

**A MODEL FOR COLLABORATION BETWEEN ALLOPATHIC AND
TRADITIONAL HEALTH PRACTITIONERS IN THE MANAGEMENT OF HIV/AIDS
AND TB PATIENTS IN VHEMBE DISTRICT, LIMPOPO PROVINCE**

By

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DECLARATION

I, **Mbulaheni Simon Nmutandani**, declare that **“A model for collaboration between allopathic and traditional health practitioners in the management of HIV/AIDS and TB patients in Vhembe District, Limpopo Province”** which I hereby submit for the **PhD degree in Public Health** at the University of Pretoria, is my own work, that all sources that I have used or quoted have been indicated and acknowledged by means of complete references, and that this work has not been submitted for any other degree at this or any other institution.

Dr M.S. NEMUṬANDANI

DATE

DEDICATION

This thesis is dedicated to:

- You, the unknown and unseen, omnipresent and omnisknowledge, Nwali- Musika-vhathu.
- Iwe vhathu vhomaine wee! midzimu nga li lale ngei matondoni, mutongolwe, tshiendeulu- nge na dzivhela na phasela zwa naka: vhaloi vho shona nge mpengo a fhola.
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ABSTRACT

HIV/AIDS and TB patients form part of the communities consulting both allopathic and traditional health practitioners. The study examined existing relationships between traditional and allopathic health practitioners, as they both manage HIV/AIDS and TB patients. The study aim was to develop a model for collaboration between allopathic and traditional health practitioners in the management of HIV/AIDS and TB patients in the Vhembe district, Limpopo Province.

Participatory action research design was used. The study was conducted in three phases following the decision taken by the stakeholders during the consultative meetings. The first phase involved the training of 437 traditional health practitioners on HIV/AIDS and TB diseases, and also assessed their knowledge levels, beliefs and practices about the HIV/AIDS and TB. The HIV/AIDS and TB training workshops prepared the traditional health practitioners for group discussions with number of allopathic health practitioners in the second phase. The second phase explored their perceptions and experiences of collaboration in the management of HIV/AIDS and TB patients, identified strategies for collaboration.

The findings confirmed that collaboration was long overdue, and it created an opportunity to build relationship to address challenges of patients' secrecy, treatment overdose and abandonment of ARV treatment. They explored how they could work together in the fight against HIV/AIDS and TB infections. Change of mindset through the decolonization process was decided as the best suitable approach moving forward.

Based on the findings of phases one and two, the third phase, which is a COHORT model for collaboration between allopathic and traditional health practitioners in the management of HIV/AIDS and TB patients was developed and described.

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LIST OF ABBREVIATIONS

AHPs	=	Allopathic Health Practitioners
AIDS	=	Acquired Immuno Deficiency Syndrome
ART	=	Antiretroviral Therapy
DoH	=	Department of Health
HIV	=	Human Immuno Virus
NSP	=	National Strategic Plan,
PAR	=	Participatory Action Research
RHT	=	Refusal of Hospital Treatment
STD	=	Sexual Transmitted Diseases
TB	=	Tuberculosis
THPs	=	Traditional Health Practitioners
UNICEF	=	United Nations Children's Fund
WHO	=	World Health Organisation
M-THP	=	Malamulele THP
T- THP	=	Tshilidzini THP
H- THP	=	Tshilwavhusiku THP
C- THP	=	Mhinga THP
M-AHP	=	Malamulele AHP
T-AHP	=	Tshilidzini AHP
H-AHP	=	Tshilwavhusiku AHP
C- AHP	=	Mhinga AHP
THPs Act	=	Traditional Health Practitioners Act, No 22 of 2007

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

This thesis focuses on the process of developing a model for collaboration between allopathic health practitioners (AHPs) and traditional health practitioners (THPs) in management of Human Immunodeficiency Virus/Acquired Immuno Deficiency Syndrome and Tuberculosis (HIV/AIDS and TB) patients. The concept of developing a model for collaboration emanated from training workshops conducted among THPs in Limpopo Province between 2006 and 2012. The training workshops were conducted in partnership with the Department of Health in Limpopo Province and the Nelson Mandela Avertis Projects for Combating TB, HIV/AIDS. The focus of the training workshop was on the causes of HIV/AIDS and TB, and the myths held among the rural communities [1].

The information obtained from the training workshops revealed that patients consulted both AHPs and THPs in search for HIV/AIDS and TB treatment. More than 95% (1 241 of 1 300) of the THPs attending the training workshops indicated that they were being consulted by HIV/AIDS and TB patients at different stages of their health conditions. Some of the patients consulted them for different health needs other than HIV/AIDS and TB as determined by their traditional practices and health belief system. Traditional health practitioners wanted to work together with the AHPs in the management of HIV/AIDS and TB patients [1]. It was these reality and request from the THPs that prompted the researcher to embark on a participatory action research in partnership with the AHPs and THPs in order to develop a model for collaboration initiated by the health providers themselves.

Chapter One will provide an overview and introduction to the research topic, background, significance, research problem, research questions, aim and the objectives of the study. The last section of this chapter provides the structure of the whole thesis in which the chapters are outlined.

1.2 BACKGROUND AND RATIONALE FOR THE STUDY

HIV/AIDS and TB has exacerbated demands on public health care systems across the African continent [2-3]. Sustained high HIV infection rates have created a renewed urgency to seek alternative methods and strategies to prevent new infections, improve quality of life for those individuals who are already living with HIV/AIDS [4-11]. The development and implementation of an expanded national comprehensive HIV/AIDS and TB prevention, treatment and care programme is one of those initiatives [8]. It has been endorsed and supported by the international community, calling on all governments and the health sectors to integrate with THPs in the fight against the HIV/AIDS and TB pandemic [11-12].

Several studies have reported that majority of HIV/AIDS patients use traditional medicine concurrently with allopathic medicine [13-25]. It is estimated that between 60 to 80 percent of HIV/AIDS patients in South Africa, use traditional medicines [26-30]. The current impact of HIV/AIDS and TB in South Africa has reached a crisis level [2]. Reports suggest that the pandemic is putting an already overburdened and understaffed allopathic health system under immense pressure and strain to a breakpoint [4, 15, 30-34]. Projections and the extent of the impact of the HIV/AIDS and TB pandemic on the health system indicate that more and more patients are seeking alternative advice; reliefs and treatment from the THPs [13-21].

Pluralism in health care can be regarded as a global phenomenon [35, 36]. It has been described as a health care system incorporating two or more models of health care traditions. It is found in most contemporary societies where there are different, co-existing, complementary or competing health systems arising from different traditions, practices and bodies of knowledge as Green and others reported that , “We are not completely westernized” [37, 38]. Within the South African context, it usually involves an allopathic health care system as a dominant player in co-existence with traditional and/or indigenous health care system.

Despite years of prohibiting traditional health practices in South Africa, pluralism in health care continued. This is not out of stubbornness or ignorance, but because the allopathic health system is unable and unwilling to offer explanations for the onset of

illness, the 'why me? Why now?' rationale which forms a crucial part of African traditional understandings of health and healing [38-41].

In addition, there are two main worldviews on the social constructions of disease and healing, namely traditional or indigenous health approach/paradigm and allopathic health approach. The two world views assign different etiological explanation and meaning to health, disease and illness [37, 39, 42, 43]. As early as 1946, the World Health Organization (WHO) which is mostly represented by practitioners holding allopathic approach, defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" [44]. There are diseases and/or illness which are associated with spirituality, acts or a call from ancestors which were not included within this definition.

The root cause of an unsuccessful management of patients, especially HIV/AIDS and TB patients, seem to be the failure of AHPs to recognise the patient's worldview and traditional beliefs. Without a knowledge and understanding of the patient's belief system and worldview, AHPs are likely to view pluralism as stubbornness, resulting in inappropriate management by THPs, poor treatment compliance and overdose [40-43].

Allopathic medicine is presently unequipped to handle the rapidly growing caseload of mental and sociopathic disorders associated with HIV/AIDS and TB. They are believed to pose a special challenge to modern scientific medicine and have plagued the psychiatric fraternity for many years [40].

1.2.1 The African ontology of disease and health

The African ontology of disease and health focuses on harmony or balance between the cosmic life forces [43, 45]. Health, within the African tradition, is perceived as a balanced relationship between individual and individual, individual and nature, and individual and the supernatural or ancestor's world [15, 42, 46, 47].

It is for this reason that etiology and symptomatology of ill health are seldom viewed as isolated phenomena. In the same breath, some diseases are, however, attributed largely to either natural or supernatural causes.

Two categories of diseases are, therefore, identifiable based on the degree of causality, namely natural diseases and supernatural diseases [32, 37].

Natural diseases are viewed as minor disorders such as colds and flu which can be easily cured by herbs or in allopathic health by a general practitioner. Supernatural diseases, on the other hand, are cured according to their cause [40]. Allopathic health system appears to be inadequately prepared to diagnose, manage and provide explanation for supernatural diseases such as those that communities and patients believe are caused by ancestors and evil spirits [demons (thuri)¹] [48].

In the case of supernatural diseases, the symptoms are in themselves an indication of a discourse in the metaphysical environment. This may be either one of three things, namely: the ancestors being angry, or the patient being exposed to witchcraft or the cause of affliction may be ritual pollution [32, 39, 47]. Supernatural explanations for disease causation serve to answer the question of “why” a particular person suffers disease or misfortune.

A further difference is in diagnosing a specific illness. Whereas the allopathic sciences’ approach is based on the manifestation of physiological irregularities in the patient, the traditional health sciences’ approach on other hand, is based on a holistic view of the individual [49-51]. In other words, traditional healing does not cater for the physical condition only, but also for the psychological, spiritual and social aspects of individuals, families and communities. This holistic approach to illness is the centre piece of the THPs’ science and philosophy [51, 52]. Communities and patients identify and relate to it easily as it reflects their culture, beliefs and traditions practiced by their forefathers and generation after generation successfully. They also find the services for the THPs inexpensive and easily accessible. It is for that reason that communities and patients continue to seek services of the THPs, whilst AHPs are talking negatively against pluralism involving the THPs [40, 52].

¹ *Evil spells thought to be in a form of a small nocturnal animal, capable of causing insanity.*

1.2.2 HIV/AIDS and TB pandemics: patients turning to traditional healing

HIV, the virus that causes AIDS, “acquired immunodeficiency syndrome” has become one of the world’s most serious health challenges. Since the beginning of the epidemic till 2013, there were approximately 35 million people living with HIV and tens of millions of people in the past have died of AIDS-related causes [2]. Sub-Saharan Africa, which is the hardest hit region, is home to 71% of people living with HIV. According to United Nations Population Fund Agency (UNPFA), South Africa has the highest number of people living with HIV (6.4 million) in the world [37]. The HIV/AIDS pandemic in South Africa is characterized by escalating HIV infection rates, and resultant increased morbidity and mortality of especially the economically active people [33]. Reports indicate that majority of people living with HIV or at risk for HIV in Africa, do not have access to prevention, care, and treatment [2, 53].

Evidence suggests low drug adherence rates in Africa as compared with industrialized countries. A case in point is the suboptimal treatment adherence of 60-70% of Malaria cases in Africa, while treatment completion rates for TB cases range from a low 37% to a moderate 78% [2].

Since the inception of large-scale Antiretroviral Therapy (ART) access early in this decade, ART programmes in Africa have retained about 60% of their patients. Even though the benefits of ART in reducing mortality among people living with HIV/AIDS are well documented, some patients still drop out of treatment programmes [54-56]. An analysis of a 33 patient cohort study from 13 Africa countries revealed that on average, 60% of patients were retained in ART care after 2 years of initiation [57]. Reasons for patient attrition from ART care have included the use of traditional medicine, costs, side effects and stigma, and belief in faith healing [21, 58].

In view of high percentage of ART defaulters (40%) resulting in the development of resistance to antiretroviral drugs, as well as sustained high HIV- infection rates, South Africa is heading towards having high rates of resistance to antiretroviral drugs among the population living with HIV/AIDS and rapid transmission of drug resistant viral strains within the sexual active generation [59].

Traditional practices, beliefs and use of traditional medicine remain important in many people's lives even when receiving western treatment such as ARV and DOT. These issues are rarely addressed in a positive way during initiation of western treatment, meanwhile, at times patients' use of traditional medicine and their religious beliefs are in conflict with allopathic treatment advice [21].

The long held view that allopathic instructions to patients “don't use and mix our medicine with traditional herbs” appears to be counter-productive [46, 52, 58]. For example, several studies conducted in sub-Saharan Africa report an increased preferences among HIV/AIDS patients for traditional medicine and/ or alternative AIDS medicine [21-23]. In Africa, patients were abandoning ART in favour of herbal remedies supplied by THPs [13, 14, 17, 21, 52, 58, 60]. In South Africa, patients used herbal remedies mainly for pain relief, as immune booster and for stopping diarrhoea. The major herbal remedies used were secretive unnamed traditional medicine, followed by imbiza (*Scilla natalensis* planch), canova (immune booster), izifozonke (essential vitamins mixed with herbs), African potato (*Hypoxis hemerocallidea*), stametta (aloe mixed with vitamins and herbs) and ingwe (tonic) [23].

The dual consultation involving THPs and the prescription of herbal remedies for “treatment” of HIV/AIDS has been discouraged by AHPs, associated with reduced ART adherence [21, 58].

Despite negative comments and instruction to patients not to consult THPs, use of herbal remedies among AIDS patients is unlikely to decrease. On the contrary, it appears to be on the increase [14, 52]. Loss to follow up and patients abandoning ARV is a common practice among the low socio-economics societies [23, 61]. The major cause of concern to AHPs seen to appear when patients exercise their rights and disclose that they are also receiving treatment from THPs [62]. The perception created by AHPs suggest that patients belong to them, with no right of choosing and consulting health providers other than themselves [62].

Understanding of the health seeking behaviour model is critical to finding solutions to the AIDS pandemic, as it could help in developing custom made model for collaboration to complement the two systems in fighting the pandemic [61-64].

This will require involvement of all stakeholders including THPs and their communities in identifying and addressing factors contributing to the spread of HIV/AIDS and TB, the ‘why I am infected’, use of traditional medicines and non-adherence to antiretroviral therapy. Lack of clear policies and programmes on integration and collaboration between THPs and AHPs results in HIV/AIDS patients consulting AHPs and THPs in search of cure, quality of life, and to reconcile or be at peace with nature and the ancestors before death and after death [65]. The researcher believes that introducing an open discussion around collaboration could be in the best interest of patients in the long run.

1.2.3 The value of collaboration between AHPs and THPs

In South Africa, the strategy to fight against the HIV/AIDS and TB pandemic has been mainly focusing on the allopathic health system which excludes the THPs [4]. The programme strategically focuses on the provision of antiretroviral therapy by AHPs to reduce HIV/AIDS-related morbidity and mortality. It is this exclusion of THPs, as well as the limitations and challenges of allopathic health care system in providing appropriate treatment and support to people living with HIV/AIDS and TB, which has prompted individuals to consult THPs in the hope of finding a cure [65 - 66].

Although the two health systems operate at different levels of sciences, they could play a complementary role in the fight against HIV/AIDS and TB in South Africa [31, 49]. More so, when the worldviews that an individual or a community holds on health and diseases, do not only influence the meanings attached to different health conditions and beliefs regarding causation of HIV/AIDS [65, 66], but also determine the type of providers who are consulted for management of it, restore health and well-being of communities.

Since a significant percentage of HIV/AIDS and TB patients consult THPs, their inclusion in the management of HIV/AIDS and TB patients is likely to save more lives in South Africa. One major advantage of collaboration with THPs is that they focus on the psychological, social and spiritual factors contributing to illness, which is perceived as a very effective approach [69]. Allopathic health system has, on other hand, the facilities and equipment to diagnose diseases accurately [69].

Without these explanations, any treatment provided, no matter how carefully it is followed, is unlikely to bestow complete healing. It has not been designed to deal with the 'ultimate cause' of illness [41, 42 46].

The primary source of illness and various conditions which occur in communities, namely psychological conditions, physical disabilities and deformities, are believed to come as a result of witchcraft, evil powers, envy, jealousy, etc. [46, 67]. In the absence of a developed model for collaboration, these beliefs and those related to the cause of HIV/AIDS and TB infections, 'why me? Why now?' continue to present a serious challenge for the convergence of the two health systems [62]. Since there was no HIV/AIDS diseases in the past, and its origin is not well understood and/or accepted by some within the traditional health communities, they are usually associated with witchcraft [70]. Patients continue to consult both health systems whilst risking overdose, drug resistance and defaulting treatment as result of combining medications from both health providers and differences in treatment approach.

In this thesis the researcher argues that both these health systems have an important role to play in the fight against HIV/AIDS and TB in South Africa. Despite obvious benefits to the people living with HIV/AIDS and TB and repeated calls for collaborations by various health organizations and governments, progress towards genuine collaboration between AHPs and THPs in the new South African health system has been rather slow.

1.3 RESEARCH PROBLEM

The HIV/AIDS pandemic has reached break point in South Africa. As a result, the National Strategic Plan for HIV, Sexually Transmitted Diseases (STIs) and TB 2012-2016 [8], which represents the country's multisectoral (including THPs) response to the pandemic, is now managed at the level of Deputy President of South Africa. While prevention is at the heart of the NSP, it acknowledges that it was not possible for the country to "treat its way out of the epidemic.... 350 000 new infections happen every year" [8]. Of the 6.2 million South Africans infected with the HI virus [2], by extension, between 60 to 80 % would be estimated to be consulting THPs and/or using traditional medicines [11]. It translates to almost 4 million HIV patients consulting THPs at various

stages of disease progression from common flu-like symptoms to full blown AIDS and ultimate death.

The two prominent health care systems existing in South Africa, the allopathic health care system and the traditional health system provide the HIV/AIDS and TB patients an option to use either of them and /or concurrently. The traditional health systems is often regarded as outdated and ineffective by AHPs [54, 56]. However, overwhelming percentages of patients believe in their relevance today [71]. In the instances where patients' traditions and beliefs are not respected, they may be compelled to be dishonest because they avoided negative perceptions linked to their beliefs. Some may sign a "Refusal of Hospital Treatment" (RHT) to discharge themselves from the hospital, whilst others may silently and secretly utilize these services concurrently under the nursing care of the AHPs. In such cases, the cause of improvement and/or the deterioration of the patient's conditions may not be truly known.

Although there are calls by WHO, African Union and South African government for the initiation of collaborations between traditional and allopathic health care systems, development of models for collaborations between the two health systems in the fight against HIV/AIDS and TB pandemic in the South African context has rather been slow despite the existing policies supporting it.

Two policy frameworks, namely the *STD/HIV/AIDS Strategic Plan for South Africa 2000-2005* (Strategic Plan) and the *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa 2003* (Operational Plan), are evidently the pillars of South Africa's response to the HIV/AIDS epidemic [4, 72]. Both documents refer to THPs as partners in the national response to the HIV/AIDS pandemic.

The promulgation of the Traditional Health Practitioners Act, No. 35 of 2004 amended as Act No. 22 of 2007 (THPs Act), attempted to legalize and legislate traditional medicine in South Africa [73]. Section 5 of the THPs Act provides for the establishment of an Interim THPs Council of the Republic of South Africa. One of the functions of this Council as outlined in Chapter 2 Section 6 (2) (a), is to promote and regulate liaison between THPs and other health

professionals registered under any law [73]. There is currently no clear information as to how the two health systems were liaising or collaborating with each other and how best allopathic and THPs can work together in the management of HIV/AIDS and TB patients.

As both types of health practitioners are working within the same communities and treating HIV/AIDS and TB patients, existing obstacles such as lack of knowledge, mistrust, and the “demonizing” of traditional health approach and practices; may have detrimental effect on the fight against the HIV/AIDS and TB pandemic in South Africa. It is likely to impede the successful implementation of the Act, thus disadvantaging a large majority of South African patients (80% +) utilizing the services of THPs.

In the light of the above challenges and the pluralism in health seeking behaviours of HIV/AIDS and TB patients, this study attempts to provide a model for collaboration between AHPs and THPs, with specific reference to programmes aimed at providing prevention, treatment, care and support to those individuals infected with HIV and TB. There has been an attempt to develop models for collaboration between AHPs and THPs, however, it is not clear whether the THPs themselves were involved in decision making regarding the development of these models. In view of that, this study will attempt to develop a model in collaboration with all stakeholders’ involvement.

1.4 RESEARCH QUESTION

The overall research question is: How will an appropriate model for collaboration between THPs and AHPs in Vhembe District of the Limpopo Province, South Africa be developed?

The following specific research questions were asked to give direction to the overall research question:

- What are the knowledge levels, beliefs and management practices on HIV/AIDS and TB infections among THPs in Vhembe District of the Limpopo Province, South Africa?

- What are the perceptions and experiences on collaboration between AHPs and THPs in the management of HIV/AIDS and TB patients in the Vhembe district of the Limpopo Province, South Africa?
- What is an appropriate model for collaboration between AHPs and THPs in the management of HIV and AIDS and TB patients in the Vhembe District of the Limpopo Province, South Africa?

1.5 AIM OF THE STUDY

The aim of the study was to develop a model for collaboration between AHPs and THPs in the management of HIV/AIDS and TB patients in the Vhembe District Municipality of the Limpopo Province, South Africa.

1.6 OBJECTIVES OF THE STUDY

- To assess and describe knowledge levels, beliefs and management practices of HIV/AIDS and TB patients by THPs in the Vhembe District of the Limpopo Province, South Africa.
- To explore and describe the perceptions and experiences on collaboration between AHPs and THPs in the management of HIV/AIDS and TB patients in the Vhembe district of the Limpopo Province, South Africa.
- To develop an appropriate model for collaboration between AHPs and THPs in the management of HIV/AIDS and TB patients in the Vhembe District of the Limpopo Province, South Africa.

1.7 PARADIGM PERSPECTIVE

A paradigm is a way in which people think and see the world around them. It also represents their worldviews, beliefs, practices, values and approach to their realities [60, 61]. Participatory action research (PAR) paradigm was chosen for this study. It is a naturalistic paradigm which assumes that numerous realities exist and admits ungeneralizable, context-specific subjectivity as a valid process of inquiry [62]. The aim of the naturalistic paradigm is to present social reality, as it exists, as ever changing meanings embedded in a cultural context.

It seeks to understand the experiences and perspectives of different types of people in the particular context studied. It focuses on people's everyday experience and their own ways of interpreting events in their lives [74, 75].

The researcher applied PAR paradigm to explore a model for collaboration between AHPs and THPs in the management of HIV/AIDS patients in Vhembe district of the Limpopo Province, South Africa. Stakeholders, namely AHPs, THPs and community members were integrated in the research project by their participating in group discussions for problem identification, planning the study design, implementing and monitoring the project, and reaching conclusions on a model for collaboration. It is for that reason that participants in this study are called co-researchers. In this study, the term researchers include principal investigator and co-researchers.

The need for this approach in developing a model was informed by the following:

- The researchers believed in the power of people making decision for themselves based on their experiences and informed by their paradigm.
- Patients do not belong to providers, they are independent, consulting both sides (traditional and AHPs). The two health systems are recognised by law in South Africa [73, 76].
- Patients have right of access to health care services [77].
- Every citizen has the right to participate in the development of health policies and on matters affecting one's own health [78].
- A patient has the right on request to be referred for a second opinion to a health provider of one's choice [78].

1.8 RELEVANCE OF THE STUDY

This study is relevant when viewed against the decisions and commitments made at both national and international levels. The need for development of collaboration has been recognized and recommended by the World Health Organization, African Union (AU), South African National Health Department, a decision by Labour Appeal Court and a study conducted by Bereda in the Vhembe district of the Limpopo Province, South Africa. A brief summary is presented below.

The World Health Organization (WHO) calls on all countries to officially recognise and integrate traditional health system into all aspects of healthcare provision [11]. Conducting this research was part of promoting collaboration between AHPs and THPs.

The African Union (AU) emphasized the urgent need for improving the working relationship between AHPs and THPs [79]. The African Summit of Heads of State and Governments declared that traditional medicine research be a priority [79]. South Africa is a member of the African Union. Conducting research on this topic is in line with the declaration by the African Union.

The study is also relevant when viewed against the decision taken by South African National Department of Health regarding institutionalization and operationalization of traditional medicine. It always emphasized the critical role that THPs play in the development of comprehensive health care system. Two policy frameworks, namely the STD/HIV/AIDS Strategic Plan for South Africa 2012-2016 (NSP) and the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa 2003 [4], are evidently the pillars of South Africa's response to the HIV/AIDS epidemic [4]. Both these documents refer to THPs as partners in the national response to the HIV/AIDS pandemic. The promulgation of the THPs Act, Act 35 of 2004 (amended as Act 22 of 2007) is the culmination thereof [73]. The Act provides for the establishment of an Interim THPs Council to 'promote and regulate liaison between THPs and other health professionals registered under any law governing the practices of health services. Conducting research aimed at developing a model for collaboration between AHPs and THPs is therefore, relevant within the current health system of South Africa.

The proposed new health care funded system, National Health Insurance (NHI), which is based on the Re-engineered Primary Health Care (PHC) approach, has been proposed to create an interface of allopathic and traditional health care systems in South Africa. The current piloting phase of the NHI has not included the proposed interface processes between allopathic and traditional health care systems [80]. By conducting this research pertaining to the Thesis, the researchers were attempting to develop and promote a model for the incorporation of the Traditional Health System in the implementation of the NHI. The research was conducted in a Vhembe District of the Limpopo Province, South Africa, which is one of the ten NHI pilot districts identified by government [80] and could serve as a model for the roll out of NHI in South Africa.

The South African Labour Appeal Court, on the 24th of July 2012, ruled in favour of the rights of patients to consult THPs and that a Sangoma's Sick Note was acceptable [81, 82]. The court further confirmed the importance of individuals practicing their traditional beliefs and recognises the importance of cultural practices. SA society is characterized by a diversity of cultures, traditions and beliefs [81, 82]. By conducting this research, the researchers have further provided the evidence that the two health systems, despite their differences of worldviews on health matters, could complement each other, taking into account the patient's beliefs and right to choose.

The findings from a study conducted by Bereda in the Vhembe district, indicated that THPs were ready for collaboration with the AHPs [49]. They have committed themselves to refer their patients to the hospitals when they are unable to treat the disease. They would also like to share their skills and experiences on patient diagnosis. In the same study, 33% of the AHPs and the health consumers were ready for collaboration. More than 66% of the total sample of the AHPs regarded traditional practices as playing an important role in the delivery of health care services, and some agreed that there were diseases which are better managed by the THPs [49].

Finally, any health intervention which disregard the existing community health beliefs, traditions and cultural practices, is likely to be resisted passively by communities if not openly by creating parallel system acceptable to the communities [18, 41, 70].

1.9 DEFINITION OF TERMS

There are different ways of defining terms. However, in this study, the following definitions are used.

Model: It is a copy, replica or analogy that differs from real thing in some way, where in parts of a model correspond to the parts of a theory [83]. Conducting this research is, in effect, setting up models of what the reality is supposed to be and then testing the model against the empirical data.

Collaboration: A process of working together in a climate where the parties acknowledge, respect and appreciate each other's roles and provide mutual assistance to help attain a common goal of managing HIV/AIDS and TB patients. It is not integration, but two conflicting parties are brought into harmony with each other for support [42].

Allopathic: A scientific and empirical medical approach which sees disease as a natural phenomenon subject to investigation by scientific methods [42].

Traditional medicine: An indigenous knowledge and practices of the medicine, inspired by narrated ancestral beliefs and /or handed down through the generation, used in the diagnosis, prevention and elimination of physical, social or mental imbalance [26].

Traditional health practitioner: A person who practices indigenous health knowledge and is recognized by community to provide health care services using tangible and intangible items, and is required to be registered in terms of the THPs Act, No. 22 of 2007 as a traditional birth attendant, traditional surgeon, diviner and herbalist [73].

Allopathic health practitioner: AHPs are those trained in the scientific western medicine and their training is upheld by law. In this study, the term will be used for medical doctors, professional nurses, pharmacists, clinical psychologists, dieticians, radiographers, physiotherapists and social workers stationed in the public hospitals [42].

Ancestors: Spirits of descendants or forefathers called upon to protect, lead and guide individuals in path of harmony between living and the dead, the Creator and his/her creations [73].

Colonization of mind: a process of stripping the mind of the colonized and marginalized people of their ancestral beliefs, values, culture and practices, and replacing it with Euro-Western beliefs, values and practices [74].

Colonized mind: uncritical imitation of western research paradigms with scientific intellectual activity [74].

Decolonization: a process of liberating the colonized mind through the consciously creation of the restoration and development of cultural practices, thinking patterns, beliefs and values which were previously suppressed [75].

Primary Health Care: It is the first level of contact of individuals, the family and the community with the national health system, bringing healthcare as close as possible to where people live and work [84].

Culture: A characteristic ways of living which guide thinking, decision process and actions of a particular group, and is a learned, shared and transmitted values, beliefs, norms and lifeway practices, transmitted from one generation to another [75].

1.10 RESEARCH DESIGN AND STRUCTURE OF THE THESIS

A Participatory Action Research (PAR) design was followed based on the needs of the stakeholders during Pre-phase consultation. The study was conducted in phases, namely: Pre-phase, Phase I, Phase II, and Phase III. Hughes [85] presents a convincing argument for carrying out action research in healthcare settings. Quoting the declaration of the World Health Organization [44] that 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', Hughes stresses that our health as individuals and communities depends on environmental factors, the quality of our relationships, and our beliefs and attitudes as well as bio-medical factors, and therefore in order to understand our health we must see ourselves as interdependent with human and non-human elements in the system we participate in. Hughes adds that the holistic way of understanding health, by looking at the whole person in context, is congruent with the participative paradigm of action research.

The trend toward greater community involvement in health care decision-making is evident in the literature [86] and includes widespread consensus amongst policymakers about the importance of participation in planning. As governments around the world adopt the concept of community participation in health care, it has become a principal underlying policy [86-88], ensuring that the principle of participation is merged into policy and planning at the local, national and international levels [85].

With this purpose in mind, the following features of the action research approach are worthy of consideration [89]:

- Action research is participative and collaborative; it is undertaken by individuals with a common purpose.
- It is situation-based and context specific.
- It develops reflection based on interpretations made by the participants.
- Knowledge is created through action and at the point of application.
- Action research can involve problem solving, if the solution to the problem leads to the improvement of practice.
- In action research findings will emerge as action develops, but these are not conclusive or absolute.

Participatory action research design was used in real situations and its primary focus was the initiation of collaboration between AHPs and THPs. It was chosen because the circumstances required flexibility, the involvement of AHPs and THPs in the research process, and envisaged change in behaviour and action which was holistic and acceptable to all participants. It provided an opportunity for THPs and AHPs to share their health system, practice and beliefs so as to bring understanding and develop a model for collaboration based on acceptance and understanding of each other.

Kemmis and McTaggart [88] developed a simple model of the cyclical nature of the typical PAR process (Figure 1). Each cycle has four steps: plan, act, observe, and reflect.

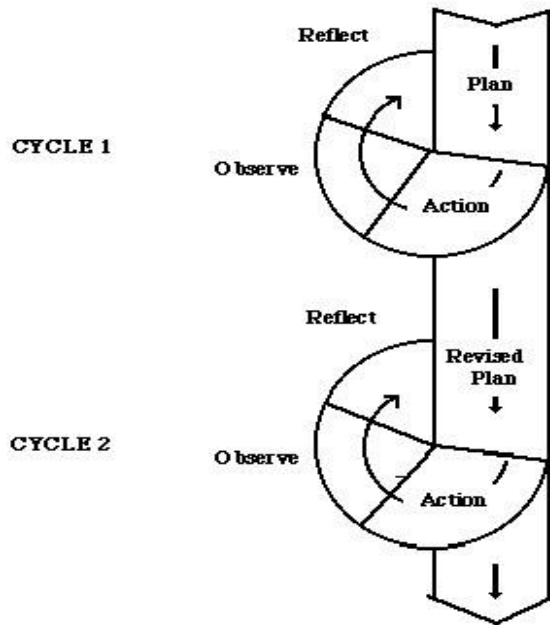


Figure 1 Simple PAR Model

(Adapted from O'Brien (1998))

According to O'Brien [90], there are five phases to be conducted within each research cycle (Figure 1). Initially, a problem is identified (lack of collaboration in management of HIV/AIDS patients) and data is collected for a more detailed diagnosis. This is followed by a collective postulation of several possible solutions, from which a single plan of action emerges and is implemented. Data on the results of the intervention are collected and analyzed, and the findings are interpreted in light of how successful the action has been. At this point, the problem is reassessed and the process begins another cycle. This process continues until the problem is resolved.

Phases of PAR

Diagnosing the problem: Throughout the eight years of conducting training workshops among THPs, it became clear that there is lack of collaboration between AHPs and THPs in management of HIV/AIDS and TB patients.

Planning process: The researchers embarked on a planning process which involved all stakeholders. Meetings and discussions were held at various places including tribal authorities. It helped to identify community viewpoints, processes to be followed and set priorities as determined by people and for the people. A plan was developed.

Action Process: The researchers and stakeholders (co-researchers) implemented the plan as decided jointly by all stakeholders.

Evaluation process: Stakeholders together with researchers had scheduled meetings to assess progress and also evaluate the implementation of the adopted plan for the development of collaboration model.

Learning Outcome: Stakeholders jointly developed the model and identified process to be followed.

The application of PAR and the details of the processes in each phase are discussed in details in Chapter 3. Ethical clearance from the University of Pretoria and the Limpopo Department of Health were obtained before the commencement of the study [Annexures A and D]. Trustworthiness of the study is also discussed in detail in Chapter 3.

1.11 AN OUTLINE OF THE CHAPTERS

Chapter 1 introduces the research topic, conceptualizes the research problem and rationale for the study, and it covered the African ontology of disease and health. It also provides an overview of the HIV/AIDS pandemic, and why patients are turning to THPs for HIV/AIDS and TB management; the value of collaboration between AHPs and THPs. The research problem, together with research questions, aim of the study, objectives, paradigm perspective and relevance of the study are first provided to guide readers. The last section focused on defining the terms applied in the study, the research design and structure of the thesis. It is concluded by providing an outline of the chapters forming part of the thesis.

Chapter 2 is a literature review of the study. Overview of the health system and the various types of THPs are described, with specific emphasis on the three categories of THPs under study, namely diviners, herbalists and spiritual healers. It explores past and current developments in the field of health collaborations involving AHPs and THPs, types and models of collaboration across continents in the fight against HIV/AIDS and TB infections.

It serves to inform the research methodology adopted for the empirical study, and provides a conceptual and contextual framework to analyze and interpret the findings of the empirical study.

Chapter 3 describes the research approach and design adopted for the study, as well as the sampling and data collection processes followed. Consultative meetings with stakeholders and decisions taken on processes to be followed. Measures to ensure trustworthiness and the challenges posed by the research design are discussed, as well as problems encountered in collecting data. The data analysis procedure is also outlined.

Chapters 4 is a discussion of the main findings of the research undertaken pertaining to the knowledge levels, beliefs and practices of THPs about HIV/AIDS in the research area.

Chapter 5 gives the main findings of the research undertaken concerning the views of AHPs and THPs about current and prospective collaboration between the two groups of practitioners. Included in this chapter are perceived impediments to collaboration.

Chapter 6 describes the PAR approach, meeting with stakeholders and the process that was used to develop the model for collaboration between AHPs and THPs.

Chapter 7 highlights the major conclusions of the research findings against the stipulated objectives of the study. Limitations of the study and recommendations are proposed based on the main findings of the research and guided by the literature study in part one.

1.12 SUMMARY

The first chapter has provided an introduction and background and rationale for the study, the research problem and questions, aims, objectives, paradigmatic perspective, relevance of the study, definition of terms, research design and methods, research strategy and an outline of the chapters of this thesis.

Chapter Two, is a literature review on the past and current developments in the field of health collaborations involving AHPs and THPs, types and models of collaboration across continents in the fight against HIV/AIDS and TB infections.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter provides an in-depth literature review on the existing collaboration models in health systems. It starts with a discussion on health systems, the THPs Act, and traditional and allopathic medicine. This is followed by literature reviews on the HIV/AIDS and TB knowledge levels, beliefs and management practices of THPs; the convergence and divergence areas between AHPs and THPs in the management of HIV/AIDS and TB patients.

The concluding section of the chapter focuses on analyses of the past and current health collaborations involving AHPs and THPs, types and models for collaboration at national and international levels. The following databases, which are part of Entrez search engines, were used: PubMed, Medline, PubMed Central, Site Search NCBI web and FTP website. Keywords used were: collaboration in health; integration in health; incorporation with traditional healers, types and models of collaborations; collaboration in fight against HIV/AIDS; role of THPs in fight against HIV/AIDS and TB. Specific focus was on the fight against HIV/AIDS and TB infections. The chapter serves to inform the research methodology adopted for the empirical study, and it provides a contextual framework for the analysis and interpretation of the findings of the empirical study.

2.2 HEALTH SYSTEMS

The WHO [78] defined a health system as, “all activities whose primary purpose is to promote, restore, and maintain health.” What sets apart a health system is that its purpose is concerned with people’s health. For such system to function normally, it would require interconnection and coordination of many parts and units. The researcher’s view was that it is the combination of available health resources, including the acknowledgment and recognition of the important role that THPs play in the delivery of primary health care services that is likely to improve health access and outcome, and

perhaps provide enhanced coordinated health services including the fight against HIV/AIDS and TB infections in South Africa.

Most health systems in Africa are dysfunctional and hardly responsive to the needs and demands of patients [91]. Access to a plural health care system and reports of patients abandoning western medicine for traditional medicine is a sign of non-responsive health system [14].

While there are many possible explanations for this state of affairs, key amongst these are the high levels of suspicion and mistrust that exists between the two health systems and the lack of policy on collaboration between the two health sectors [92]. This is clearly demonstrated by the piecemeal rather than holistic approaches to health systems strengthening [92].

Some of the current health system failures are directly linked to the existing dominant practices by AHPs, and the lack of respect and recognition of traditional health systems [62, 63]. These negative relationships were acknowledged by co-researchers in this study (see results in Chapter 5) to persist even after the introduction of THP Act, (no 22 of 2007). There are different types of relationships that exist between the two health systems:

2.2.1 Exclusive system

An exclusive (monopolistic) system recognises only the practice of AHPs, and severely restricts all other forms of health practices including traditional health practices. Antiquated laws, such as Witchcraft Suppression Act of 1957 and the Witchcraft Suppression Amendment Act of 1970, which are remnants of European colonisation and their beliefs in the supremacy of allopathic health system, outlawed the practice of THPs in South Africa, associating it with “witchcraft” and was thus actively discouraged [93]. Although the Witchcraft Suppression Act of 1957 was repealed by the incoming black majority government in the early 1990s, the health system in South Africa has exclusively remained dominated and controlled by AHPs.

2.2.2 Tolerant system

Where there is a tolerant system, the national health care system is based entirely on allopathic health system, with certain practices of THPs tolerated by law [25]. In South Africa, THPs are in the process of being recognised [73], after many years of being suppressed. Despite that suppression of THPs and the structural arrangements which ignored traditional medicine, patients continued to refer themselves to THPs [52]. The demands and use of traditional medicine by patients (estimated to be 80%) has put pressure on AHPs to acknowledge that THPs have a role to play in South Africa. Such acknowledgement should not be viewed as an acceptance and recognition of the role that THPs should play in the delivery of health services, but rather that patients are 'going back to their roots', to experience the complete Ubuntu treatment provided by THPs [63].

2.2.3 Inclusive system

An inclusive system recognises THPs and indigenous knowledge, but has not yet integrated it into all aspects of health care (i.e. delivery, training, education, or regulation) [25]. This system is what is being pursued in SA, and may also be referred to as a parallel system since more than one system of health care co-exists within the country. The introduction of the THPs Act No 22 of 2007 points to the fact that informal traditional health system integrates with the formal allopathic health system. The mere act of introducing this ACT, symbolises the respect and recognition of the THPs in preparation for possible inclusion in the main health system controlled and dominated by AHPs but we do not have evidence that this may be the case. Most of the initiatives in developing countries, as reported in later section of this chapter, have applied this system in their effort to recognise THPs.

2.2.4 Integrated systems

There has been a global consciousness regarding the necessity to move away from exclusive, tolerant and inclusive systems and move towards integrated systems characterised by the amalgamation of all health care systems available in a society, for purposes of optimising health care for all. Such systems seem to be well

implemented in Asian countries such as China and South Korea [25]. This system would be more relevant in SA, where a significant percentage of patients consult THPs [25, 29, 31].

The WHO [81] refers to an integrative system, whereby THPs are officially recognised and incorporated into all areas of health care provision. This entails (i) including traditional medicine in the relevant country's national drug policy; (ii) registering and regulating providers and products of traditional healing; (iii) providing access to THPs at both public and private hospitals and clinics; (iv) reimbursing treatment with traditional medicine under health insurance; (v) undertaking relevant research in traditional health practices; and (vi) making education in traditional healing available. Very few countries have been able to integrate traditional and western health care systems into a single national health care network. South Africa has not achieved that. The introduction of THPs Act, and the formation of Interim Traditional Health Council is a step in the right direction, albeit progress is very slow. To date, only the Democratic People's Republic of Korea, China; the Republic of Korea and Vietnam have arguably attained an integrated health care system [25]. Selected initiatives in various countries aimed at integrating THPs and AHPs are discussed in section 2.5 of this chapter.

2.3 RECOGNITION OF THPs IN SOUTH AFRICA

It is well-documented that in developing countries, especially in rural areas (including that of South Africa), THPs operate in close proximity and in association with the communities to treat various diseases and ailments [32, 40, 49, 50]. Although traditional healing has its shortcomings, the World Health Organisation (WHO) recognised that THPs could be an answer, especially in dealing with psychosocial problems which are based on culture-specific worldviews. In a study conducted in Vhembe district, Bereda [49] confirmed that THPs were well established health care providers, utilizing plants, animals and mineral substances together with methods based on the social, cultural and religious background, as well as prevailing community knowledge, attitudes and beliefs for the physical, mental and social well-being of the community.

