans speaking respondents (46% used CAM). When the different African languages were added together, 66.7% (6/9) had used CAM.

Most of the respondents have more than one degree (72.1%), with 53.8% of them not using CAM. The Faculty of Health Sciences had the highest response rate (33.9%; 56/165), with 66.1% of these respondents not using CAM. The Faculty of Humanities had the highest rate of CAM users (71.4%; 15/21 of their staff).

The demographic profile of the CAM users in this study (see Table 1) was similar to other surveys done in the USA (Ernst, 2000; NCCAM, 2007; Neiberg et al., 2011), United Kingdom (Chau & Furnham, 2008; Harris & Rees, 2000; Hunt et al., 2010), Australia (Sarris, 2012; Xue et al., 2007) and the Netherlands(Jong et al., 2012) with regard to gender, education level, health states, safety of CAM, reasons to use CAM and therapy choices. It was different, however, from a study done in Chatsworth, South Africa, among the Indian community, which found no demographic factor to be significant of CAM usage (Singh et al., 2004). A systematic review of published and unpublished research investigations done by Peltzer (2009) show a lack of data about CAM use among the general South African population.

The highest prevalence of CAM users in this study were in the age group 31–40 years (57.1% of 35 respondents). This finding corresponded with reports from the UK (Chau & Furnham, 2008; Hunt et al., 2010), the Netherlands (Jong et al., 2012) and Australia (Xue et al., 2007), being younger than those using CAM in the USA (age 50–59 years) (NCCAM, 2007). The second highest usage in our study was among participants in the age group 51–60 years (51.4% of 48 respondents).

Health status and perception on safety of CAM

The questionnaire made provision to obtain respondents' opinion on their perceived health status. Despite the fact that 73.9% of respondents regarded themselves to be in good health, 45.1% of them visited a CAM practitioner. The respondents who assessed their health status as fair (24.8%) had the highest rate of visiting CAM practitioners (65.9%). Only two persons (1.2%) reported to be in poor health.

The largest percentage of respondents felt that non-conventional medicine was moderately helpful (29.7%) and 9.1% felt it is not helpful at all. Only 5.5% felt that CAM was harmful and 43.6% felt it was mostly safe.

Source of referrals and reasons to use CAM

The responses regarding the source of referral to use CAM therapies and why they were used are summarised in Table 2. Most of the respondents were referred to a CAM practitioner by friends (56.6%), while 98.8% indicated that the recommendation by a friend or relative was the reason for visiting a CAM practitioner.

Other reasons for using CAM were that they did not want to take medications such as antibiotics (60.2%), had good previous experience with CAM therapists (57.8%) and felt that conventional medicine was ineffective in treating their problems (49.4%). A need for effective treatment

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that would also provide more self-control over their healthcare problems (mostly chronic and lifestyle diseases) combined with curiosity led them to alternative options.

Health conditions for which respondents decided to use CAM

Respondents who visited CAM practitioners were requested to list the health problems for which they decided to use non-conventional medicine. Responses are given in Table 3. This was an open-ended question that every respondent could complete with his/her own description. Many of them used CAM for general wellness (20.5%) and stress (20.5%)

Therapies mostly used by respondents

Table 4 gives a summary of the therapies that were mostly used by the total group of respondents (CAM and non-CAM users) during the two-year period preceding the survey. Most of the respondents used prayer for health reasons (71.5%). Of these, three (1.8% of the total group) respondents exclusively used prayer and no other CAM therapies for their health. Nutritional supplements that were not prescribed by a medical doctor were used by 63.6% of the respondents, with 14 (8.5%) of respondents using nutritional supplements as only CAM therapy. Homeopathy (38.2%), herbal treatment (31.5%), home remedies (26.7%) and massage therapy (24.2%) were also popular.

From the responses, it became clear that a number of CAM treatments (per definition based on the literature) were not really considered as CAM by the respondents, as non-CAM users made use of certain CAM therapies. These included nutritional supplements not prescribed by a medical doctor and used as dietary strategies to address prevention or cure of disease, prayer for health reasons, home remedies, massage therapy, yoga and meditation. Other therapies recognised by the Allied Health Professions Council, although not part of conventional medical training, including homeopathy, herbal treatment (naturopathy), aromatherapy and reflexology, were also widely used. If the use of nutritional supplements and praying for health reasons were excluded, the most popular CAM therapies would be homeopathy and herbal treatment. This observation may indicate that the abovementioned therapies are already considered as part of the public's perception of healthcare, even if it is not included in formal health training in South Africa.