In 1978 the Declaration of Alma-Ata [84] on primary health care recommended, among others, that THPs be integrated into primary health care services in order to respond to the expressed health needs of communities. The WHO has since then repeatedly emphasised the necessity to ensure respect, recognition and collaboration among practitioners of the various health care systems concerned. Part of the call by WHO was heeded almost 40 years later in South Africa. Respect and collaboration seem to be posing a challenge, especially when it involves accepting and respecting traditional medicine as a health science which can work side by side with allopathic medicine [43]. It would appear that the legacy of colonialism, western cultures and exclusive defining of health sciences through the lens of allopathic medicine will persist for some time in South Africa.

The promulgation of the THPs Act and the draft policy on African Traditional Medicine for South Africa, Notice No 906 of 2008, has been an important epoch in the history of the new democratic South Africa, whereby THPs are no longer viewed as “witches” in societies but part of health providers [73]. This THPs Act is an initial milestone in the development of indigenous health knowledge, the encouraging the interaction between AHPs and THPs.

Prior to the THPs Act, the Witchcraft Suppression Act of 1957 was the only legislation which related to THPs, and it referred them as “witches” [93]. The *THPs Act*, commits to enhancing the quality and credibility of the traditional health system in South Africa through the execution of numerous objectives and functions, some of which are in line with international resolutions and frameworks promoting the development of training and research in traditional systems of medicine, such as the Alma-Ata Declaration [84] and the WHO Traditional Medicine Strategy and Plan of Action 2000-2005 [11].

The purpose of the Act was to:

- Establish the Interim THPs Council of South Africa;
- Provide for the registration, training and practices of THPs in the Republic; and
- Serve and protect the interests of members of the public who use the services of THPs.

The primary goal of the Interim THPs' Council (ITHPC) (inaugurated in February 2013) was to assist the health department to integrate traditional health medicine into the national health system.

In doing so, the council should protect and enhance the indigenous knowledge system in the field of medicine and also address public concerns over unscrupulous and bogus THPs and practices.

The purpose of the council in terms of the act was to:

- Promote public health awareness.
- Ensure quality of health services within traditional health practices.
- Protect and serve the interests of members of the public who use or are affected by the services of THPs.
- Promote and maintain appropriate ethical and professional standards required from THPs.
- Promote and develop interest in traditional health practice by encouraging research, education and training.
- Promote contact between the various fields of training within traditional health and to set standards for such training.
- Compile and maintain a professional code of conduct for traditional health practice.
- Ensure that traditional health practice complies with universally accepted health care norms and values.

The council has 20 members and is constituted by representatives of practitioners from all provinces including; a legal expert, a member of the Health Professions Council of South Africa (a medical practitioner), a member of the SA Pharmacy Council (a pharmacist), community representatives, diviners, herbalists, traditional birth attendants, traditional surgeons, academics, researchers and the Department of Health at national level.

The THPs Act came at a time when the public health care system was in a dire need to reflect on the diverse health disciplines which citizens utilized for their healthcare needs. Allopathic health system has been overstretched, severely strained by staff

shortages [30] whilst on other side, THPs were an untapped health resource that could complement and strengthen healthcare services in South Africa [9, 22], especially with the supervision and management of HIV/AIDS and TB patients. There are however AHPs who do not support collaboration with THPs [10, 40], citing various factors which are further explained in section 2.5 below.

The exact number of THPs in South Africa is not known. It is estimated that there are between 450 000 and 600 000 of them in SA, with approximately 60 000 of them in Limpopo Province: population ratio estimated at 1:100 for Limpopo [95].

2.4 TYPES OF TRADITIONAL HEALTH PRACTITIONERS

A traditional health practitioner, also known as a traditional healer, is defined as, “someone who is recognised by the community in which s/he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious backgrounds as well as the prevailing knowledge, attitudes and beliefs regarding physical, mental and social well-being and the causation of disease and disability in the community” [84].

There are different reasons for a person to become a traditional health practitioner. It is believed some THPs are “called” before they are born, whilst others are “called” during childhood or adulthood. The “call” could take a form of a dream, misfortune, illness, a passion or a feeling [42, 48, 96, 97]. If the ‘calling’ is not obeyed, the person becomes ill or continues to suffer until he or she accepts the ‘calling’ and enters into an apprenticeship with a more experienced traditional health practitioner, through a process of initiation, referred to as “u thwasa” [97, 98]. While the knowledge of diseases is passed on from older generation of THPs to new THPs during apprenticeship, the knowledge of medicines, preparation and application is directly communicated to THPs by his/her ancestors only. It is a guarded secret from the ancestors [96, 97].

Not all THPs perform the same functions, nor do they all fall into the same category. Some have their own field of expertise. Even the techniques employed differ considerably [73].

They have their own methods of diagnosis and preferences of medicine. This is critical for the management of HIV/AIDS and TB. What follows is the description of the various categories of the THPs in South Africa.

2.4.1 Diviners

Diviners are categories of THPs who diagnose diseases and illness by throwing bones, shells, sticks or any other special objects in order to interpret the message of the ancestors [43, 96]. In addition to diagnosing illness through divination, diviners are also called upon to interpret misfortune, and to perform family rituals to secure the protection and guidance of ancestors [41, 43]. Diviners form a crucial link between humans and the supernatural [42].

2.4.2 Herbalists

Herbalists or medicine experts are ordinary people who have acquired an extensive knowledge of herbal treatments and technique using roots, barks, leaves, fats, minerals etc. but do not possess occult powers. Unlike diviners, herbalists are not 'called' upon by ancestral spirits [95]. They voluntarily decide to undergo training with an established herbalist, and then practice on their own. They diagnose and prescribe medicines to prevent and to alleviate illness, ailment, and to provide protection against witchcraft and misfortune or evil, and to bring prosperity and happiness [95].

2.4.3 Spiritual healers/prophets/faith healers

Prophets also known as spiritual or faith traditional healers have recently emerged as a third type of THPs. They use prophesy and faith in God as source of their power [41, 98]. Their hallmark feature is their apparel (long coats; usually white, red or green) with robes tied around the waist. They are closely associated with and operate within the framework of the African Independent Churches. In their diagnosis and treatment of a patient, prophets/faith THPs use prayer, candlelight or water. Sometimes, upon cure, a patient automatically becomes a member of the church to which the faith healer who cured him/her belongs [41, 42, 98].

There is division within this category of THPs and it is based largely on legitimacy and beliefs. Prophets/spiritual healers themselves express different views about the legitimacy of spiritual healers based on calling and supernatural source of communication. One group of spiritual healers claim to have visions related to God and so-called heaven as their calling. This group also claim to communicate directly with God in the healing process and do not make use of roots and other raw plant materials to make traditional medicines. Instead, they use water and processed herbs to heal. However, the second group of spiritual healers claim to have visions of objects and people as their calling (similar to diviners) [41, 42, 98].

Furthermore, this group of healers communicates with ancestors in the healing process, and they utilise raw plant material to make medicinal remedies in their healing practices. Each of the two groups of spiritual healers views themselves as legitimate healers, whilst viewing the other as illegitimate. There is a debate as to whether prophets- church based healers should be recognised and accepted as THPs. The current view among the Interim Traditional Health Council Members, and supported by other THPs, is that it should be excluded from the Act [95].

Apart from these three categories, the THPs Act has the following additional categories of THPs included, namely traditional surgeons (of which the scope is not clear), and traditional midwives/ birth attendants.

2.4.4 Traditional birth attendants/ midwives

Traditional Birth Attendants (TBAs) often serve the communities located in isolated and remote areas where they are consulted as a matter of necessity due to cultural beliefs and medical conditions which AHPs are not able to explain and manage, such as *gokhonya and gon²* (a Venda word). However, they also render their services in urban/semi-urban communities, and to those who despite their exposure to Western health care services may still prefer TBAs.

² A birthmark like condition on the body of a new born baby. It is traditionally believed that the condition is transmitted from a mother to a child during pregnancy and /or deliver. Believed to be 100% fatal if not treated traditionally. Vaginal itching and tissue overgrowth found on nursing mothers are some of the classical signs associated with it.

2.5 HIV/AIDS AND TB: KNOWLEDGE, BELIEFS AND MANAGEMENT PRACTICES OF THPs

Although HIV/AIDS is not well understood and has puzzled many THPs, they have various explanations for its cause, origin and why, thereby experimenting with a cure [49]. On the one side, AIDS is considered by THPs as either the development of an untreated syphilis, or gonorrhoea. In other cases, it is associated with a curse from the ancestors for society's infidelity, disrespect for traditions and abandoning ancestral spirits and ceremonial rituals. King [100] reported that THPs believed that HIV/AIDS is generally attributed to individuals not following taboos related to pregnancy, birth, marriage and death.

Despite these differences in understanding among THPs regarding the cause of HIV/AIDS, the concepts behind most of their explanations are similar. There are, however, some traditional health practitioners who associate the symptoms of HIV/AIDS with the calling by ancestors to be a traditional health practitioner. Our research found that some of the common signs and symptoms of HIV/AIDS and TB infections are similar to those experienced by individuals being called by ancestors to become a THP and/ or being punished for violating taboos, not performing rites or performing them improperly. The symptoms range from unexplained weight loss, lack of appetite for food, hallucinations, herpes zoster (*banda or mulilo wa vhadzimu*); vaginal and oral thrush. These beliefs are further discussed in Chapter Four.

The existing beliefs and perceived ability to cure HIV/AIDS is a topical issue which is creating an ever increasing rift, not only between THPs and their allopathic counterparts, but also among patients and traditional practitioners themselves. Although the mainstream of THPs denounce claims that AIDS can be cured by traditional medicines, claims by some THPs of traditional "cures" prevail [100].

The findings of our research reveal that the beliefs that HIV/AIDS can be cured by traditional medicine is prevalent among THPs in Limpopo Province, despite the denouncement by some THPs of this claim on public platforms.

Lack of collaboration between AHPs and THPs seem to have serious consequences on the fight against these diseases. THPs are considered as knowledge holders and community advisors also. They could play an important role in behaviour changes such as influencing the acceptance of condom, HPV vaccination, HIV testing, and male circumcision [97]. There is also existing perception that loss of follow and ARV defaulting is a result of claims by some THPs that their herbal products are effective against HIV/AIDS [16]. Whether their claims are true or not, the percentage of patients who seem to believe in their advice and herbal product should be a matter of concern. Therefore, the entry point to successful strategy on the fight against HIV/AIDS and TB diseases, especially in rural areas, would likely not succeed if it does not recognise and involve THPs. Of late, some efforts are being made to initiate collaboration between AHPs and THPs and cross referrals of patients between the two systems. Where it existed, it is for the benefit of AHPs receiving patients referred by THPs [41, 42].

In the previous section, 2.2 above, the researcher explained how the different health systems may be structured by the Health Authorities to relate to each other. The next section (2.6) focuses on the different functional relationships between AHPs and THPs.

2.6 COLLABORATION BETWEEN AHPs AND THPs

There are different views on the definition of collaboration. Michael Schrage [101] defined it as “a process of value creation that our traditional structures of communication and teamwork cannot achieve.” The key concept highlighted here is “process and purpose to create value” and establish relationship. The WHO [11] indicated that collaboration happens when multiple health providers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality of care. Henneman [102] argues that it is “a joint communicating and decision making process with the expressed goal of satisfying the patient’s wellness and illness needs while respecting the unique qualities and abilities of each professional”.

The main concepts highlighted are: providers from different health persuasions, patients centred, and quality of care-which is the outcome. Health providers refers to all people engaged in actions whose primary intent is to enhance health, including those who promote and preserve health, those who diagnose and treat disease, health management and support providers, and professionals with specific areas of competence, whether regulated or non-regulated conventional or complementary [76].

Collaboration between different categories of health care providers is challenging in virtually all settings [62, 64]. It is often dominated by AHPs. The nature of collaboration has mainly been that of organizing THPs attending training programmes on HIV/AIDS and TB, (they listen and learn from us approach) and laboratory testing of traditionally used herbs [62]. King [103] and Kabongo and others [62] argued that effective collaboration should involve mutual understanding through dialogue between AHPs and THPs where in an exchange of information, skills, materials and technology is freely negotiated between parties.

This negotiated memorandum of understanding should contain among other items, intentions, obligations and mutual responsibilities between the collaborating parties, especially so, where there are different views on health care approach and management of diseases.

2.6.1 Different models of collaboration

There are three main models of collaborations.

2.6.1.1 An integrative model

An integrative model refers to blending the two systems, though allowing providers of both systems to practise together irrespective of philosophical and epistemological views involved [104]. There are four critical factors which constitute an integrative model: Trust among members; cooperation within members; confidence on roles and responsibilities of the members and predictability concerning what others may do [104]. Integrative model for collaboration has not been developed in South Africa. Current collaboration model is assimilation.

2.6.1.2 Assimilation model

The assimilation model involves selecting sections of a THPs practice, testing it and incorporating it into an allopathic setting as it is practised, depriving it from its philosophical and other cultural aspects. Assimilation may be the result of power, financial and political dimensions [104]. However, true integration is different from assimilation. True integration takes into consideration the non-biomedical practice's philosophical values of holism, client centeredness and empowerment. It is sometimes called cooperation/networking: i.e the most informal type of alliance, used primarily for resource exchange. This model has been used to exploit THPs and their knowledge of medicines and skills to the benefit of AHPs [105]. Several researchers have written about abuses and unethical practices experienced through such cooperation and networks [105-107].

2.6.1.3 Pluralist model

The pluralist model, on the other hand, fosters cooperation and mutual relationship and acceptance between AHPs and THPs. It recognises the fundamental epistemological and methodological differences between them. Multidisciplinary teamwork predominates in such situations where co-operating professionals remain independent, but are coordinated and structured in a given fashion [104]. For this to

happen, both groups of partners need to recognise that each system can offer clinically valuable treatment options. Communities and their patients are informed of various choices available, and at the same time promoting and respecting their preferences and values [78]. In both true integrative and pluralist models, interdependence between the partners has to be clearly asserted [104]. The researcher holds the view that this model would be best suited for communities in South Africa, only if both sides are prepared to accept that each health system can offer clinically valuable treatment options. THPs are more likely to accept this approach. As for AHPs, they hold the view that they could contribute positively by changing the negative perceptions against traditional medicine, culture and their health practices [41].

The PAR approach applied in this study has been based on the premise that the two health systems have a role to play within the South African health system.

Their uniqueness and strength of each system combined may provide solution to the current HIV/AIDS and TB pandemic [9, 31, 35, 62, 63].

2.6.2 HIV/AIDS collaborations in Sub-Saharan Africa

King [103] documented initiatives within sub-Saharan Africa which were identified by the Joint United Nations Programme on HIV/AIDS (UNAIDS) as depicting best practices in collaboration between AHPs and THPs in HIV/AIDS prevention and care. The report further highlights selected initiatives from these identified by UNAIDS, as flagship projects [103]. These initiatives are discussed in Table 2.1 against the backdrop of their objectives, activities and outcomes. The table highlights initiatives which portray effective collaboration between AHPs and THPs in the area of HIV/AIDS prevention, counselling and treatment.

Table 2.1 HIV/AIDS collaboration between traditional and AHPs in sub-Saharan Africa

COUNTRY	PROJECT/INITIATIVE	OBJECTIVES	OUTCOMES
Botswana	Botswana Dingaka AIDS awareness and training programme (1991-1993)	<ul style="list-style-type: none"> ▪ Provide a forum for exchange of information and experiences between traditional and biomedical health practitioners ▪ Promoting cooperation and collaboration for health services ▪ Creating awareness on AIDS among THPs ▪ Training core trainers who will, in turn, pass on the information to other THPs in selected pilot areas 	<ul style="list-style-type: none"> ▪ Twelve trained THPs trained, on average, 45 other traditional practitioners per district (six districts) in two years ▪ 72% of THPs said they had changed something in their practice in relation to AIDS training ▪ 80% of THPs said they recommended condoms to their clients ▪ 31 of the 32 THPs said that they had referred HIV/AIDS patients to clinics or to a hospital ▪ a great majority of the nurses who participated in the project said that they had referred patients to THPs ▪ a flip chart addressing practices of THPs was produced
Central African Republic	Action to Define, Broaden, and Strengthen the Role of Traditional Practitioners (ADERT) (1995)	<ul style="list-style-type: none"> ▪ To identify and reinforce aspects of traditional medicine believed to promote public health, while discouraging those that have negative health impacts ▪ To enable THPs to deliver preventive messages, support persons living with HIV/AIDS and modify their own risk practices 	<ul style="list-style-type: none"> ▪ THPs' knowledge improved, except with regard to their own risk practices.
Ghana	Unit for traditional medicine established in Ministry of Health (1990)	To involve THPs in primary health care	<ul style="list-style-type: none"> ▪ To involve THPs in primary health care

COUNTRY	PROJECT/INITIATIVE	OBJECTIVES	OUTCOMES
Guinea	Ministry of Health, traditional medicine unit. Integration of THPs into health activities (1985)	<ul style="list-style-type: none"> ▪ To identify the factors within traditional medicine that can increase the effectiveness of the fight against AIDS in Guinea ▪ To increase THPs' knowledge of modes of HIV transmission and prevention, clinical manifestations, care and support 	<ul style="list-style-type: none"> ▪ THPs are registered with the Ministry of Health ▪ Research on 898 THPs since the beginning of the programme found that increasing numbers of traditional healers refer to health centres, hospitals and other traditional practitioners, using a referral form, for diagnosis and treatment ▪ Biomedical health providers also refer to THPs
Malawi	Training on AIDS for THPs (1992)	<ul style="list-style-type: none"> ▪ To better understand the practices and roles of practitioners in their communities ▪ To promote greater communication between THPs and the formal health care sector ▪ To educate THPs about HIV/AIDS and STD transmission and prevention ▪ To encourage community-based HIV/AIDS prevention and care by THPs 	<ul style="list-style-type: none"> ▪ Increase in community education, condom distribution, and patient counselling activities
Mozambique	Anthropological research on traditional medicine (1995)	<ul style="list-style-type: none"> ▪ To improve intersectoral cooperation in the prevention and treatment of STDs ▪ To identify and reinforce aspects of traditional medicine believed to promote public health, while discouraging those believed to have negative health impacts 	<ul style="list-style-type: none"> ▪ Developed a culturally appropriate strategy for the National AIDS Control Programme (NACP) involving THPs in STD control ▪ Eight clients of THPs were interviewed and showed increased knowledge on HIV transmission, condom use and promotion
	Extend the HIV Health Workforce. (Audet et al, 2015)	<ul style="list-style-type: none"> ▪ To involve THP in validation of eHIV diagnosis and antiretroviral therapy 	<ul style="list-style-type: none"> ▪ THPs were found to improve treatment adherence

COUNTRY	PROJECT/INITIATIVE	OBJECTIVES	OUTCOMES
Namibia	Collaboration with traditional healers in validation of ethnomedicines for HIV/AIDS(2009)	<ul style="list-style-type: none"> ▪ To involve THP in validation of ethnomedicines for treatment of HIV/AIDS infections. 	<ul style="list-style-type: none"> ▪ Ethnomedicines increased CD4 and reduced viral loads ▪ Identified ethnodeicines used for HIV/AIDS infections by THPs.
South Africa	Training of trainers for practitioners (1992)	<ul style="list-style-type: none"> ▪ To engage THPs in combating HIV/AIDS in South Africa through training other health practitioners and incorporating HIV/AIDS prevention into their practices 	<ul style="list-style-type: none"> ▪ 630 THPs were trained by 28 trained traditional practitioners on basic AIDS facts including death and dying ▪ After a seven month follow-up, more than 80% of the trained THPs had retained correct STD/AIDS information and practiced counselling
	Training programme for THPs in Kwazulu-Natal (1994)	<ul style="list-style-type: none"> ▪ To increase AIDS prevention, education and management in KwaZulu-Natal by providing training and resources to THPs ▪ To help trained THPs become accepted by the biomedical system in KwaZulu-Natal 	<ul style="list-style-type: none"> ▪ THPs were able to identify signs and symptoms of AIDS after training ▪ THPs identified a need for rural AIDS hospices and trained home-care personnel to care for persons living with HIV/AIDS ▪ 75% of THPs believed that they could cure AIDS before training whereas none believed they could after training
Uganda	Traditional and Modern Health Practitioners Together against AIDS (THETA, 1992)	<ul style="list-style-type: none"> ▪ To provide a resource center for information sharing on traditional medicine and AIDS ▪ To provide training for THPs in community counselling and HIV/AIDS education, basic clinical diagnosis and patient management ▪ To advocate for traditional medicine 	<ul style="list-style-type: none"> ▪ Collected a wide variety of materials on traditional medicine and AIDS. ▪ Increased counselling and AIDS education by trained traditional healers and increased knowledge and condom use among clients of trained THPs ▪ Over 120 THPs trained and more than 96 000

		among health professionals and other scientists in order to build a true collaboration.	persons benefited in two years. <ul style="list-style-type: none"> Produced two videos in Uganda and English for educational and informational use
	Community-based home care (1993)	<ul style="list-style-type: none"> To disseminate information on herbs and disease To train volunteers to provide care and support to the sick using a primary care herbal kit developed by the project. 	<ul style="list-style-type: none"> THPs trained 68 volunteers involved in home care and distributing herbs for common AIDS-related symptoms
COUNTRY	PROJECT/INITIATIVE	OBJECTIVES	OUTCOMES
Tanzania	Tanga AIDS Working Group (TAWG) (1990)	<ul style="list-style-type: none"> To raise HIV/AIDS/STD awareness among traditional practitioners in three districts with a view to safeguard both practitioners and clients from being infected during practices To train traditional health practitioners as community-based HIV/AIDS/STD educators and home-based care providers for people living with HIV/AIDS and their families. To promote community-based condom distribution 	<ul style="list-style-type: none"> 160 THPs were trained in HIV/AIDS and health information healers are involved in collaborative clinical work, AIDS education, counselling, home visits and village theatre groups. training manual produced
Zambia	AIDS research, training and follow-up (1994-1996)	<ul style="list-style-type: none"> To educate THPs about HIV/AIDS and STD transmission, prevention and care To enable traditional health practitioners to educate their patients about these issues and motivate them to avoid high-risk behaviour. 	<ul style="list-style-type: none"> 2000 THPs were trained on AIDS facts and 120 traditional practitioners were trained in community education knowledge increased, traditional health practitioners started selling condoms through a social marketing programme.

Source: King 2000

Majority of the initiatives focused on integrating THPs in HIV-prevention and counseling programmes. As evident from the selected initiatives presented in Table 2.1, the role of THPs in the battle against HIV/AIDS encompasses far more than merely prevention. It is equally important to explore and understand the role that they play in the treatment and management of HIV/AIDS. Integrating traditional practitioners in treatment and care programmes has only recently gained momentum in sub-Saharan Africa. Initiatives most worthy of mention are, inter alia, the Tanga AIDS Working Group (TAWG) in Tanzania, and the Traditional and Modern Health Practitioners Together against AIDS (THETA) project in Uganda. Although these are not perfect, they are exemplary of initial successful collaboration between the traditional and allopathic health care systems in providing treatment and care to people living with HIV/AIDS.

2.6.3 Convergent and divergent views between AHPs and THPs

In reviewing the convergent and divergent views between AHPs and THPs, the researcher introduced the reader to the existing challenges which could impact on the development of collaboration between the allopathic and THPs in management of HIV/AIDS and TB.

The increasing number of HIV/AIDS and TB infections in Southern Africa is a matter of great concern to health authorities. Two decades after democratic transition, South African prevalence rates continue to rise. The South African Human Sciences 2014 report indicated that there was approximately 469,000 new infections in 2012, suggesting that the rate of infection was not halting [33]. As evidence emerge that HIV/AIDS and TB patients are turning to THPs, traditional medicine is increasingly coming to be viewed as valuable by those operating within an allopathic mindset. There is an urgent focus in mobilizing all the existing and potential resources, including THPs, to fight against the spread of HIV/AIDS and TB infections [6, 22, 50]. There are however, areas where allopathic and traditional medicine appear to converge and diverge. Despite the two health systems having their own source of knowledge and sciences, traditional medicine is still largely taken to be secondary to allopathic medicine in importance [40].

Waldram and Hatala [108] indicated that the two systems converge in their method and approach to patient care. They tend to show sympathy to their patients, and are caring individuals focused on the wellbeing of their patients. Both systems have high expectations for patient accountability. While they both work from a body of latent empirical knowledge; and both engage in elaborate processes of manifest empiricism in their efforts to diagnose and treat HIV/AIDS patients, there is a tendency among AHPs to think that traditional medicine is static, and its body of knowledge and practices remained sealed during the course of human evolution [42].

The two health systems display differences in knowledge and science. This may be best understood ontologically as it was built up culturally and historically over the years. There is a clear cut line of understanding sciences of these two health systems. The allopathic perspective is that allopathic medicine is based on science while traditional medicine is based on supernatural powers. Allopathic health practitioners seem to find it difficult to accommodate the supernatural aspect of it within their “rational” scientific framework. From as early as 1948, THPs have been largely understood to be secondary to allopathic medicine in importance, *and* dismissed as “the antagonist(s) of the physician for centuries” [019, 110], “ancestor[s] of the priest”, “witchdoctors” of the “dark continent” [93]. It may be for that reason that AHPs appear not ready to recognised THPs as health “doctors”.

The allopathic model of disease focuses on the pathology while the traditional model relies heavily on the aspects of the supernatural powers for diagnoses and patient treatment [42]. Unlike in the allopathic medicine, where disease and illness are as the result of pathogens or physiological changes, the THPs believe that diseases and illness are caused by supernatural forces and for a reason. There are various theories of explaining ‘why me and now’. It can be brought about through either one’s own spiritual mishaps, provocation of ancestors by violating taboos, obligation, responsibilities or a mere ‘call’ by ancestors to perform rituals. It can also be caused by the bewitching of individuals by others [100, 106, 110]. Within the traditional medicine, witchcraft is understood to play a central role in the causation of diseases [70, 97, 99]. It is thus not surprising that some of the THPs could be holding the view that HIV/AIDS is the result of supernatural causes [98].

The other area of difference is on the understanding of science. The starting point would be on how knowledge or empiricism as a science is defined. According to Lett [111], empiricism is the accumulation of knowledge through experience and observation. Waldram and Hatala [108] further divided it into “latent” and “manifest” empiricism. Latent empiricism referred to the existing, collectively-held medical knowledge pertaining to diagnoses or treatment, and the standard against which clinical efficacy is judged. In biomedical terms, this is characterized by both scientifically-derived “textbook” knowledge learned by clinicians in formal educational settings and the knowledge previously accumulated through experience with specific medical cases [41, 42].

Latent empiricism is the collection of professional or procedural knowledge that, after sufficient practice, one is said to be an expert in that field. In allopathic medicine, textbooks are used to pass that knowledge. Among the THPs, knowledge is handed down often orally, from healer to apprentice, generation after generation [32]. It provides the form, model or “paradigm” through which and by which a particular case is observed, “the entire constellation of beliefs, values, techniques, and so on shared by the members of a given community” as health practices [41].

The allopathic health system separates the mind and body [41, 42, 111]. It is based on a naturalistic understanding of the body and initially viewed disease as a form of biological malfunctioning which resulted from chemical, anatomical or physiological changes [41]. The AHPs base their diagnosis on the patient’s medical history, a physical examination and, if necessary, laboratory tests. Healing is viewed as the scientific process of correcting diseases through appropriate medical, surgical and chemical interventions [108, 111]. This health approach and followers of allopathic medicine do not acknowledge that there are health conditions which are better managed by THPs using spiritual powers from ancestors, with high success rate and patients satisfaction than the AHPs [41, 42].

2.7 FIGHTING THE HIV/AIDS AND TB PANDEMIC TOGETHER- ESTABLISHING COMMON GROUND

Waldram and Hatala [108] found that allopathic and traditional medicine are compatible in their sciences of treating and managing HIV/AIDS patients. They argued that the AHPs, using their existing biomedical knowledge of HIV/AIDS-related illness, would set a course of treatment that emphasize antiretroviral medications and hospital treatment. On other hand, THPs, invoking existing knowledge of sicknesses caused by spirits, set a course of treatment that emphasized herbal medicines, sacrifices, and ritual ceremonies to appease ancestors. Chilisa [74] would further argue that both approaches are typical of all medical systems in that they “frame problems in relation to the solutions they have to offer” and how they understand it to be according to their existing knowledge as defined by their health system- textbook or ancestors.

Despite the existing bias against THPs and the negativities associated with those consulting them, collaboration between AHPs and THPs in the management of HIV/AIDS, is certainly possible [1, 112, 125-127]. Of the two main health care systems operating in South Africa today, traditional health system is probably by far the most accessible and user-friendly health system [6, 35, 112, 113]. Traditional healers outnumber AHPs by almost 10:1 [94].

It is therefore, essential that efforts should not be directed towards the dismissal of traditional health systems as a static and the THPs as “*the antagonist(s) of the physician and ancestor[s] of the priest*” [42], but rather toward education and integration of AHPs and THPs’ knowledge. Instead of trying to “demonize” the THPs’ knowledge of conditions such as HIV/AIDS, collaboration should focus on pluralism and convergence of the two systems [95]. The reality is that communities and patients on both sides cross the divide and consult the alternatives available to them. What the patient wants is the patient’s rights to choose from the available options meeting their needs and beliefs, irrespective of where to get it, how to get it and who is providing it [113, 114].

For some, engaging with supernatural powers brings meaning and acceptance of their suffering, even if allopathic medicine explained the cause of the disease. This is very important considering that currently, there is no cure for HIV/AIDS, and the patients will be on ARV for life time.

On reflecting about the existing challenge of HIV/AIDS pandemic facing South African communities, the idea of seeking intervention from supernatural forces would not be so strange and uncommon practice as many contemporary AHPs would like to think. Most hospitals in Africa were built by missionaries and had chaplains of various religious beliefs attached to them, to offer prayer and support to both patients and health providers. Appealing to supernatural force was part of complementing the treatment being provided [115]. A study by Nasiri and others [116] reported that a coronary patient was healed as a result of supernatural power of prayers. There was a similar case of HIV/AIDS patients in the St Petersburg, Russian Federation, in 2014 [117]. Whilst the efficacy of prayer and supernatural forces remains controversial, majority of South Africans seem not to have conflict in requesting supernatural intervention.

The superiority of allopathic medicine when it comes to diagnostic tests and management of HIV/AIDS is unquestionable, despite some skepticism made by denialists [118] and sporadic claims by THPs to have found cure for HIV/AIDS [119, 120]. As reported by Shisana and others [33], there is ever increasing rate of HIV infections in South Africa, despite availability of condoms and health awareness campaigns. Simbayi and others [136] suggest that there are other contributing factors at play, such as the risky behaviours associated with alcohol and substance abuse, whilst in the Vhembe district of the Limpopo Province, traditional beliefs and long held risky practices were identified as one of the possible silent factors contributing to the increase of HIV/AIDS infections [121].

There is a missing element within the current approach that is being applied to fight the HIV/AIDS pandemic in South Africa [33, 34]. As these researchers acknowledged that the existing HIV/AIDS measures have not succeeded in changing behaviour, calls are being made to revisit the available strategies such as HIV and AIDS education

programme, condom distribution and management of HIV/AIDS and TB patients. Results of a thesis report conducted in Limpopo Province indicated that spiritualists were already contributing to support those infected and affected with HIV/AIDS [123]. The THPs could play a vital role in the provision of culturally-sensitive forms of HIV/AIDS education and the encouragement of prevention behaviours [41, 42].

To date, the role of THPs, their skills and wealth of knowledge on indigenous modelling of community behaviours and management of patients have not yet been fully explored in a health system. They are being side-lined partly due to the imposition of western health systems and beliefs. It is nearly a decade since the promulgation of the THPs Act and slow progress has been made to recognise and develop it alongside western medicine [124].

2.8 THE MISSING ELEMENT: DECOLONIZATION OF MIND PROCESS

There is general agreement, albeit with sceptical view, among HIV/AIDS researchers, policymakers, health authorities and AHPs to accommodate THPs in their formal health sector [41, 124-126]. This invitation to “come join our rank” in the fight against HIV/AIDS and TB infections has not been made entirely clear [127, 128] especially when it comes to the supernatural aspects which forms part of their sciences [41, 42]. As Flint and Payne reported [42], the invitation extended to THPs “may be seeking to reconcile the irreconcilable”.

The HIV/AIDS and TB pandemic resulted initiation collaboration in sub-Saharan Africa. This include THETA in Uganda, TAWG in Tanzanian and many others. In all these collaborations, AHPs dictated their terms and conditions to THPs. Wreford [129] argued that such collaboration would not be sustainable for long.

The researcher reviewed the existing body of literature on HIV/AIDS and TB collaborations, and observed that the current reported collaboration models have not jointly involved the stakeholders in defining the research problem. It is the invitation approach ‘come join our rank’ to address the perceived allopathic problems of the HIV/AIDS and TB strategies not being effective, the growing number of HIV infections, high number of HIV/AIDS and TB patients defaulting treatment, HIV/AIDS patients

turning to THPs and the ever increasing risk of herbal medicines interfering with treatment efficacy of allopathic medicine.

The second observation that the researcher made was that the research methods and approach applied did not involve the participants from the onset, jointly involve them developing the research plan and in conducting the research. The irony of it is that these researchers were applying a Euro-Western centric paradigm approach among communities that have experienced centuries of dehumanization and destruction of traditional beliefs and practices without applying the decolonization process for the participants. Such collaborations may not last long as they ignored critical step of decolonization process. Scholars on indigenous knowledge and research maintain that community participation in decision making and the decolonization process play a critical role in empowering previously disadvantaged communities such as THPs [42, 74].

In this respect, then, this study is unique and different as it applied the PAR approach from the initial stages of jointly identifying the community problem (later became the research problem), planning process and finding ways to address the problem (research design and methods), taking the confidence of the community and conducting the research with them as co-researchers, and finally the development of the model for collaboration between allopathic and THPs in management of HIV/AIDS and TB patients in Vhembe district of the Limpopo Province, South Africa. It is also unique in the sense that this study was conducted among communities (Vhavenda and Tsonga communities) which have a history strong beliefs on the role of THPs and maintenance of culture and traditions [130,131]. This district has the lowest HIV/AIDS prevalence rate (17.7%) in the Limpopo Province [132].

2.9 SUMMARY

The researcher reviewed the literature on the different types of relationships that exist between allopathic, the recognition and different types of THPs operating in South Africa, and their knowledge and beliefs on HIV/AIDS and TB infections. Various collaboration concepts, models for collaboration, and HIV/AIDS collaboration between allopathic and THPs in sub-Saharan Africa were critically reviewed. Despite divergences indicated between the two systems, literature review suggested that the existing HIV/AIDS strategies have failed to reverse, if not halt the HIV/AIDS and TB pandemic in South Africa. There is both a missing link (human behaviour) and element (decolonization of mind process) in the current approaches used by the health policy makers and HIV/AIDS and TB researchers.

The next chapter is about the research design and methods. It provides detailed information on the processes followed in conducting this study in the context of empowering the community through decolonizing process and came up with a model for collaboration between allopathic and THPs in the management of HIV/AIDS and TB in Vhembe district of the Limpopo Province, South Africa.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

Chapter Two addressed the literature reviewed regarding collaboration of AHPs and THPs. This chapter will focus on the research design and the methods used in this study. The final agreed process was the Participatory Action Research (PAR) process as already described briefly in Chapter One. The study was conducted in phases, starting with consultative meetings, negotiations and gaining access to the research settings with key stakeholders. The research strategies, the population, sample, sampling methods, sampling size, the inclusion criteria, the pilot study, the setting, data collection methods, ethical considerations data analysis and measures taken to ensure trustworthiness will be discussed.

The following five phases of PAR, which are cyclical, were followed.

- Diagnosing the problem. Throughout the eight years of conducting training workshops among THPs, it became clear that there is lack of collaboration between allopathic and THPs in management of HIV/AIDS patients.
- Planning process: The researchers embarked on a planning process which involved all stakeholders. Meetings and discussions were held at various places including tribal authorities. It helped to identify community viewpoints, processes to be followed and set priorities as determined by people and for the people. A plan was thus developed.
- Action process: The researcher and co-researchers implemented the plan as decided jointly by all stakeholders.
- Evaluation process: Stakeholders together with researchers had scheduled meetings to assess progress and also evaluate the implementation of the adopted plan for the development of a collaboration model.
- Learning outcome: Identify general findings; write reports and recommendations on initiating collaboration using PAR.

The PAR process followed was cyclical in nature. It is summarised in a table format below.

Table 3.1. Summary of the research phases followed

<p><i>PRE- PHASE</i></p>	<p>Gaining access to the research setting</p>	<p>Objective: To explore community based method suitable for initiation of collaboration among THPs and AHPs in managing HIV/AIDS and TB patients.</p> <p>Design: PAR</p> <ul style="list-style-type: none"> • Consultative meeting with health authorities, ARV managers, THPs committee, Vhembe AIDS council and traditional leaders was done. Data was collected through hand written notes during the meetings. <p>Key question: How should AHPs and THPs work together in fight against HIV/AIDS and TB?</p> <ul style="list-style-type: none"> • Agreed on process design, research objectives and participants. • Provide support and approval for the project jointly as co-researchers. • set up Advisory Group of local THPs and AHPs representatives <p>Data analysis: Data was analyzed using grounded theory method.</p>
<p><i>PHASE I</i></p>	<p>Baseline data on HIV/AIDS and TB knowledge , beliefs and practices among THPs</p>	<p>Objective: To assess and describe knowledge level, beliefs and management practices of HIV/AIDS and TB patients by THPs</p> <p>Method: Quantitative approach</p> <ul style="list-style-type: none"> • <i>Design:</i> This was a cross-sectional descriptive study with exploratory discussions on knowledge level, beliefs and management practices of the oral and facial lesions associated with HIV/AIDS. • <i>Settings:</i> The study was conducted in seven areas, covering all four local municipalities under Vhembe District, viz 1 Mutale, 1 Musina, 3 Makhado and 2 Thulamela municipalities. • <i>Participants and sampling:</i> Participants were THPs conveniently sampled to attend HIV/AIDS and TB training workshops at 7 areas under Vhembe district. • <i>Data collection tool:</i> Questionnaire with open and closed-ended questions and check list of pictures on HIV/AIDS related lesions. • <i>Data analysis:</i> Stata 12 was used to analyse data.

<p>PHASE II</p>	<p>Joint group discussions with THPs and AHPs</p>	<p>Objectives: To explore and describe perceptions and experiences of collaborations between AHPs and THPs in management of HIV/AIDS and TB patients, identify opportunities and obstacles of initiating collaboration.</p> <p>Qualitative research approach:</p> <ul style="list-style-type: none"> • <i>Design:</i> This was PAR using group discussions with AHPs and THPs • <i>Settings:</i> Three group discussions were conducted jointly with AHPs and THPs in Vhembe district (Elim, Tshilidzini and Malamulele hospitals). • <i>Respondents and sampling:</i> Participants were THPs purposively sampled from the list of THPs who attended HIV/AIDS and TB training workshops in the selected seven areas under Vhembe district. AHPs with 2 years working experiences at HIV/AIDS clinic <p>Data collection tool: Audiotape was used to record the group discussions.</p> <p>Key question: what are your views and experiences on working together /collaboration with AHPs /THPs?</p> <ul style="list-style-type: none"> • Opinions and experiences shared. • Regulation, training, sciences and standard of care debated. • Opportunities and treats of collaboration explored. • Data was analyzed using grounded theory method.
<p>Phase III</p>	<p>Model development with stakeholders</p>	<p>Objective: To present results findings and develop model for collaboration between AHPs and THPs.</p> <p>Approach and process followed:</p> <ul style="list-style-type: none"> • Report back on main findings was done • Discussions and consensus on acceptable model for collaboration was reached. • Stakeholders: advisory committee members selected in Pre Phase, 3 THPs and 3 AHPs involved in Phase II. • Audiotape was used to record the group discussions • Agreed on future need for testing the model developed.

3.2 PRE-PHASE I: CONSULTATION WITH COMMUNITIES: ACCESS TO THE RESEARCH SETTING

The main aim was to develop a model for collaboration between AHPs and THPs in the management of HIV/AIDS and TB patients. Within the constructive paradigm, the researchers selected a PAR approach, wherein the participants became actively involved in the planning and execution of the research plan as co-researchers. The PAR approach encourages egalitarian research relationships and full involvement of those being researched in every aspect of research project- from initial conceptualisation of the research (establish working relationship between them) to the final implementation of the research. In this study, co-researchers developed a model for collaboration.

This approach fits well with the African philosophy and tradition of Ubuntu. (Muthu ndi muthu nga vhathu) “I am what I am because of who we all are.” It is an embodiment of peace, reconciliation and, harmony with oneself, the living and the dead, physical and spiritual beings, and finally with the environment. It accepts and respects participants' world view and community' intangibles beyond allopathic concepts of sciences [74].

The researcher approached the people with the research problem, and when the researcher was with the people, the people determined the method to be used. They led the research process in terms of the form and direction of the research. Although the researcher had research objectives stipulated under Chapter One, the objectives were now determined by participants, referred to in this study as co-researchers. They are grounded knowledgeable people with the capability to use their information to jointly create and evaluate a model for collaboration among themselves. This is community empowerment which usually results in social cohesion, ownership and sustainability of jointly identified solutions.

An initial meeting was organised in the health boardroom of the Vhembe Health District. Traditional leaders did not honour the invite for the consultative meeting as it was against their African tradition and culture to attend a meeting called by commoners.

The meeting was postponed for another date. The researcher had to go and meet the traditional leaders at their place, with a token in a form of an animal (a separate date for a visit to tribal leaders was arranged). Their views and opinions regarding collaborations were captured using hand written notes during the meeting by an assistant researcher.

A separate meeting with the health managers, ART managers, THPs committee members and Vhembe AIDS council committee members was arranged. At the meeting, the researcher welcomed the participants, and requested the meeting to be officially opened. The initial suggestion that prayer alone will be enough was rejected by THPs. Opening prayer was followed by a traditional opening ceremony. THPs knelt down in a circle with their shoes off and requested one traditional health practitioner to communicate with ancestors through the process of pouring snuff on the ground (U shela fola na u suma mushumo). THPs were dressed in their regalia including animal skins, beads and tshela (instrument for communicating with ancestors). The seating arrangement was in a way that participants faced each other. Just after the opening, the initial seating arrangement where AHPs and THPs grouped themselves separately was changed by agreement.

After an introduction of the stakeholders present, the researcher gave an overall purpose of the consultative meeting by means of 8-10 minutes PowerPoint presentation. The purpose of the consultative meeting was to brief stakeholders about the research question which emanated from series of HIV/AIDS and TB training workshops conducted among THPs across the Limpopo Province-“How can THPs and AHPs work together in the management of HIV/AIDS and TB patients?” The presentation was followed by discussions. Stakeholders debated the matter for approximately an hour. Their comments, views and suggestions were captured and noted by the assistant researcher during the meeting. Towards the end of the meeting, minutes of the meetings together with the decisions taken, were read and adopted by means of ululating (mifhululu) and clapping of hands, as the way forward.

This approach of collective decisions making was informed by traditional practices commonly practiced in communal meetings such as “zwivhidzo musanda” (community meetings), “khoroni” (tribal leadership meetings) etc.

The researcher facilitated the process of jointly developing a model for collaboration between AHPs and THPs (co-researchers), starting with consultative meetings (Pre-phase), training and sharing of information (Phase I), group discussions among the co-researchers (Phase II), and round table discussions involving the co-researchers, community members and stakeholders identified during the Pre-Phase consultations. The objective of the discussions was to reach consensus among members and develop a model for collaboration between AHPs and THPs in the management of HIV/AIDS and TB patients in the Vhembe district of the Limpopo Province, South Africa (Phase III). It is for that reason that AHPs and THPs are referred to as co-researchers in this study. This approach has been unique in the sense that communities and patients, as the focal point and consumers of these services, had a voice in how the two systems could work together without changing their beliefs, right to choose and access to health services.

3.2.1 Entrance to the research environment and setting

Events are usually understood when they are placed in the wider social and historical context. This study encompassed physical, social, spiritual and cultural contexts. The physical and social context entailed conducting the study in a geographical area of Vhembe District Municipality, where allopathic and THPs practised their professions. It is one of the 11 districts piloting the implementation of National Health Insurance plan in South Africa. This district is one of five in the province, and has a population of approximately 1.5 million people [132].

Its borders include the Kruger National Park, Botswana and Zimbabwe. Due to these borders, there is a large influx of foreigners into the district. Large parts of the land falls under Tribal Authorities; where traditional leaders and health practitioners play a pivotal role in maintaining cultural practices, norms and standards among the communities.

Over 53% of the district's population is women. The youth in the age group 10-19 years are significantly higher in the population than all other age groups. The majority of the population has no private medical insurance and relies on traditional healers and the public health sector. The district health services consist of six district hospitals, 112 primary health care clinics, eight community health centres and a number of mobile clinics. There is also one regional hospital as well as a specialized psychiatry hospital situated in the district. All the health services in the district are reasonably well utilized. The lack of basic amenities like water at clinic visiting points, shortage of medicine, health professionals (especially doctors and nurses), poor roads and communication networks in some of the health facilities are the major challenges in the provision of health and social development services in the district [133].

The 2012 National Antenatal Sentinel HIV and Herpes Simplex type-2 prevalence survey published in 2013 indicates that there was 17.7% HIV prevalence rate in Vhembe District (Provincial average was 22.3%). Compared to other districts in the Limpopo Province, Vhembe had the lowest [132].

The Vhembe district comprises of four sub-districts viz Thulamela, Makhado, Mutale and Musina, of which the first two are the most populous. The majority of households in the district are headed by those older than 24 years, with 3.3% households headed by those under 19 years. The majority of all the households have an annual income of less than R38 000, most of these households are mainly rural and headed by females. 12% of households have a monthly income of less than R400. The per capita non-hospital expenditure on health is high in the district, higher than the provincial and national average. Almost 19% of the population is unemployed. Eighteen percent live in traditional and informal dwellings, shacks and squatter settlements. Twenty one percent of the households do not have electricity, and 86% have no municipal refuse removal [133].

Traditional health practitioners operate in two worlds –the dead and the living. Life and death are concepts that one could easily understand using lens of the living and the dead, mind and body, spirit and souls. Health, as defined by WHO and accepted by AHP, is limited to mind and body.

The idea of spirits, whether evil or good, affecting and inflicting illness on the patients is beyond the measuring instruments of the allopathic health sciences. Traditional health sciences as practiced by THPs, connect the worlds of the living and the dead using physical and spiritual methods in providing treatment to their patients.

3.2.2 Identification of stakeholders and negotiation process

Purposive sampling was used in order to obtain the broadest range of information, perspectives and experiences with regard to working with THPs in fight against HIV/AIDS and TB. Their divergent views and experiences were best placed to provide the response to “How can AHPs and THPs work together in the management of HIV/AIDS and TB patients?”

Four key stakeholders were identified and invited.

- District Executive Manager and District Health Management Team, consisting of senior managers (PHC, Hospital CEOs, Family Physician specialist) at district level, senior clinical managers of hospitals, managers of HIV and TB, and mother, Child and Youth Health programmes. It represents AHPs who interact and provide health care services to patients at public facilities.
- Vhembe District AIDS Council (VDAC). This consists of community representatives, non-governmental organizations, HIV/AIDS organizations and political leaders led by the District Executive Mayor. The VDAC is a statutory body formed to strengthen the strong political leadership as well as to ensure inclusion of civil society, private sectors and government in the overall response to the scourges of HIV/AIDS, TB and STI in the district. It is chaired by a political head, who is the District Executive Mayor.
- Vhembe THPs: Representatives of all organizations of THPs. They provide health services to patients at their private homes and consulting rooms (called phande) using herbs, traditional health sciences and beliefs.
- Traditional leaders. These are the custodians of African tradition and culture. They work closely with THPs, to regulate matters of tradition and culture and register THPs within their territory.

3.2.3 Seeking approval from Nwali and the ancestors

Although the Faculty of Health's Research and Ethics Committee of the University of Pretoria (REC: 399/2013) and the Limpopo Department of Health (PMREC-54/2013) granted the approval for this study, it was not enough to enter the THPs "sciences and world" without getting permission and approval from the holders of sciences of visible and invisible subjects and traditional medicine, Nwali (Supreme being) and the ancestors.

The principal investigator had several one on one meetings with leaders of THPs at district and provincial level, to explain the purpose and importance of having this joint meeting with AHPs. Their main concern was that their members and knowledge are being abused by researchers. The researcher was invited to their ritual ceremony (muphaso) and introduced to THPs community and ancestors, wherein they requested permission, guidance and approval from their ancestors to join the research project. The researcher brought a goat that was slaughtered during the ceremonial function. Before the meeting started, the purpose of the meeting and the background to the problem was explained.

3.2.4 Data collection method

Request for permission to use of audiotapes during group interviews and taking of pictures was rejected. Fear for misrepresentation and lack of trust on each other appeared to be the main reason for refusal. Data was collected by means of hand written notes from consultative meeting consisting of representatives from Department of Health, THPs, non-governmental organizations, AIDS council and traditional leaders.

Profile of the members for consultative meeting is presented in Table 3.2 below.

Table 3.2 Profile of the members for consultative meeting

Stakeholder	Position	Gender	Services in years
THPs	Chairperson	Male	30+
	Secretary	Female	9
	Coordinator	Female	25 +
Department of Health: Vhembe	HIV manager	Female	15
	TB manager	Female	20
	District Exec Manager	Male	4
Non-government organisations	FPD manager	Female	6
	ARV/STI/TB mentors	Female	4
AIDS council	Traditional leader	Male	5
	People living with HIV/AIDS	Female	4
	Municipal councillor-Health	Male	3

3.2.5 Community decides

Although it is not usually acceptable to integrate the data collection method with the results or findings, the researcher will briefly report on what transpired during the consultation meetings. The following recommendations emanated from the meeting:

3.2.5.1 Improving HIV knowledge and quality of health care through training of THPs

It was noted and accepted that most patients, diagnosed and undiagnosed HIV positive patients do consult THPs.

Although the attitudes and views expressed by participants differed from one individual to another, the general consensus was that THPs should be trained on signs and symptoms of HIV/AIDS and TB. This would make it easy for THPs to refer their patients to hospitals. Referrals from AHPs to them was not supported.

“...If they are properly trained, we will work with them as ARV and DOT supporters. Will they not mix our medicine with their herbs...?” [HIV manager]

It was decided that THPs from all four municipalities should attend a training workshop on HIV/AIDS and TB diseases. Phase 1 in Chapter 3 provides detailed information of the process followed.

3.2.5.2 Collaboration is the way forward

There was generally a lack of knowledge among AHPs regarding the THPs Act no 22 of 2007 regulating THPs' matters in South Africa. Some of the participants were not even aware that THPs are recognised as health professionals "what is going on now? Are they going to come in our hospital? ...we were never consulted" [AHP] and they should be integrated into the main health system. Despite lack of detailed information on how (plan) and under what situation should they collaborate, the new Act was seen as a step in the right direction. Many patients will benefit if not save their lives.

The meeting agreed that all role players, namely, allopathic and THPs should come together to discuss their experiences and on how they could work together. The views of community members, more importantly, the HIV patients should find expression in the report. Phase II & III in Chapter 3 explain the process applied.

3.2.5.3 Monitoring the process

The meeting felt that there was a need to establish a small committee consisting of three members from THPs and three members from AHPs and two representing community and/or HIV positive patients. The purpose of this committee was to market and promote working relationship among health providers and to monitor progress. It will also function as a stakeholders meeting to review the research process and model being developed. Marketing was done through community radio stations and participation in public events. Every Sunday evening between 7pm-8pm an interview with THPs was conducted on a local language radio station Phalaphala SAFM.

3.3 PHASE I: KNOWLEDGE, ATTITUDES AND PRACTICES OF HIV/AIDS AND TB AMONG THPs

The main objective of conducting this phase of the study was to assess baseline knowledge level, beliefs and management practices of HIV/AIDS and TB patients by THPs in Vhembe District. The purpose of which, was to recruit them for collaboration project.

3.3.1 Research design

Quantitative cross-sectional descriptive study design, population and data collection

During the pre-phase consultative meeting; and for the purpose of planning the initiation of collaboration; it was agreed that THPs should attend training workshop on signs and symptoms of HIV/AIDS and TB diseases, assess their beliefs and management practices of HIV/AIDS and TB patients.

Design: This was a cross-sectional descriptive design with exploratory approach to determine the baseline data which assisted in the group discussions with the AHPs.

Settings: The study was conducted in seven areas, covering all four local municipalities under Vhembe District, viz 1 in Mutale, 1 in Musina, 3 in Makhado and 2 Thulamela municipalities.

3.3.2 Study population and sampling

Participants: The participants were THPs attending HIV/AIDS and TB training workshops in the seven selected areas under Vhembe district.

The Vhembe Traditional health council provided the list of all THPs registered with their organisation in the four local municipalities under the Vhembe district. In order to complement the list and to include THPs who are not members of Vhembe Traditional Health council under the four local municipalities, the researcher requested traditional leaders to convene meetings of all THPs under their jurisdictions. The names and contact details of THPs under local municipalities were obtained.

An updated list of THPs was thus established irrespective of their membership of Vhembe Traditional Health Council or not.

Sampling procedures: THPs in this thesis were conveniently selected. These are the THPs who attended the training workshops on HIV/AIDS and TB on selected dates in four local municipalities of Vhembe district. It was a non-probability sampling method which involved the conscious recruitment of participants based on convenience and ease access to them [134].

The researcher together with traditional leaders and the Vhembe THPs' Council selected and recruited the participants who were representative of the THPs and had wealth of experience in their respective fields. Some were acknowledged by the key stakeholders to be able to represent the perspectives of a group.

Inclusion criteria

Joint Agreed inclusion criteria with Vhembe THPs organisation and traditional leaders, were:

- South African born citizens of either Venda, Pedi or, Tsonga ethnicity,
- Either a diviner, traditional healer, herbalist, spiritualist, or traditional birth attendant.
- At least having two years working experiences as a traditional health practitioner in the Vhembe district.
- Practicing from home or regular identifiable office or space in Vhembe district.
- Willing to participate in the study and have a reasonable patient's workload of at least 5 patients a week.

The THPs who met the above inclusion criteria were invited to a training workshop on HIV/AIDS and TB infections, the clinical signs and symptoms; and the management of HIV/AIDS and TB patients.

Data collection instrument

Closed and opened ended questionnaire adapted from other similar studies (Annexure C) was used to collect the data from THPs [125, 135, 136]. All recruited THPs consented to participate in the study. On the day of the training, before the start of HIV/AIDS and TB training workshops, the researcher and research assistant self-administered the questionnaires to all the participants. Some THPs who were illiterate were assisted to fill in the answers. All THPs who were invited completed the questionnaires, n= 437.

Part I of the questionnaire focused on knowledge and beliefs of what are causes, transmission route, signs and symptoms of HIV/AIDS and TB diseases.

Part II of the questionnaire had a check list of pictures on lesions commonly associated with HIV/AIDS (candidiasis, gonorrhoeal infections and herpes zoster). They were asked to identify the lesion, belief on aetiology, indicate if they have treated such lesions, whether it's associated with HIV or not and how they managed these lesions.

During the training workshops, check list pictures and any question related to HIV/AIDS and TB information was addressed. Traditional names of lesions/conditions, treatment and management rationales for HIV/AIDS and TB were shared with understanding that there were differences in health viewpoints and approaches.

3.3.3 Validity and reliability

Validity is a measure of truth or accuracy of the study. De Vos and others [134] defines validity as “the degree to which a measure does what it is intended to do”. For internal validity, the instrument was pre-tested in order to improve on any identified problems in understanding amongst the respondents. The piloting of the study was conducted among 30 THPs who were not selected for the main study, from the sub districts within the Vhembe District because they were accessible. It was to determine if the questions generate information that can be used by the researcher and establish if the interview technique was suitable [134]. The questionnaire was improved accordingly. The research assistant was trained in standardized data collection procedures.

External validity is the extent to which the study findings can be generalized beyond the study sample [137]. The sampling method could affect generalisation results.

Reliability is defined as the test of the stability of a measure [137]. It is the reproducibility of responses to the scale. In this study, reliability was assured by using a tool (questionnaire) already tested for reliability in the pilot study and in previous studies in similar settings [136]. However, since some questions were formulated by the researcher and others were modified the internal consistency of the questionnaire was re-assessed using Cronbach's alpha.

Data analysis:

In Phase I, the data were entered into Excel programme by research assistant, verified by researcher. Captured data were transported and analysed using Stata 11 (Stata Cooperation). For the *closed-ended questions*, frequencies, means and proportions were calculated.

Open-ended questions: In this thesis, the researcher decided to use inductive strategy to analyse the data. Unlike deductive coding which uses theory to construct response categories, in inductive coding, the coding scheme is established based on preliminary analysis of representative sample of the material, without any references to an existing theory or framework [134]. Repetitive reading of the responses to open ended questions was done, aimed at providing an understanding of the data in context.

Twenty percent of the responses were read and coded by the researcher and research assistant together. Emerging responses were determined and coded accordingly. The remaining data was coded using the determined coding.

3.4 PHASE II: RESEARCH DESIGN AND METHODS

In this phase, perceptions and experiences of traditional and AHPs were explored and described. A qualitative exploratory research design was used. Polit and Beck [138] defined qualitative study as “the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design”.

3.4.1 Study population and sampling

Chilisa [60] defines study population as the universe of units from which a sample is to be selected. Universe is a broad term. It would be all potential subjects who possess the attribute in which the researcher is interested [134, 138, 139]. A more appropriate definition, which set boundaries for our study population was used [74, 139].

There were two study populations in this phase: All allopathic and THPs working in the Vhembe District Municipality, Limpopo Province.

The first population group was AHPs. They diagnose and manage HIV/AIDS and TB patients using western health standards of treatment in public health facilities. They have access and control of anti-retroviral drugs and TB medications.

The second population group comprised of the THPs, as they take care of both diagnosed and undiagnosed HIV/AIDS and TB patients at their consulting rooms and patients' homes. They perform traditional rites and rituals; and provide traditional medicine to manage HIV/AIDS and TB patients.

Sampling method is defined as the process of selecting a group of people that represent the population being studied [139]. For THPs, the researcher preferred the purposive sampling method. Purposive sampling is the selection of people with direct reference to the research questions being asked [74, 134, 139]. The purposive sampling technique was considered suitable for this study because it focused on those THPs who attended HIV/AIDS and TB training workshops and AHPs involved in the management of HIV/AIDS and TB patients in the Vhembe district.

For AHPs, it comprised of registered professional nurses, medical doctors, pharmacists, social workers, clinical psychologists and dieticians rendering services to HIV/AIDS and TB patients at the government HIV/AIDS wellness clinics in the Vhembe District.

For THPs, it was comprised of the following: -traditional doctors, herbalists, diviners, faith healers and traditional birth attendants who were practising their profession in the Vhembe District. List of names for THPs working and registered with the Vhembe THPs Association was used and also updated during consultative meetings with traditional leaders.

3.4.2 Inclusion criteria

Inclusion criteria for this study was the characteristics which our co-researchers share with larger study population [139]. The researcher found that there were few AHPs working at ARV clinics and who meet the requirement for inclusion in the study. In most cases, there was only one social worker, one clinical psychologist, one dieticians, two doctor and less than four professional nurses at ARV clinics.

The researchers included all AHPs with two years working experiences at wellness clinic in public health facilities in Vhembe district.

3.4.2.1 Allopathic health practitioner who was:

- Either a medical doctor, professional nurses, pharmacist, social worker, clinical psychologist or dietician working in the public HIV/AIDS wellness clinics in Vhembe district.
- Willing to participate in the study and has at least two years working experiences as an allopathic health practitioner in Vhembe district.

3.4.2.2 Traditional health practitioner who was:

- A South African born citizen of either Venda, Pedi or, Tsonga ethnicity.
- Either a diviner, traditional doctor, herbalist, spiritualist, or traditional birth attendant (traditional surgeon and has attended the training workshop on HIV/AIDS and TB diseases.
- Willing to participate in the study and had at least two years working experiences as a traditional health practitioner in Vhembe district.
- Practicing from home or regular identifiable office or space in Vhembe district.

3.4.3 Sample size

Sample size should be large enough to identify relationships among variables or determine differences between groups [134]. Researchers argue that group interviews should be controllable and manageable [74, 134, 139]. The critical issue is the selection of the participants meeting the set criteria and willing to actively participate in the discussion [74, 139].

There were between 10 and 15 participants in each group discussions conducted between AHPs and THPs. Saturation of data was achieved after conducting the third group discussions. Saturation is a term used to describe “the point at which one has heard the range of ideas and is not getting new information; the point at which one is

not gaining new insight” [74, 140, 141]. The researcher tested the saturation level by conducting another group discussion which involved a THP, AHP and HIV patient in a community setting at Mhinga clinic. It was also used to assess community views and perceptions on a collaboration model.

3.4.4 Setting of the study

This study was conducted in Vhembe district, Limpopo Province. It is one of the five districts in Limpopo Province. There are four local municipalities under Vhembe district: Makhado, Musina, Thulamela and Mutale local municipalities. Dominant groups are Vhavenda and vaTsonga. Due to the long history of intermarriages between the two groups, they now share similar culture, practices, beliefs and dominant ancestral spirits, which are Vhandau, Vatshenge and Vhangona.

The setting for data collection was determined by the type of population group. The interviews were conducted in a convenient place which was safe and participants were comfortable. In all the seven sites, boardrooms were identified as conducive/quiet environments to use as venues to conduct the group discussions.

As mentioned previously, permission to conduct the study was received from stakeholders meeting at Pre-Phase, committee of THPs, ancestors at ritual ceremony, Vhembe AIDS council, Department of Health Limpopo Province and the Research Ethics Committees of the University of Pretoria.

The sampled participants were invited by written letters, personal visit to their homes and word of mouth at training workshops on HIV/AIDS and TB. Information leaflet explained the aim of the study, providing detailed information on the process and procedures of the study. Regular contact with co-researchers was maintained, as the researcher had maintained close working relationship with all co-researchers. THPs were refunded their travelling cost based on local taxi fares, the maximum limit was R100 return. Light meal was provided after the interviews. Special efforts were also made to ensure that food were prepared according the ritual and beliefs of THPs.

Thorough explanations were given the participants prior the commencement of the study. The researcher ensured that the participants fully understood what was involved in the research study before they agreed to participate in it.

3.4.5 Data collection technique and procedure

In this study, group discussion technique, rather than focus group discussion (FGD) was used to explore the views and experiences of two groups with different backgrounds and experiences. Focus group discussions, which is defined as “a group of interacting individuals having some common characteristics” [142], would not provide the desired outcome. Unlike in group discussions and other groups such as community forums and community meetings, the purpose of a focus group discussion is data collection. It is a good way to gather together individuals from similar backgrounds or experiences to discuss a specific topic of interest [142].

Group discussion techniques resemble the freedom and spontaneity of focus groups, but differs in that, it is often directed at solving particular problems, to develop consensus, to arrive at an agreeable plan, or to make a decision about which course of action should be taken [139, 140]. The researchers, having assessed others techniques, came to the conclusion that group discussions is similar if not the same technique applied in the traditional and tribal meetings to resolve community conflicts and differences between individuals [74, 139, 142].

How the researcher approaches the community is critical. Chilisa [74] emphasized that researchers should resist the temptation of approaching a community as “an expert”. They should be willing to learn, walk and experience the route travelled by the communities”. As Letendrea and Williams [139] put it “I Hear You” gives voice to the community. It should be an open and transparent process centred on respect for community values, practices and beliefs [74, 139, 141, 142].

Based on the need to increase voice and participation of all co-researchers, especially the THPs, group discussion method also known as talking circles was used [74, 139, 141]. Unlike the Euro-Western tradition of focus group discussion, where co-researchers only “focus collectively on a topic or issue presented to them’ [137, 143],

co-researchers in group discussion have much greater say on the direction of the group discussions [74, 139, 144]. Research becomes a ceremony and not a once off event. It encourages sharing of ideas, respect of each other's ideas and equality. In group discussions, co-researchers set the agenda, flow and the direction of meeting. It resembles the African practice known 'khoroni", wherein the chief or leader (in this case, the researcher) guides the process and also act as a moderator [74, 136, 144, 145].

Each group discussion interview had between 10-15 participants. On average, the interviews took about an hour. Before starting the interview, the researcher had an opportunity to assemble and pilot test the tape-recorder. Participants were arranged in a circle to facilitate voice capturing on the tape and eye contact among co-researchers themselves and also with the researcher.

On the day of the interview, the researcher introduced himself, welcomed and thanked the co-researchers for honouring and making themselves available for the meeting. Where THPs and AHPs were seated next to each other, the researcher suggested that they move, and seat next to AHPs or THPs.

Data collected without understanding and respecting community values, and culture is not representative of the community's tradition. Chilisa [74] argued that the data collected in such manner deprives the researcher an opportunity to ground himself or herself of being informed. Researchers often make wild assumptions and overgeneralization of the results due to lack of cultural exposure. Traditional beliefs and rituals associated with each group of the THPs were observed, respected and acknowledged appropriately. It also included the ceremony conducted by THPs to request permission from the ancestors and God to participate in the study. This is informed by their beliefs and understanding that ancestors and God is the Knowledge Holder from generation to generation.

After the introduction and welcome remarks by the researcher, AHPs opened the meeting by prayer, and thereafter THPs performed ritual and opening ceremony to inform the ancestors. In almost all venues of the meetings, with exception of Tshildzini

hospital, AHPs walked out of the room during ritual performances, and returned for discussion after the THPs had finished their rituals. THPs appeared not offended.

The co-researchers were briefed about the research objectives, purpose of the interview, recruitment process, and the use of a tape-recorder as a tool to help capture everyone's comments. They were requested to complete a consent form to indicate their voluntary willingness to participate in the research study and also assured about the confidential nature of the interview. It was highlighted to them that they are free to withdraw from participating whenever they wish to. All their questions related to the study were clarified to their satisfaction before the interview commence.

The interview was conducted in Tshivenda at Tshilwavhusiku and Tshilidzini; and in Xitsonga at Malamulele and Mhinga. In order to be in full control of the situation, the researcher requested that any participant wishing to contribute to the discussion should indicate by putting up her or her hand or clapping of hands.

Ground rules were jointly discussed and established. The four main questions developed from the main research questions were used as the interview guide. Key questions are:

- What are your opinions about coming together of THPs and AHPs?
- What are your experiences regarding HIV/AIDS and TB patients and impact of their health?
- What are your perceptions and views on developing collaboration in the management of HIV/AIDS and TB patients?
- What are the opportunities and obstacles on developing collaboration?

As an introductory question, participants were asked to explain what comes into their minds when they were seated next to each other and meeting for the first time in hospital setting. The aim of asking an introductory question was to get clues about the participants' views and for them to actively drive the research process and direction. The researcher probed and paused to allow sufficient time for full discussion, keeping in mind that the key questions are being explored at the end.

The researcher focused on facilitating the group discussions by maintaining a conducive environment for all co-researchers to actively participate, express their views and experiences without reservations in a non-threatening environment.

A research assistant operated the audiotape and took field notes to back up the audiotape recordings. After the third interview, it became clear that data saturation was reached. There were no new information coming out from the co-researchers participating at group discussion at Malamulele hospital. De Vos and others [134] defined data saturation as “no new concepts are emerging and it is considered fruitless to continue with data collection”.

The researcher tested the saturation level by conducting another group discussion involving THPs and AHPs in a community setting involving community members and patients at Mhinga clinic. It was also used to assess community views, their preparedness for collaboration and appropriate model for collaboration.

Social scientists and indigenous scholars have advocated for this approach, where in communities get actively involved during and after research [74, 139, 145].

On completion of each group discussion, before switching off the audiotape recorder, the researcher requested one volunteer each from AHPs and THPs to summarise what has been said, and to also give vote of thanks on behalf of the group. This approach has been empowering by creating ownership and commitment to what has been discussed.

The reader is further made aware that follow up interviews were held with different groups from different municipalities under the Vhembe district, to enhance the depth of the data and also corroborate some of the issues that were not clear. Five sessions were held with each group. The workshops and the meetings are still continuing on the spiral path of the constructive paradigm. For the sake of this thesis, the researcher had to report on the Pre-Phase, Phase One and Two, and the five subsequent interviews held till the model was developed.

3.4.6 Data analysis

There are range of approaches, processes and procedures to qualitative data analysis. Chilisa [74] argues that data analysis is a process of fitting data together, reduction into themes and subthemes, presentation and interpretation of data.

De Vos and other [134] defined data analysis as bringing order, structure and meaning to collected data. The process of data analysis could start whilst more data collection is being conducted [74, 134, 138, 146, 147]. Chilisa [74] emphasized that the process is “an ongoing, iterative process where data collection, processing, analysis and reporting are intertwined, and not merely a number of successive steps”.

It assists in identifying ideas that could be applied in the next interview or help improve it. The first interview at Tshilwavhusiku assisted the researchers to focus on “opinion about coming together”, at the next interview conducted at Tshilidzini hospital. At the third interview at Malamulele, it was becoming clear that no new information was forthcoming. As already indicated, subsequent interviews were arranged to discuss the upcoming themes with the co-researchers. Their inputs assisted to validate the findings and where necessary, they added and subtracted what the researcher had interpreted rightly or wrongly until the consensus was reached.

The following process recommended by De Vos and others [134] was followed in analysis data from group discussions conducted to explore and describe perceptions and experiences on collaboration between THPs and AHPs in management of HIV/AIDS and TB patients in Vhembe district.

3.4.6.1 Data preparation

All audiotapes were translated from Tshivenda and Xitsonga to English and transcribed verbatim. Since the data was coming from various co-researchers with different backgrounds, occupations, educational level, gender etc, it became clear that the researcher should provide a description of the co-researchers for the readers to understand the worldviews within the demographic context of the co-researchers.

The researcher transcribed data from the audiotapes and field notes, ensuring that the transcriptions were accurate, reflected the totality of the interview plus the non-verbal cues such as facial expressions and silence expressed by co-researchers. Laughter, gestures and traditional greetings were added to give meaning to spoken words.

Data was analysed in terms of group dynamics. The researcher indicated the area first as where the interview was conducted by “ T” for Tshilidzini hospital, “ H” for Tshilwavhusiku health centre, “M” for Malamulele hospital, “ N” for Mhinga clinic; and secondly, by type of co-researchers speaking by “ T” for traditional health practitioner, “A” for allopathic health practitioner and “P” patient. The figure at the end of abbreviation was used to differentiate co-researchers. Eg. TA2- The respondent is from (T) Tshilidzini an (A) allopathic health practitioner and is a (2) professional nurse. TT2 - The respondent is from (T) Tshilidzini, a (T) traditional health practitioner and a (2) traditional birth attendant.

Transcribed data together with original audiotapes were presented to a co-coder to check data and confirm its reliability [74, 134].

3.4.6.2 Coding of data

Creswell and others [159] define coding as the process of reading carefully through transcribed data line by line, and dividing it into meaningful analytical units. The researcher read the transcripts several times and organised the transcribed data into meaningful segments, and thereafter assigned a code or label to signify that particular segment. The labelling of codes enabled the researcher to collect, review and retrieve all text and other data related and associated with thematic ideas to be looked at together. This was an open coding process. Unlike a priori coding (where codes are developed before examining the data), the codes emerged from the data as the researcher was reading and reading the data.

3.4.6.3 Organizing related codes into themes, categories and subcategories

The next step was organising of the codes into themes. Some codes fit well with one or more themes, and the researcher decided to allocate them within the themes which inductively was emerging from the data and related to the main research questions.

Themes were identified by reading through the data to check issues or themes that recur in the data. Through a process of moving back and forth through data, subcategories were grouped under categories. Categories were grouped according to the main theme being developed. Three main themes emerged with 6 categories and thirteen sub-categories. Detailed information is presented in Chapter 5.

3.5 ETHICAL CONSIDERATIONS

Traditional healing and medicine, especially practiced by Africans in most African countries, is frowned upon and disparaged by many AHPs for its lack of scientific substance. THPs are very often associated with witchcraft and sorcery, ignorance and illiteracy, as well as with harmful practices. These negative associations have conjured up suspicion and mistrust among THPs of researchers and the media. Furthermore, regulations limiting THPs from disclosing information about their profession have been put in place in an attempt to prevent the exploitation of this cadre of practitioners

Given that the researcher is from Vhembe District, trained in allopathic health system and has been consulting both THPs and AHPs, the researcher remained objective at all stages of the research process and encouraged participants to be free, open and honest during focus group interviews. The researcher guarded against influencing the views of all participants by bracketing³. In the bracketing process, the researcher acknowledges his or her previous experience, attitude and beliefs, but tries to set them aside for the duration of the study to see the object of study anew. Bracketing has also been suggested to contribute to a more rigorous study and better validity [74, 140-143].

These obstacles and challenges were acknowledged in all phases of the research (Section 3.8 below), and stringent procedures were adhered to in obtaining authorization to conduct the research in the selected study sites, and with the selected co-researchers (traditional and AHPs).

³ Bracketing is a method used in qualitative research to mitigate the potentially deleterious effects of preconceptions that may taint the research process.

The protocol received an approval and ethical clearance from the Research and Ethics Committee of the University of Pretoria (REC 399-2013). In Limpopo Province, ethical clearance and permission were received from Limpopo Provincial Health Research Council, Polokwane Mankweng- Hospital Complex, Presentation and approval was received from Limpopo THPs Council and Vhembe AIDS Council.

Permission and approval to enter the THPs “sciences and world” was received from Nwali (Supreme Being) and the holders of sciences of visible and invisible subjects, ancestors, during the ritual ceremony (muphaso). Participants’ information leaflet with informed consent attached, explaining the purpose and procedures of the study, was forwarded to all stakeholders in Vhembe district. Confidentiality of all research respondents was ensured at all times and trust relationships established by various organizations and initiatives in the research sites were honoured. Developing good rapport with the respondents, although time consuming, facilitated the collection of rich, trustworthy and quality data.

3.6 MEASURES TO ENSURE TRUSTWORTHINESS OF STUDY

In order to ensure trustworthiness of the study, the researcher coded the raw data and developed the themes. A clean set of transcripts were sent for analysis by an independent coder who was familiar with qualitative research. The independent coder developed themes which were later compared to the themes developed by the researcher. An agreement was reached on the developed themes.

Trustworthiness of a study can be evaluated by determining:-

- how transferable and applicable these findings are to another setting or group of people;
- how reasonably sure one can be that the findings would be replicated if the study were conducted with the same participants in the same contexts and;
- How sure one can be that the findings are reflective of the subjects and the inquiry itself rather than a creation of the researcher’s biases or prejudices of the study [147, 148].

Shenton argued that “the trustworthiness of qualitative research generally is often questioned by positivists, perhaps because their concepts of validity and reliability cannot be addressed in the same way in naturalistic work”. Many naturalistic investigators have, however, preferred to use different terminology to distance themselves from the positivist paradigm. One such author is Guba, who proposes four criteria of trustworthiness that he believes should be considered [148].

The trustworthiness of the study was ensured by using Guba’s model of trustworthiness [148]. They correspond to the criteria employed by the positivist investigator:

- a) Truth value: credibility (in preference to internal validity)
 - How credible the findings of the study are?
- b) Applicability: transferability (in preference to external validity/generalisability);
 - How transferable and applicable these findings are to another setting or group of people?
- c) Consistency: dependability (in preference to reliability);
 - How reasonably sure one can be that the findings would be replicated if the study were conducted with the same participants in the same contexts?
- d) Neutrality: confirmability (in preference to objectivity).
 - How sure one can be that the findings are reflective of the subjects and the inquiry itself rather than a creation of the researcher’s biases or prejudices of the study?

3.6.1 TRUTH VALUE

Truth value establishes how confident the researcher is with the truth of the findings based on the research design, co-researchers and the context [134, 147, 149]. The strategy used to ensure truth value is credibility which refers to the truth as known, experienced or deeply felt by the people being studied and interpreted from the findings of co-participants’ evidence as the “real world” or the truth in realities. This includes subjective, inter-subjective and objective realities. Credibility requires

adequate submersion in the research setting to enable recurrent patterns to be identified and verified [149].

Strategies used to increase credibility included:

3.6.1.1 Triangulation:

Triangulation is a process of using multiple methods of data collection with a view to increasing the reliability of observation [74, 134, 149]. Triangulation is based on the idea of convergence of multiple perspectives for mutual confirmation of data to ensure that all aspects of a phenomenon have been investigated. The triangulated data sources are assessed against one another to cross-check data and interpretation. The underlying assumption is that, because various methods complement each other, their respective shortcomings can be balanced out [150].

In this study, triangulation of data sources was done by group discussions and individual interview with a variety of AHPs, THPs and patients. Triangulation was further done at Phase IV of model development by subjecting the finding to stakeholders meeting for inputs.

3.6.1.2 Peer examination:

It entailed discussing the research process and findings with other impartial colleagues who had experience with qualitative methods and who were able to increase credibility by checking categories developed out of data and by looking for disconfirming or negative cases [150]. The use of peer groups can contribute to preventing researcher bias and can have a valuable therapeutic function.

- Use of audiotape recorder to obtain accurate information and contextual validation helped to increase credibility of the study.
- In this study peer examination was done by using independent coders who were provided with verbatim transcripts of interviews.
- Discussion of the research process and findings with other impartial colleagues who had experience with qualitative methods were done. They also checked categories developed out of data and by looking for disconfirming or negative cases.

- The supervisors critically assessed the group interview transcripts.
- Discussion of the results and development of the model for collaboration was jointly arrived at with all stakeholders involved in the research

3.6.2 APPLICABILITY

Applicability refers to the degree to which the findings can be applied to other contexts, settings or with other groups. It is the ability to generalize from the findings to larger populations [158]. The purpose of this study was to explore and describe the phenomenon and not to generalize.

There was sufficient descriptive data presented to allow comparison with other studies in similar settings. The following strategies were applied to address the issue of applicability: representativeness in selecting traditional and AHPs was done; qualitative design were used, triangulation and unstructured interviews which provided dense information about the participants, research context and setting were also applied.

3.6.3 CONSISTENCY

Consistency refers to whether the findings would be consistent if the enquiry were replicated with the same participants or in a similar context [147]. The researcher in this study provided the exact method of data gathering and analysis. Such dense description of methods provides information as to how repeatable the study might be or how unique the situation is. Consistency was also achieved through triangulation to ensure that the weaknesses of one method of data collection were compensated for by the use of an alternative data-gathering method [134]. Peer examination was done to check the research plan and implementation by using an independent coder.

3.6.4 NEUTRALITY

Neutrality is the freedom from bias in the research procedures and results. It also refers to the degree to which findings are a function of the informant and conditions of the research and not of other biases, motivations and perspectives. The criterion of neutrality is confirmability which means obtaining direct and often repeated

affirmations of what the researcher has heard, seen or experienced with respect to the phenomenon being studied [150].

Neutrality was done by requesting an independent coder to critically review the researcher's analysis (peer review) and by keeping field notes, which can be retrieved if findings are challenged by other researchers.

- Evidence was also obtained from the participants about the findings of the researcher (member checking).
- The researcher also subjected his results to stakeholders for discussions and development of a model for collaboration.

3.6.5 AUTHENTICITY

Authenticity refers to the extent to which the researcher has given a fair, faithful, honest and balanced account of social life from the viewpoint of someone who lives it every day, showing a range of different realities [138]. In establishing authenticity, researchers provided an environment wherein the co-researchers shared their lived experiences and perceptions regarding the management of their HIV/AIDS and TB patients.

3.7 LIMITATIONS AND CHALLENGES EXPERIENCED

Although the research strategy and approach selected was jointly agreed with stakeholders, various challenges were, nonetheless, experienced along the way. The following posed the main limitations and challenges:

- Research design- The participants opted to choose the methods that they felt will answer their research problem. This is in line with the constructivism paradigm, which is often aligned with the mixed methods.
- The researcher did not opt to choose the types of mixed methods as it would warrant different paradigm. Together with the co-researchers, we resorted to use quantitative approach for the first phase and qualitative approach for the second and third phases as it fits well with PAR and the constructivism paradigm.

- Authorisation – Due to incidences of so-called traditional health practitioner exploitation by researchers in the Limpopo Province, both THPs and health officials were cautious in providing authorisation for the research. Hence, the process of securing authorisation from the relevant officials to conduct interviews with THPs was a lengthy one, and delayed the onset of data collection. In addition, it was important that authorisation be obtained from ancestors and traditional leaders, as failure to do so creates further conflicts and anger from ancestors.
- Most of the THPs are elderly people with little or no education. Conducting training workshops on HIV/AIDS and TB was generally challenging. And this was anticipated from the start as the researcher had been working with them. Patience and thorough explanation was done, and it took more time. Some of them had hearing and eyesight problems. It may have affected the visual identification of HIV/AIDS associated lesions and communications during the study.
- Some THPs, especially diviners, rely on divinations and incarnation by ancestors' spirits to make diagnosis and treatment plans. The fact that their consulting rooms are habitat for ancestors and that they had not brought their “tools” for investigations and diagnosis; assessment of their knowledge and diagnosis of presented lesions during the training workshops may be different.
- Group discussions: Enquiring about the least busy working days and times of AHPs prior to data collection assisted in securing interviews and causing the least interruption both with interviews as well as the work schedules of respondents. However, the most problematic respondents, in terms of securing time for interviews, were medical doctors. Meetings had to be rescheduled two times to accommodate them.

In this part of the world, ritual killing is common and often associated with THPs. Many of them were persecuted, some murdered for communicating and believing in the supernatural powers and ancestors. Some of the THPs, especially the very old women, appeared to be reluctant about participating in this study. Many of them have lived and experienced harassment, witnessed community' killing of “witches”/their

colleagues by burning. The researcher had to assure them that they will not be victimized.

Group of THPs were initially refused access to the hospital by security officials due to their appearances and traditional regalia that they were wearing. Comments such as “What is this? What is going on? Witches!! Are they now allowed to see patients in the hospitals? It looks like, things are changing, ancestors will be happy” were uttered by onlookers at Tshilidzini hospital as THPs were allowed into hospitals premises for the group discussions with allopathic practitioners.

In most places, the initial sitting arrangement round the table had hallmarks of the historical years of suspicions, separations and adversary. Researchers had persuaded and convinced co-researchers to change sitting arrangements and be relaxed.

3.8 SUMMARY

This chapter was about research design and methods. It provided a detailed description of how the study was conducted, consultative stages with stakeholders, the decision processes and direction taken with stakeholders in order to achieve the research objectives. Participatory action research approach was adopted. The research was conducted in Phases. Quantitative and qualitative approaches were used. Pre-phase is about consultation with communities and exploring community based method suitable for initiation of collaboration among AHPs and THPs in managing HIV/AIDS and TB patients. Phase one aimed at determining the Baseline data on HIV/AIDS and TB knowledge, beliefs and practices among THPs.

Phase two was a joint group discussions between allopathic and THPs. It explored and described perceptions and experiences of collaborations between THPs and AHPs in management of HIV/AIDS and TB patients, identify opportunities and obstacles of initiating collaboration. Findings from Phase one and two were applied to develop model for collaboration, as described in Chapter 6 (model development). The next chapter deals with presentation and discussion of findings for Phase 1.