The views of the respondents who used CAM on the inclusion of CAM as part of the conventional Health system.

As CAM has not yet been incorporated into the conventional health system in South Africa, the respondents' thoughts on how it would be included in a public health system were evaluated, as shown in Table 5. The non-CAM users were not obliged to complete this part of the questionnaire, and only the opinions of the 83 CAM users are represented in the table.

The largest percentage of respondents (43.4%) was in favor of the idea that CAM should be offered by a non-conventional health therapy clinic with multiple providers under a medical doctor's supervision. They also would prefer that the therapy be provided by a medical doctor trained in non-conventional medicine (37.9%) or a trained non-conventional health therapist (34.9%). The majority (81.9%) of these respondents wanted CAM to be part of the health system in South Africa. The respondents further indicated that they wanted their medical doctors to be more open to the use of CAM (94.0%) and also more informed about CAM (94.0%). More than half (55.4%) of the respondents who used CAM informed their medical doctors about it.

Table 1: Demographic and educational data of the respondents.

Variable	Total group (n=165)		Visited CAM practitioners (n=83)	
	Frequency	%	Frequency	%
Total group	165	100	83/165	50.3
Gender				
Female	116	70.3	68/116	58.6
Male	49	29.4	15/49	30.6
Age group				
18–30 years	13	7.9	6/13	46.1
31–40 years	35	21.2	20/35	57.1
41–50 years	46	27.9	20/46	43.4
51–60 years	48	29.1	26/48	51.4
61–64 years	8	4.8	3/8	37.5
≥ 65 years	15	9.1	8/15	23.3
Language				
Afrikaans	124	75.2	57/124	46.0
English	32	19.4	19/32	59.4
Sesotho	4	2.4	4/4	100
isiXhosa	2	1.2	1/2	50.0
German	2	1.2	2/2	100
Setswana	2	1.2	1/2	50.0
Italian	1	0.6	1/1	100
isiZulu	1	0.6	0/1	0
Racial group				
Asian	1	0.6	0/1	0
Black	10	6.1	7/10	70.0
Coloured	2	1.2	2/2	100
White	152	92.1	74/152	48.7
Religion				
Christian	144	87.3	71/144	49.3

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Atheist	7	4.2	1/7	14.3
Muslim	1	0.6	0	0
Not mentioned	13	7.9	11/13	84.6
Education				
More than one degree	119	72.1	55/119	46.2
University degree	25	15.1	14/25	56.0
University of Technology degree	8	4.8	6/8	75.0
School grade 12	8	4.8	4/8	50.0
School grade 10	1	0.6	1/1	100
Qualification from other than the abovementioned institutes	10	6.1	8/10	80.0
Faculties				
Health Sciences	56	33.9	19/56	33.9
Natural & Agricultural Sciences	33	20.0	14/33	42.4
Humanities	21	12.7	15/21	71.4
Other divisions	55	33.3	35/55	63.6

Table 2: The source of referral and reasons why CAM was used by respondents.

	Visited CAM practitioners (n=83)	
	Frequency	**%**
ırce of referral		
Friends	47	56.6
Self	39	47.0
Family	17	20.5
Own research	15	18.1
Literature	9	10.8
Magazines	4	4.8
ason why CAM was used		
Recommendation by a friend or relative	82	98.8
Do not want to take medications, e.g. antibiotics	50	60.2
Good previous experience with non-conventional treatments	48	57.8
Conventional treatments were ineffective in treating the problem	41	49.4
Non-conventional treatments offered more control over my healthcare	26	31.3
Advertisements in newspapers, magazines, TV	23	27.7
Recommendation of a medical doctor, nurse, clinic sister, pharmacist	23	27.7
Conventional treatments produced adverse effects	23	27.7
Non-conventional treatments more compatible with my beliefs of health	23	27.7
Disappointed with conventional medicine	16	19.3
Wanted to try non-conventional treatments	16	19.3
Conventional treatments too costly	11	13.3

Table 3: Health conditions for which respondents decided to use CAM

Disease/condition for which CAM was used	Visited CAM practitioners (n=83)	
	n	**%**
General wellness	17	20.5
Stress	17	20.5
Sinusitis	12	14.5
Back pain	11	13.3
Muscle spasm	9	10.8
Cold, flu	9	10.8
Colon problems	8	9.6
Headaches	7	8.4
Arthritis	6	7.2

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Fatigue	5	6.0
Skin problems	5	6.0
Stomach problems/pain	5	6.0
Insomnia	5	6.0
Allergy	4	4.8
Weight control	4	4.8
Pain	4	4.8

Table 4: Therapies mostly used by respondents.