CHAPTER 4

PRESENTATION AND DISCUSSION OF THE FINDINGS FOR PHASE I

4.1 INTRODUCTION

This chapter is about the presentation and discussion of findings for Phase I. Phase 1 provides the baseline knowledge, beliefs and practices on HIV/AIDS and TB among group of the THPs who attended training workshops on HIV/AIDS and TB in Vhembe District of the Limpopo Province, South Africa. The information collected assisted the researcher to prepare and recruit participants for group discussion on developing a model for collaboration in the management of HIV/AIDS and TB patients with AHPs. It followed a decision taken by stakeholders at a consultative meeting (Pre-Phase) to explore a community based method suitable for initiation of collaboration among AHPs and THPs in managing HIV/AIDS and TB patients, Refer to Section 3.2 in Chapter 3- Consultation with communities.

Due to the exploratory nature of the study, descriptive statistics were the main methods of analysis. These facilitated an organized description and summary of the variables under investigation. ANOVA- an inferential statistic – provided further examination of the existence of relationships between knowledge and demographic variables. The p-value used to determine the level of significance between variables was taken to be 0.05. The results of the study are presented first, then followed by the discussions.

4.2 PSYCHOMETRIC PROPERTIES OF THE QUESTIONNAIRE

The pre-data collection involved piloting the questionnaire with five THPs in order to assess the instrument's validity and appropriateness for use. The participants' answers were plausible and relevant to the information required, suggesting that they aptly understood the questions. Individuals were asked about clarity and readability of the questions in an attempt to improve validity. Moreover, in order to enhance the design of the instrument, many of the questions were compiled from various related studies where reliability and validity had been demonstrated. The knowledge section demonstrated a good internal consistency with a coefficient alpha of 0.794.

4.3 PRESENTATION OF THE FINDINGS

4.3.1 Demographic characteristics of THPs

A total of 437 THPs were interviewed. The types of THPs are presented in Table 4.1 below. The largest numbers of THPs were diviners (Nanga) and traditional birth attendants, combined is equal to 74.2% of THPs. These are traditional healers who perform divination (throwing of bones or ancestral channelling), family protectors (u vhea muḁi) and birth attendants. Those who use knowledge of plants, herbs and animal products to cure illness were 36 (8.2%). Spiritualists who include faith healers, prophets and fortune tellers (u femba) accounted for 77 (17.6%). Traditional surgeons were not many 10 (2.3%). Although not many, they were exclusively males, responsible for male circumcisions.

Table 4.1 Types of THPs

Type of THPs	n	%
Diviners #(Nanga)	101	23.1%
Traditional birth attendants/family physicians	223	51.10%
Herbalists	36	8.2%
Spiritualists/Faith healers/prophets	67	15.3%
Traditional surgeon	10	2.3%

Note: # all diviners are herbalists. Not all herbalists are diviners

With regard to gender, almost two- thirds of THPs were females. Table 4.2 presents the profile of THPs. Half of the THPs 218 (50.0%) were above 60 years of age, 32.9% were between 41 and 60 years old. A significant percentage 152 (34.8%) of them reported that they had no formal education, 178 (40.7%) indicated that their highest level of education was primary school. Only 43(9.8%) of THPs had passed matric, and 14 (3.2%) got further qualifications.

The working experiences of THPs varied. Majority of them (356) had more than 5 years working experience; 97 (22.2%) had between 6 -10 years of working experience: 139 (31.8%) had between 11 and 20 years of working experience, whilst 120 (27.5%) had 21 years and more years of working experience. Almost all participants 408 (93.4%) reported that they were attending HIV/AIDS and TB training workshop for the first time. Eighty –seven percent of THPs conceded that they do not know their HIV status. Only 57 (13.0%) tested for HIV.

Table 4.2 Profile of THPs (n=437)

Characteristic		N	%
1. Gender	Male	112	25.6%
	Female	325	74.4%
	<18	10	2.3%
	19-40	65	14.8%
	41-60	144	32.9%
	>61	218	50.0%
2. Highest level of education	No schooling	152	34.8%
	Primary school	178	40.7%
	Incomplete secondary school	50	11.5%
	Matric	43	9.8%
	Higher education	14	3.2%
3. Working experiences as THPs	>5 years	81	18.5%
	6-10 years	97	22.2%
	11-20 years	139	31.8%
	<21 years and above	120	27.5%
4. Previously attended HIV/AIDS/TB workshops	Yes	29	6.6%
	No	408	93.4%
5. Tested for HIV infections	Yes	57	13.0%
	No	380	87.0%

4.3.2 Knowledge on HIV/AIDS and TB infections

Table 4.3 presents the knowledge levels and beliefs of THPs about HIV/AIDS and TB infections.

The causes of HIV/ AIDS were correctly identified by most of the THPs 337 (77.1%). Their knowledge about the causes of TB was much higher than that of HIV/ AIDS (89.7%).

A significant portion of them felt that evil spirits and spells were the main reasons why patients had HIV/AIDS (22.9%) and TB (10.3%) infections respectively. With regards to their knowledge of HIV transmission, majority of the THPs (91.2%) agreed that HIV/AIDS could be transmitted through blood, unprotected sex (88.1%) and breast milk (59.3%). A high percentage (86%) indicated that HIV/AIDS could also be transmitted through kissing. Inhaled air (94.3%), blood (56.8%), kissing (49.4%) and contaminated foods (86.3%) were stated as route of TB transmission.

Table 4.3. HIV/AIDS and TB knowledge and beliefs among THPs

Condition	Questions related to		Response n=437 (%)
1. HIV & AIDS	1.1 Causes of AIDS	HIV infections	337(77.1)
		Evil spirits/spells	100 (22.9)
	1.2 Transmission routes identified	Blood	398 (91.2)
		Unprotected sex	385 (88.1)
		Kissing	376(86.0)
		Breast milk	259 (59.3)
	1.3 Ancestors/Muti can protect against HIV	Yes	151 (34.6)
		No	199 (45.5)
		Not sure	87(19.9)
	1.4 Common signs and symptoms identified	Weight loss	423(96.8)
Sores and herpes zoster		406(92.9)	
Diarrhea		369(84.4)	
Candidiasis		81(18.5)	
1.5 Traditional herbs can cure AIDS	Yes	183(41.9)	
	No	200(45.8)	
	Not sure	54(12.3)	
2. TB	2.1 Causes of TB indicated	TB-Bacterial infections	392(89.7)
		Evil spirits/air/spells	45(10.3)
	2.2 Transmission routes identified	Inhaled air	412(94.3)
		Contaminated items	377(86.3)
		Blood	278 (56.8)
		Kissing	216(49.4)
	2.3 Common signs and symptoms	Persistent cough/pain/blood	433(99.1)
		Night sweating	414(94.8)
		Weight loss	361(82.6)
		Loss of breath and fatigue	405(92.7)
2.4 Traditional herbs can cure TB	Yes	233 (53.3)	
	No	211(48.3)	
	Not sure	203(46.5)	
			23 (5.2)

Traditional health practitioners generally demonstrated a high quality knowledge regarding HIV/AIDS (77.1%) and TB (89.7%) overall. Common signs and symptoms which THPs associated with HIV/AIDS infections were: unexplained weight loss (96.8%), sores and herpes zoster (92.9%) and diarrhoea (84.4%). More than 81.5% of THPs were not aware that oral candidiasis is one of the main signs in the oral cavity, which indicates the severity of immune system suppression and possibility of high viral load in the blood system.

Identified TB symptoms were persistent coughing with pain/blood (99.1%), night sweating (94.8%), weight loss (82.6%) and loss of breathe and fatigue (92.7%). An ANOVA was performed to determine if demographic variables of age, gender, types of THPs and level of education (independent variables) had an effect on level of

knowledge (dependable variables). There was insufficient evidence to suggest that there was a difference in the knowledge results between the groups, as related to age ($F=1.402$; $p=0.259$); gender ($F=1.363$; $p=0.0269$); type of THPs ($F=0.978$; $p=0.453$), and education level ($F=0.897$; $p=0.0365$). It implies that these demographic variables did not play a role in relation to knowledge differences.

4.3.2.1 Traditional beliefs about HIV/AIDS and TB infections

Nearly one third (22.9%) of THPs believed that AIDS was caused by witchcraft and evil powers (**Table 4.3**). Significant number of THPs indicated that HIV/AIDS patients (41.9%) and TB patients (48.3%) could be healed. Thirty-four percent believe that there are traditional herbs, muthi and powers from the ancestors which are able to provide protection against possible HIV infections. They would also believe that those herbs and muthi were capable of providing effective protection against HIV infections. Some believe that the power to heal come from the ancestors.

4.3.3 Recognition and management of lesions associated with HIV/AIDS infections, Table 4.4

Part II of the questionnaire had open-ended questions linked to three A4 colour pictures, of herpes zoster appearing on patient face and abdomen, gonorrhoea on male genital; and oral thrush on soft and hard palate (Annexure F). This approach was applied to assess the THPs' knowledge levels of HIV/AIDS related lesions and how they would manage these lesions. Their responses are summarized in **Table 4.4**. They were categorized into: recognition and beliefs on causes, management and relationship of lesions with HIV/AIDS.

Table 4.4 Recognition and management of lesions associated with HIV/AIDS, N (%)

Questions	Lesion	Correct	Incorrect	Unsure	
1. What is this condition	1.1. Herpes Zoster	401 (91.8)	30 (6.8)	6 (1.4)	
	1.2. Gonorrhoea	378 (86.5)	50 (11.4)	9 (2.1)	
	1.3. Oral thrush	57 (13.1)	66 (15.1)	314 (71.8)	
		Witchcraft/Evil/ancestors	Infections	Others	Unsure
2. What causes it?	2.1. Herpes Zoster	412 (94.3)	10 (2.5)	7 (1.6)	8 (1.8)
	2.2. Gonorrhoea	42 (9.6)	393 (89.9)	2 (0.4)	-
	2.3. Oral thrush	107 (24.4)	26 (5.9)	23 (5.3)	281 (64.3)
		Herbal medicine	Referral to AHP	Referral to THPs	
3. How would you manage it?	3.1. Herpes Zoster	320 (73.2)	18 (4.1)	99 (22.7)	
	3.2. Gonorrhoea	418 (95.6)	-	19 (4.4)	
	3.3. Oral thrush	57 (13.0)	342 (78.3)	38 (8.7)	
		Yes	No	Not sure	
4. Is there relationship with HIV/AIDS infections?	4.1. Herpes Zoster	59 (13.5)	366 (83.8)	12 (2.7)	
	4.2. Gonorrhoea	259 (59.3)	103 (23.5)	74 (17.2)	
	4.3. Oral thrush	67 (15.3)	107 (24.6)	263 (60.1)	

4.3.3.1 Recognition and beliefs on causes of the lesions

Respondents were asked to indicate whether they have seen these lesions, what are they, in their daily encounter with patients (**Table 4.4**). Most of the participants, 401 and 378, were able to recall seeing similar lesions in their surgeries and were spot on in identifying herpes zoster (91.8%) and gonorrhoea (86.5%). Nearly two-thirds of THPs (71.8%) could not relate to oral thrush, and were unsure.. Herpes zoster was called by different names: “mulilo wa vhadzimu”⁴ “mulilo wa vhaloi”⁵, maswa vhusiku”⁶, “banda la Mozambique”⁷, “banda la Zimbabwe”

The knowledge of causes of herpes zoster was worrisome. Almost all respondents (94.3%) believe that evil forces and anger from the ancestors were the cause of these dreadful disease, visiting healthy community members in the middle of the night.

⁴ Skin blisters believed to be as a result of a fire caused by ancestors

⁵ Skin blisters believed to be as a result of a fire caused by witches

⁶ Skin blisters believed to be as a result of an excessive heat during the night

⁷ A band-like lesion appearing along the nerve supply, believed to be found among Mozambican immigrants

With regard to gonorrhoea, a high percent of THPs (89.9%) knew that it was a sexually transmitted infection. The possible cause of oral thrush unknown, as majority of them not sure.

4.3.3.2 Management and relationship of lesions with HIV/AIDS.

As reported in **Table 4.4**, herbal medicine were the most preferred and sought after treatment choice for herpes zoster (73.2%) and gonorrhoea (95.6%). Majority of the THPs refer patients presenting with oral thrush to AHPs (78.3%). Knowledge levels on the association of herpes zoster with HIV/AIDS infections were very low (13.5%). It supports the belief that herpes zoster is caused by evil powers. More than half (59.3%) of the THPs associated gonorrhoea with high risks of HIV/ AIDS infections.

4.4 DISCUSSION OF THE FINDINGS

4.4.1 Characteristics of THPs

The study found that there was a high number of THPs who performed divination as their professions. Traditional health practitioner is a profession which has been practiced for centuries in Africa, long before western medicine became the dominant health system. Their knowledge and practice of herbs, roots, and other medicine has been passed down through generations. It is acquired during their ancestral calling to become a traditional health practitioner (thwasana⁸) [48, 110, 111].

A call to become a traditional health practitioner could start at any age and present in different ways including unexplained illness, constant headaches, dreams and night mares associated with ancestors, loss of weight [48, 97, 151, 152]. Unlike in medical schools, becoming a traditional health practitioner does not follow selection criteria such as grades achieved at grade 12, entry level examination, age limit etc [153]. Although not rare to find children employed fulltime in different economic sectors in rural areas, it was surprising for us to find that ancestors have called children to become THPs.

⁸ Intern traditional health practitioner

Some of them had been practicing for more than five years, suggesting that they may have been called to become a traditional health practitioner at an estimated age of 9 years or so.

Majority of THPs were adult women (74.4%) with no formal education (34.8%). It compared well with Vhembe District Profile [133], which reported that over 53% of the district's population was women, with little or no formal education. In 2002, Bereda found similar results, 59% of her participants were not educated. This may influence the findings as lower levels of education have been correlated with lower level of knowledge of transmission, treatment and prevention [151]. They have also demonstrated that black people generally tend to have poorer HIV/AIDS knowledge due to poverty, poor literacy levels or lack of formal education.

Their wealth of experience and source of knowledge of traditional medicine and patient' management is from ancestral spirits incarnated during their initiation process (u wisiswa). Such knowledge and practice of herbs, roots, and other medicine has passed down through generations. Compared to allopathic health professionals who are required to attend continuous training and update on latest medical developments, theirs is to comply with ancestral spirit that called them to become THPs [41, 42]. In a western paradigm these fields and practices are considered backwards, unscientific, erroneous and potentially harmful [41, 154].

4.4.2 Knowledge levels of HIV/AIDS and TB infections

The THPs seem to be aware of the danger HIV/AIDS and TB poses. Their knowledge on the causes of HIV /AIDS (77.1%) and TB (89.1%) infections can be considered to be exceptionally high, especially that most of them are not formally educated. This was consistent with other research [155, 156] and implies that programmes emphasizing dissemination of information have succeeded in so far as increasing knowledge is concerned. HIV/ AIDS diseases maybe foreign to their ancestors and forefathers. It has been discovered in the early 1980s.

Another factor would be that virus and bacteria concepts are not separated in traditional medicine. Diseases and illness are often, if not always caused by mimuya⁹ (spirits, spells), similar to what religious followers would call evil spirits and/ or thuri¹⁰ [41]. Added to that, is that there is no common traditional name for HIV/ AIDS conditions [21, 98]. Mashamba et al., [156] have also reported high knowledge of HIV/AIDS among the THPs in the Vhembe district. It compared well with a report from a study conducted by Peltzer and others [125] in the Kwa-Zulu Natal Province. Among the African people, AIDS is called by many names, which are usually the descriptions of its clinical presentation such as herpes zoster (bannda or maswa vhusiku), oral thrush (vhudaadaa or mahada) etc.

A great deal of debate has been spurred on this issue, particularly with the South African government making an argument for poverty as the cause of AIDS [157, 158]. That could have led to some confusion and possible reason for delays in reaching out to THPs. Such confusion has widespread implications for understanding of the diseases and management of HIV/AIDS and TB patients.

The other factor worth noting was that almost a quarter of them had no formal education. Their source of knowledge was most likely to have been through public media (radio discussions, announcements), television, one to one conversations and community awareness campaigns.

Their good and correct knowledge on identified transmission routes, common signs and symptoms for these diseases is very important, especially in the fight against an increasing high rate of new infections despite increased funding for health education, prevention and treatment [33, 34]. It would influence patient adherence and thus prevent spread of disease in the community ([9]. If given the necessary support and training on the management of HIV/AIDS and TB, THPs could help improve quality of life among affected and infected people in Limpopo Province, South Africa [156, 159, 160]. Knowledge of how the virus is transmitted and how to avoid contracting it will encourage some THPs to take protective measures when handling blood and body

⁹ Tshivenda word for evil forces, winds and spirits.

¹⁰ Evil spells thought to be in a form of a small nocturnal animal, capable of causing insanity.

fluids, but knowledge alone is unlikely to change individual behaviour and practices sufficiently to prevent the spread of HIV infection [33, 34].

4.4.3 Health assumptions and traditional beliefs about HIV/AIDS and TB diseases

THPs play a very important role in African communities [41]. Significant percentages of patients consult THPs [6, 41, 42]. Often the decision is made out of necessity as AHPs fail to explain “why me” question and “the ancestors are not happy”. THPs often provide an explanation which the patients and community could relate to and understand based on the existing traditional beliefs and cultural practices [161].

Their position in the communities is one of great respect and influence: they are the first to be consulted when disease strikes a community. They can either refer patients to western clinics or treat them in their own way. This choice had a major effect on the patient's health and thus on the entire community. Such power could be harnessed in favour of patients. Educating the THPs has been shown to significantly improve their knowledge of HIV/AIDS and TB diseases [17, 62, 64]. Through their role as family “doctors” they could reach out to the whole community, thus improving the process of diagnosis and referral, which may lead to prevention or spread of diseases.

The researcher assessed the existing beliefs and myth associated with HIV/AIDS and TB, and found that there were major gaps in their knowledge. The results of this study brought both interesting and worrisome information to light. A significant number of THPs believed that the evil spirits (*mimuya*) and spells (*thuri*) were the main reasons why patients had HIV/AIDS (22.9%) and TB (10.3%) infections. This should be understood within the African context and lack of better words for virus and bacteria which cannot be seen by naked eyes [159]. Sifunda et al., [159] reported that these social construction and cultural meanings of diseases played a major role in providing the culture –specific prevention methods. With exceptions to conditions and diseases caused by visible parasites (*tshivhungu*) all other diseases and illnesses are caused by “mimuya” (evil spirits). It is for that reason that the illness and death which cannot be directly linked to visible and acceptable explanation, is often referred to the diviners and prophets for explanations [9, 41].

The beliefs about HIV/AIDS being caused by witchcraft seem to be common, although not publicly acknowledged to be so. To address that belief, it would require that all stakeholders with influence in the society and culture are involved, including opinion leaders and traditional leaders, as has been done more than 30 years in Zaire [162]. THPs with community leaders represented an important social change towards sex and use of condoms in the prevention of HIV infections in Zaire. Some of the current beliefs in this study, may have a negative effect on the patient's health and are the source of spread for HIV and TB. The most notable beliefs of concern was that the ancestors' powers and muthi were capable of providing protection against HIV infections. Recent death of miners at Marikana mine was also linked to these false beliefs [163]. Despite availability of HIV awareness campaigns and condom distributions, recent report indicates that HIV infection rate in South Africa has increased over the years [2, 33]. If these untested claims continue to prevail and communities including health authorities do not take proactive measures to counter such claims, the current low HIV/AIDS infection rate in the Vhembe district is likely to increase.

A significant number (41.9%) of the THPs in the study claim that their traditional herbs can cure AIDS. This is a very common claim among THPs [14, 16, 164]. In a study conducted by Burnett et al., [164] in Zambia, 51% of the THPs claimed a cure existed for AIDS. That claim was not limited to THPs only, 15% of AHPs interviewed supported the claim [164]. This is worrisome, and may indicate lack of knowledge about HIV/AIDS diseases and opportunistic infections associated with AIDS. It could be a reflection of misinformation circulating publicly which attributes cures to various unproved treatments or an indication of an issue whereby public health education has not been explicit enough [157, 158].

As previously stated, THPs define HIV/AIDS by its clinical appearances. It is not surprising that the disappearance of clinical signs and symptoms of HIV/AIDS is believed to be a cure for it. Although the traditional therapy is believed by some to have no scientific basis [93, 165, 166], their process of diagnosis is believed to correct as some of the THPs are able to diagnose numerous illnesses [41, 42]. THPs trained on signs and symptoms of HIV/AIDS and TB, played a significant role in the fight

against the spread of HIV/AIDS and TB infections [6, 7, 9]. Some THPs actually acknowledge their inability to treat HIV/AIDS and TB; however, others claim that their herbs and therapy for HIV/AIDS and TB has always been successful.

Knowledge concerning HIV/AIDS and TB, therefore, varies greatly among THPs, and would result in some referring patients whom they believe to suffer from HIV/AIDS and TB to AHPs while others treat them using traditional medicine. Subsequently, HIV/AIDS will pose more of a threat to the health of the population. Therefore, a large-scale health education programme, targeted at THPs, and could positively improve HIV/AIDS and TB treatment, adherence, and reduce spread of it. THPs are ready for collaboration with AHPs in mutual respect for each other's tradition and practices [43, 112, 167-169].

4.4.4 Recognition and beliefs on causes of the lesions

The finding of the study demonstrated that high number of THPs were treating herpes zoster and gonorrhoea lesions. It confirms previous study report which indicated that THPs were managing lesions associated with HIV/AIDS [170-172], without having facilities and adequate resources to perform test for diagnosis. It was noted that most of the THPs were not able to relate to and identify oral thrush. Intra oral examination on "healthy" patients presenting with no oral health complains is probably not a common practice among THPs. Having said that, oral thrush is one of the most common oral lesion associated with HIV/AIDS patients [173, 174]. Unless the patient has secondary infections such as gingivitis and periodontitis, oral thrush is not painful, and the patients may not be aware that s/he has a lesion. Only a curious and observant traditional health practitioner will recognise that the oral tissue is not normal. Recent findings by Ramphoma and Naidoo [175] revealed that even the oral health care workers working in the well-resourced facilities were not vigilant enough to check for oral lesions, some were unable to correctly identify the lesions as they lacked adequate knowledge of the common oral lesions associated with HIV/AIDS.

The low knowledge level of oral thrush and the low recognition for oral thrush among the study participants was comparable to the study results (22.4%) conducted by Rudolph et al., [170] among 63 THPs nearly 10 years ago.

However, the identification and knowledge level of herpes zoster (91.8%) among our participants appear to have improved significantly over the years when compared to those reported by Rudolph et al., (57%). The ability of the THPs to recognise and identify that those lesions were associated with HIV/AIDS infections provides a golden opportunity to engage them in the fight against HIV/AIDS.

A question on “what is the cause of these lesions” revealed their beliefs in supernatural powers and the depth of traditional medicine. These responses were most probably the reflection of the past and present prevailing beliefs among THPs. Almost all responses (94.3%) were of the opinion that herpes zoster was caused by evil forces and ancestors. The explanation on what is thought to be the cause herpes zoster, appeared to link it with the indigenous name for it:

- Mulilo wa vhadzimu¹¹- ancestors were the cause of the lesions. It is thought that *“ancestors visited the patient in the middle of the night and burned the skin overlying the area where there is a lesion”*.
- Mulilo wa vhaloi¹²- witches caused the lesion during the night-*“When witches fail to take you away during your sleep, they burn you as a sign of their anger and failure”*
- Maswa vhusiku¹³- excessive heat in a form of hot air externally caused the burns
- Banda la Mozambique or Zimbabwe. It’s an infection which is thought to be coming with patients from Mozambique or Zimbabwe to Vhembe district.

African names have meanings and are related to events. Komolafe et al., [186] reported of similar cases in Nigeria, where local names such as "Atao", "African pepper" and "poisonous dart or arrow" from evil spells were believed to be the cause of herpes zoster. Understanding of the local names used for HIV/AIDS and other related diseases is important as they are usually related to the causes.

In this study, most of the THPs still subscribed to a stone-age myth and belief that herpes zoster or “mulilo wa vhaloi” as they call it, was caused by witches and or spirits.

¹¹ Skin blisters believed to be as a result of a fire caused by ancestors

¹² Skin blisters believed to be as a result of a fire caused by witches

¹³ Skin blisters believed to be as a result of an excessive heat during the night

Although the psychological explanation provided by THPs to their patients could be regarded as convincing and acceptable then, it is highly problematic today after the repeal and or replacement of Witch Craft Act with THPs Act no 22 of 2007. The use of such phrases suggested that some THPs are witches and also that foreigners are to be blamed for these diseases. These beliefs have divided community members. Some THPs were accused of being witches, and were burned alive, other were banished [176-178]. Lack of plausible cause and explanation for “why me” and “now”, when there is no visible signs that one is sick, contribute to this belief. It comes as no surprise that community members first consult THPs to get an answer for ‘why me, now’ [37, 38]. “Maswa vhusiku¹⁴” appears to be the only herpes zoster not associated with evil powers or ancestors.

There was no question to explore how ancestors/ evil spirits/witches or foreigners cause the diseases and for what reason, and why that the lesion appears as band during the night. This omission is unfortunate as it would have been of interest to ascertain further views and beliefs on how THPs perceive those patients with herpes zoster associated with HIV/AIDS, and also for patients who had no contact with either Zimbabweans or Mozambicans.

With regard to gonorrhoea, 89, 9% correctly indicated that it was a sexually transmitted infection. Oral thrush was unknown (71.8%) to most of the respondents. Few (5.3%) had speculated about possible aetiology, whilst 64.3% confessed that they were not sure.

4.4.5 Management and the relationship of lesions to HIV/AIDS

Management of these conditions were in line with the understanding of the cause of diseases. It was therefore not surprising to note that the traditional management of herpes zoster by herbal medicine (73.2%) was the preferred choice of treatment. If in doubt, patients would be referred mostly to other THPs (22.7%), possibly being the specialist THPs or for second opinion. Despite lack of formal policy on referrals, a significant percent indicated that they would refer their patients to AHPs. The

¹⁴ Skin blisters believed to be as a result of an excessive heat during the night

researcher did not explore why they would refer their patients to AHPs and how it would be done- self referral or accompany patients.

This referral to AHPs, no matter how insignificant it may appear, signals the right approach to collaboration with AHPs. A small gesture of recognition and acknowledgment from AHPs to THPs for referring patients to the clinics could be seen as the beginning of change in mindset.

A small percentage of THPs knew that patients presenting with herpes zoster (13.5%) and oral thrush (15.3%) may be as a result of HIV/AIDS infections, which suppresses the immune system. They associated sexually transmitted infections, gonorrhoea (59.3%), to HIV/AIDS.

The involvement of THPs in the management of HIV/AIDS patients has been a thorny issue. Despite the calls made by WHO [179-183], the number of HIV prevention workshops conducted to improve THPs skills and their capacity to manage HIV patients in the genuine collaboration remains a future dream for THPs.

Existing collaborations are unfavourable for THPs. Where they exist, THPs are restricted if not limited to only become subjects of the research processes, and not participate as co-researchers. Many AHPs remain sceptical about collaboration with THPs in managing HIV/AIDS and TB patients [13, 166-168]. They are concerned about THPs knowledge of HIV/AIDS and science thereof: focusing on the differences in theory of disease causation and management approach to patients [41, 42]. These differences and protectionist approach for allopathic medicine could probably be contributing to the delay in registering THPs in South Africa [124]. There are benefits of working with THPs. A study by Homsy et al [184] to evaluate the herbal medicine for the management of herpes zoster in human immunodeficiency virus-infected patients in Kampala, Uganda, found that management of herpes zoster by THPs, using herbal treatment, was effective and comparable to allopathic medicine.

Assessing the knowledge and management of these lesions by THPs could go a long way in preventing the HIV/AIDS pandemic. As both the diagnosed and un-diagnosed HIV patients consult THPs at various stages of the diseases, training them to examine

patients for early signs of oral thrush could help to diagnose HIV infections among the unsuspecting patients. It could also prevent further risk of contracting HIV/AIDS.

Certain traditional practices could be modified through sharing of information and engagement of the two health systems. It is common practices for THPs to use bare hands (ungloved) to apply topical medicine on open wound and sores such as those thought to be caused by ancestors. Many also utilize their mouths to suck blood from their patient's body as part of disease management [185].

A small percentage (13.5%) of the THPs associated herpes zoster to HIV/AIDS. Based on traditional beliefs that herpes zoster “mulilo wa vhadzimu¹⁵”, is caused by ancestors, the use of physical and personal protective measures (such as hand gloves) against such lesions would be unthinkable and disrespectful. Lack of infection control knowledge and access to hand gloves may result in THPs handling HIV/AIDS related lesions bare hand. The researcher believes that engagement with THPs on best alternative practices and the sharing of knowledge through collaboration could help prevent further spread of HIV and TB infections. Collaboration with THPs would require change of attitudes and mindset of AHPs.

There is a perception among AHPs that traditional medicine and its sciences is superstitious and such irrational (unscientific) practices that should avoided [41]. In most instances, the perception was based on ignorance and lack of knowledge about traditional medicine [45]. Although ancestors remained the source of all knowledge for diseases over centuries and THPs are the mediators through which ancestors' knowledge is applied, its body of knowledge and practices (sciences) has not been static, nor is it restricted to the tools of allopathic medicine and its definition of what is called health sciences [42]. Flint and Payne [42] argued that whilst the two health systems apply different approaches and methods to health conditions, their measure of success is comparable. Both the health systems apply body of knowledge to render healthcare services. The emergence of new infections such as the HIV/AIDS, Ebola etc., dictate that both groups of healthcare providers should adapt and review their practices accordingly. Allopathic approach, in South Africa, has not succeeded in

¹⁵ Skin blisters believed to be as a result of a fire caused by ancestors

halting the pandemic. The response to the global HIV/AIDS pandemic calls for a different and unusual approach in the fight against HIV/AIDS and TB infections [155].

That could be done by developing collaboration based on the consensus of all stakeholders rather than the adversarial and domineer approach which is normally used [35, 64].

Not to say that there are no challenges and concerns from AHPs. Difficulties exist in penetrating the traditional beliefs and cultural paradigm. Although some THPs were correctly informed and knowledgeable about 'modern' diseases such as HIV/AIDS and TB diseases and the effectiveness of the western medicine [56], their traditional medicines are also able to manage similar diseases with good outcome and to the patients satisfactions [42, 63, 158]. In a recent study conducted by George and Chitindingu [112] to evaluate THPs' knowledge and practices related to HIV testing and treatment in South Africa, they reported that THPs were enthusiastic about the possibility of collaborating with AHPs in the prevention and care of HIV/AIDS patients. This is significant considering they already service the health needs of a large percentage of the South African population. In the same study, the researchers recommend that further development of training programmes and materials for THPs on HIV/AIDS related issues was necessary. Our co-researchers have shown adequate knowledge on the subject of HIV/AIDS and TB infections. In the previous Chapter Two, (section 2.7, the researcher highlighted the missing element in those initiated collaborations, and argued for involvement of THPs in all the processes of collaborations.

There has also been concern and reluctance on the part of THPs to collaborate with AHPs [62, 64]. Allopathic health practitioners were reported to be extracting herbal knowledge and exploiting THPs ignorance of scientific processes and intellectual rights [62, 64]. To avoid such experiences in this study, the researcher and co-researchers identified the problem, developed the research objectives and research methods and design, and finally developed the model for collaboration based on their worldviews and committed themselves to change of attitudes and mindset.

4.5 SUMMARY

The THPs who attended the training workshops were observed to have inadequate knowledge of HIV/AIDS and TB transmission, signs and symptoms. The prevailing myths and beliefs that HIV/AIDS and TB patients were bewitched, were held by few THPs. It was partly as a result of legendary beliefs of similar lesions not associated with HIV/AIDS, and punishment from ancestors for violating traditional taboos.

THPs were managing some of the HIV/AIDS related lesions without knowingly that those lesions may be as a result of HIV infections. Their current beliefs and management of herpes zoster appeared to pose a great danger to themselves and their patients.

The information collected at the pre-training assisted the researcher in identifying areas which required more focus and engagement with THPs to address prevailing myths, management practices and beliefs that HIV/AIDS and TB patients were bewitched, and that THPs have muti and herbs capable of curing it.

The next chapter, Phase II, is about group discussions between purposive sampled THPs who attended the training workshops discussed above and AHPs. Detailed information on method and design was explained in Chapter 3 (section 3.5).

CHAPTER 5

DISCUSSION OF FINDINGS AND LITERATURE CONTROL FOR PHASE II

5.1 INTRODUCTION

The previous chapter dealt with presentation and interpretation of findings from Phase One. This chapter reports on the presentation of findings, discussion and literature control for Phase II. The findings emanated from group discussions between AHPs and THPs, who are referred to as the co-researchers in this study.

A total of three group discussions at three different venues (Tshilwavhusiku, Tshilidzini and Malamulele hospitals) and a panel debate at Mhinga clinic were conducted. The reader is reminded that there were subsequent interviews held with different groups from different municipalities under the Vhembe district, to enhance the depth of the data and also corroborate some of the issues that were not clear. Five sessions were held with each group. The workshops and the meetings are still continuing on the spiral path of the constructive paradigm. For the sake of this Thesis, the researcher reports on the findings for Phase Two and the subsequent interviews held till the model was developed.

The main questions focused on (i) their opinions about coming together of the two distinct groups i.e. THPs and AHPs, (ii) their perceptions and experiences on collaborations, and (iii) their views on how they could work together in the management of HIV/AIDS and TB patients in the Vhembe district of the Limpopo Province, South Africa. From the inception of the study, AHPs and THPs have been involved in the development of this study by participating in identification of the research problem and the aim of the study, objectives to be achieved and how to go about achieving those objectives in order to address the research problem.

Ethical principles were adhered to at all times. In all the group discussions conducted, co-researchers were made aware that they could withdraw at any time if they so wished. Instead, more people wanted to participate. Due to community interest in the matter, an original group discussion scheduled for Mhinga clinic, changed its status and became a panel debate, wherein community members were allowed to come in

as part of audience. The panel members were ARV manager, traditional health practitioner managing HIV/AIDS and TB patients, and a community member representing the HIV/AIDS patients. The researcher moderated the debate.

5.2 RESEARCH FINDINGS

In this study, data was collected through the group discussions between AHPs and THPs and a panel discussion at Mhinga clinic. There were three group discussions conducted at different venues across the Vhembe District. The venues were at Tshilwavhusiku, Tshilidzini and Malamulele. Given the overlap of the findings between the three group discussions and the panel debate, the findings from the panel discussion was integrated into the findings of the group discussions. The following table 5.1 provides the abbreviations for venues and type of the responder.

Table 5.1: Abbreviations used for the venues and type of responder

THP	Traditional health practitioner	AHP	Allopathic health practitioner
M-THP	Malamulele THP	M-AHP	Malamulele AHP
T-THP	Tshilidzini THP	T-AHP	Tshilidzini AHP
H-THP	Tshilwavhusiku THP	H-AHP	Tshilwavhusiku AHP
C-THP	Mhinga THP	C-AHP	Mhinga AHP

NB: (n) is a number allocated to the specific THP and AHP during the discussions

5.2.1 Profile of the co-researchers

Profile of the category of co-researchers involved at group discussions is highlighted in Table 5.2. Majority of the THPs regarded themselves as diviners, herbalist and birth attendance at same time. Gender, which is represented by the figure in bracket, was evenly represented in the group discussions.

Table 5.2: List of co-researchers involved at group discussions

Traditional health practitioners (T)	Tshilidzini (T)	Malamulele (M)	Tshilwavhusiku (H)	Mhinga Panel for debate
Herbalist	2	0	0	One traditional health practitioner representing them in a panel debate
Birth attendance	0	1	1	
Spiritualists/Prophet	2	0	0	
Traditional Surgeon	1	2	2	
Diviner	4	5	3	
Total	9(4)	8(5)	6(3)	One traditional health practitioner representing them in a panel debate
Allopathic health practitioners (A)				
Medical doctors	3	2	0	One community member representing patients and community
Pharmacists	1	1	1	
Clinical psychology	1	0	0	
Maternity/ pediatrics nurses	1	2	2	
ARV nurses	1	2	2	
Social workers	1	0	0	
Total	8 (4)	7 (3)	5(3)	

5.2.2 Themes, categories and subcategories

During the analysis of data from the three group discussions and the panel debate, 3 main themes emerged with 6 categories and fifteen sub-categories (Table 5.3). They are synchronized and aligned to provide answers to the research questions identified and posed during the consultative meetings with the co-researchers in the Pre-phase. The three main themes are:

Theme One. Opinions of the co-researchers about collaborating as healthcare providers with different skills.

Theme Two. Experiences of the co-researchers regarding the consultations and treatment of HIV/AIDS and TB patients.

Theme Three. Perceptions and views on initiation of collaboration in management of HIV/AIDS and TB patients.

Table 5.3: Themes, categories and subcategories

THEME	CATEGORIES	SUB-CATEGORIES
1. Opinions of the co-researchers about coming together as healthcare providers with different skills.	1.1 Recognition of the traditional health practitioners	1.1.1 Feeling of Disbelief and shock 1.1.2 Feeling of being acknowledge
	1.2 Opportunity to build trust and relationship	1.2.1 Establishment of trust and hope for the future. ✓ reflection on past and mourning process ✓ acceptance and appreciation
2. Experiences the co-researchers regarding HIV/AIDS and TB patients and impact of treatment	2.1 Secrecy of patients surrounding consultations	2.1.1 HIV/AIDS patients are consulting both sides. 2.1.2 Rights of patients denied.
	2.2 Treatment modalities	2.2.1 Traditional health practitioners interfered with the efficacy of ARV treatment. 2.2.2 AHPs disrespect traditional medicine, Witnessing treatment overdose. 2.2.3 Patient confusion.
3. Perceptions and views on initiation of collaboration in management of HIV/AIDS and TB patients.	3.1 Perceived differences on knowledge, sciences and practices.	3.1.1 Unscientific methods and Standards of care 3.1.2 Lack of HIV/AIDS knowledge, skills and resources 3.1.3 Capacity building
	3.2 Support for the development of collaboration.	3.2.1 Change of attitudes and mindset. 3.2.2 Advantages of collaboration. 3.2.3 Strategies for collaboration.

Each theme, categories and subcategories is discussed below. The themes are introduced first, then categories and subcategories followed by what the co-researchers said. At end of each theme, the researcher presents the discussion which include the contextualization of the categories and sub-categories within the broader worldviews and the existing body of knowledge.

5.2.2.2 Theme One: Opinions of the co-researchers about coming together as healthcare providers with different skills

The first theme that emerged from the group discussions was on the opinions of the co-researchers about coming together as healthcare providers from different health systems. The theme came up based on the reflections of the co-researchers,

especially the THPs, of the past South African laws which prohibited and outlawed indigenous communities from exercising their beliefs and rights to consult THPs [73].

One of the objectives of the THPs Act, was a “liaison with other health providers” and this was being implemented for the first in their life time [73]. The meeting created hope for the future, which would be based on acceptance and appreciation of each other’s role in the fight against HIV/AIDS and TB infections. The opinions of the co-researchers were further divided into two categories.

Table 5.4 displays the theme, categories and sub-categories on the opinions of the co-researchers about the meeting and having the opportunity to come face to face to discuss a health problem as healthcare providers with different skills and management approaches.

Table 5.4 Opinions of the co-researchers about coming together

THEME ONE	CATEGORIES	SUB-CATEGORIES
1. Opinions of the co-researchers about coming together as healthcare providers with different skills.	1.1 Recognition of the traditional health practitioners	1.1.1 Feeling of Disbelief and shock 1.1.2 Feeling of being acknowledge
	1.2 Opportunity to build trust and relationship	1.2.1 Establishment of trust and hope for the future. ✓ reflection on past and mourning process ✓ acceptance and appreciation

Category one: Recognition of the THPs

The mere fact that THPs were meeting with AHPs in government health facilities meant a lot for them. It was previously not possible. They felt a sense of being recognised as one of the role players in the South African health system. There were two subcategories which emerged from data analysis.

- **Subcategory one: Feeling of disbelief and shock among THPs**

It appeared that such meetings were never expected to happen. The initial responses from both the traditional and AHPs showed high level of disbeliefs and shock, whilst at the same time they were acknowledging that the meeting was long overdue. The co-researchers indicated that they view the coming together of the two distinct health systems and ultimate hosting of group discussions between AHPs and THPs as a

historic event. There was not a platform in the past, wherein they could discuss their problems. Therefore, this meetings created an environment for the co-researchers to share their opinions about the meeting. Their opinions reflected variety of feelings including shock, disbeliefs and also appreciation. As one of the THPs at Tshilidzini hospital expressed the feeling of shock and verbalized it as follows:

“What is going on? Witches!! Yoo! Are we now allowed to see patients in the hospitals? It looks like, things are changing, ancestors will be happy” [T-THP (1)].

The feeling of shock and disbeliefs about what was unfolding in their life time appeared to be like a dream to them, which would need a dream interpreter, to make it clearer for them. The exclamation, “witches Yoo” could be understood as a way that they were expressing their years of suffering under apartheid and European laws, as the most evil and inhumane, dreadful and scary actions comparable to those of witches. The meeting presented an opportunity for outburst with emotions, and shouting as a way of taking out the unwanted feeling of being treated with disrespect and finally, the mourning process full of solace in the belief and affirmation that ancestors are happy now that they were recognised as health providers.

It could also mean that they were reflecting on the past laws, Witchcraft Act of 1957, which used to call THPs as ‘witches’. And now, as ‘witches’, they find themselves having a meeting with AHPs. This was unexpected and never anticipated, entering the hospital premises with their traditional beads and regalia on. They do not limit their experiences to themselves alone. Indigenous knowledge holders in the form of their ancestors were expected to support the initiative that they were undertaking to collaborate with AHPs [93, 100].

The feelings of excitement and shock were not the same for AHPs. Although they appreciated that the meeting was taking place, their opinions was focused on wasted time and impact on patients. One allopathic practitioner stated that: *“I think it is long overdue; in fact we’ve been bit slow... because our patients are one patient” [M-AHP (1)].*

- **Subcategory two: Feeling of being acknowledged**

The meeting was taking place at the time when the promulgated THPs Act was putting the traditional health practices on the centre stage. The National Health Department appointed an interim THPs council to look into the matter of traditional health system, the registration and the recognition as health providers. The meeting created a feeling of being accepted, now that the ACT allows, and also being acknowledged for the role that THPs play. This was supported by statements made by allopathic health practitioner:

“...we know that several studies have been done which show that huge number of our patients consult first with THPs before coming to the hospital. Some put the figures at 40% more than that, the first place they will go to is to THPs. ‘ee’ even very educated people, those on very good medical aid, they still consult with THPs” [T-AHP(3)].

“The Act is going to make it easy for us to work with you. I suppose it clearly states the roles and scope of your practices” [M-AHP (4)]

The above statements clearly indicate that some AHPs do accept and acknowledge that THPs have a role to in the delivery of healthcare services in South Africa. Similar findings were reported by Bereda in 2002. In that study, nearly half of the AHPs did not think that THPs have a role to play in the healthcare system [49]. After almost 21 years of achieving freedom and democracy, the captive mind of colonized some AHPs appears to be permanently paralysed. Chilisa cautioned this uncritical imitation of Euro-Western values and beliefs, especially displayed by intellectuals [74]. The Act has made it easy for them to accept and recognise that they are part of health workers.

The approach of the THPs towards collaboration was based on Venda proverb mentioned by another traditional health practitioner to support the need for their recognition and acknowledgment: “munwe muthihi a u ṭusi mathuthu” which translate ‘one finger cannot pick cooked grains’ this means that selfish actions based on individualism is likely not to achieve much when compared to collective effort.

The cooked grain may also mean the HIV/AIDS and TB pandemic, and was preventable. One finger could mean the one health system, where the AHPs were operating alone in isolation from THPs. In so doing, it was not succeeding in halting the HIV/AIDS and TB pandemic in South Africa. The recognition of the role that THPs could play, and the acknowledgment of their existence should form part of the strategies to fight the HIV/AIDS and TB pandemic. There should be commitment from both health systems to cooperate and collaborate in the interest of patients. As Shisana and others [38] indicated that the current strategies of fighting the HIV/AIDS and TB pandemic were not succeeding, it would appear that more health partners with new ideas were required.

Category two: Opportunity to build trust and relationship

In the past, the relationship between allopathic and THPs was always that of adversaries and competitors. It was mainly caused by years of colonization and Europeanization of the indigenous people. The process of decolonization and building confidence and trust required honesty from all the participants.

- **Subcategory one: Establishment of trust and hope for the future**

The existing differences on health sciences and patients management approach were put aside in an effort to build trust and create an environment for collaboration among the co-researchers. One got the sense that this meeting was a relief for some. The extent of the problems resulting from lack of communication between the two systems appeared to have placed AHPs under severe strain, as supported by the following statement from an allopathic health practitioner.

“ee’, maybe I should put it this way briefly, one can say, we are in the situation where we can no longer run away to from rain because we are already wet, meaning we have been affected by the problem already, but what is important now is to look for a way forward. We need to try to hide from rain as we move forward” [T-AHP (1)].

The rain symbolizes natural and powerful force which cannot be prevented. One can only protect himself or herself by exploring other means for protection.

The move to hide from rain as “we move forward” signifies the willingness to embrace THPs in finding solution. Both sides expected the meeting to help bridge the gap of misunderstandings, mistrust, fear of unknown and misconception about each other’s health system.

“... But for years, the modern medical profession and THP treated each other with suspicions; ‘ee’ it is mainly due to lack of understanding; ‘ee’ we sometimes doubt what they are doing, sometimes they doubt what we are doing... it is just different way of treating health conditions”[T-AHP (2)].

“Meeting... is an important thing. We wish if [it] can be strong and become effective... to defeat this deadly disease. This is because it is true that there is negative tension that exists between these two groups... do not accept one another. But if we can accept and trust one another, things will go well...” [T-THP (1)].

“It is time to meet now. ... now, if we have joint meetings like this...we will no longer be afraid of them and we will refer our patients freely” [T-THP (6)].

The meeting created a shock and disbelief as it was bringing the two distinct health systems together after a lengthy period of time not talking to each other let alone the acknowledgement of the role which THPs play in rural areas.

The traditional health system was outlawed in South Africa [93]. It was only recently (2007) that THPs were recognised through an ACT in South Africa [73]. Despite the promulgation of that Act, the South African Health System remains exclusively managed by AHPs [186]. While there may be feelings of excitement about these meetings and optimism for collaborations, one should be cautious for now. There are the high levels of suspicions and mistrust that exists between the two health systems, and added to that is the lack of policy on collaboration between the two health sectors [42], and the slow pace of recognising traditional medicine in South Africa [82, 124].

The opinions of the co-researchers about coming together as healthcare providers with different skills suggested that there was desire to collaborate as expressed by subcategories above. The first impressions created by the coming together, and the initial experiences felt by the co-researchers may play a role in determining the success and failure of their planned collaborations. These, according to Flint [42] are the pillars of building trust and hope for lasting relationships.

The relationships between THPs and AHPs have been reported to be dominated by AHPs [103, 104, 122]. The dominance of AHPs in our group discussions was not visible. The co-researchers in our study expressed their opinions openly and committed themselves to working together to change negative attitudes, lack of trust and the fear of unknown. They planned to work on building trust and establishing good working relationship through joint meetings, training and sharing of knowledge and skills between co-researchers. The main goal is to save lives of the patients.

5.2.2.2 Theme Two. Experiences of the co-researchers regarding HIV/AIDS and TB patients and impact on treatment

Theme Two explored and described the experiences of the co-researchers with regard to the consultation and treatment of HIV/AIDS and TB patients, and how the management and treatment plans were being affected. The experiences of the co-researchers were categorized under (1) patients' secrecy surrounding their consultations with health providers, and (2) the treatment modalities and how it was affecting treatment compliances and the management of HIV/AIDS and TB patients.

As their health systems were different, there were difference of opinions regarding treatment modalities for HIV/AIDS and TB patients.

Table 5.5 displays the theme, categories and sub-categories on their experiences of the co-researchers regarding the consultation of HIV/AIDS and TB patients and how the consultations impacted on the treatment and medications prescribed by either the traditional or AHPs.

Table 5.5. Experiences of the co-researchers regarding the consultation of HIV/AIDS and TB patients and impact of treatment

THEME TWO	CATEGORIES	SUB-CATEGORIES
2 Experiences the co-researchers regarding HIV/AIDS and TB patients and impact of treatment	2.1 Secrecy of patients surrounding consultations	2.1.1 HIV/AIDS patients are consulting both sides. 2.1.2 Rights of patients denied.
	2.2 Treatment modalities	2.2.1 THPs interfered with the efficacy of ARV treatment. 2.2.3 AHPs disrespect traditional medicine, 2.2.4 Witnessing treatment overdose. 2.2.5 Patient confusion.

Category one: Secrecy of the HIV/AIDS and TB patients surrounding consultations

The existing differences between traditional and allopathic health systems has affected how patients and communities consult. It usually happens that when they are not satisfied with treatment A from health provider A, they seek alternative treatment from health provider B. The experiences of the co-researchers were indicating that their patients, especially HIV/AIDS and TB patients, were not disclosing that they were also consulting alternative health providers. Their none-disclosing behaviour was supported by two subcategories discussed below.

- **Subcategory one: HIV/AIDS patients are consulting both sides**

The co-researchers were aware that their patients, including those who were infected and affected by HIV/AIDS and TB infections, were also seeking alternative treatment and advice from other health practitioners. As one allopathic health practitioner pointed out, HIV positive patients were abandoning the western treatment including ARV, for alternative medicine.

“Most of the time, we receive THPs’ patients who are HIV positive, and are accompanied by relatives. We initiate ARV treatment. After 4 or 6 months or one year on treatment, they disappear from us, and we don’t know where they have gone to. We don’t know. But when we trace them and follow them up...Using tracer team...we managed to get 5 or 6 of them, but now, they are also not coming for treatment... They are gone” [H-AHP (1)].

Another comment by despaired AHPs,

“Whether they are being treated in the churches or by THPs, we don’t know. They have the right to choose where to access services or where they think they will get better services. But after that, they come back to us, when condition have complicated. Most of them come back after a year or two. Some of them, when we introduce them to ARVs again, the treatment becomes ineffective because of what we call drug resistance. Unfortunately most of them die.” [H-AHP (2)].

This statement suggest that AHPs respect the rights of HIV/AIDS patients to consult alternative health practitioners. Some of the AHPs were open and honest, to disclose their personal experiences with regard to dual consultations and beliefs in traditional medicine.

The nature of discussion resulted in some of the AHPs acknowledging that traditional medicine managed some conditions better than allopathic medicine. A senior medical doctor at Tshilidzini confessed that he was consulting THPs and further said that:

“There are certain health conditions which THPs manage better than us, because they are able to talk to their patients at the same level patients understand them. ‘ee’ which for us we look a disease,....and say okay, each disease must have a cause, either germ is a cause of the disease.

But it is not always that we understand all diseases. We cannot pinpoint and the patients do better when they visit THPs”...I have consulted I do secretly refer patients to them” [T-AHP (4)].

Some AHPs believe in traditional medicine, and they privately and secretly recommend and unofficially refer their patients to the THPs. Lack of policy and regulation on referrals between the two health systems prevent some of them to openly collaborate with THPs. A pharmacist from Malamulele hospital, still consults his traditional health practitioner who saved his life in the early 1990s, after he had undisclosed condition which nearly killed him after AHPs have failed to cure him.

“Personally, I was exposed to the THPs’ medicines from while I was still a young boy”...jaa’ thus what I am saying... there are situations which we cannot be able to cure in hospital, which is nnnn... I cannot tell you about them, [people laughed]. All of us know that there are certain conditions which can only be cured following indigenous or traditional practices outside hospital premises”[M-AHP (3)].

Some AHPs felt that there should be a limit to what THPs could do. That view was supported by this statements “That is where traditional health practitioner’s play part you see but, conditions such as TB, HIV/AIDS that is where biomedical treatment comes in you see” [C-AHP].

“We need to refer patients to one another... And I think when we come to the issue of HIV/AIDS/ TB, we need to know that this part, AHPs, are good at addressing it... while at the same time, we still need to know what role could the THPs play in treating those diseases” [M-AHP (4)] .

That did not go well with other AHPs at Malamulele. There were disagreements among AHPs themselves. Some were open to the idea of patients consulting both sides irrespective of their conditions, as long as they were aware of the consequences and the health provider being consulted is knowledgeable about the management of HIV/AIDS and TB patients.

The experiences of THPs were slightly different. They did see the patients from the hospitals and clinics, some of these patients informed them that they were on HIV/AIDS and TB treatment. One traditional health practitioner indicated that she had managed few HIV/AIDS and TB patients without knowing that they had consulted allopathic health practitioner previously. The following comments made support the statement.

“These patients from the hospital do come to us, but unfortunately we find ourselves not knowing whether this patient is coming from the hospital or not or whether he/she has been given pills in the hospital or not because they hide these things” [T-THP (3)].

“They do not tell us that the AHPs failed to cure them. That is the problem. So, because they don’t tell us whether they are coming from the hospital or not, we simply observe the patient and prescribe the medications in our own ways and ask the patient to use them...” [T-THP (3)].

The dual consultation was viewed by traditional health practitioner as a problem, especially when the patients consulting them were uncured [1, 6, 16]. It would appear that THPs were aware of the danger posed by treating an HIV/ AIDS and TB patients

[23, 40]. This knowledge on the risks of HIV/AIDS and TB transmission was also observed during the training workshops on HIV/AIDS and TB infections (ref to Chapter 4 of this thesis).

The general impression, although not able to explore during the group discussions, seem to suggest that patients were consulting both sides as a result of many factors such as lack of formal communication and exchange of information between the traditional and AHPs. The other contributing factor may be the personal beliefs and preferences of the patients. This brings the researcher to the next subcategory of the patients' rights to exercise their rights.

- **Subcategory two: Rights of patients denied**

The South African National Patients' Rights Charter states that every citizen has a right to consult health providers of their choice [78]. The recognition of THPs as health providers by the THPs Act, (no 22 of 2007), the long held perception that patients are owned, and limited to the services of the allopathic health system only was being exposed. There were incidences which both traditional and AHPs could vividly remember, wherein the AHPs violated the rights of the patients. A professional nurse at Malamulele hospital shared her experiences on why she denied patient the right to consult THPs based on the Departmental policy.

“Yes we normally admit patients. During the course of the treatment, we normally encounter situations where a patient or relatives come and say we have our doctor at home so we are asking you to allow us to go. They would say the patient is suffering from evil spirit, spells which requires a traditional healer. So I think you know that we cannot let them go just like that” [M-AHP (2)].

The policy of the National Department of Health directs health professionals to deny patients the right to terminate healthcare and treatment until such a patient has signed the Refuse Hospital Treatment Form. It would appear that the patient was not offered that opportunity to sign the Refuse Hospital Treatment Form. If there were a policy

and regulation on the referrals between the two worldviews, patients would not be denied the right to treatment by the health provider of their choice. As reported by Flint and Payne [41], it would also provide an opportunity for AHPs to learn from THPs.

Category two: Treatment modalities

This category emerged from the experiences of the co-researchers who were applying different approaches of management of HIV/AIDS and TB patients. Although they were all committed to patients care, at times their individual health approach and treatment modalities were not complementing each other to the benefit of patients. They were instead creating more rift between the two health systems, which further complicated the already strained relationships between them, and affected patients. Five subcategories forming part of the treatment modalities are presented below.

- **Subcategory one: THPs interfered with the efficacy of ARV treatment.**

AHPs felt that traditional medications were interfering with their medication to the same patients. Some of their HIV/AIDS patients were abandoning ARV treatment and later reappear when the condition has worsened. This is evident in the following quotes from ARV manager at Tshilwavhusiku Health Centre:

“Most of the patients do not come after we have initiated them on ARV treatment. There is general belief around this area, whether true or wrong, I don’t know. But is said that our THPs are mixing ARV tablets with their traditional herbs to manage HIV/AIDS patients...”

“Not so long ago, one of our ARV patient returned with his wife crying, begging us to save his life.... He had been to THPs, treating him with brown liquid... We threw it away” [H-AHP (1)].

The above comments seem to suggest that patients belong to them. This authority over patients’ sometimes goes against patients’ rights to make their own decisions about health matters, including the right to practice of their beliefs and consult health

provider of their choice. It may be argued that THPs were rendering their services based on their health system, and patients preferred to consult them as alternative health providers.

- **Subcategory two: AHPs disrespect traditional medicine**

The years of colonization and indoctrination of African people to disown their own ways of living and health practices is still evident in the new democratic South Africa. The perception that traditional beliefs and practices belonged to the dark ages and uncivilized societies seemed to have destroyed the opportunity to accept THPs.

Even the so called educated and liberated middle class African health professional have not been prepared to shake off the shackles of indoctrination. As raised strongly during the discussion, almost all THPs supported the view that AHPs have negative attitudes toward THPs. They were also treating traditional medicine with disrespect. In some cases, AHPs were even discouraging patients from consulting THPs. The following statements by different THPs provide the support for that:

“The main challenge is the existing negative perceptions you have about us. This is more prevalent among the educated and middle class people... consult secretly, with skepticism, doubts and pride....” [T-THP (4)].

“I think nurses need to be taught that the THPs have special knowledge than those doctors on certain areas. The problem is that these nurses go to church too much and they are confined to their Christian beliefs which is acceptable in their church doctrines, and they rejects all practices of the THPs” [T-THP (2)].

“The problem is that these people (AHPs) do not accept us or believe in our health sciences” [T-THP (5)].

“...we want to work in collaboration with AHPs... But, these AHPs are the ones who prevents and interfere with our patient from using traditional medicines” [M-AHP (2)].

“AHPs should first acknowledge that we are there, and accept us. Patients have the rights to consult both sides depending on their beliefs. We must first agree that we each have role to play in patients’ health, and both sides are competent. Unless you accept that, collaboration will not be possible” [M-AHP (4)].

The disrespect for traditional practices was evident and even displayed during the opening of the meeting. Facial expressions, shaking of head, moving out of the room whilst THPs were performing their opening ceremony, were some of the actions which could be considered to be insensitive and disrespectful for one’s belief and practices. The irony of it was that among those who were displaying signs of disrespect, there were AHPs with visible facial scars of the razor incisions normally performed by THPs. As one grows older, get exposed and interact with others, the worldviews and beliefs which the community and individuals subscribed to may be abandoned. Especially if it is driven by economic factors and opportunities.

The following comment by an allopathic health practitioner provided a clue to some of the possible reasons why they displayed negativity and disrespectful attitudes towards the traditional medicine.

“There are a number of [traditional] practices which I would want us to talk about, which we as health care professionals feel, they are no longer or should no longer be practiced, should not be done. ‘Ee’ such meeting will help us understand and it will help us to change certain practices which we think are not helping at all” [T-AHP (1)].

These comments, whilst they are seeking to change the traditional beliefs and practices of THPs and communities, they may clearly be indicating the lack of knowledge and understanding of the traditional medicine on the part of AHPs [94]. The

coming together and initiation of the collaboration between the two health systems would provide an opportunity to share and learn the best practices from both sides in the fight against the HIV/AIDS and TB infections.

- **Subcategory three: Witnessing treatment overdose.**

As patients were consulting both sides, and not disclosing that they were on treatment from the other side, drug interaction and overdose was reported. AHPs argued that the use of traditional medicine was the source of treatment overdose. They had experiences of patients coming to hospital with renal failure, which they associated with traditional medicine prescribed by the THPs. This is evident in the following quote from an allopathic health practitioner:

“Ee, the other cases which we have been managing are certain herbal medication, which are in the form of laxative, the patient get sick and say I am going to clean myself. THPs give them medicine to clean, when we ask them why you were cleaning. They give various reasons. There are complications, and this of course, the kidneys shut down. Those medicines are so strong, they shut down kidneys. Patients come with renal failure, we have to transfer them to Polokwane, and actually, that renal failure unit is said to be for the Venda people. Because lots of patients who go there are due renal failure recordable to herbal medication” [T-AHP (4)].

That statement did not go down well with THPs. The quote from traditional health practitioner summarizes it all. *“Our medications do not cause overdose or harm as you suggested.... It is the pills which you give to your patients. Some have no names, manufactured long time ago. Ours are freshly harvested for the patients when they arrive. I should also indicate that these patients do not inform us that they were receiving your treatment... Do you stop your medications when they come to you with our medications? The answer is No. So why us?”*

According to the National Patients' Rights Charter [76], patients do not belong to providers. They have a right to be treated by health provider of their choice [78]. The problem arises when the patient does not disclose that he or she is on treatment from the other health provider. That could be as a result of the two health systems not communicating with each other, lack of referral policy and fear of being victimised for showing disloyalty to specific a worldview.

If collaboration between the two health systems existed, may be the cases of treatment overdose were going to be reduced. There would be no need for patients to hide their medications, maintain secrecy about treatment that they were receiving-whether it was from allopathic or THPs.

The closing remarks of the pharmacist towards the end of the discussion are worth mentioning. These remarks appeared to represent the feeling of almost all the co-researchers after a robust discussion. Nodding of heads as sign of agreeing are some of the common practices among indigenous communities. Few extracts from the closing remarks are presented to support the statement:

"I heard both AHPs and THPs stating that patients do consult with them. I also heard the THPs saying nurses tell our patients to stop taking our medicines. I think we must start there, that kind of approach to patients is wrong... for the patients to consult with you, doesn't mean you have the authority to stop them from going to the hospital or stopping them not to take hospital medicines (agreeing, nodding)..."

"I don't think you have that authority to tell a patient not to consult with THPs neither to use traditional medicines".

"...both THPs and AHPs should understand this... when all these medicines are used by the same person to treat the same condition at the same time, they eventually become an overdose".

“The main point I wanted to make here is that we cannot mix or use both biomedicines and traditional medicines at the same time...” [T-AHP [5].

These comments from one of the AHPs appeared to change the mindset of the AHPs, and realised that patients do not belong to them. Patients were on their own, and they should be allowed to consult whom so ever they wish to consult, and without fear of being blamed for consulting THPs. This rediscovery of the new information about the causes of treatment overdose and the “acquittal of traditional medication as source of treatment overdose”, was the beginning of the decolonization of mind process. There was a feeling of remorse and mourning for the damage that was being done to the patients and traditional medicine.

“..So when the patient come to us after consulting with the THPs, either they have now complicated or too late, we say “what were you doing, why you went there, you are so educated, why did you have to go there... It is just because we don’t understand that it’s not wrong to blame them or stop them from consulting them, and it is just different way of treating health conditions...”[T-AHPs (3)].

- **Subcategory four: Patient confusion**

The last subcategory on treatment modalities was the confusion experienced by the patients as a result of the lack of communication and collaboration between AHPs and THPs. The current status quo and lack of collaboration among the health providers create confusion among the patients by separating the Traditional Healing System from Allopathic Health System. This is evident in the following quotes from a clinical psychologist working at Tshilidzini hospital:

“As long as we separate these two healing systems, we are planting bad seed in patient’s minds. This is because when people come from the hospital, they find themselves confused and not knowing which healing system they should use whether to use biomedicines or medicines prescribed by THPs. We

started separating these things; we acted as if biomedical healing system is better than traditional healing system. So we plant this seed to people which make them think that if they use this healing system, they should not use the other...” [T-AHP (2)].

The confusion was compared to a seed planted in the minds of patients. It grew with time, and overpowered the rational mind with colonized mind. Now that the patient is confused, the same trajectory of changing the mindset through the “new seed” of decolonization of mind process of the providers, it is hoped that the patient will recover from confusion to a sober mind.

The solution to this problem of consuming patients was also suggested during the discussions. Noting that the confusion was caused by separating the two healing systems, the co-researchers supported the concept of collaboration. The following quotes were in support of the statement:

“So if we meet together like this, I am definitely sure that we shall manage to change people’s perceptions and mindset and they will know that these healing systems can complement one another. This is because patients consult with THPs first there at their homes before they come to be part of those who consult with hospital treatment, isn’t it? [T-AHP (2)].

“This means if we share our ideas and become a collaborative unit, people will no longer be confused, they will no longer have any problem with regard choosing where and how to get an operation because will be cooperating towards one another. Even the community members we serve will now be aware that these two healing systems are complimenting each other since we will be turning to different healing systems options at times. This is what I can say now because this collaboration will be advantageous to all people” [T- AHP (3)].

This historic meeting was also long overdue considering that many patients from either sides, when not happy or unsatisfied with service rendered and/or treatment outcome, they would refer themselves to alternative provider without referral letters [18, 37]. The presentation of patients to allopathic facilities, especially the self-referred from THPs, appeared to harbour secrets ranging from source of disease, beliefs and practices, treatment received [40, 50]. The meeting was viewed as providing an opportunity for the AHPs to get exposure to some of the traditional health beliefs and practices, and reflects on them. From the THPs' perspectives, they focused on why their patients were not allowed by AHPs to exercise their beliefs and practices. Their patients were discouraged from consulting and taking traditional medicines.

The THPs indicated that the attitudes and behaviours of AHPs, especially that of nurses, were biased against patients who do not practice Christianity as a religion. This negative attitude was reported by Troskie [187] to be the cause of patients not disclosing that they were also consulting THPs. In other studies, patients were brave to disclose that they consulted THPs [37, 52]. Robust discussions sometimes raise emotions and past injustices experienced. In our case, they were differences of opinions expressed, but it was the closing remarks which harnessed the co-researchers to a sober mind- "it is not about us" but the patients and the HIV/AIDS and TB pandemic which was not abating in South Africa [33, 34]. The increasing number of HIV/AIDS patients abandoning ARV treatment for traditional medicine [16, 17, 37, 47], is a strong case for the allopathic and THPs to collaborate in the fight against the disease [9, 22]. The experiences of our co-researchers were not different from the finding of a study conducted by Peu and others [188] in the North West Province of South Africa. Their results indicated that respondents demonstrated positive attitudes towards working with traditional healers, showed respect, recognition and sensitivity it deserved. Traditional health practitioners, as was also confirmed by findings of this study, are committed to collaboration with the AHPs. It is the model for collaboration which the two health providers were exploring for their situation in the Vhembe district, Limpopo Province.

The proposed collaboration model between THPs and AHPs was be based on HIV/AIDS and TB patients, who were consulting both sides, and with different beliefs.

There are approximately 6 million HIV infected people in South Africa who may consult traditional health practitioner first and later seek advice from allopathic health practitioner and or vice versa [14, 17, 19]. The co-researchers acknowledged that their patients, including those who were infected and affected by HIV and TB infections, were consulting both sides. As one allopathic health practitioner pointed out, HIV positive patients are abandoning western treatments including ARV, for alternative medicine.

The 'disappearance' of HIV/AIDS patients from public health facilities and the possibility that they are being treated by THPs appeared to be frustrating AHPs. More so, when they do not have control over it and or solution for it.

Patients are exercising their rights [28, 37]. Dual consultations is a common practices across the world. There are various factors contributing to it, including beliefs in supernatural powers and fulfilling rituals [41, 42, 98].

There was a general perception among AHPs which appeared to suggest that patients belonged to them. That authority over patients' sometimes went against patients' rights to make their own decisions about health matters, including the right to practice their beliefs and consult a health provider of their choice [189-191]. Traditional health practitioners understood their limitations with regard to HIV and AIDS. One of them commented, "... if our patients have disclosed that they are HIV positive, ...we do not have cure for it....we monitor that patient properly take their [ARV] pills [T-THP (7)].

On probing further, one gets the impression that THPs were not actively discouraging their patients from ARV treatment. Apart from the fact that ARV treatment was only available and dispensed by AHPs, THPs were encouraging patients to continue with ARV treatment alongside their herbal medicine. AHPs had a problem with that practices and cited that mixing of medicines interfered with efficacy of their treatment. The reverse could be true- allopathic medicine was interfering with efficacy of traditional medicine.

In 2007, Wanyama and others [58] reported that the practice of mixing antiretroviral therapy with traditional medicine was prevalent in Uganda. Three years later, Walwyn

and Maitshotlo [48], found the same trend in South Africa. Traditional health practitioners believed that their medicine, mixed with water, will help patients to swallow ARV treatment easily, especially pills. The assertions made by AHPs suggesting that traditional healers were advising patients not to take ARV treatment was refuted by this comment:

“We now know the signs and symptoms of HIV/AIDS and TB, we can help take the patients to the hospital for HIV/AIDS test before we treat them with our traditional medicines” [T-AHP (7)].

On the contrary, their role would seem to be that of health care workers complementing and supporting patients to continue their treatment. Generally, the involvement of the THPs would likely help reduce ARV defaulting [17].

One get the sense that allopathic practitioners would support collaboration where in THPs are restricted to being treatment supporters and default tracers. Statements such as *“when we come to the issue of HIV/AIDS/ TB, we need to know that in this area of HIV/AIDS, western medicine is good at addressing it”* [M-AHP (1)], does suggest that it is a sole terrain for them [6, 17, 127]. Traditional medicine would then come in, as and when invited on terms and conditions set by AHPs. This approach has not worked, and if pursued, it risks achieving the same results, lack of trust and cooperation [9]. There are strong arguments to suggest that allopathic practitioners should change their approach, if they want collaboration to work.

5.2.2.2 Theme Three: the perceptions and views of the co-researchers on initiation of collaboration between AHPs and THPs in management of HIV/AIDS and TB patients

The views of AHPs on the issue of initiating collaboration with THPs, especially in management of HIV/AIDS and TB patients were measured. There were concerns about certain traditional beliefs and practices which were not compatible and comparable with allopathic standards of medicine and its sciences. On the one side, THPs expressed a need to collaborate, learn and acquire knowledge about aspects of western medicine in management of patients, but only in as far as it will not mean

abandoning their traditional beliefs and practices. This commitment was shown when they attended our training workshops on HIV/AIDS and TB conditions. Despite being qualified and competent health providers rendering services to the same communities and patients as AHPs, THPs committed themselves to learn from AHPs.

Table 5.6 displays the theme, categories and sub-categories on the perceptions and views of the co-researchers on initiation of collaboration between AHPs and THPs in management of HIV/AIDS and TB patients.

Table 5.6. The perceptions and views of the co-researchers on initiation of collaboration in management of HIV/AIDS and TB patients.

THEME THREE	CATEGORIES	SUB-CATEGORIES
3. Perceptions and views on initiation of collaboration in management of HIV/AIDS and TB patients.	3.1 Perceived differences on knowledge, sciences and practices.	3.1.1 Unscientific methods and Standards of care 3.1.2 Lack of HIV/AIDS knowledge, skills and resources 3.1.3 Training and capacity building
	3.2 Support for the development of collaboration.	3.2.1 Change of attitudes and mindset. 3.2.2 Advantages of collaboration. 3.2.3 Strategies for collaboration.

Category one: Perceived differences on knowledge, sciences and practices

The crucial part of the discussion was centred on the perceived differences about source of knowledge, the sciences applied and health care practices. This perceived differences could easily lead to the success or failure of the collaboration between the two groups. Therefore, mutual understanding of the worldviews and management of the HIV/AIDS and TB patients between allopathic and THPs was central to initiation and the sustainability of the envisaged model for collaboration.

- **Subcategory one: Unscientific methods and standard of care**

The first and main concern for the AHPs was about the unscientific methods used by the THPs in the management of their patients. They went to an extent of questioning THPs' source of knowledge and knowledge level on health matters, especially that of HIV/AIDS and TB. That perceived difference and lack of understanding was evident in the following statements exchanged during the robust and also interesting discussions:

“I have a question. Now, if there is a patientwith HIV/AIDS and taking ARV treatment...Is there any measuring scale or dosages that they use for their medications?

Do they explain to their medications to patients when prescribing it? How often should patients take their medication? What about medications that are taken after or before meals?

Do you explain to your patients how medications should be taken and the overdose issues etc.?”[H-AHP (5)].

This type of questioning seemed to suggest that THPs lacked knowledge and understanding about the science of drugs including their origins, composition, pharmacokinetics, therapeutic use, and toxicology- pharmacology/kinetics. Lack of exposure to and depth in traditional medicine and practices has resulted in several researchers expressing similar concerns [41]. As if the question was a direct challenge to her traditional practices and its sciences of medicine, the response from one softly spoken old woman, in her late 70s, was spontaneous, elaborate and focused.

“Our herbal medications are not different to your tablets, medications. There are medicines that are taken three times a day and others that are taken in the morning only. We do give instructions, same as you do for your medications. Our medications should not be taken on an empty stomach. For an example, we even go to an extent of instructing our patients to take medications with porridge. All medicines, including yours, have side effects potentials, and may do harm than good intentions. Medications are processed from herbs” [H-THP (1)].

The existing perceptions that the processes of diagnoses and treatment of diseases by the THPs was not standardized, was another contributing factor to AHPs’ hesitation in accepting collaboration with THPs. *“The other problem which I personally have even for whatever conditions as they are treated by our colleagues, it is not universal or standard in approach and communication” [M-AHP (3)].*

It would appear that AHPs' main issues and concerns were premised, firstly, on not accepting that traditional medicine has a right to exist, and that they were not managing the HIV/AIDS and TB patients well and that they subscribed to their own sciences.

The second issue was that, if they were to be accepted and recognised, it would appear that they should forsake their sciences, 'repent and convert' to the prescribed western standards and its sciences. It then becomes the only source of knowledge.

"I heard good news and that they [THPs] agreed that when they have an ill patients, some presenting with unknown conditionssend those patients to us... I would emphasize that they should send every patient that they see..." [H-AHP (1)].

This type of argument limits intrinsic and extrinsic exploration of new knowledge other than what is believed by followers of allopathic medicine and held by the AHPs. That approach and belief may not go well for collaboration. THPs see themselves as more than just supporters of others. They would want to be partners in decision making as part of the rediscovery and recovery process moving forward. That would create an environment of learning for both sides as they were exchanging their views.

The argument presented by THPs indicate that their wealth of experiences and source of knowledge for traditional medicine and patients' management was from the ancestral spirits, incarnated during their initiation process (u wisiswa) and some through years of experiences. Such unparalleled knowledge and practice of herbs, roots, and other medicine (reported above) has been passed down through generations [15, 41, 43]. Compared to allopathic health professionals who are required to attend continuous training and update on latest medical developments, theirs is to comply with ancestral spirit that called them to become THPs [41, 155].

"We use indigenous knowledge while you use scientific knowledge. But if you can check these people [THPs], they are not educated but normally there are no people who died because of overdoses. This is because they have been given wisdom by

their ancestral spirits from day A, as such, they are so well educated they know what happens when they give medicine to the patient” [M-THP (2)].

Flint [41] reported that THPs relied mostly on supernatural powers of the spirit. It is no different from what the early missionaries who were ‘evangelizing’ the indigenous communities’ applied: prayer and faith alongside allopathic health services in their hospitals [41, 98, 115]. If traditional health knowledge is resourced from ancestral spirit; which (who) is believed to be omnipresent and omniscient; it could be argued that the traditional medicine and its sciences are operating at a much higher level than that of allopathic medicine. If that assertion is correct, THPs would therefore not depend and/or rely on memory aspect for their knowledge and/or to remember what they have learnt, but are inspired and instructed by the spirits of ancestors or supernatural powers from time to time. This would be challenging when assessing it through the worldview of the allopathic medicine.

Traditional medicine operates at three levels of human being: body, spirit and mind; whilst allopathic medicine is limited to the body level. It is for that reason that traditional medicine and its sciences could not be subjected to and measured using only allopathic standards and ‘microscopes’.

For now, the western medicine doesn’t have an instrument/tool which is able to measure /detect/ diagnose spiritual diseases such as those associated with evil spirits, spells, demons [190, 192].

As one put it “it is little bit difficult to say how we can work together. The challenge ...is that for us to know that the person has HIV/AIDS, we rely on the testing machines. We don’t know how our counterparts (THPs) detect the virus” [T-AHP (5)].

The western perspective is that knowledge of the THPs and practices are considered backwards, unscientific, erroneous and potentially harmful [126, 135]. It could also be true that “we are still far from each other in terms of understanding the nature and causes of HIV/AIDSMaybe someone may approach it differently”[T-AHP (5)], so

that collaboration succeed among health practitioners of different persuasions and belief systems. The above discussions required the shift in the mindset to rediscover what the other health provider hold and believe dearly to be their sciences and source of knowledge.

- **Subcategory two: Lack of HIV/AIDS knowledge, skills and resources**

The knowledge levels, beliefs and practices of HIV/AIDS among THPs has always been questionable despite the assurances given and the confirmation that they have attended training workshops on causes, signs and symptoms of HIV/AIDS and TB infections. One participant even went further and stated that, *“As THPs, we don’t claim to understand nor have cure for HIV/AIDS. Even ARVs don’t cure HIV/AIDS, they just sustain and prolong the life of the patients”* [T-THP (6)] thereby trying to convince AHPs that after attending training workshops, they now have high knowledge level of HIV/AIDS and TB diseases. It can be argued that their knowledge is on par with other health care workers in South Africa. Several studies have showed the benefits of utilizing THPs in the fight against HIV/AIDS and TB infections [112, 158]. It would appear that their knowledge of HIV/AIDS and TB was always suspect,

“when coming to the issue of HIV/AIDS, the best way that we can follow in order to work together is that we must have common understanding of the nature of HIV/AIDS disease,... know what type of disease is this, how is it diagnosed and how is it managed. From that point, we can thus work together on treatment. Another thing is that we should know that TB is an opportunistic disease of HIV/AIDS disease” [T-AHP (7)].

The support for collaboration was not without power struggle and compromises. AHPs hold the power and control for this nature of collaboration [41, 64]. They would rather prefer that THPs be excluded from HIV counselling and testing. As indicted by their responses to a question on whether they would accept trained THPs to get involved in HIV counselling and testing, they appeared not ready to collaborate with THPs beyond being ARV and DOT treatment supporters.

“No, I mean that they should give advises to their patients and also to find out if their patients have tested for HIV/AIDS” [T-AHP (1)].

“I would emphasize that they should encourage every patient that they see, with or without signs and symptoms, they should ask them about their HIV status...” [T-AHP (7)].

“I support that. It is good that THP’s intervene in the fight against HIV as a supporter, educator and tracer... I mean that they should give advises to their patients and also to find out if their patients have tested for HIV/AIDS. If their patients say no, they should ask them to get tested” [H-AHP (1)].

It clearly demonstrates that in an environment whereby the legacy of the past inequalities is not addressed, collaboration will not be on equal basis. It will always favour the domineering AHPs. As long as the state continues to recognise and support the allopathic health system to the exclusion of the traditional health system, any effort of convincing AHPs to collaborate with THPs as equals will always be a struggle. It would require a change in the mindset of the AHPs. The introduction of the THPs Act is step in the right direction. However, the progress towards the establishment of the traditional health system appeared to have stalled, if not very slow for now [124]. There seem to be reluctance to accelerate the process. Unless the development of the traditional medicine is adopted as part of national priorities in South Africa, it may not achieve the desired outcome of developing it alongside the allopathic health system. Anecdotal reports suggest that there was lack of political will and commitment to develop it, as it is not easily controlled and influenced by multinational drug industries and monetary system and value.

Subsequent to the discussions and arguments on perceived differences on the source of knowledge, the sciences applied as well as the health care practices, the co-researchers committed themselves to develop a model for collaboration in the management of HIV/AIDS and TB patients. They further suggested various processes which could be implemented in order to develop an effective collaboration.

- **Subcategory three: Training and Capacity building**

The discussion highlighted some of the areas which would need exchange of information and learning from each other. The first critical area necessary for collaboration, was to assess the knowledge levels, beliefs and practices of the THPs on HIV/AIDS and TB diseases. That was identified during the consultative meetings with stakeholders that HIV/AIDS and TB training workshops be conducted as preparation for the collaboration. The knowledge acquired during the training workshops and understanding of HIV/AIDS and TB diseases was evident during the discussions.

“...it is true that there is negative tension that exists between us...but if we can accept and trust one another, things will go well because we as THPs, we know ‘ee’ they cause this deadly disease which is HIV/AIDS, so we as THPs we do not take chances...” [T-THP (6)].

Another comment by the leader of the THPs emphasized what they have learnt during the training workshops.

“I am standing on behalf of THPs, since THPs got the training; there is no THP who does not know sign and symptoms of HIV/AIDS. The only difference is that they struggle because they do not have testing machines ...they are forced to work with the AHPs” [T-THP (6)].

The traditional health practitioner further explained the processes that they would follow when they are working in collaboration with the AHPs.

“The first thing that we do before treating the patient, we send him/her to the AHPs for HIV/AIDS test and verification. THPs will only proceed with their treatment of HIV/AIDS after the doctor’s machines has recommended that the patient can start with the treatment. It is then that we start to encourage the patient to swallow the pills at the recommended time” [T-THP (6)].

The comments made by the leader of THPs helped in changing the mindset of the AHPs with regard to collaboration. During the discussions, it appeared that the AHPs were convinced about the knowledge levels which THPs had on HIV/AIDS and TB diseases, and they were amenable to exploring the possibilities of collaboration with them.

'ee' we agree in principle we can work together, ...If we want to work together, we must start from the point of transparency... if that transparency is not there, it's going to be very difficult to work..' [C-AHP].

It is the openness and transparency among the two health systems which will bring them closer. For years the current researcher was conducting training workshops among the THPs, they have always been open to learning and said that they want to learn more about the HIV/AIDS and TB conditions. The findings of the discussions support what they have been requesting all along. The THPs committed themselves based on assessment of their own strength and weaknesses. As one traditional health practitioner explained earlier, their weakness was that they don't have facilities and expertise to conduct diagnostic tests for HIV/AIDS and TB. The acknowledgement of this weakness appeared to have made THPs accept that their roles in management of HIV/AIDS and TB infections, was limited to providing community education on HIV/AIDS and TB, prevention strategies such as condom usage and the support for patients on HIV/AIDS and TB treatment [6]. Earlier study report from the Vhembe district, had similar commitment made [49]. They were confident that their relationship with their patients would not change as results of refereeing their patients to allopathic facilities.

The last category, "Support for development of collaboration" was discussed as a way forward.

Category two: Support for development of collaboration

At the time of conducting this study, co-researchers indicated that there was no existence of collaboration between the two health systems in the Vhembe district.

Patients were consulting both sides, and at most taking the prescribed medications without realizing the risks of drug interactions and overdose. There was however, an unofficial informal unilateral (one-way) referral of patients from THPs to western health practitioners.

- **Subcategory one: Change of attitudes and mindset**

Despite the perceived challenges highlighted above, co-researchers seem to have changed their attitudes, put their differences aside and focused more on what can be done to save patients' lives. From the onset, it became clear that both groups placed serious emphasis on respecting patients' rights to consult health provider of their choice and beliefs. This was demonstrated by the following statements which was supported by means of clapping the hands.

“As we are seated around this table here, we are not merely representing ourselves as either THPs or AHPs. It’s not about us, it is about the patients....We have no authority to tell a patient not to consult with THPs neither to use traditional medicines”...the critical and very important thing is that we should help the patient to survive, we should not contribute to the death of the patient” [T-AHP (5)].

This change of attitude and mindset cannot be pinned to one incidence. It has been a process of rediscovery and recovery during the consultative meetings with stakeholders, training workshops and finally during the group discussions. It will continue even during the implementation of the developed model for collaboration. It’s a lifelong process of cyclical discovery and recovery and rediscovery cycles.

The critical step was that of self-discovery and also noting that something was wrong. The following statements indicate what the co-researchers assessed with respect to their actions and behaviour, and come to the conclusion that;

“...we have actually been colonised so much that we cannot even shake ourselves from vision of the colonizers themselves.

We are no longer able to see that we cannot continue functioning as separate individual healing systems” [T-AHP (2)].

The mind has been “infected’ by colonizers. It was compared to unstable double faced and fictitious character of Mr Hyde and Jackal. “You cannot be Dr Hyde and Mr Jackal. Thus what we are, in a day time we are white, and in the night we are black” [M-AHP (4)].