Therapies used by respondents	Total group (n=165)		CAM users (n=83)	
	Frequency	%	Frequency	%
Nutritional supplements (non-prescription)	105	63.6	64	77.1
Use only nutritional supplements	14	8.5	2	2.4
Do not use any nutritional supplements	60	36.4	18	21.7
Prayer for health reasons	118	71.5	48	57.8
Use only prayers	3	1.8	0	0
Homeopathy	63	38.2	53	63.9
Herbal treatment	52	31.5	40	48.1
Home remedies/folk remedies/"boereraat"	44	26.7	29	34.9
Massage therapy	40	24.2	30	36.1
Aromatherapy	32	19.4	28	33.7
Chiropractor	20	12.1	20	24.1
Reflexology	20	12.1	15	18.1
Yoga	14	8.5	12	14.5
Meditation	13	7.9	12	14.5
Bach flower remedies	12	7.3	12	14.5
Iridology	11	6.7	11	13.3
Biofeedback therapy	11	6.7	11	13.3
Acupuncture(not provided by a physiotherapist)	10	6.1	10	12.1
Chinese remedies	3	1.8	3	3.6
Ayurvedic remedies	3	1.8	3	3.6
Traditional African treatments	3	1.8	3	3.6
Other options	49	29.7	47	56.6
None of the options listed	11	6.7	3	3.6

Conclusion

With only one in 20 members of staff participating in this survey, the study had limitations regarding numbers, the variety of respondents, the fact that the questionnaire was answered without explanation of terms (respondents were guided by their own interpretation), and the research tool (email responses). On the basis of the data obtained, it is also problematic to speculate on the true usage of CAM among the UFS staff and also to translate it to the general population of the country. Despite these limitations, several noteworthy and consistent trends emerged that corresponded with international trends. The most likely users of CAM are female, middle aged and well-educated. A substantial portion of CAM users do not inform their doctors of their usage. The majority of users employ CAM as an adjunct to mainstream medicine for the prevention rather than the treatment of illness.

Our results are merely descriptive of a very limited population in South Africa, but it can provide a basis for multicentre, cross-cultural research studies to further evaluate the applicability of CAM in the South African healthcare system. As most of the respondents used CAM for prevention and for chronic diseases for which allopathic treatment did not give them satisfactory relief, it is worthwhile to investigate different CAM therapies to relieve the burden that chronic diseases and aging are placing on healthcare providers and the healthcare system. This integration has the potential to expand currently available treatment options, improve patient and provider satisfaction, and better balance the deficiencies in each system.

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Table 5: The views of the respondents who used CAM on the inclusion of CAM as part of the conventional Health system.

Questions	Visited CAM practice (n=83)	
	Frequency	%
Where do you want CAM to be provided to you?		
Non-conventional health therapy clinic – multiple providers with medical doctor's supervision	36	43.4
Non-conventional health therapist private practice	32	38.6
Non-conventional health therapy clinic – multiple providers	15	18.1
Who should provide CAM therapies?		
A medical doctor trained to provide non-conventional treatments	31	37.3
Non-conventional health therapist in collaboration with medical doctor	23	27.7
Non-conventional health therapist (e.g. acupuncturist, naturopath, chiropractor)	29	34.9
Do you want the medical doctor to be knowledgeable about CAM?		
Yes	78	94.0
No	5	6.0
Did you inform your medical doctor about your CAM therapies usage?		
Yes	46	55.4
No	37	44.6
Do you want your medical doctor to be open to the use of CAM?		
Yes	78	94.0
No	4	4.8
Do you want CAM to be part of the conventional health system?		
Yes	68	81.9
No	15	18.1

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