African AHPs practice allopathic medicine which they have been trained to practice on their patients. Despite knowing that there are safer, successful and beneficial traditional practices as Bereda found [49], AHPs behave as if they do not know. Some consult THPs secretly at night. The possible explanation may be that (1) they are not proud of their culture and practices (2) their medical training has not prepared and developed them to explore beyond what was in the text book and mind of the colonizers. Their training may lack community based learning and engagement with other health providers [49, 79].

The years of colonization has not only destroyed the mind, but also the ability to free oneself from the effect of colonization [79]. It affected the behaviour. As one puts it, they were no longer sure of what to do, “...we need to be aware that we are confused...” [C-AHP]. Confused individual usually experience problems with making decisions and it may affects how that individual perceive the world. Self –discovery has led the co-researchers to realise that something was wrong in both their actions and attitudes towards patients and towards each other. It needed to be fixed as part of changing the mindset. The following statements are in support of the change of mindset:

“We need to know ...and it circulates around the issue of perceptions, perceptions, perceptions ... we can’t be coconuts in dealing with collaboration issue. We need to meet, talk and talk and look at our challenges here and what should be the way forward and I think we need to unpack those issues...we need to talk to each other and meet so often, more often” [M-AHP (4)].

The perceptions and attitudes around collaborations with THPs was now being brought to the front. They cannot avoid it any more. As stated in the opening remarks “it is long overdue”. There was readiness and convergence of ideas among the AHPs from different areas in the processes of collaboration, with understanding that “Patients do not belong to us” [M-AHP (4), T-AHP (5)]. A traditional health practitioner being aware of the problem, contextualised it by refereeing to it in a common phrase used among the communities,

“ndou mbili dzi tshi lwa, hu fa hatsi” it translate ‘When two elephants are fighting, the ground and grasses are destroyed’.
“This means when two health systems wage conflict with each other, patients will be victimized’ [T-THP (7).

The two elephants are the two health systems which have been fighting each other for years whilst patients suffer. There is no communication between them, yet they are treating the same patients referred to as the ‘grasses and the ground’, suffering the consequences of overdose, drug interactions and unnecessary death at the end.

The change of mindset required commitment from both sides with regard to the plan of action going forward. One AHP suggested that there should more meetings and sharing of ideas,

“...these are things we need to be unpacked in the interest of ‘ee’ all, so what I would say as a way forward is for us to have more session together. We cannot hide behind the rules and the regulations, avoiding to meet with THPs”... And they cannot also wave to us their rules to us. We need to bring those rules together and say let’s sit down how do we interact [M-AHP (4)].

Other co-researchers have suggested different strategies which could be applied to strengthen the collaboration. These strategies are discussed under the following subcategory.

- **Subcategory two: Advantages of collaboration**

There were advantages which the co-researchers associated with this unique and historic meeting. Firstly, the meeting created an opportunity for the two different health views to openly share their experiences with regard to their patients. It was the process of rediscovery of the other side of the health practitioners rendering services to their patients without formal and official referrals. The informal referral shows that they two health systems could easily identify the bridge between them and use it to formalize the referral system through the memorandum of cooperation and understanding.

The advantage of such agreement will be for the benefits of patients. There will be no need for secrecy, patients abandoning ARV treatment for traditional medicine, as the two system will be collaborating jointly in the management of HIV/AIDS and TB patients.

The establishment of collaboration will enable the AHPs to share their knowledge on management of HIV/AIDS and TB with the THPs through the training workshops and learning at work. As Bereda reported, THPs want to bring their skills on moulding human behaviour and the spiritual component of it. The spiritual aspect of managing patients is missing in allopathic health system. Noting that for now, HIV/AIDS has no cure, the participation of THPs would be very important for the patients who want meaning to the cause, source and also during palliative care for the dying patients [41, 42, 49]. Allopathic health system discharges the dying to die away. Traditional health system show empathy, caring and sympathy till death [161,190].

- **Subcategory three: Strategies for collaboration**

During the discussions, several strategies were identified as necessary for development of collaboration. They included the need for continuous meetings between the two health systems, openness and transparency with regards to each sharing of information, training, building of trust, establishment of relationships and respect for each other. The co-researchers focused more on what they could do together, measurable and achievable, as evident in these quotes:

“We now got an opportunity to sit down together like this, advising each other nicely securing our society, now our society is going to survive” [T-AHP (1)].

An opportunity has been created to exchange ideas on how to fight HIV/AIDS and TB together. As the THPs have been willing to learn, and have attended the training workshop, it became easy for them to accept the call for more training. Another allopathic health practitioner extended it further and provided a detailed information on what could be included in the training course. It was aimed at having the same understanding of the HIV/AIDS and TB diseases and how it was managed.

“...the best way that we can follow in order to work together is that we must have common understanding of the nature of HIV/AIDS disease. For instance, we need to know what type of disease is this, how is it diagnosed and how is it managed” [T-AHP (4)].

There was a call for AHPs to be open minded and start to realise that THPs are knowledgeable health practitioners, and should be treated with respect and trust they deserve. This statement coming from the AHPs created a deafening silence, as if it was not anticipated. However, most of the co-researchers consciously or unconsciously were nodding their heads as a sign of support and agreeing to what was being said.

“... mm, the most important thing is for us to change our mindset, both groups, (ok) we have to understand, [that] there are a number of things which THPs can come along with in terms of method, expertise, approach, when treating HIV/AIDS, thus the point of departure” [T-AHP (6)].

There was also a call for commitment to working together and the respect for difference of opinions.

“...we are in this together. We should not allow these systems to discriminate against each other in terms of saying this system is

more civilised than the rest. I think thus where we make mistakes” [H-AHP (4)].

Another AHP emphasized the issue of transparency on the part of the different practices and medications being prescribed.

“If transparency is not there, it’s going to be very difficult to work, because a lot of traditional medicine is in secrecy” [T-AHP (4)].

That did not go well with the THPs. They strongly rejected it and in no uncertain terms indicated that they will not disclose the content of their medications due to various reasons including beliefs that ancestors would punish them. The other reason was that of protecting their knowledge from AHPs [42].

“Nursing is a profession achieved through training. It is career with certificate, is it not so? (Participants agreed). THPs is a profession conferred to us by our ancestors. We cannot tell you... As soon as a patient arrives and diagnosed, ancestors direct us specifically for that patient.... Unlike yours, our medications don’t expire because it is not ready mix nor prepared in advance by others” [H-THP (2)].

The researchers summarized all the strategies identified and called it the COHORT strategies necessary for the development of collaboration model between the allopathic and THPs in the management of HIV/AIDS and TB patients in the Vhembe district, Limpopo Province.

Some of these strategies have been reported to be critical for collaborations.

“That is easy, if there is a policy to guide us on what to do. If there is a policy and permission is granted, there is no problem. They will be rendering health services which we are not providing. They have an expertise qualifying them to render that type of service and we have our own. I suppose they will be coming as

an approved specialist by government for goni/gokhonya...” [H-AHP (1)].

“Ee, this would be very good thing for them. ...If there is a policy that allows for co-operation patients will benefit more. I think it can help those Christians/ church goers who disguise themselves when consulting THPs or go during the night” [M-AHPs (4)].

Summerton [127] identified that the lack of collaboration was mainly due to (a) a lack of recognition of traditional practitioners by the AHPs; (b) undermining of and disrespect for THPs; (c) lack of policy and regulations on collaboration and plans for the inclusion of THPs into the official health care system; and (d) lack of commitment on the part of Government in unifying THPs.

Lack of existing policy and regulation on how the two systems should relate to each other directly affects the relationship between the two health providers [97, 140]. Without they policy, formal interactions and referrals would be a serious violation of their ethical conduct [193].

“...we have already indicated in the beginning that [Department of Health] they have appointed us and there are [HPCSA] bodies that regulate us...If I do something wrong, they know that they will say why did you that...” [T-AHP (1)].

Although negative sentiments were uttered towards collaboration, prescripts in the form of circulars and regulation would make it legal and easy for officers to comply and thus work with them.

The general feeling that collaboration will be possible based on the commitments and change of attitude towards each other. A senior clinical manager invited THPs to openly refer their patients to the hospital and he will do the same with those who have attended the training workshops on HIV/AIDS and TB, and are recognised by authority as THPs.

“... people need to declare when they come into the ward, that they are from [THPs], ‘ i was on treatment from him but I’m not getting well’ or whatever the reason is for me to be here” [M-AHP (2)].

This unique opportunity to develop a model for collaboration require a change in the mindset of all co-researchers. As other researchers have reported, years of colonization has created unparalleled mistrust and destruction of relationships between traditional and allopathic health systems [6, 10, 23, 29, 40-43]. A new different approach would be required to develop a long lasting relationship among the co-researchers [45,52]. It is this different approach for collaboration between THPs and AHPs, which the researchers were pursuing. For collaboration to succeed, all parties critically evaluated their strengths and weaknesses, and changed their attitudes and mindset; and commitment to the patient’s life), appreciated the opportunity to learn from each other, and to be honest and transparent in dealing with each other and operate within competency and openness to different views and paradigms. The researcher coined the above prerequisite as COHORT approach to development of collaboration between THPs and AHPs in Vhembe district.

The concluding statement by one of the co-researchers summarizes it well, and it is worth quoting “...I want everyone to know that whether we reach consensus on collaboration or not, the patient will still go to both of us depending on their religious faith (clapping of hands).The critical and very important thing is that we should help the patient to survive, we should not contribute to the death of the patient” [T-AHP (5)].

The above five strategies in “change of mindset”, were applied as a guide in model development for collaboration between THPs and AHPs in management of HIV/AIDS and TB patients in Vhembe district (Chapter 6). It was developed through participatory approach involving THPs, AHPs and Community members.

5.3 SUMMARY

Chapter 5 covered Phase Two of the research study. The purpose of the study was to elicit the perceptions and experiences among group of co-researchers to obtain information which assisted in the development of model for collaboration between allopathic and THPs in management of HIV/AIDS and TB patients in the Vhembe District of the Limpopo Province, South Africa. Data was obtained and transcribed from the group discussions at three venues and a panel debate. From the analysed data, three themes with categories and subcategories were identified. From the first theme, “opinions of the co-researchers about the coming together as healthcare providers with different skills”, THPs expressed feeling of shock and appreciation, acceptance and recognition for the first in their life. AHPs were concerned about traditional medicine and their interference with efficacy of western treatment. The co-researchers committed themselves to working together in the interest of patients and fighting against the HIV/AIDS and TB pandemic. The way forward required commitment to change of attitude and mindset using the COHORT strategies.

The next chapter is about model development and the description of the model (Phase Three).

CHAPTER 6

MODEL DEVELOPMENT AND DESCRIPTION

6.1 INTRODUCTION AND BACKGROUND TO A MODEL DEVELOPMENT

The previous chapter dealt with the discussion of findings emerging from group discussions which were conducted with AHPs and THPs. The discussion also integrated findings from a literature control and field notes. In chapter two, the researcher reported on the different models of collaborations and highlighted the shortcoming of the initiated collaborations between AHPs and THPs. Summary of the identified shortcoming ranged from lack of community participation in the initial planning and execution of the collaborations and application of Euro-centric designs and methods in conducting the research.

This chapter focuses on the processes which led to the researchers deciding on a particular model for collaboration between allopathic and THPs in the management of HIV/AIDS and TB patients in Vhembe district of the Limpopo Province, South Africa. Several consultative meetings and discussions were held with five different groups before consensus was reached.

The majority of Euro-western researchers prefer to use the six aspects of activity by Dickoff and others [194], Chinn and Kramer [195] and also Walker and Avant [196] for concept analysis in model development. The researcher, having noted their strategies which are based on Euro-Western epistemologies and methodologies, argues that the postcolonial indigenous researchers should develop indigenous epistemologies and methodologies which dismantle, deconstruct and decolonize the traditional ways of thinking and conducting research. It must be ethical, transformative and participatory to address community needs.

A number of Indigenous scholars [45, 74, 197-199] argued that the first thing that must be done is to decolonize, change the mindset and set their agenda for collaboration. Indigenous communities have been colonized, oppressed, stripped of human dignity and died inside long time ago, the first thing that must be done is to decolonize the

mind, change attitude and restore the value which indigenous health systems, beliefs and Ubuntu spirit play within the African communities.

As part of the rediscovery of the indigenous people's self-determination and recovering process from the decolonization of the mind of both the allopathic and THPs, the researchers applied the indigenous-based research paradigm to develop the model. Indigenous paradigm "is a way of both decolonizing indigenous minds by 're-centring' indigenous values and cultural practices and placing indigenous people and their issues into dominant, mainstream discourses which until now have relegated indigenous communities to being the subject of research by western researchers [45]. The researcher will first discuss the Chilisa's decolonization process and its spiral aspects. It will be followed by the steps that were followed to develop COHORT model

6.2 CHILISA'S DECOLONIZATION PROCESS

Chilisa's decolonization process was selected as a suitable processes of bringing together the colonized AHPs and THPs unable to free themselves from the years of self-denial and hatred for African identity, animosity and distrust between the two health systems caused by captive mind of the colonizers. The captive mind is the uncritical mind of the colonized people that it imitate and worship everything from the West, and demonize everything about indigenous practices a, beliefs and values [199, 201]. The researcher applied the processes in developing the collaboration model.

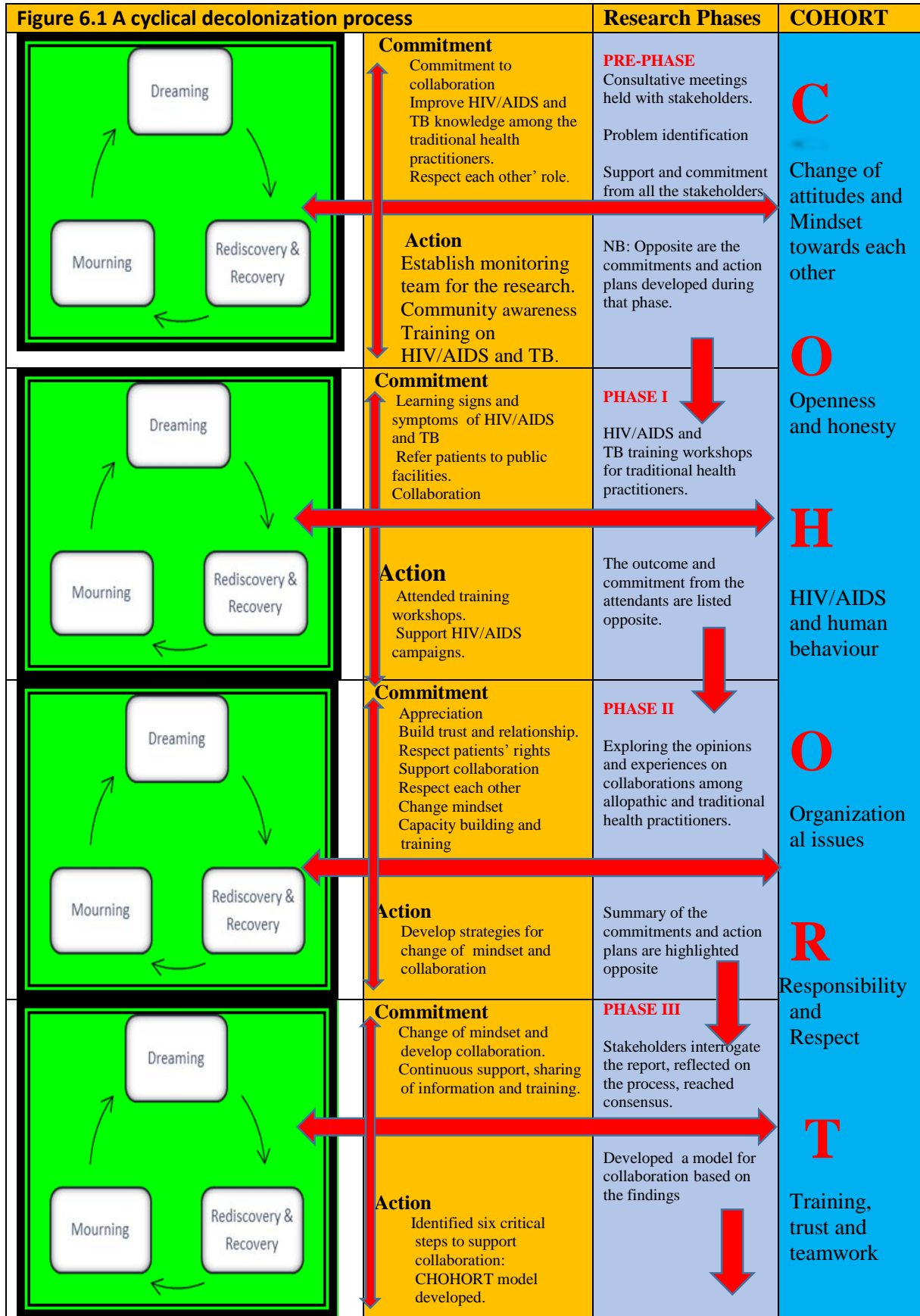
Colonization is defined as the subjugation of one group by another [74, 201]. There are three separate form of colonization, yet intertwined; the political, economic and scientific colonization. Most of the colonized countries may have achieved political freedom from their masters. It is the economic and mindset or scientific liberation which evade indigenous scholars [74, 199, 201]. The colonized scientific scholars are unable to use their worldview to interrogate and interpret their world and environment, unless it meets the western worldview. Unlike the previous collaborations reviewed in Chapter Three, this study applied a PAR approach in which the two health systems workout the problem, source of the problem and decide on plan of actions to solve the problem.

Decolonization is a process of liberating the subjugated, submissive, and slavery mind from the oppressor through restoration and development of cultural practices, beliefs and values which reflect community empowerment [74, 45].

The Chilisa's processes of decolonization fit well with our participatory action research approach selected: community empowerment through honest and open discussion about the need for collaboration. It focuses on changing the mindset and attitudes of the colonized indigenous people through participatory process. Chilisa has identified five phases involved in the Decolonization process: (1) rediscovery and recovery, (2) mourning, (3) dreaming, (4) commitment, and (5) action. The phases, are first discussed, and then followed by their application in the study. As indicated in Figure 6.1, these processes were not applied in a linear way. They cut across all the Phases of this research. In some phases, one process became prominent, depending on the activities being done.

Pre-Phase: Rediscovery, recovery and dreaming featured prominently during this phase. The decolonization process resulted change of mindset and attitudes. Its demonstrated by the red horizontal line linking the cyclical process during the phases and COHORT. It's a two-way process. Any strategy of COHORT feeds back into decolonization process. Eg. Openness may results rediscovery and recovery of self, leading to mourning, dreaming, new commitment and coming up with new action plans. Training results new knowledge, which may follow the same decolonization process.

The horizontal red line indicates the linkage between the cyclical process with commitment and action plan processes.



6.2.1 Rediscovery and recovery process

This is the first phase in the process of decolonization. The colonized communities go through the process of self-discovery and interrogations and questions about the current status of their problem. It gives the oppressed and colonized people the ability to decontaminate their minds whilst at the same time they are thought process in which they can define their real world and problems associated with it. Chilisa further indicated that they should decide on their term of references and rules of engagement with themselves and others [74]. This process was displayed throughout all the phases of this research.

During the Pre-Phase stage, co-researchers interacted with each other and committed themselves to finding the solutions their problems. At the same time, there was change of attitudes and mindset towards each other. Commitment took place through the dreaming, change of attitude and mindset, and start to talk to each other. Their dreaming process of working together culminated in establishing a plan of actions such as establishing the monitoring team, training workshops for THPs on signs and symptoms of HIV/AIDS and TB.

6.2.2 Mourning process

This refers to the process of lamenting on the injustices that have been done by colonization and how it has affected their self-esteem and image in the communities, the impact it had on their practices, traditions and practices. This process has been missing in the reviewed literatures on collaborations. It has been argued to be the important part of healing and moving to dreaming [74]. The years of assault and damage done to the minds of indigenous people, their traditions, value and belief system may never be recovered. This process was prominent for the THPs. Statement such as *“What is going on? Witches!! Yoo! Are we now allowed to see patients in the hospitals? It looks like, things are changing, ancestors will be happy”*, illustrate the deep mourning also linked to deep feeling and spirit. Some AHPs with traditional background and exposures displayed feeling of remorse and sympathy towards the THPs. As for the THPs, they found solace in their ancestors and performed ritual prayers for approval and guidance in engaging on the collaboration with the AHPs.

Their commitment was on saving lives. Despite the two health systems being affected differently, it was the loss of life and missed opportunity to work together to help the community which trouble them. Although this process was displayed throughout all the phases of this research, it was more prominent during the group discussions. It was during this phase that co-researchers became open and honest to each other. This process is crucial for establishing collaboration and building relationships moving forward. Both health systems have limitations when to management of HIV/AIDS and TB patients. The concept of working together as highlighted during the group is critical in fighting the HIV/AIDS and TB pandemic in South Africa [31].

6.2.3 Dreaming process

This involves the colonized communities, after mourning their process, exploring their way of doing things, wearing they own spectacles to see their way out of the captive mind. It is a process in which the different possibilities are explored in order to free yourself from being uncritical colonized individual, imitating the western approach of solving indigenous problems long before the colonizers have left. Deep thought was given to the idea of collaboration, explored about the type, form and model for collaboration to be pursued. It was finally decided that that joint group discussions be conducted, with a small committee members to assess progress and take remedial actions when necessary. This process was displayed throughout all the phases of this research. The process which followed was the commitment made by the co-researchers.

6.2.4 Commitment Process

Chilisa defined it as the process where there first three processes are put into commitment [74]. There are roles and responsibilities which are assigned to the co-researchers. There is commitment to work together in a climate were mutual respect, assistance and help is provided by both parties to attain a common goal. The common goal is to develop a model for collaboration in the management of HIV/AIDS and TB patients in the Vhembe District of the Limpopo Province. The first commitment was displayed during the Pre-Phase, when the two health systems acknowledged and appreciated the role that each health system play in South Africa. THPs committed

themselves to learning more about the signs and symptoms of the HIV/AIDS and TB diseases, willing to refer HIV/AIDS and TB patients to the health facilities. AHPs were committed to training THPs and also having an opportunity to learn the best practices and skills for patients' diagnosis and management.

6.2.5 Action Process

The last process in decolonization is when the plan of action is developed jointly. The dreams and commitments are translated into strategies for transformation in the way health services is delivered in the Vhembe district. Chilisa called it the participatory action research to give voices to the previously marginalised THPs. They are now part of the decision making and planning the model for collaboration with their counterpart. Right from the beginning to the end of this research, co-researchers have engaged each other, discovered that they each have a role to play in the delivery of health services and decided to embark on a process of developing a custom model for collaboration suitable for their settings.

Before discussing the steps followed for model development, a summary of the research journey and findings from the previous chapters will be presented with the aim of familiarising the reader with the environment in which the decolonization process and model development was based on. Figure 6.2 presents a diagram depicting the flow of events. They moved in a cyclical process, back and forth in search for a model which fits the collaboration between allopathic and THPs in the management of HIV/AIDS and TB patients. Bearing in mind that majority of THPs had no formal education, the process moved at a slow pace, making sure that it had the buy in, cooperation and support from all stakeholders.

6.3 RESEARCH JOURNEY

6.3.1 Working with THPs

As stated in Chapter 1, the researcher spent eight (8) years conducting training workshops for THPs, in partnership with the Department of Health in Limpopo Province, South Africa and the Nelson Mandela Avenir Projects for Combating TB, HIV/AIDS in Limpopo Province.

- The information obtained from the training workshops revealed that patients, including those infected and affected with HIV/AIDS, consult both allopathic and THPs in search of relief and treatment. More than 95% (1 241 of 1 300) of the THPs (THPs) indicated that they were being consulted by HIV/AIDS and TB patients at different stages of their health conditions.
- Some of the signs and symptoms of HIV/AIDS and TB (herpes zoster and candidiasis) were reported by THPs (37.9%) to be similar to those caused by or associated with ancestors and/ or evil spirits/ spells (*mulilo-wa-vhadzimu* and *goni/gokhonya vhudaadaa*).

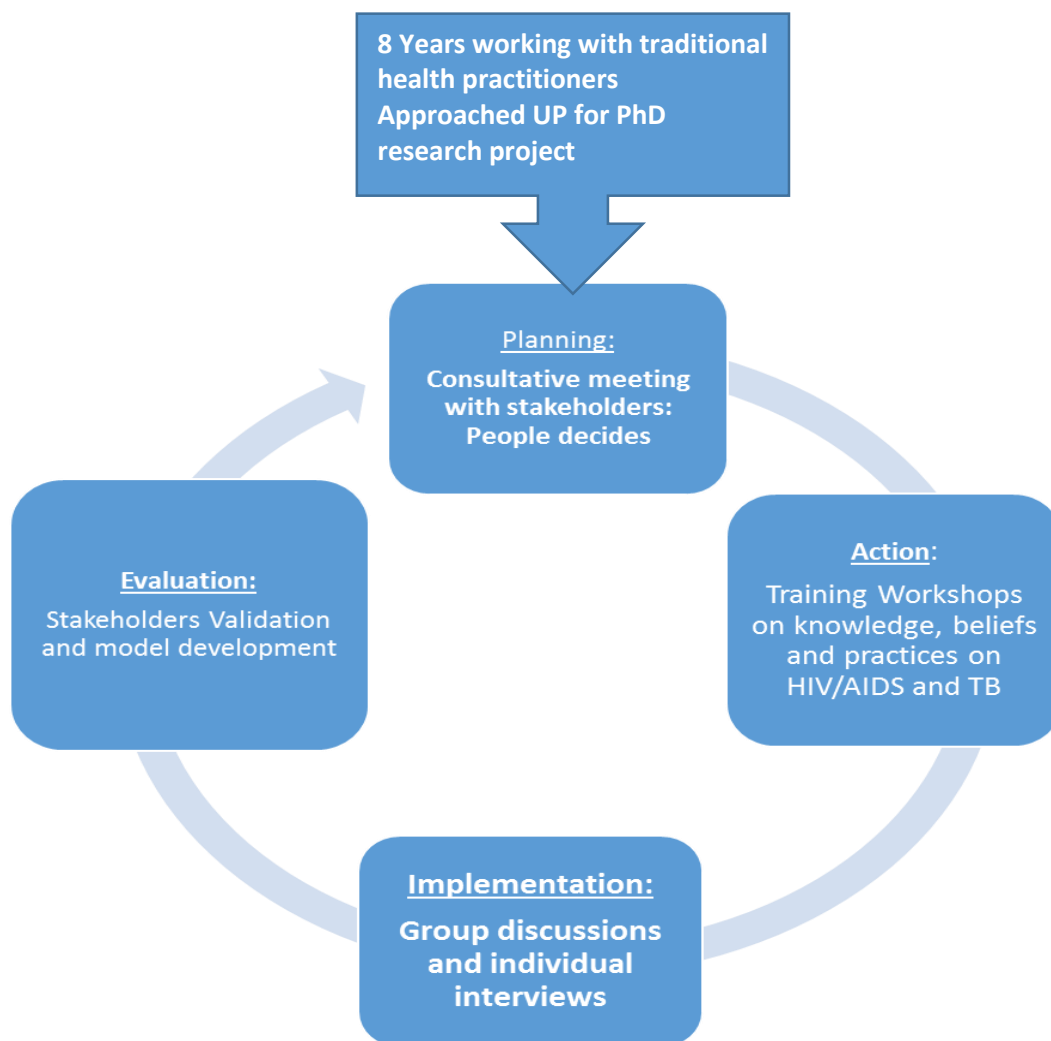


Figure 6.2 Flow chart of the research process followed

Rediscovery and recovery through the consultative meeting with stakeholders

Pre-Phase: It was during the consultative process of the Pre-Phase that most of the rediscovery and recovery phase took place. The initial problem identified by the researcher was presented and discussed during the meeting with the co-researchers. The co-researchers went through a self-critique and introspection process to find out how the two health systems could be so far apart when they are all Africans with same background and sharing the same environment. It was in this meeting that the critical first step was jointly decided and owned by all, after they have discovered that they each have a role to play in the South African Health System. That demonstrated change of attitude and mindset **(C)**. The meeting decided on the term of references including public pronouncement through the radio and rules on how they were going to develop the model for collaboration. One of the decision taken was that there should be an HIV/AIDS and TB training workshops for the THPs **(H)**.

Rediscovery and recovery has been the process of interrogating the western colonizing practices. The process sets free the colonized mind so that both the AHPs and THPs are able to define in their own term what will be an acceptable model for collaboration in the Vhembe district. They should also be able to define the problem and how to address it in an open and honest spirit **(O)**. The researcher, being aware of the challenges of collaborations (personal experiences, published reports), embarked on a process of consultative meetings with health authorities, ARV managers, THPs committee, Vhembe AIDS Council and traditional leaders. This process was necessary to highlight the existing challenges, which were the lack of collaboration between the two health systems, and how to address the problem in a process of rediscovery and recovery.

Mourning process is defined by Chilisa [74] as laminating the continued dehumanization and assault on historically oppressed people. The assault and humiliation of THPs was done through an Act. Their practices was prohibited and associated with witchcraft [93]. The process of mourning happened simultaneously with that of rediscovery and discovery of self-identity. THPs mourned the decades of humiliations caused by both the Act and actions of AHPs by disregarding their

knowledge and associating traditional beliefs with witchcraft [81, 124]. After the process of mourning, stakeholders embarked on a process of dreaming and commitment.

Dreaming process was when the co-researchers started to discuss the possibilities of developing a solution for their identified problem [74]. Dreaming is the process of assessing and imagining possibilities as a way forward for collaboration between the two health systems. The process of dreaming was followed by commitment to finding a solution together. They agreed on the following:

- People agreed on a suitable process to be followed and modified the research project to reflect community participation in the whole project as co-researchers.
- They provided support and set up an advisory group, consisting of local AHPs and THPs, community representatives referred to as stakeholders.
- Having noted the concern of AHPs and the need for more information on HIV/AIDS, it was decided that there should first be HIV/AIDS and TB workshops for THPs, followed by group discussions between the two groups.

6.3.2 Phase I: Workshops

The purpose of Phase I was first to get baseline data on HIV/AIDS and TB knowledge, beliefs and practices, and subsequently, train THPs on causes, signs and symptoms of HIV/AIDS and TB infections.

Seven workshops were conducted in seven areas, covering all four local municipalities under Vhembe District, i.e. 1 in Mutale, 1 in Musina, 3 in Makhado and 2 Thulamela municipalities. Refer to Chapter 5, Knowledge, beliefs and practices on HIV/AIDS and TB among rural THPs, South Africa.

- The workshops started by assessing their knowledge level, beliefs and management practices of HIV/AIDS and TB patients.
- The information assisted the researcher to understand THPs worldviews and prepare for best approach and means of engaging with them, at the level they could understand and relate to. After training, their knowledge of HIV/AIDS and TB and management protocol was comparable with other health workers.

- Participants recommended their members to participate in the group discussions with AHPs.

6.3.3 Phase II: Group discussions

During the group discussions, rediscovery and recovery process, mourning and dreaming processes occurred simultaneously. The purpose of that phase was to explore the perceptions and experiences on collaboration between AHPs and THPs in management of HIV/AIDS and TB patients.

Three group discussions were conducted jointly with AHPs and THPs in Vhembe district (Tshilidzini hospital, Tshilwavhusiku Health Centre and Malamulele hospital). The discussions focused on:

- Their opinions about coming together as healthcare providers from different health care approach, belief model and source of knowledge;
- The experiences that they had with regard to patients from either side;
- Their perceptions on initiating a model for collaboration in the management of HIV/AIDS patients.

The main themes which emerged throughout the group discussions guided by Chilisa's Decolonization process are:

Theme 1: Opinions about coming together as healthcare providers with different skills

Theme 2: Experiences regarding HIV/AIDS and TB patients and impact on treatment;

Theme 3: Perceptions and views on initiation of collaboration in management of patients.

6.4 STEPS FOLLOWED IN DEVELOPING THE MODEL

This phase focuses on the development and description of model for collaboration between traditional and AHPs in the management of HIV/AIDS and TB patients in Vhembe district of the Limpopo Province. The reader is reminded that this process is not linear. It is cyclical and moves back and forward as the co-researchers are engaging each other through decolonization process.

Based on the findings from Pre Phase, Phases One and Two, it was becoming clear that the following six critical steps will form the base for collaboration between AHPs and THPs in Vhembe district. Throughout the discussions, it became clear that the following items should be addressed if the two health systems were to collaborate:

- C:** Change of attitudes and mindset: Change of mindset indicated the commitment that was made towards the development of model for collaboration between the two health systems,
- O:** Openness and honesty in acknowledge of limitations. This follows under rediscovery and discovery as they openly discuss their problems and identify their limitations
- H:** HIV/AIDS /Health behaviour is complex. That was the dreaming process as they start to contemplate the possible solution to the complex challenge of changing human behaviours towards HIV/AIDS and TB infections
- O:** Organizational issues, scope of practices and openness,
- R:** Responsibility and respecting patient beliefs and rights
- T:** Training, skill transfer and building trust on each other and Team work. The action process was translated into training, skill transfer and building teamwork.

As previously stated, follow up discussions were held with different groups from different municipalities under the Vhembe district. The purpose of the meeting was to present and discuss the findings as well as the identified steps necessary for collaboration among AHPs and THPs in Vhembe district. Five sessions were held with each group to narrow the gap and reach consensus on the process required. The final report on the agreed steps was further discussed and adopted in a meeting with the main stakeholders selected during the consultative phase: Pre-Phase. Table 6.1 provides profile of the stakeholders who developed the model of collaboration during the meeting held on the 13 August 2015. Applying the Decolonization process discussed earlier under **Section 6.2** (Chilisa's Decolonization process) and integrating it with the themes, the researchers identified these six steps as COHORT model for collaboration between AHPs and THPs in management of HIV/AIDS and TB patients in the Vhembe district, Limpopo Province.

Table 6.1: Profile of stakeholders to validate research findings and formulate a model for collaboration

PROFILE OF THE STAKEHOLDERS		
AHPs	Snr Clinical Managers	2
	Family medicine	1
	Clinical Psychologist	1
	ARV nurses	2
	Pharmacist	1
	Medico-legal	1
	NGO	2
THPs	Spiritualist	2
	Diviners/TBA/Herbalist	6
	Surgeons	2
Community members	Traditional leaders	3
	HIV/AIDS/TB Patients	2
	AIDS Council member	2

The steps are interdependent, interrelated and interlinked, as illustrated in Figure 6.2 and mentioned earlier. Figure 6.3 below is a graphic representation of the COHORT model of collaboration between AHPs and THPs.

6.5 GRAPHIC REPRESENTATION OF THE COHORT MODEL

A model can be defined as a graphic/symbolic representation of a concept, relationship, structure, system other than itself [74]. The objectives of our model is to facilitate understanding by eliminating unnecessary parts and networks and connections between components or activities aimed at achieving collaboration between traditional and allopathic health providers in the management of HIV/AIDS and TB patients in Vhembe district.

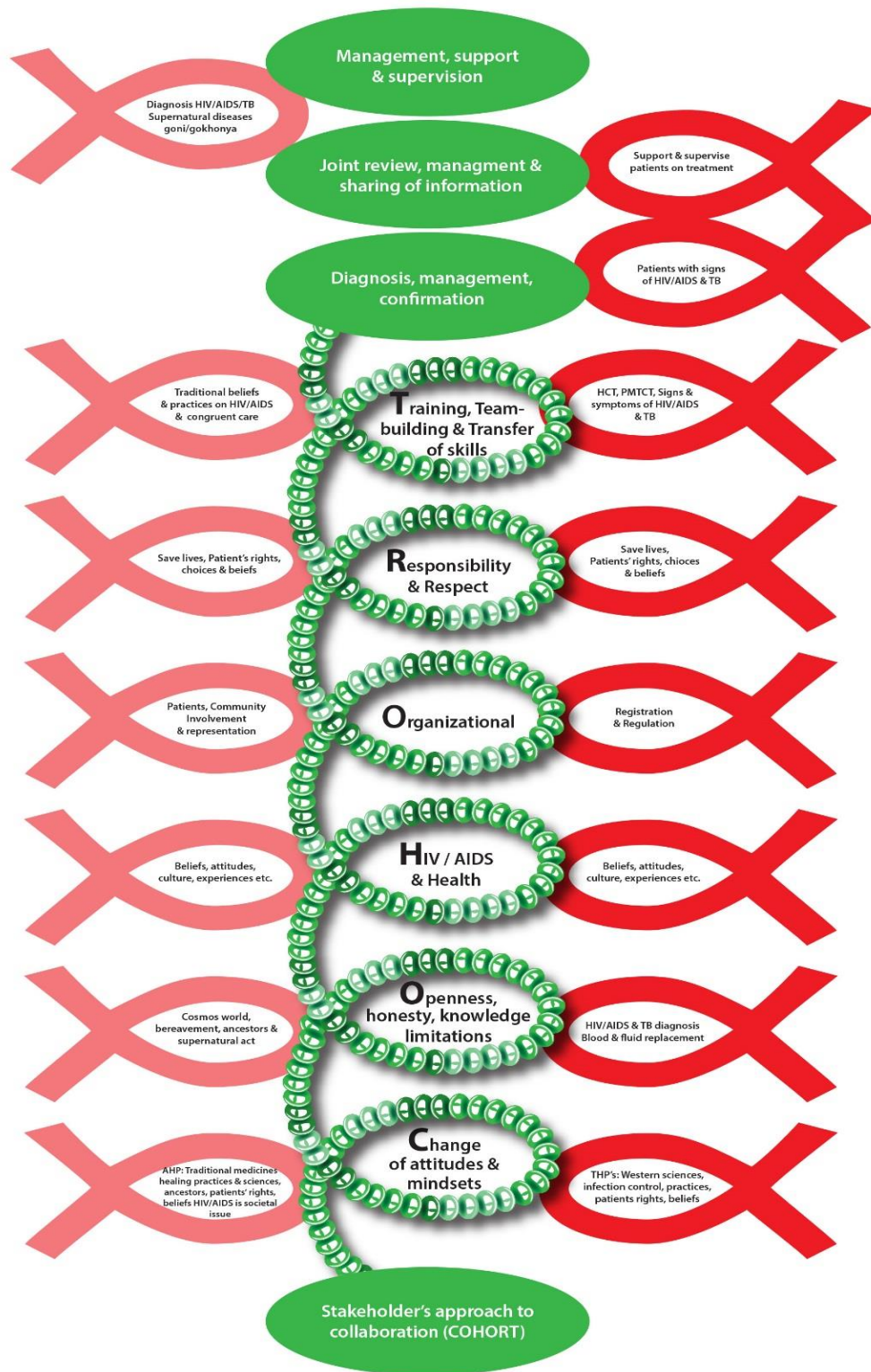


Figure 6.3. A COHORT model for collaboration between allopathic and THPs in the management of HIV/AIDS/TB patients

6.7 DESCRIPTION OF COHORT MODEL FOR COLLABORATION

The model indicates the trajectory of how collaboration between allopathic and THPs in management of HIV/AIDS and TB patients in the Vhembe district could be developed. The model was developed based on the themes identified and decolonization process (Section 6.2 provides the details). The components of the model as developed from the themes are:

6.7.1 Change of attitudes and mindset

It is the findings from **Theme I**. The success of the envisaged collaboration is solely based on the commitment of all stakeholders involved in the management of HIV/AIDS and TB patients. Stakeholders emphasized the need to change the existing attitudes and mindset towards each other, their professional body of knowledge, and patient's right to choices. This process of interrogating their actions and behaviour (colonized mind) towards each other to recover their own identity, culture and own history is referred to as rediscovery process [74, 201]. Findings from the group discussions in Chapter 5 indicated that allopathic and THPs have a history of animosity and negative attitude towards each other, especially by AHPs towards both THPs and patients who believed in their services.

It is necessary to remind readers that there had been a strong feeling during the group discussions, which was also supported by the other stakeholders during the consultations, indicating that the current animosity was a well-planned, designed and an intended structural plan by European colonizers to first sow division and distrust, secondly, destroy their tradition and beliefs and finally, bring their "super" culture, tradition and standards. The new "European way of health care" appears to have changed the mindset of African and /or traditional people. During the discussions, it became clear that years of colonisation had "destroyed" the normal traditional practices" in the minds of many Africans , to an extend that the colonized people hate and reject their own identity and embrace foreign practices as if allopathic health medicine is better than traditional health medicine. The second aspect, recovery process, starts with the change of attitude and mindset as one of the co-researchers

suggested “the decolonization of mind”. The group discussion interviews provided the platform for stakeholders to openly reflect on their action and attitudes.

The two parties were committed to freeing themselves from “shackles of colonizers and Europeans” and function side by side by supplementing each other for the benefits of their patients. The change of attitudes and mindset was part of the discovery and rediscovery processes whereby there was agreement that:

- Neither health model is better than the other. They should complement each other.
- A community’s culture, beliefs and traditions influence health seeking behaviour.
- HIV/AIDS and TB diseases are not only a health problem affecting one party. As it infects individuals, it also affects the whole community. It leaves behind a social, political, religious and economic problem. Conventional procedures and strategies for prevention, treatment, care and support are not adequate [202]. As reported from the discussions above, both AHPs and THPs were treating the same patients.
- Patients belonged to themselves, and were not owned by anyone. They should be allowed to practise and exercise their beliefs.
- Lack of communication between the two systems has created more harm to the patients. Efforts to save patients’ lives should be the main focus of every health care provider. Therefore, collaboration for them was being viewed as a way forward, rather than being an option to be considered and or debated continuously.

Mutual acceptance between AHPs and THPs were identified as one of the expected antecedents for collaboration and a clear sign of recovery and change of mindset that would benefit patients and communities.

6.7.2 Openness and honesty: Mourning

It is aligned to **Theme I**. The gathering of AHPs and THPS created an opportunity for them to share their experiences and also reach out to others, whilst seeking to be understood in the context of their sciences and health model. For years, THPs have not been recognised in South Africa. The current THPs Act provides glimpse of hope, despite progress towards establishing their council being very slow. Stakeholders suggested that both sides should be open to each other and share information among

themselves on conditions and diseases affecting their patients. The study focused on developing a model for collaboration in management of HIV/AIDS and TB patients. The parties committed themselves to working together and also to identify conditions which are best practices on either side.

Studies indicate that collaborations are likely to fail due to lack of openness and transparency between patients and health providers, allopathic and THPs [203, 204]. Findings from our group discussions highlighted the fact that patients often do not disclose that they had consulted other health practitioners, especially when they consulted THPs based on their beliefs. More worrying was the fact that THPs and AHPs were treating the same patients without communicating with each other. There was an acknowledgment of knowledge and skills limitations on both sides. THPs acknowledged that they do not perform blood and fluid transfusions, and are not competent to diagnose HIV/AIDS and TB. On the other hand, diseases such as “goni and gokhonya” and illness associated with ancestors, spirits and supernatural forces are beyond scope of allopathic medicine. Parties committed themselves to working together. They now realised that they wasted a lot of time fighting each and missed opportunity to save patients’ lives. Nevertheless, they made commitment to work together. This process is referred to as mourning for opportunities loss of learning, working together and saving lives [74].

6.7.3 HIV/AIDS and health behaviour

It is aligned to **Theme II**. Health, as defined by WHO, is limited to allopathic science and their experiences. This most commonly quoted definition of health, formalized by the World Health Organization over half a century ago; “as a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity, is silent about diseases caused by supernatural acts, demons, ancestors etc. As death is a spiritual disease of ending the biological life. The spirit of dead people transcends as ancestors, and that spirit lives within and around the living in the spiritual world [205]. When it comes to spiritual diseases such as demons, evil spells, etc. allopathic science does not have the resources including the equipment to diagnose and manage supernatural forces [41, 98, 205].

Findings from group discussions confirmed that patients consulted both health models. If patients believe that herpes zoster, also called mulilo wa-vhadzimu (lesion caused by ancestors' fire) is caused by ancestors, such patients are most likely to consult THPs.

Human behaviour is a complex matter. It is not always predictable. The health seeking behaviour may be influenced by internal factors including patients' beliefs, attitudes, experiences etc. and/or external factors such as the availability and accessibility of services and providers etc. Stakeholders emphasized that collaboration would require that both providers accept that patients may interchangeably consult both sides at times, for same conditions influenced by their beliefs and the prevailing circumstances.

6.7.4 Organizational matter: mourning

It is aligned to **Theme II**. It was only recently, 2007 to be specific, that THPs were recognised officially in South Africa. It was therefore not surprising to note that some AHPs were not aware that THPs form part of health care delivery workforce. They highlighted the urgent need for THPs to have a statutory body to register and regulate traditional health profession. The current interim traditional health council was specifically established to address that matter. Through their regulating body, stakeholders believe that it would be easy to identify genuine traditional healers and collaborate with them. It was also highlighted that public hospitals should open up for inclusion of THPs as members of hospital boards, community health workers, and other health organizations in the health sector [73, 93, 97].

6.7.5 Responsibility, respect and patient's rights

It is aligned to **Theme II**. For years, AHPs did not accept THPs as co-health workers. The meeting narrowed the gap. It was emphasised that for collaboration to succeed, AHPs would need to accept THPs beliefs and practices, and initiate mutual and trusting relationship so that they can work together as a team.

The findings confirmed that lack of collaboration between the two health providers was detrimental to the patients' health. Many patients were left confused, while some decided to "close up" and never disclose that they were on treatment for the same condition. Drug interactions and overdose was reported to be one of the main challenges experienced.

Both parties have committed themselves to putting patients first and save lives. Patients belonged to themselves, they were not owned by specific practitioners. Patients have the right to consult providers of their choice. It became evident that the current practices of informal referral, usually one sided and discouraging patients from consulting THPs violated their rights and denied them an opportunity to exercise their tradition and beliefs. A typical case was the belief in goni, gokhonya and herpes zoster, which was agreed in principle that it could be managed traditionally.

Both parties should allow patients to exercise their rights when it comes to consulting either of the two health systems. Respect for patients' choice of provider and need for establishing formal communication was emphasized.

6.7.6 Training and skill transfer

It is aligned to **Theme III**. From the onset, stakeholders recommended that THPs should be trained on signs and symptoms of HIV/AIDS and TB in preparation for collaboration. Both parties would need to be orientated and trained in order to get requisite knowledge and skills for collaboration. Training was identified as one of the concerns raised by AHPs during data analysis of the perceptions and experiences of AHPs on collaboration. THPs supported the idea of training workshops on signs and symptoms of HIV/AIDS and TB. Both parties would undergo training to change their current attitudes and to start to accept each other as part of healthcare providers directly involved in the provision of patient care. AHPs are to receive training in traditional beliefs and practices on HIV/AIDS and TB, as well as culturally congruent care, in order to have culturally competent knowledge and skills and be able to meet the cultural needs of diverse patients. The THPs were to receive training on signs and symptoms of HIV/AIDS and TB infections, HIV counselling and testing, PMTCT, HIV preventions and awareness campaigns. Sharing of skills among them and information

sharing through training, will help reduce the current animosity, resolve team conflicts and achieve effective collaboration [206].

Findings from our study suggest that team building will help improve relationships and narrow the gap between AHPs and THPs. It is believed that parties will have common purpose, share information, and support each other. Regular meetings may be relevant especially to share common problems and discuss the achievements and challenges being experienced.

6.7.7 Teamwork and collaboration

It is aligned to **Theme III**. This is the dreaming process, whereby trained THPs would be able to recognise signs and symptoms of HIV/AIDS and TB infections among their patients, persuade and encourage such patients to consider visiting allopathic facility for HIV or TB testing before further treatment is continued by THPs.

Allopathic facilities would refer back both HIV and TB positive or negative patients to THPs, for further management, support and supervision of patients on treatment.

Patients consulting AHPs, with beliefs on traditional medicine, supernatural powers and spirits, and beliefs in “goni” or “gokhonya”, will be referred to a recognised THPs trained on HIV/AIDS and TB diseases.

6.7.8 Joint review, management and sharing of information

It is aligned to **Theme III**. The dreaming process consisted of joint review meetings, management and sharing of information. In that process, THPs will form part of a larger pool of community health workers supporting and promoting compliances to DOT and ARV treatment. They would participate in the joint review of the HIV/AIDS and TB patients with AHPs at wellness clinics, participate in management and sharing of HIV/AIDS and TB information at regularly scheduled meetings where the patients' progress are discussed. When the dreams and commitments of the stakeholders are put into action in a participatory research approach, Chilisa [74] defines it as the last process of decolonization and the beginning of communities taking ownership of the present and moving into the future together.

6.8 SUMMARY

This chapter focused on development and description of a model for collaboration in management of HIV/AIDS and TB infections. A model was developed based on the people decisions from pre-phase (consultative meeting with stakeholders), Phase One (training workshops for THPs, findings), Phase Two (Group discussions) and Phase Three (Individual interviews with HIV/AIDS and TB patients. The model was described under the following aspects: COHORT approach following rediscovery and recovery, mourning, dreaming, commitment and action. Chapter Seven will focus on conclusions, limitations and recommendations for further research.

CHAPTER 7

FINDINGS, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

This final chapter concludes the journey navigated by the researcher led by co-researchers in the search for an appropriate model for collaboration between allopathic and THPs in management of HIV/AIDS and TB patients in Vhembe district, Limpopo Province. The main findings of the research are summarized and key conclusions which inform the main aim of the research is presented. It is followed by the study limitations and recommendations. However, the meetings and workshops are continuing. The research topic was introduced in Chapter 1, contextualised by doing a literature review in Chapter 2 and followed by Chapter 3 which focused on research methods and approach conducted in phases as decided by stakeholders.

This chapter provides an opportunity for the researcher to illustrate to the reader whether the research questions and the purpose of undertaking this study, as stated in Chapter 1 has been answered and achieved.

The overall research question was: What is an appropriate model for collaboration between THPs and AHPs in Vhembe District?

The following specific research questions were asked to give direction to the overall research question:

- What are the knowledge level, beliefs and management practices on HIV/AIDS and TB infections among THPs in Vhembe District?
- What are the perceptions and experiences of THPs and AHPs on collaboration in the management of HIV/AIDS and TB patients in the Vhembe district of the Limpopo Province?
- What is an appropriate model for collaboration between THPs and AHPs in the management of HIV and AIDS and TB patients in the Vhembe District?

7.2 FINDINGS

The study was conducted in Phases. Based on the findings discussed in Pre-Phase, Phases I, II and III, the most significant findings will be summarized and presented as the main conclusions of the study. The conclusions will be guided by the stipulated research objectives, and will be presented according to the most salient themes that emerged from the findings.

7.2.1 Pre-Phase-Consultative meeting with stakeholders: co-creation

The researcher, being aware of the challenges of collaborations (personal experiences, published reports), embarked on a process of consultative meetings with health authorities, ARV managers, THPs committee, Vhembe AIDS council and traditional leaders, referred to here as stakeholders. Refer to Chapter 4, titled “which route to take?”

- People agreed on a suitable process to be followed and modified the research project to reflect community participation in the whole project as co-researchers.
- They provided support and set up an advisory group, consisting of local THPs, AHPs and community representatives referred to as Stakeholders.
- Having noted the concern of AHPs and need for more information on HIV/AIDS, it was decided that there should first be HIV/AIDS and TB workshops for THPs, followed by group discussions between the two groups.

In this study, community participated and made decision in all the process of study. The researcher, together with community as co-researchers achieved their set objectives of answering the following community concerns (research questions).

7.2.2 Research question 1: What are the knowledge level, beliefs and management practices on HIV/AIDS and TB infections among THPs in Vhembe District?

The purpose of Phase I was first to get baseline data on HIV/AIDS and TB knowledge, beliefs and practices. The information collected was used in the planning and development of an appropriate training materials for the THPs. It also assisted in the group discussions with AHPs. There were a total of 437 THPs interviewed before the start of the training workshops. Below is the summary of the finding.

- THPs appeared to be aware of the danger of infections posed by HIV/AIDS and TB; and their knowledge on the causes and transmission route of HIV and AIDS (77.1%) and TB (89.1%) infections can be considered to be exceptionally high percentage, especially as most of them are not formally educated.
- A small portion ((22.9% for HIV/AIDS and 10.3% for TB) of them hold the view that the evil spirits and spells (*mimuya*) were the main reasons why patients had HIV/AIDS (22.9%) and TB (10.3%), and some believed that ancestors' powers and *muti* provide protective effects against HIV infections.
- High percentage of THPs was treating herpes zoster (91.8%) and gonorrhoea lesions (86.5%). It was noted that most of THPs were not able to relate to and identify oral thrush.
- There are strong beliefs (94.3%) among THPs and probably in the communities that herpes zoster is caused by supernatural powers :
 - ✓ Mulilo wa vhadzimu (fire caused by ancestors) - ancestors were the cause of the lesions. It is thought that "*ancestors visited the patient in the middle of the night and burned the skin overlying the area where there is a lesion*".
 - ✓ Mulilo wa vhaloi (fire caused by witches) - witches caused the lesion during the night-"*When witches fail to take you away during your sleep, they burn you as a sign of their anger and failure* "
 - ✓ Maswa vhusiku (Burned during the night) - excessive heat in a form of hot air externally caused the burns.

- ✓ Banda la Mozambique or Zimbabwe (Band like lesion from Mozambique or Zimbabwe). It's an infection which is thought to be coming with patients from Mozambique or Zimbabwe to Vhembe district.

The researcher was therefore able to assess and describe the knowledge level, beliefs and management practices on HIV/AIDS and TB infections among THPs in Vhembe District, Limpopo Province.

7.2.3 Research question 2: What are the perceptions and experiences of THPs and AHPs on collaboration in the management of HIV/AIDS and TB patients in the Vhembe district of the Limpopo Province?

The purpose of conducting this phase was to explore the perceptions and experiences on collaboration between THPs and AHPs in management of HIV/AIDS and TB patients.

The researcher applied a qualitative, exploratory, descriptive and contextual approach wherein four group discussions with allopathic and THPs were conducted to achieve this objective. Three group discussions were conducted jointly with AHPs and THPs in Vhembe district (Tshilidzini hospital, Tshilwavhusiku Health Centre and Malamulele hospital).

One of the group discussions, at Mhinga Health Centre, took a different approach due to the huge interest from the community members including home-based carers and AIDS volunteers. They wanted to be part of this historic event, and share their experiences. The researcher decided to apply the debate approach wherein three representatives (community health worker formerly called home-based carers, a professional nurse and a traditional health practitioner) participated in the debate in front of an audiences of approximately 50 community members.

Opinions about coming together as healthcare providers with different skills.

- The coming together of the co-researchers opened an opportunity for them to reflect deeply on the source of the existing animosity, lack of respect for each other and mutual or trusting relationships; and seen as a platform for bridging the existing

animosity between the two health systems, by creating an atmosphere of listening and reflecting on experiences whilst appreciating and understanding each other's world views. All participants, for instance, indicated that there was no formal interaction between AHPs and AHPs.

- They supported collaboration as it will benefit patients and communities. Their working relationship was characterised by a one-sided informal referral system, with THPs referring patients to AHPs and thus appeared not to be reciprocated by AHPs. There was lack of communication between the two health systems which was observed to be negatively impacting on the management of patients. It was reported that patients were delaying in initiating ARV treatment, some default whilst others die of renal failure due to overdose and herbal intoxication.
- The divergence situation was said to emanate from the negative attitude of AHPs toward traditional health system. The negative attitude was perceived to be the result of the problems encountered by AHPs which emanated from the practices of THPs, lack of exposure to traditional medicine and absent of standard procedures and regulations. THPs believe that their standard of sciences was comparable with that of allopathic medicine.
- Co-researchers, especially THPs, explicitly indicated that their understanding of collaboration was the recognition and acceptance of their health system and the role it plays in the delivery of health services. Added to that was the need for change in mindset of the AHPs, which will enable a reciprocal referral of patients between AHPs and THPs. For them, this was the crux of the matter. An essential element for collaboration was to accept, understand each other and dispel elements of mistrust.

Commitment from health providers

- There was commitment for collaboration between traditional and western health practitioners in, especially, providing treatment and care for people living with HIV/AIDS. Change of attitudes and of the mindset was central to achieving effective collaboration. The reported need for collaboration between the two groups of practitioners was based on both the perceived weaknesses and strengths of the two health systems that provide healing and care for the patients. The following factors were viewed as necessitating collaboration between traditional and western

health practitioners, namely (a) high utilisation rate of THPs in communities served by western health practitioners; (b) insufficient knowledge among THPs about HIV/AIDS; (c) immune system weakening properties and toxicity of some traditional medicines; (d) drug interactions caused by unknown traditional medicines which are used in conjunction with western medicines; (e) unhygienic traditional practices which exacerbate vulnerability of PWAs to infections; (f) immune boosting properties of some traditional medicines; and (g) substantiation of the authenticity of traditional healing methods and medicines, (h) community beliefs on traditional healing.

Perceptions and views on collaboration

- Co-researchers agreed that the two health systems should work together and they identified areas of great concern to test collaboration: management of herpes zoster (also called *maswa vhusiku/ mulilo-wa-vhadzimu* according to traditional beliefs) and birth mark (believed to be *goni/gokhonya*). Building the capacity of each group by holding meetings together, conducting workshops, offering training and conducting research were activities that were highlighted as essential for fostering a sustainable collaboration between the two groups of health practitioners.

The group discussion between AHPs and THPs has been unique and historic for both categories. The researcher is of the view that this approach was best suited to answer the research question, as co-researchers explained themselves, discussed and described their experiences with self-referred patients or those referred by THPs or AHPs; and expressed their views on collaboration between THPs and AHPs in the management of HIV/AIDS and TB patients in the Vhembe district of the Limpopo Province.

7.2.4 Research Question 3: What is an appropriate model for collaboration between THPs and AHPs in the management of HIV/AIDS and TB patients in the Vhembe District?

The purpose of this last stage in this research study was to develop an appropriate model for collaboration between AHPs and THPs in the management of HIV/AIDS and TB patients in the Vhembe District. The model has to be decided by the people, based on their understanding of the environment, culture, beliefs and existing health systems.

The researcher facilitated the process, starting with several consultative meetings with communities, identifying with them, their existing problem with regard to HIV/AIDS and TB patients (lack of collaboration between AHPs and THPS in managing the diseases). Communities decided on the approach to be used in addressing their identified problem. Findings from the phases were discussed and validated by stakeholders during subsequent meetings. A custom COHORT model for collaboration was developed.

The researcher achieved the final objective of developing a model for collaboration between AHPs and THPs, using the Decolonization process outlined by Chilisa [60]. Decolonization is a process of liberating the subjugated, submissive, and slavery mind from the oppressor through restoration and development of cultural practices, beliefs and values which reflect community empowerment [74]. Chilisa's process of decolonization focuses on changing the mindset and attitudes of the colonized indigenous people through participatory process of: (1) rediscovery and recovery, (2) mourning, (3) dreaming, (4) commitment, and (5) action in developing collaboration model.

Stakeholders identified six critical steps to facilitate collaboration among AHPs and THPs in Vhembe district.

- (a) **C:** Change of attitudes and mindset,
- (b) **O:** Openness and honesty in acknowledge of limitations,
- (c) **H:** HIV/AIDS /Health behaviour is complex,
- (d) **O:** Organizational issues, scope of practices and openness,

- (e) **R:** Responsibility and respecting patient beliefs and rights
- (f) **T:** Training, skill transfer and building trust on each other and Team work

These are evidence-based steps which were informed views and experiences of the co-researchers and stakeholders. It is envisaged that they will address concerns raised during the group discussions and also going forward in the implementation of the model.

These steps are interdependent, interrelated and interlinked, and the researchers coined them as COHORT steps to collaboration in management of HIV/AIDS and TB patients in Vhembe district, Limpopo Province.

The researcher abbreviated these six steps as COHORT steps for collaboration.

In applying decolonization process using COHORT steps, the researcher has achieved the aim of the study: “to develop a model for collaboration between AHPs and THPs in the management of HIV/AIDS and TB patients in the Vhembe District Municipality of the Limpopo Province in South Africa”. There has been contribution of new knowledge, which may assist health planners and policy makers for health, consumers of health services and further research projects.

7.3 CONCLUSION

The study has highlighted that when the research agenda is set by communities and the participants are co-researchers, the research becomes a powerful tool in the hands of a community to empower them to develop solutions suitable for their environment in solving their problems.

Allopathic and THPs resolved to collaborate together in the best interest of the patient’s beliefs, despite ideological differences between their health systems. The reality is that approximately 4 million out of 6 million HIV+ patients in South African are consulting THPs. Patients are free to exercise their rights and beliefs, and concerted effort is applied to address dual and simultaneous consultation by patients.

The researcher succeeded in developing and describing the model for collaboration between allopathic and THPs in the Vhembe district, Limpopo Province.

The consultative meetings between AHPs and THPs are continuing. Allopathic health practitioners are being organised to attend training workshops on traditional beliefs, practices and congruent care and management of HIV/AIDS and TB. The training workshops will be conducted by THPs.

7.4 LIMITATIONS AND CHALLENGES

Despite this study achieving its objective of developing a model for collaboration, some limitations were experienced during the process of conducting the study. Although the research strategy and approach selected was jointly agreed with stakeholders, various challenges were, nonetheless, experienced along the way. The following posed the main limitations and challenges:

- **Authorisation:** Due to incidences of so-called traditional health practitioner exploitation by researchers in the Limpopo Province, both THPs and health officials were cautious in providing authorisation for the research. Hence, the process of securing authorisation from the relevant officials to conduct interviews with THPs was a lengthy one, and delayed the onset of data collection. In addition, it was important that authorisation be obtained from ancestors and traditional leaders, as failure to do so creates further conflicts and anger from ancestors.
- **Illiterate participants:** Most of the THPs are elderly people with little or no education. Conducting training workshops on HIV/AIDS and TB was generally challenging. And this was anticipated from the start as the researcher had been working with them. Patience and thorough explanation was done, and it took more time. Some of them had hearing and eyesight problems. It may have affected the visual identification of HIV/AIDS associated lesions and communications during the study.
- **Incarnation and diagnostic processes:** Some THPs, especially diviners, rely on divinations and incarnation by ancestors' spirits to make diagnosis and treatment plans. The fact that their consulting rooms are habitat for ancestors and that they had not brought their "tools" for investigations and diagnosis; assessment of their

knowledge and diagnosis of presented lesions during the training workshops may be different.

- **Group discussions:** Enquiring about the least busy working days and times of AHPs prior to data collection assisted in securing interviews and causing the least interruption both with interviews as well as the work schedules of respondents. However, the most problematic respondents, in terms of securing time for interviews, were medical doctors. Meetings had to be rescheduled two times to accommodate them.
- **Bogus THPs:** This study was conducted in a period (2013-2015) where the National Interim Council of THPs was busy putting its house in order, calling on all THPs to organise themselves. THPs in the province were then required to form associations in readiness for registration with the Interim THPs Council of South Africa. Number of organisations has been formed with different objectives based on their understanding and expectations. There has been number of bogus THPs who exploited the situation for their own benefits. The researcher, being aware of this trend, decided to approach the village chiefs and traditional leaders to get the list of recognised THPs in their area.
- **Nonverbal eye contact communications:** There has been and immeasurable damage to the mindset of colonized people when indigenous practices were prohibited and labelled as witch craft. In this part of the world, ritual killing is common and often associated with THPs. Many of them were persecuted, some murdered for communicating and believing in the supernatural powers and ancestors. Some of the THPs, especially the very old women, appeared to be reluctant about participating in this study. Many of them have lived and experienced harassment, witnessed community killing of “witches”/their colleagues by burning. Even though the Witchcraft Act is replaced with the one that recognises them as part of health workforce, memory of the past experiences affected their response to certain questions. During the group discussions, the researcher being aware of the existing belief, requested them to explain the aetiology of “mulilo wa vhaloi” (Lesion associated with witches) commonly referred to as herpes zoster. Nonverbal eye contact communications among themselves

resulted in some of them being cautious and brief when responding to research questions and not spontaneous and elaborative. On observing this situation the researcher had to assure them their beliefs and practices is protected by law. Furthermore, conscious effort was made to create a relaxed and free atmosphere.

- **Challenges faced by the researcher:** The researcher was born and raised in rural areas, consulting THPs. The researcher is also trained as a AHPs. In most situations, the researcher is mostly confronted with a question “Who are you now, Sangoma’ or a doctor?” and “what do you believe works?” Although this questions are genuine and would be easy to answer, responding to them was going to compromise the study. The study could have been conducted by either a “Sangoma’, a doctor etc., it does not matter. What does matter is that both members are represented equally, and were free to express their views and opinion on collaboration, without being afraid of what others would say. The researcher maintained neutrality by bracketing himself during the research process and achieved that objective by allowing co-researchers to express their views without being intimidated and also in the language of their choice.
- **Collaboration model and ancestors:** The researcher holds the view that the developed model was the work of all stakeholders consulted during the study processes. Although THPs developed and agreed on the model for collaboration, they were not representing themselves. There was no way that the researcher could verify that ancestors agreed with the developed model. It is only after the validation and implementation of the model, wherein the approval or disapproval of collaboration may be postulated to be correct or not.

7.5 RECOMMENDATIONS

Recommendations are proposed based on the main conclusions deduced from the findings of the research. The researcher would like to make the following recommendations with specific reference to knowledge on HIV/AIDS and TB, curriculum of higher education and training institutions, collaboration between allopathic and THPs, policy-making, department of health, and further researches.

7.5.1 Knowledge on HIV/AIDS and TB among THPs

The traditional health practitioners in Vhembe district require more detailed knowledge about all aspects of HIV/AIDS including the relationship between HIV/AIDS and herpes zoster, STI and fungal infections.

THPs are encouraged to first refer their patients, presenting with signs and symptoms similar to those reported among HIV/AIDS patients, for HIV testing before they manage and/ or train them as THPs etc. However, such knowledge sharing needs to be culture-specific and profession-friendly, rather than strictly western-based.

7.5.2 Institutions of higher learning and training

The researcher recommends that the curriculum and contents of allopathic training institutions should be revised to reflect and recognise the role of traditional health system and its sciences, respect and reconcile community health beliefs and practices with western health systems.

It is further suggested that as part of their community engagement /based education programme, allopathic students must visit THPs at their workplaces so that they become acquainted with traditional medicine, diversity of health systems and dual consultations by patients, at an early stage of their careers.

7.5.3 Changing mindset of allopathic and THPs.

There should be regular exchange of patients' information between the two health systems and joint training workshops to supplement lack of exposure and knowledge, so that collaboration between the two health providers is smooth.

Joint workshops should be conducted for allopathic traditional and health practitioners towards demystifying traditional healing methods. The nature of the workshops should be such that practitioners of both health systems are allowed to interact and clarify misconceptions and myths related to each profession. Workshops should also be conducted to educate traditional practitioners about the basic principles and theories of western medicine. In turn, AHPs should be educated about the basic principles and ideologies which form the backbone of the traditional healing system.

A structured training programme based on both the traditional and western health systems should be developed in close consultation with practitioners from the respective systems. The training programme should be mainstreamed into the training of both allopathic practitioners, as well as traditional practitioners.

7.5.4 Health policy

Based on the findings of this study, the researcher and co-researchers recommends that traditional health systems should be recognised as a science which compliment allopathic health systems, and should run as parallel to the allopathic health system with identified areas of collaboration from either side.

A referral policy should be developed to promote collaboration. It should allow reciprocal referral of patients between traditional and western- trained practitioners.

Policy-makers in the Department of Health must consider training THPs in HIV/AIDS Counselling and Testing (HCT) programme, inclusion or absorption of them into the provincial health system as Community health workers.

7.5.5 Department of Health: Administration

Provincial health departments should play a more active role in propagating, and initiating collaboration between allopathic and THPs, and facilitating the healing system at the primary health care level. It should place more effort into initiating discussions between traditional and western health practitioners in order to reach joint decision-making between the two entities about how both health care practitioners can improve the health status of their respective communities in a collaborative relationship. Change must be effected at the grassroots level and not merely on paper. Not only should it initiate collaboration, but Department of Health should also be the watchdog to ensure that collaboration is taking place in a mutually respectful and effective way.

7.5.6 Further research

Further research may focus on:

- The validation and implementation of the model for collaboration between THPs and AHPs in the management of HIV/AIDS and TB patients in Vhembe district.
- The attitude of ancestors towards collaboration with AHPs
- Impact of collaboration on HIV/AIDS and TB infections in Vhembe district.
- Different types of diseases such as “goni and gokhonya diseases”.

REFERENCES

1. Unpublished report. HIV/AIDS and TB training workshop for traditional health practitioners; Bolivia Lodge, Polokwane, Limpopo Province. South Africa. 6-10 September 2012.
2. UNAIDS. UNAIDS Global AIDS Response Progress Reporting on the global AIDS epidemic 2013. Geneva: UNAIDS. 2013. Available at http://www.unaids.org/sites/default/.../UNAIDS_Global_Report_2013_en_1.pdf. Retrieved 12 July, 2015.
3. Gommersall CD, Shi L, Joynt GM, Taylor BL. Pandemic preparedness. *Current Opinion in Critical Care*. 2007; 6:742-747.
4. Department of Health. Operational Plan for Comprehensive HIV and AIDS Care, and Management and Treatment for South Africa. 2003. Available at <http://www.info.gov.za/otherdocs/2003/aidsplan.pdf>. Retrieved 15 June, 2015.
5. Holmes CB, Sanne I. Changing models of care to improve progression through the HIV treatment cascade in different populations. *Curr Opin HIV AIDS*. 2015; 10(6):447-50.
6. Audet CM, Hamilton E, Hughart L, Salato J. Engagement of traditional healers and birth attendants as a controversial proposal to extend the HIV health workforce. *Curr Opin HIV/AIDS Rep*. 2015; 12(2):238-45.
7. Callaghan M, Ford N, Schneider H. A systematic review of task-shifting for HIV treatment and care in Africa. *Hum Resour Health*. 2010; 8: 8-14.
8. National Strategic Plan on HIV, STIs and TB, 2012 - 2016. Available at <http://www.info.gov.za/view/DownloadFileAction?id=155622>. Retrieved 27 September, 2015.
9. Homsy J, King R, Balaba D, Kabatesi D. Traditional health practitioners are key to scaling up comprehensive care for HIV/AIDS in sub-Saharan Africa, editorial Comment *AIDS*. 2004; 18:1723–1725.
10. Freeman M, Motsei M. Planning health care in South Africa: Is there a role of traditional healers? *Social science and medicine*. 1992; 34(11): 1183-1190.
11. WHO. The WHO traditional medicine strategy: 2014-2023. Geneva. 2013.

12. World Health Organization (WHO). Promoting the role of traditional medicine in health systems: a strategy for the African Region 2001-2010. Harare: World Health Organization.2000.
13. Mills E, Singh S, Wilson K, Peters E, Onia R, Kanfer I. The challenges of involving traditional healers in HIV/AIDS care. *Int J STD AIDS*. 2006; 17(6):360-3.
14. Babb DA, Pemba L, Seatlanyane P, Charalambous S, Churchyard GJ, Grant AD. Use of traditional medicine by HIV- infected individuals in South Africa in the era of antiretroviral therapy. *Psychol Health Med*. 2007; 12(3):314-20.
15. Mills E, Cooper C, Seely D, Kanfer I. African herbal medicines in the treatment of HIV: Hypoxis and Sutherlandia. An overview of evidence and pharmacology. *Nutr J*. 2005; 4:19-22.
16. Langlois-Klassen D, Kipp W, Jhangri GS, Rubaale T. Use of traditional herbal medicine by AIDS patients in Kabarole District, western Uganda. *Am J Trop Med Hyg*. 2007; 77:757–63.
17. Peltzer K, Preez NF, Ramlagan S, Fomundam H. Use of traditional complementary and alternative medicine for HIV patients in KwaZulu-Natal, South Africa. *BMC Public Health*. 2008; 8:255-7.
18. Peltzer K, Mngqunaniso N. Patient’s consulting traditional health practitioners in the context of HIV/AIDS in urban areas in KwaZulu-Natal, South Africa. *Complement. Alter. Med*. 2008; 5:370–379.
19. Gail H, Tarryn B, Oluwaseyi A, Denver D, Oluchi M, Charlotte VK, Joop de J, Diana G. An ethnobotanical survey of medicinal plants used by traditional health practitioners to manage HIV and its related opportunistic infections in Mpoza, Eastern Cape Province, South Africa. *J Ethnopharmacol*. 2015; 171:109-15.
20. Liu J. The use of herbal medicines in early drug development for the treatment of HIV infections and AIDS. *Expert Opin Investig Drugs*. 2007; 16:1355–64.
21. Malangu N. Self-reported use of traditional, complementary and over-the-counter medicines by HIV-infected patients on antiretroviral therapy in Pretoria, South Africa. *Afr J Trad CAM*. 2007; 4:273–278.

22. Unge C, Ragnarsson A, Ekström AM, Indalo D, Belita A, Carter J, Ilako F, Södergård B. The influence of traditional medicine and religion on discontinuation of ART in an urban informal settlement in Nairobi, Kenya. *AIDS care*. 2011; 23(7): 851-858.
23. Walwyn D, Maitshotlo B. The role of South African traditional health practitioners in the treatment of HIV/AIDS: a study of their practices and use of herbal medicines. *South Afr J HIV Med*. 2010; 11(2):11–16.
24. Adejumo OA, Malee KM, Ryscavage P, Hunter SJ, Taiwo BO. Contemporary issues on the epidemiology and antiretroviral adherence of HIV-infected adolescents in sub-Saharan Africa: a narrative review. *J Int AIDS Soc*. 2015; 18(1): 20-49.
25. WHO Traditional Medicine Strategy 2002–2005. World Health Organisation; Geneva, Switzerland: 2002.
26. Traditional Medicine. World Health Organisation; Geneva, Switzerland: 2008.
27. Mbatha N, Street RA, Ngcobo M, Gqaleni N. Sick certificates issued by South African traditional health practitioners: Current legislation, challenges and the way forward. *South Afr. Med. J*. 2012; 102:129–131.
28. Makhubu N. SABS Urged to Standardize Traditional Cures. Available at <http://www.iol.co.za/news/special-features/the-zuma-era/sabs-urged-to-standardise-traditional-cures-1.1161993#.U-h5TvlDv8E>. Retrieved 8 July, 2015.
29. Natrass N. Who consults Sangomas in Khayelitsha? An exploratory quantitative analysis. *Soc. Dyn*. 2005; 31:161–182.
30. Nmutandani MS, Maluleke FR, Rudolph MJ. Community service doctors in Limpopo Province. *S Afr Med J*. 2006; 96(3):180-2.
31. UNAIDS. Collaborating with traditional healers for HIV prevention and care in sub-Saharan Africa: suggestions for programme managers and field workers. Geneva: UNAIDS. 2006. Available at <https://books.google.co.za/books?isbn=9291733423>. Retrieved 12 Jan, 2015.
32. Van Wyk NC, Bourne B, Gericke GJ, Mokoena JD, Mulaudzi FM, Van Wyk IWC. Integrative healthcare: a guide to meet the needs of Africa. Cape Town: Juta and Co Ltd. South Africa. 2009.

33. Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Zungu N, Labadarios D, Onoya D. South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Human Sciences Research Council Press; Cape Town, South Africa: 2014.
34. Simbayi LC, Shisana O, Rehle T, Onoya D, Jooste S, Zungu N, Labadarios D, Zuma K. South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Available at <http://www.hsrc.ac.za/en/research-data/view/6871#sthash.I8xHvxY7.dpuf>. Retrieved 29 October 2015.
35. Liverpool J, Alexander R, Johnson M, Ebba EK, Francis S, Liverpool C. Western medicine and traditional healers: partners in the fight against HIV/AIDS. *J Natl Med Assoc.* 2004; 96(6):822-5.
36. Batchelor S, Waldman L, Bloom G, Rasheed S, Scott N, Ahmed T, Khan NU, Sharmin T. Understanding Health Information Seeking from an Actor-Centric Perspective. *Int J Environ Res Public Health.* 2015; 12(7):8103-24.
37. Green G, Bradby H, Chan. A, Lee M. “We are not completely westernised”: Dual medical systems and pathways to health care among Chinese migrant women in England. *Soc Sci Med.* 2006; 62(6):1498-509.
38. Moshabela M, Pronyk P, Williams N, Schneider H, Lurie M. Patterns and implications of medical pluralism among HIV/AIDS patients in rural South Africa. *AIDS Behav.* 2011; 15:842-852.
39. Van Dyk AC. “Why me and not my neighbour?” HIV/AIDS care and counselling in a traditional African context. *Curationis.* 2001; 24(3): 4-11.
40. Puckree T, Mkhize M, Mgobhozi Z, Lin J. African traditional healers: what health care professionals need to know. *Int J Rehab Res.* 2002; 25:247–251.
41. Flint AG, Payne JR. Reconciling the Irreconcilable? HIV/AIDS and the potential for middle ground between the traditional and biomedical healthcare sectors in South Africa. *Forum Develop. Stud.* 2013; 40:47–68.
42. Flint AG. Traditional Healing, Biomedicine and the Treatment of HIV/AIDS: Contrasting South African and Native American Experiences. *J Environ Res Public Health.* 2015; 12(4): 4321–4339.

43. The Art and Science of traditional medicine. Part 1: TCM Today- a case for integration. Science 19 December 2014; 346(6216):1569. Available at <http://www.sciencemag.org> > 19 December 2014. Retrieved 21 May, 2015.
44. WHO. 1946. Definitions of health/wellness. Available at http://www.pnf.org/Definitions_of_Health_C.pdf. Retrieved 20 Jan 2015.
45. Kuokkanen R. Towards an “Indigenous paradigm” from a Sami perspective. The Canadian Journal of Native Studies. 2000; 20(2): 411-436.
46. Van Wyk NC, Bourne B, Gericke GJ, Mokoena JD, Mulaudzi FM, Van Wyk IWC. Integrative healthcare: a guide to meet the needs of Africa. Cape Town: Juta and Co Ltd. South Africa. 2009.
47. Nyika A. Ethical and regulatory issues surrounding African traditional medicine in the context of HIV/AIDS. Dev World Bioeth. 2007; 7:25–34.
48. Conley RJ. Cherokee Medicine Man: The Life and Work of a Modern-Day Healer. University of Oklahoma Press; Norman, OK, USA: 2005.
49. Bereda JE. Traditional healing as a health care delivery system in a transcultural society. M.A. Dissertation. Pretoria: University of South Africa. 2002.
50. Lovell B. The integration of bio-medicine and culturally based alternative medicine: implications for health care providers and patients. Glob Health Promot. 2009; 16(4):65-8.
51. Loughlin M, Bluhm R, Fuller J, Buetow S, Upshur RE, Borgerson K, Goldenberg MJ, Kingma E. Philosophy, medicine and health care - where we have come from and where we are going. J Eval Clin Pract.2014; 20(6):902-7.
52. Dahab M, Charalambous S, Hamilton R. That is why I stopped the ART’’: Patients’ & providers’ perspectives on barriers to and enablers of HIV treatment adherence in a South African workplace programme. BMC Public Health. 2008; 8:63-9.
53. UNFPA South Africa-HIV. Available at <http://country.office.unfpa.org/south-africa/2013/05/03/6675/hiv/>. Retrieved 25 May 2015.
54. Ayisi R. Traditional Healers' Practices under AIDS Spotlight. Mail and Guardian Online. Dec 23, 2006. Available at <http://mg.co.za/article/2006-12-23-traditional-healers-practices-under-aids-spotlight>. Retrieved 3 Dec, 2015.

55. Gourlay A, Birdthistle I, Mburu G, Iorpenda K, Wringe A. Barriers and facilitating factors to the uptake of antiretroviral drugs for prevention of mother-to-child transmission of HIV in sub-Saharan Africa: a systematic review. *J Int AIDS Soc.* 2013; 16(1): 185-88.
56. Nozaki I, Kuriyama M, Manyepa P, Zyambo MK, Kakimoto K, Bärnighausen T. False beliefs about ART effectiveness, side effects and the consequences of non-retention and non-adherence among ART patients in Livingstone, Zambia. *AIDS Behav.* 2013; 17(1): 122–126.
57. Rosen S, Fox MP, Gill CJ. Patient retention in antiretroviral therapy programs in sub-Saharan Africa: a systematic review. *PLoS Med.* 2007; 4:e298.
58. Wanyama J, Castelnovo B, Wandera B, Mwebaze P, Kambugu A, Bangsberg DR, Kanya MR. Belief in divine healing can be a barrier to antiretroviral therapy adherence in Uganda. *AIDS.* 2007; 21(11):1486-7.
59. Keeton C. Aids Update: ARV resistance looms as 40% fail to follow regimen. Available at <http://www.timeslive.co.za/thetimes/2015/01/11/aids-update-arv-resistance-looms-as-40-fail-to-follow-regimen>. Retrieved 15 September 2015.
60. Abstracts from the 37th Annual Meeting of the Society of General Internal Medicine. *J Gen Intern Med.* 2014 April; 29 (Suppl 1): 1–545.
61. Roura M, Busza J, Wringe A, Mbata D, Urassa M, Zaba B. Barriers to sustaining antiretroviral treatment in Kisesa, Tanzania: a follow-up study to understand attrition from the antiretroviral program. *AIDS Patient Care STDS.* 2009; 23(3):203-10.
62. Madiba SE. Are Biomedicine Health Practitioners Ready to Collaborate with Traditional Health Practitioners in HIV and AIDS Care in Tutume Sub District of Botswana? *Afr J Tradit Complement Altern Med.* 2010; 7(3): 219–224.
63. Madamombe I. Traditional healers boost primary health care: Reaching patients missed by modern medicine. *African Renewal.* 2006; 19: 10-12.
64. Kayombo EJ, Uiso FC, Mbwambo ZH, Mahunnah RL, Moshi MJ, Mgonda YH. Experience of initiating collaboration of traditional healers in managing HIV and AIDS in Tanzania. *J Ethnobiol Ethnomed.* 2007; 3: 6-10.
65. O'Brien S, Broom A. HIV in (and out of) the clinic: biomedicine, traditional medicine and spiritual healing in Harare. *SAHARA J.* 2014; 11:94-104.

66. Olaore IB, Olaore AY. Is HIV/AIDS a consequence or divine judgment? Implications for faith-based social services. A Nigerian faith-based university's study. SAHARA J. 2014; 11:20-5.
67. Necek R. Moral and religious issues in health care. Przegl Lek. 2012; 69(6):271-4.
68. Stoner BP. Understanding medical systems: Traditional, modern, and syncretic health care alternatives in medically pluralistic societies. Med. Anthropol. Quart. 1986; 17:44–48.
69. Van Wyk NC. Similarities in the meta-paradigm of nursing and traditional healing: An attempt to contribute to the integration of traditional medicine and western medicine in Africa. Health SA Gesondheid. 2005; 10:14–22.
70. Schatz E, Gilbert L, McDonald C. 'If the doctors see that they don't know how to cure the disease, they say it's AIDS': How older women in rural South Africa make sense of the HIV/AIDS epidemic. Afr J AIDS Res. 2013; 12(2):95-104.
71. Moshabela M, Schneider H, Silal SP, Cleary SM. Factors associated with patterns of plural healthcare utilization among patients taking antiretroviral therapy in rural and urban South Africa: a cross-sectional study. BMC Health Services Research. 2012; 12:182.
72. Department of Health. HIV/AIDS and STD Strategic Plan for South Africa 2000-2005. Pretoria: Department of Health, 2000.
73. The Traditional Health Practitioners Act, Act 22 of 2007. Pretoria: Government printers. Republic of South Africa, 2007.
74. Chilisa B. Indigenous Research Methodologies. SAGE Publications Inc. United States. 2012.
75. Smith LT. Decolonizing Methodologies: Research and Indigenous Peoples. Zed Books Ltd. 2nd Edition: United Kingdom. 2012.
76. National Health Act, 2003 (Act No. 61 of 2003). Pretoria: Government printers. Republic of South Africa, 2003.
77. Constitution of the Republic of South Africa [No. 108 of 1996]. Pretoria: Government printers. Republic of South Africa, 1996.
78. National Patients' Rights Charter (2008). HPCSA guidelines for good practice in the health care professions. National Patients' Rights Charter booklet 3.

- Pretoria. Available at
http://www.hpcsa.co.za/downloads/.../booklet_3_patients_rights_charter.pdf.
Retrieved 3 December 2015.
79. African Union. African health strategy 2007-2015: third session of the African Union conference of Ministers of Health. Johannesburg: African Union.2007. From <[http:// www.carmma.org/download/file/fid/154](http://www.carmma.org/download/file/fid/154). Retrieved 10 Nov, 2014.
80. National Health Insurance in South Africa: Policy Paper. Pretoria: Republic of South Africa, 2011. At <http://www.info.gov.za/view/DownloadFileAction?id=148470>. Retrieved 20 November 2015.
81. Aphane M. 2009. Why is my sangoma's medical certificate not valid? Johannesburg: UNISA Press. Available at <http://www.unisa.ac.za/default.asp?Cmd=ViewContent & Content ID=7012>. Retrieved 10 November 2015.
82. Labour Appeal Court. 2012. Sangoma sick note valid: Labour Appeal Court. 24 July 2012. Available at <http://www.labourtalk.co.za>. Retrieved 12 February 2015.
83. Scientific modelling | Science learn Hub. Available at <http://www.sciencelearn.org.nz/Contexts/The-Noisy.../Science.../Scientific-modelling>. Retrieved 22 July 2015.
84. World Health Organization. (1978, September). Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, U.S.S.R. available at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf. Retrieved 13 October 2015.
85. Hughes I. 'Action research in healthcare', in P. Reason and H. Bradbury (eds), The SAGE Handbook of Action Research: Participative Inquiry and Practice. London: SAGE publications.2008.
86. Meyer, J. 'Using qualitative methods in health related action research', BMJ. 2000; 320: 178–181.
87. Morgan LM. 'Community participation in health: perpetual allure, persistent challenge' Health Policy and Planning. 2001; 16 (3): 221-4.
88. Kemmis S, McTaggart. Participatory Action Research: Communicative Action and the Public Sphere. In DENZIN, Norman K. and LINCOLN, Yvona S, (eds.)

- The SAGE Handbook of Qualitative Research. 3rd ed. London: SAGE Publications.2005
89. Koshy E, Waterman H, Koshy V. Action Research in Healthcare. SAGE Publications, Limited. 2010.
 90. O'brien R. An overview of the methodological approach of action research. Faculty of Information Studies, University of Toronto.1998.
 91. African Health Leadership and Management Network. 2007. Available at <http://www.ahlmn.org/>. Retrieved 10 June, 2015.
 92. Puoane TR, Hughes GD, Uwimana J, Johnson Q, Folk WR. Why HIV positive patients on antiretroviral treatment and/or cotrimoxazole prophylaxis use traditional medicine: perceptions of health workers, traditional healers and patients: a study in two provinces of South Africa. *Afr J Tradit Complement Altern Med*. 2012;9(4):495-502
 93. Witchcraft Suppression Act, No. 3 of 1957, Government Printers, Pretoria, Republic of South Africa. 1957.
 94. WHO Traditional Medicine Strategy 2002-2005. Geneva, WHO, 2002
 95. Interview Conducted by Author with Chairperson of the Interim Council of Traditional Health Practitioners, 27 July 2014.
 96. Mehl-Madrona L. Coyote Medicine: Lessons from Native American Healing. Scriber; New York, USA: 1997.
 97. Kale R. Traditional healers in South Africa: A parallel health care system. *British Medical Journal*. 1999; 3(10):1182-1185.
 98. Dowson M, Devenish S. Religion and Spirituality. Information Age Publishing, Inc. Charlotte, North Caroline. Available at [http:// www.infoagepub.com](http://www.infoagepub.com).2010. Retrieved 14 May 2015.
 99. Roura M, Nsigaye R, Nhandi B, Wamoyi J, Busza J, Urassa M, Todd J, Zaba B. 'Driving the devil away': Qualitative insights into miraculous cures for AIDS in a rural Tanzanian ward. *BMC Public Health*. 2010; 10(1):427
 100. King R. Ancient Remedies, New Disease: Involving traditional healers in increasing access to AIDS care and prevention in East Africa. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS). 2002.

101. Schrage M. *Shared Minds: The New technologies of collaboration*. Random House, USA. 1990.
102. Henneman HA, Lee JL, Cohen JI. *Collaboration: a concept analysis*. *J Adv Nurs*. 1995; 21:103-109.
103. KING R. *Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan Africa. A literature review*. Geneva: UNAIDS. 2000.
104. Kaptchuk TJ, Miller FG. *Viewpoint: what is the best and most ethical model for the relationship between mainstream and alternative medicine: opposition, integration, or pluralism?* *Acad Med*. 2005 Mar; 80 (3):286-90.
105. Campbell-Hall V, Petersen I, Bhana A, Mjadu S, Hosegood V, Flisher AJ. *Collaboration between traditional practitioners and primary health care staff in South Africa: developing a workable partnership for community mental health services*. *Transcultural Psychiatry*. 2010; 47(4): 610-628.
106. Petersen I, Baillie K, Bhana A, *Understanding the benefits and challenges of community engagement in the development of community mental health services for common mental disorders: Lessons from a case study in a rural South African subdistrict site*. *Transcultural Psychiatry*. 2012; 49: 418-437.
107. Keikelame MJ, Swartz L. 'A thing full of stories': Traditional healers' explanations of epilepsy and perspectives on collaboration with biomedical health care in Cape Town. *Transcult Psychiatry*. 2015 Oct; 52(5):659-80.
108. Waldram JB, Hatala AR. *Latent and manifest empiricism in Q'eqchi' Maya healing: a case study of HIV/AIDS*. *Soc Sci Med*. 2015; 126:9-16.
109. Vogel V. *American Indian Medicine*. University of Oklahoma Press; Norman, OK, USA: 1970.
110. Brownlee F. *Some experiences of native superstition and witchcraft*. *Afr. Affairs*. 1940; 39:54–60.
111. Lett J. "Science, religion, and anthropology." *Anthropology of religion: A handbook* (1997): 103-20.
112. George G, Chitindingu E, Gow J. *Evaluating traditional healers knowledge and practices related to HIV testing and treatment in South Africa*. *BMC Int. Health Human Rights*. 2013; 13:1–7.

113. Novins DK, Beals J, Moore LA, Spicer P, Manson SM. Use of biomedical services and traditional healing options among American Indians: Sociodemographic correlates, spirituality, and ethnic identity. *Med. Care.* 2004; 42:670–679.
114. Langlois-Klassen, D, Kipp, W, Rubaale, T. Who’s talking? Communication between health providers and HIV-infected adults related to herbal medicine for AIDS treatment in western Uganda. *Soc Sci Med.* 2008; 67: 165-76.
115. Dusek JA, Sherwood JB, Friedman R, Myers P, Bethea CF, Levitsky S, Hill PC, Jain MK, Kopecky SL, Mueller PS, Lam P, Benson H, Hibberd PL. Study of the Therapeutic Effects of Intercessory Prayer (STEP): Study design and research methods. *Amer. Heart J.* 2002; 143:577–584.
116. Nasiri M, Fayazi S, Ghaderi M, Naseri M, Adarvishi S. The Effect of Reciting the Word “Allah” on Pain Severity After Coronary Artery Bypass Graft Surgery: A Randomized Clinical Trial Study in Iran. *Anesthesiology and Pain Medicine.* 2014; 4(5):e23149.
117. Pecoraro A, Pacciolla A, O’Cleirigh C, Mimiaga M, Kwiatek P, Blokhina E, Verbitskaya E, Krupitsky E, Woody GE. Proactive coping and spirituality among patients who left or remained in antiretroviral treatment in St Petersburg, Russian Federation. *AIDS Care.* 2015; 13:1-6.
118. Sicher F. A randomized double-blind study of the effect of distant healing in a population with advanced AIDS. Report of a small scale study. *West. J. Med.* 1998; 169:356–363.
119. Dickinson D. *A Different Kind of AIDS: Folk and Lay Theories in South African Townships.* Jacana Media; Sunnyside, CA, USA: 2014.
120. Treatment Action Campaign Translation of uBhejane Video Transcript. Available at <http://www.tac.org.za/community/files/TranslationOfUbhejaneVideoTranscript.pdf>. Retrieved 12 November 2015.
121. Nmutandani MS, Adedaja D, Nmutandsani V. Orofacial injuries among traditional bare-fisted fighters. *SADJ.* 2012; 67(4):164-7.

122. Nmutandani MS, Adedoja D, Nmutansdani V. Aids Pandemic: Traditional Practices Increasing Risk of HIV Infections in South Africa. *J Clin Res Bioeth.* 2014; 5:173-5.
123. Moswane PCN. The role of churches in HIV prevention among young adults in Polokwane Municipality, Limpopo Province. Masters in Arts Thesis, 2013. University of South Africa, 2013.
124. Kuper J. Sangoma's power challenges state. *Mail & Guardian* June 19 to 25, 2015.
125. Peltzer K, Mngqundaniso N, Petros G. A controlled study of an HIV/AIDS/STI/TB intervention with traditional healers in KwaZulu-Natal, South Africa. *AIDS Behav.* 2006; 10(6):683-90.
126. Natrass N. AIDS and the scientific governance of medicine in post-apartheid South Africa. *Afr. Affairs.* 2008; 107:157–176.
127. Summerton JV. Western health practitioners' view about African traditional health practitioners' treatment and care of people living with HIV/AIDS. *Curationis.* 2006; 29(3):15-23.
128. Ross E. Traditional healing in South Africa: ethical implications for social work. *Soc Work Health Care.* 2008; 46(2):15-33.
129. Wreford J. *Working with Spirit: Experiencing Izangoma. Healing in Contemporary South Africa.* Berghahn Books; Oxford, UK: 2008.
130. Matshidze PE. The role of Makhadzi in traditional leadership among the Venda. Unpublished Ph.D thesis, University of Zululand, KwaDhlangezwa, KwaZulu-Natal. 2013.
131. Mafukata MA. Mandevu. *Journal of Arts and Humanity.* 2015; 4(1):14-26.
132. The 2012 National Antenatal Sentinel HIV and Herpes Simplex type-2 prevalence Survey, South Africa, National Department of Health, 2013. Available at http://www.health-e.org.za/wp-content/uploads/2014/05/ASHIVHerp_Report2014_22May2014.pdf. Retrieved 8 December 2015.
133. Vhembe District Fin - Health-e. Available at <http://www.health-e.org.za/wp-content/uploads/.../Vhembe-District-Fin.pdf>. Retrieved 28 October 2015.

134. De Vos AS, Strydom H, Fouche CB, Delpont CSL. Research at grassroots. Pretoria: Van Schaik. 2007.
135. Mashamba T, Peltzer K, Maluleke TX, Sodid T. A Controlled Study of an HIV/AIDS/STI/TB Intervention with Faith Healers in Vhembe District, South Africa. *Afr J Tradit Complement Altern Med*. 2011; 8(5 Suppl): 83–89.
136. Haasnoot PJ, Boeting TE, Kuney MO, van Roosmalen J. Knowledge, attitudes, and practice of tuberculosis among Maasai in Simanjiro district, Tanzania. *Am J Trop Med Hyg*. 2010; 83(4):902-5.
137. Burns N, Grove SK. The practice of nursing research, appraisal, synthesis and generation of evidence. 6th ed. St Louis. Elsevier. Saunders. 2009.
138. Polit DF, Beck CT. Generating and Assessing Evidence for Nursing Practice. 8th Edition. Lippincot Williams & Wilkins, a Wolters Kluwer business. 2008.
139. Letendrea J, Williams LR. “I Hear You”: Using Focus Groups to Give Voice to Adolescent Girls' Experiences with Violence. *Social Work with Groups*. 2014; 37(2):114-128.
140. Babbie E. The practice of social research. 11th edition. Thousand Oaks: SAGE Publishers. 2007.
141. O'Reilly K. Key Concepts in Ethnography. SAGE Publications Ltd. Loughborough University, 2009.
142. Barbour RS, Kitzinger J. Developing focus group research. Politics, theory and practice. Thousand Oaks: Sage publications. 1999.
143. Burns N, Grove SK. The practice of nursing research, appraisal, synthesis and generation of evidence. 6th ed. St Louis. Elsevier. Saunders. 2009.
144. Wilson S. Research is ceremony: indigenous research methods. Manitoba. Canada: Fernwood. 2008
145. Wang CX, Anstadt S, Goldman J, Lefaiver MLM. Facilitating Group Discussions in Second Life. *MERLOT Journal of Online Learning and Teaching*. 2014; 10(1):139-151.
146. Marshall C, Rossman GB. Designing qualitative research. 3rd edition. Thousand Oaks: SAGE publications. 1999.
147. Clark VLP, Creswell JW. Understanding research: A consumer's guide. Pearson Higher Ed, 2014.

148. Shenton AK. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*. 2004; 22: 63–75.
149. Klassen AC, Creswell J, Clark VLP, Smith KC, Meissner HI. Best practices in mixed methods for quality of life research. *Quality of Life Research*. 2012; 21 (3):377-380.
150. Tashakkori A, Teddlie C. *Handbook of mixed methods in social and behavioural research*. California: Sage Publications Inc. (eds.) 2003
151. Shisana O, Zungu-Dirwayi N, Toefy Y, Simbayi LC, Malik S, Zuma K. Marital status and risk of HIV infection in South Africa. *S Afr Med J*. 2004; 94(7):537-43.
152. Dalmida SG, Holstad MM, Dilorio C, Laderman G. The meaning and use of spirituality among African American women living with HIV/AIDS. *West J Nurs Res*. 2012; 34(6):736-65.
153. Struthers S, Eschiti V.S, Patchell B. Traditional indigenous healing: Part I. *Complement. Ther. Nurs. Midwifery*. 2004; 10:141–149.
154. Bodeker, G (2000) Complementary medicine and evidence. *Ann Acad Med Singapore* 29: 3-6.
155. Gqaleni N, Shongwe V, Seleti Y. "Traditional Medicine in the Era of HIV/AIDS in South Africa", International Convention Centre, Durban, 28th to 30th July 2010. *Afr J Tradit Complement Altern Med*. 2012; 9(3 Suppl):1.
156. Mbutho NP, Gqaleni N, Korporaal CM. Traditional complementary and alternative medicine: knowledge, attitudes and practices of health care workers in HIV and AIDS clinics in Durban hospitals. *Afr J Tradit Complement Altern Med*. 2012 Feb 13; 9(3 Suppl):64-72.
157. Squire C. *HIV in South Africa*. Routledge; London, UK: 2007.
158. Furin J. The role of traditional healers in community-based HIV care in rural Lesotho. *Journal Community Health*. 2011; 36: 849–856.
159. Sifunda S, Reddy PS, Braithwaite RB, Stephens T, Bhengu S, Ruiter RA, Van Den Borne B. Social construction and cultural meanings of STI/HIV-related terminology among Nguni-speaking inmates and warders in four South African correctional facilities. *Health Educ Res*. 2007; 22(6):805-14.

160. Semenya SS, Potgieter MJ. Sexually transmitted infections and their diagnosis: Bapedi experience. *Afr. Health Sci.* 2013; 13:1047–1053.
161. Sharkey AB, Chopra M, Jackson D, Winch PJ, Minkovitz CS. Pathways of care-seeking during fatal infant illnesses in under-resourced South African settings. *Trans R Soc Trop Med Hyg.* 2012; 106(2): 110-116.
162. Schoepf BG. AIDS, sex and condoms: African healers and the reinvention of tradition in Zaire. *Med Anthropol.* 1992; 14(2-4):225-42.
163. Naicker C. Marikina: taking a subaltern sphere of politics seriously. Masters Thesis. Rhodes University. Faculty of Humanities, Political and International Studies, 2014.
164. Burnett A, Baggaley R, Ndovi-MacMillan M, Sulwe J, Hang'omba B, Bennett J. Caring for people with HIV in Zambia: are traditional healers and formal health workers willing to work together? *AIDS Care.* 1999; 11(4):481-91.
165. Farrand D. Is a combined western and traditional health service for Black patients desirable? *South African Medical Journal.* 1984; 66(17): 779-780.
166. Freeman M, Motsei M. Planning health care in South Africa: Is there a role of traditional healers? *Social science and medicine.* 1992; 34(11): 1183-1190.
167. Gqaleni N, Hlongwane T, Khondo C, Mbatha M, Mhlongo S. Biomedical and Traditional Healing Collaboration on HIV and AIDS in KwaZulu-Natal, South Africa. *Universitas Forum.* 2011; 2(2). Available at <http://www.universitasforum.org/index.php/ojs/article/view/62/240>. Retrieved 8 June 2015.
168. Gqaleni N, Mbatha T, Mkhize A, Naidoo M, Makhathini T, Buthelezi V, Davids I, Moodley I. Education and development of Traditional Health Practitioners in isiZulu to promote their collaboration with public health care workers. *Alternation.* 2011; 17(1):10-14.
169. Audet CM, Salato J, Blevins M, Amsalem D, Vermund SH, Gaspar F. Educational intervention increased referrals to allopathic care by traditional healers in three high HIV-prevalence rural districts in Mozambique. *PLoS One.* 2013 Aug 1; 8(8):e70326.

170. Rudolph MJ, Ogunbodede EO, Mistry M. Management of the oral manifestations of HIV/AIDS by traditional healers and care givers. *Curationis*. 2007; 30(1):56-61.
171. Shibangu KC, Worku ZB, de Jongh MA, van Wyk AE, Mokwena SO, Peranovic V. Assessment of effectiveness of traditional herbal medicine in managing HIV/AIDS patients in South Africa. *East Afr Med J*. 2004; 81(10):499-504.
172. Komolafe OO, Ogunleye OT, Fasina OO, Komolafe OA. African traditional medication and keloid formation in herpes zoster ophthalmicus. *Niger J Clin Pract*. 2011; 14(4):479-81.
173. Obileye MF, Agbelusi GA, Orenuga OO, Temiye EO. Immune Suppression and Oral Manifestations of HIV in a Group of Nigerian Children. *West Afr J Med*. 2014; 33(4):270-5.
174. Muller K, Kazimiroff J, Fatahzadeh M, Smith RV, Wiltz M, Polanco J, Grossberg RM, Belbin TJ, Strickler HD, Burk RD, Schlecht NF. Oral Human Papillomavirus Infection and Oral Lesions in HIV-Positive and HIV-Negative Dental Patients. *J Infect Dis*. 2015; 212(5):760-8.
175. Ramphoma KJ, Naidoo S. Knowledge, attitudes and practices of oral health care workers in Lesotho regarding the management of patients with oral manifestations of HIV/AIDS. *SADJ*. 2014; 69(10):446, 448-53.
176. Ashforth A. *Madumo: A Man Bewitched*. University of Chicago Press; Chicago, IL, USA: 2000.
177. Ashforth A. *Witchcraft, Violence, and Democracy in South Africa*. University of Chicago Press; Chicago, IL, USA: 2005.
178. Niehaus I. *Witchcraft, Power and Politics: Exploring the Occult in the South African Lowveld*. Pluto Press; London, UK: 2001.
179. WHO Kobe Centre, 2002. Formalisation of traditional health services. Planning for cost-effective traditional health services in the new century. Available at http://www.who.or.jp/tm/research/bkg/5_formalisation.html. Retrieved 02 June 2015.

180. World Health Organization (WHO). Promoting the role of traditional medicine in health systems: a strategy for the African Region 2001-2010. Harare: World Health Organization. 2000.
181. World Health Organization (WHO). WHO Traditional Medicine Strategy 2002-2005. Geneva: World Health Organization. 2002.
182. World Health Organization (WHO). Report on Traditional Medicine Strategy 2002-2005. Geneva: World Health Organization. 2003.
183. A World Health Organization (WHO). Traditional medicine. Fact sheet 134. Available at <http://www.who.int/mediacentre/factsheets/fs134/en/print.html>. Retrieved 23 May 2015.
184. Homsy J, Katabira E, Kabatesi D, Mubiru F, Kwamya L, Tusaba C, Kasolo S, Mwebe D, Ssentamu L, Okello M, King R. Evaluating herbal medicine for the management of Herpes zoster in human immunodeficiency virus-infected patients in Kampala, Uganda. *J Altern Complement Med*. 1999 ;(6):553-65.
185. Chipfakacha VG. STD/HIV/AIDS knowledge, beliefs and practices of traditional healers in Botswana. *AIDS Care*. 1997 ;(4):417-25.
186. Health System Trust. South African Health Review 2013/2014. September 2014.
187. Troskie TR. 1997. The role of health care workers in collaborating with traditional healers in primary health care-Part 1. *Health SA Gesondheid*. 1997; 2(1):29-35.
188. Peu MD, Troskie R, Hattingh SP. 2001. The attitude of community health nurses towards integration of traditional healers. *Curationis*. 2001; 24(3):49-55.
189. Pantelic M, Cluver L, Boyes M, Toska E, Kuo C, Moshabela M. Medical pluralism predicts non-ART use among parents in need of ART: a community survey in KwaZulu-Natal, South Africa. *AIDS Behav*. 2015; 19(1): 137–144.
190. Semanya SS, Potgieter MJ. Bapedi traditional healers in the Limpopo Province, South Africa: their socio-cultural profile and traditional healing practice. *J Ethnobiol Ethnomed*. 2014.10; 10:4-9.

191. Stuttaford M, Al Makhamreh S, Coomans F, Harrington J, Himonga C, Hundt GL. The right to traditional, complementary, and alternative health care. *Global Health Action*. 2014; 7:10-18.
192. Sibley LM, Sipe TA. Does traditional birth attendants training increase use of antenatal care. A Review of evidence. *Journal of Midwifery and Women's Health*. 2007; 49 (4): 208-305.
193. Professional Conduct & Ethics – HPCSA. Available at <http://www.hpcsa.co.za/Conduct/Ethics>. Retrieved 22 September 2015.
194. Dickoff J, James P, Wiedenbach E. Theory in a practice discipline. Part II. Practice oriented theory. *Nursing Research*. 1968; 17 (5):544-9.
195. Chinn PL, Kramer MK. *Integrated knowledge development in nursing (7th Ed.)*. St. Louis, MO: Elsevier-Mosby. 2008.
196. Walker LO, Avant KS. *Strategies for Theory Construction in Nursing*. 4th Edition. CT: Appleton & Lange Norwalk. 2005.
197. Bishop R. Freeing ourselves from neo-colonial domination in research: A Kaupapa Maori approach to creating knowledge. In N.K. Denzin and Y. Lincoln (Eds). *The landscape of qualitative research (3rd Ed.)*. Thousand Oaks, CA: Sage publications. 2008.
198. Jernigan VB, Jacob T; Tribal Community Research Team, Styne D. The adaptation and implementation of a community-based participatory research curriculum to build tribal research capacity. *Am J Public Health*. 2015; 105 Suppl 3:S424-32.
199. Denzin NK, Lincoln YS, Smith LT. *Handbook of Critical and Indigenous Methodologies*. Thousand Oaks, CA: Sage Publications. 2008.
200. Young I. Border crossing and other journeys: Re-envisioning the doctoral preparation of educational researchers. *Educational Researcher*. 2001; 30(5):3-5.
201. Laenui P. Processes of decolonization. In M. Batista (Ed.), *Reclaiming indigenous voice and vision*. Toronto: UBC Press. 2001.
202. Kalipeni E, Oppong J, Zerai A. HIV/AIDS, gender, agency and empowerment issues in Africa. *Social Science & Medicine*. 2007; 64 (5): 1015-1152.

203. Gommersall CD, Shi L, Joynt GM, Taylor BL. Pandemic preparedness. *Current Opinion in Critical Care*. 2007; 6:742-747.
204. Forde R, Aasland OG. Moral distress among Norwegian doctors. *J Med Ethics*. 2008; 34: 521-525.
205. Mark Chapter 5 verse 2-4. New King James Version (NKJV) Bible. 1982.
206. Stone RW, Bailey JJ. Team Conflict Self-Efficacy and Outcome Expectancy of Business Students. *Journal of Education for Business*. 2007; 82 (5):258-266.

ANNEXURES

ANNEXURE A: PERMISSION FROM DEPARTMENT OF HEALTH IN LIMPOPO PROVINCE



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Selamolela Donald

Ref:4/2/2

Dr MS Nmutendani
University of Limpopo
Polokwane
0700

Greetings,

Re: A model for collaboration between allopathic and traditional health practitioners in the management of HIV/AIDS and TB patients in Vhembe District.

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
 - Further arrangement should be made with the targeted institutions.
 - In the course of your study there should be no action that disrupts the services.
 - After completion of the study, a copy should be submitted to the Department to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.

Head of Department

Date

2018/04/16

18 College Street, Polokwane, 0700, Private Bag x9302, POLOKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: <http://www.limpopo.gov.za>

The heartland of Southern Africa - *development is about people*

ANNEXURE B: PERMISSION FROM LIMPOPO TRADITIONAL HEALTH PRACTITIONERS

LIMPOPO TRADITIONAL HEALTH PRACTITIONERS

BOX 1275

NZHELELE

0993

14 APRIL 2013

Enq: Mr Mbulaheni Neluvhola- Secretary

Tel/Cell number: 0827661263

To: Dr MS Nemutandani

Polokwane Mankweng Hospital Complex

Department of Health. Limpopo Province

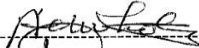
Dear Dr MS Nemutandani

An approval, permission and support for research proposal "A model for collaboration between allopathic and traditional health practitioners in the management of HIV/AIDS and TB patients in Vhembe District, Limpopo Province" is granted.

I would like to inform you that research proposal that you have presented to our council on 04 April 2013 has been approved and supported

1. The Limpopo Traditional Health Practitioners gives you permission to approach/consult and involve Vhembe Traditional Health Practitioners council in your project.
2. You should be prepared to assist in the interpretation and implementation of the recommendation where possible
3. At the end of your research, The Limpopo Traditional Health Practitioners would expect you to present your research findings and copy for its resource centre.

Yours

Secretary : Mr M. Neluvhola. Signature  Cell: 0827661263

Chairperson : Mr A.C Tsiane. Signature  Cell: 0825508919

ANNEXURE C: AAC: APPROVAL FOR THE RESEARCH TOPIC AND THESIS



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Denklesers • Leading Minds • Dikgopolo tsa Dintlalat

Faculty of Health Sciences
School of Health Systems and Public Health

18 September 2013

Dr MS Nmutandani
13002512
PhD (Public Health)

Dear Dr Nmutandani

Approval Academic Advisory Committee

This serves to confirm that your protocol was served and approved at the Academic Advisory Committee on 17 September 2013.

Please note that your title was approved:

"Development of a model for collaboration between allopathic and traditional health practitioners in the management of HIV/AIDS and TB patients in Vhembe District, Limpopo Province"

Please ensure that this title is reflected on your thesis.

Sincerely

Prof K Vuyi
Chairperson
Academic Advisory Committee

cc Prof Stephen JH Hendricks

School of Health Systems and Public Health
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<http://www.facebook.com/SHSPH>

ANNEXURE D: HEALTH SCIENCES ETHICS COMMITTEE-REC- ETHICAL APPROVAL NO: 399/2013

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 13/04/2011 and Expires 13/04/2014.



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

25/10/2013

Approval Certificate New Application

Ethics Reference No.: 399/2013

Title: Development of a model for collaboration between allopathic and traditional health practitioners in the management of HIV/AIDS and TB patients in Vhembe District, Limpopo Province

Dear Dr Mbulaheni Simon Nemuṭandani

The **New Application** as supported by documents specified in your cover letter for your research received on the 20/09/2013, was approved by the Faculty of Health Sciences Research Ethics Committee on the 23/10/2013.

Please note the following about your ethics approval:

- Ethics Approval is valid for 3 years
- Please remember to use your protocol number (399/2013) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:

- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

DRB SOMMERS; MBChB; MMed(Int); MPharmMed.
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee
University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

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✉ Private Bag X323, Arcadia, 0007 - 31 Bophelo Road, HW Snyman South Building, Level 2, Room 2.33, Gezina, Pretoria

ANNEXURE E: PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT

TITLE OF THE STUDY: DEVELOPMENT OF A MODEL FOR COLLABORATION BETWEEN ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS IN THE MANAGEMENT OF HIV/AIDS AND TB PATIENTS IN VHEMBE DISTRICT, LIMPOPO PROVINCE.”

PRINCIPAL INVESTIGATOR: DR SIMON MBULAHENI NEMUṬANDANI

SCHOOL OF HEALTH SYSTEM AND PUBLIC HEALTH

FACULTY OF HEALTH SCIENCES

UNIVERSITY OF PRETORIA

CONTACT TELEPHONE: 083 3015505

Dear participant

1. Introduction

You are invited to participate in the research study mentioned above. The participant information leaflet is a piece of paper which contains all the information regarding the proposed study. This information leaflet will help you to decide if you want to participate. Before you agree to be part of this research project, you should be well informed and fully understand what it is all about. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the principal investigator mentioned above.

2. Nature and purpose of the study

The aim of the study is to develop a model for collaboration between AHPs (AHPs) and traditional health practitioners (THPs) in the management of HIV/AIDS and TB patients in the Vhembe District Municipality of the Limpopo Province in South Africa. Collaboration is when the two different health practitioners are working together for the benefits of the patients. You, as a participant, are a very important source of information which could help develop a model for collaboration between AHPs and THPs in the management of patients.

3. Explanation of the procedures to be followed

This study involves the selection AHPs and THPs: (a) full time AHPs with at least two years working experience. It will be comprised of registered nurses, medical doctors, pharmacists, social workers, psychologists and dieticians rendering services to HIV/AIDS and TB patients at the government HIV/AIDS wellness clinics of the Vhembe District; and (b) THPs with at least two years working experience. It will be comprised of the following: -traditional doctors, herbalists, diviners, faith healers and traditional birth attendants who are practising their profession in the Vhembe District. List of names for THPs working and registered with the Vhembe Traditional Health Practitioners Association will be used. After selection of the AHPs and THPs there will be collection of data using a focus group interviews. The group discussions will comprise of 10- 15 participants. Structured questionnaire will be used to collect data from patients. The researcher is requesting permission to record data using audiotape during the focus group interview. The information collected will be kept confidential. To ensure anonymity numbers will be used during data collection instead of real names.

4. Risks and discomfort involved

There are no risks in participating in this study. However there might be only minimal risks or discomforts involved in participating in the study such as taking some of your time during focus group interviews. To minimise this discomfort, the researcher will stick to the agreed time for focus group interviews. Participants will be encouraged to respect other peoples' viewpoints in order to avoid emotional harm and discomfort to others. The interview will take about an hour of your time.

5. Possible benefits

Although you will not benefit directly, through your sharing of experiences and viewpoints you will be assisting in development of a model for collaboration between allopathic and traditional health practitioners to improve patients care and this will optimize service delivery to the benefit of all community members.

6. What are your rights as a participant?

Your participation is entirely voluntary. You can refuse to participate or stop or withdraw at any time during the study without giving any reason. Your withdrawal will not affect you in any way.

7. Ethical approval

The study has received an approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and the Department of Health in Limpopo Province. Letters are available if you wish to have one.

8. Compensation

Voluntary participation/refusal/discontinuation: Your participation is voluntary. No compensation, just a contribution for THPs, towards your transport expenses to a maximum of R100-00 will be given for your participation. Your decision of whether to participate or not will in no way disadvantage/ affect you at present or in the future.

9. Confidentiality

All information collected will be kept strictly confidential. Your identity will not be revealed in any discussion, description or scientific publications. Access to findings: Any new information or benefit that develops during the course of the study will be shared with all the participants.

10. Consent to participate in the study

The information above was clearly explained to me by Dr MS NĒMUṬANḌANI. I was given the opportunity to ask questions, time to decide freely and all these questions were answered satisfactorily. I am participating willingly. I have received copy of this informed consent agreement. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalization.

**I HEREBY CONSENT VOLUNTARILY TO PARTICIPATE IN THE ABOVE
MENTIONED PROJECT**

Signed/confirmed at(place) on.....(date)

Name of participant.....Signature.....

Name of Investigator..... Signature.....

Name of witness.....Signature.....

ANNEXURE F: DATA COLLECTION INSTRUMENT DURING TRAINING WORKSHOPS

HIV, AIDS and TB knowledge, beliefs and practices among traditional health practitioners in Vhembe District

This questionnaire tests THPs knowledge before the HIV/AIDS and TB workshop.
 To be administered by principal researcher: 10-15 minutes.

**APPENDIX A:
 INTERVIEW SCHEDULE FOR TRADITIONAL HEALTH PRACTITIONERS (THP) (Interview schedule 1)**

1. CONTACT DETAILS and BIOGRAPHICAL INFORMATION					
Name			Age:	ID:	
Gender			Village/Area:		
Type of THP			Highest level of education		
No of years as THP					
Previously attended HIV/AIDS/TB	Yes	No	Tested for HIV/AIDS	Yes	NO

2. SECTION B: Knowledge and beliefs

STATEMENT	Till true or false for all	TRUE	FALSE	DON'T KNOW
2.1 HIV/AIDS is caused by	Virus			
	Evil spirits			
2.2 TB is caused by	Bacteria			
	Evil spirits			
2.3 HIV/AIDS may be transmitted through	Blood			
	Unprotected sex			
	Kissing			
	Breast feeding			
2.4 TB may be transmitted through	Blood			
	Unprotected sex			
	Kissing			
	Breathing			
	Breast feeding			
	Contaminated items			
2.5 HIV/AIDS patients	can be cured			
2.6 TB patients	can be cured			
2.7 Ancestors/muti protect	patients from getting infected with TB/HIV			
2.8 Symptoms of HIV/AIDS	Loss of weight			
	Diarrhea			
	Sores			
2.9 Symptoms of TB	Night sweating			

	Weight loss			
	Tiredness			
	Coughing: pain /blood			
2.10.THPs	can cure HIV/AIDS			

3. SECTION C: Knowledge and management of lesions associated with HIV/AIDS

Recognize pictures on Herpes Zoster, Gonorrhoea and oral Candida (Researchers own collection).

	Have you treated such patients?	
	What is the cause?	
	How did/would you manage the patient?	
	Is it associated with HIV/AIDS	
	Have you treated such patients?	
	What is the cause?	
	How did/would you manage the patient?	
	Is it associated with HIV/AIDS	
	Have you treated such patients?	
	What is the cause?	
	How did/would you manage the patient?	
	Is it associated with HIV/AIDS	

4. SECTION D: COMMENTS

4.1 What role can you as THPs play in your community in reducing spread of HIV/AIDS and TB?

Thank you

ANNEXURE G: INTERVIEW GUIDE FOR GROUP DISCUSSIONS

TITLE OF THE STUDY: DEVELOPMENT OF A MODEL FOR COLLABORATION BETWEEN ALLOPATHIC AND TRADITIONAL HEALTH PRACTITIONERS IN THE MANAGEMENT OF HIV/AIDS AND TB PATIENTS IN VHEMBE DISTRICT, LIMPOPO PROVINCE.

Researcher: NEMUTANDANI MS.

Promoter: Prof SJ Hendricks. **Co-promoter:** Prof MF Mulaudzi.

The objectives of this study were to explore and describe the perceptions and experiences of collaborations between THPs and AHPs, develop an appropriate model for collaborations in the management of HIV and AIDS and TB patients, and identify opportunities and obstacles of initiating such collaboration.

The following questions were asked

A: What (is your opinions) comes to your mind when you think about having this type of meeting with traditional healers/ health professionals?

B: What are your experiences regarding HIV/AIDS and TB patients referred or self-referred from THPs/AHP about the THPs practices and how they manage their patients?

C: Now that Traditional Health Practitioners Act, no 22 of 2007, recognises THPs as a health profession,

- **How can the two systems work side by side in fight against HIV/AIDS and TB?**
- **What are the possible challenges and How should they be addressed and how and by who?**
- **What are your suggestions about best ways to promote working together in management of HIV/AIDS and TB patients?**

Thank you

ANNEXURE H: INVITATION OF STAKEHOLDERS FOR REPORT BACK MEETING AND MODEL DEVELOPMENT



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

TO: All stakeholders identified below

3 August 2015

CEOs: Sekororo, Elim and Tshilidzini hospitals

CC: DEM-Vhembe District,

SGM-Health Branch,

Chairperson- Limpopo Traditional Health Practitioners.

From:

Dr MS NEMUṬANḌANI: UWC, UNIVEN, WITS, UL, UNISA, KEMU.

Public Health Specialist & Researcher

PMHC. Department Of Health. Limpopo Province, RSA

Postal: Pietersburg Hospital, Private Bag 9316, Polokwane, 0700, RSA. Tel +27(0)15 2875473 Fax +27(0)86 6635218. Cell +27(0)833015505

Email: ve2si@yahoo.com or ve22si@gmail.com

Invitation to report back meeting on Development of collaboration between traditional healers and western health providers: Vhembe District.

Date and venue: 13 August 2015. 10 am- 12.30. Tshilidzini Boardroom

Background:

- 1) Majority of community members (60-90%) including HIV/AIDS patients consult traditional healers/prophets before and after consulting western health providers. This reality has an impact, positive or negative, on South Africa' achieving (MDGs) millennium development goals 4, 5 and 6.
- 2) Witchcraft Suppression Act of 1895 and later Act no 3 of 1957, which labelled our traditional healers as witches, has been abolished and replaced by Traditional Health Practitioners Act no 22 of 2007. This new Act, signed by President of the Republic of

South Africa, seeks to confirm and affirm the roles of traditional healers in the delivery of health services. It calls for their recognition and working together (collaboration) with western health providers.

- 3) You will recall that I had group discussions and interviews with you (traditional healers, western health providers, and patients) at all four municipalities under Vhembe district, discussing how traditional healers and western health providers could work together. Summary of the main points discussed is ready for presentation.

As an important stakeholder/ participant in the discussions we had, you are invited to the report back meeting. Your final inputs to this unique and first collaboration project between traditional and western health practitioners in RSA is very much important.

Date and venue: 13 August 2015. 10 am- 12.30. Tshilidzini Boardroom

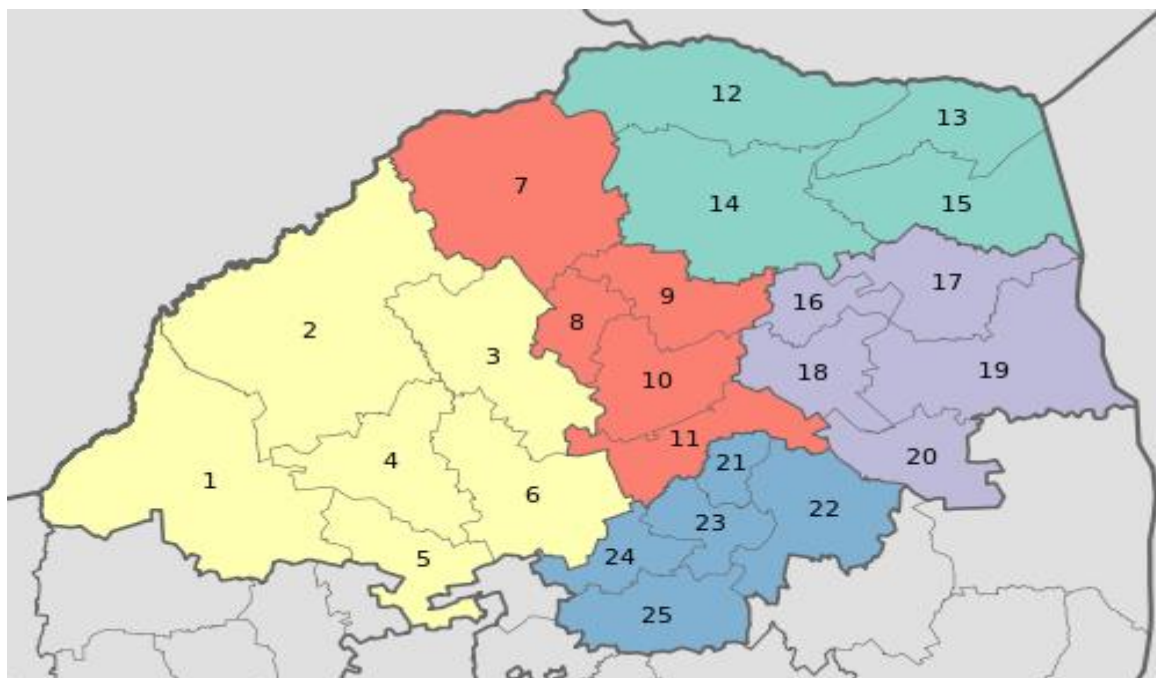
Yours faithfully



Dr MS NEMUṬANDANI Cell +27(0)833015505

ANNEXURE I: MAP OF VHEMBE DISTRICT IN THE LIMPOPO PROVINCE

Map of Limpopo with Vhembe District



Map key	Name	Seat	Area (km ²)	Population (2011) ^[1]	Pop. density (per km ²)
7–11	<u>Capricorn District Municipality</u>	<u>Polokwane</u>	16,988	1,261,463	74.3
16–20	<u>Mopani District Municipality</u>	<u>Giyani</u>	24,489	1,092,507	44.6
21–25	<u>Sekhukhune District Municipality</u>	<u>Groblersdal</u>	13,426	1,076,840	80.2
12–15	<u>Vhembe District Municipality</u>	<u>Thohoyandou</u>	21,349	1,294,722	60.6
1–6	<u>Waterberg District Municipality</u>	<u>Modimolle</u>	49,504	679,336	13.7

Local municipalities in Vhembe District

Name	District	Seat	Area (km ²)	Population (2011) ^[1]	Pop. density (per km ²)
12. <u>Musina Local Municipality</u>	Vhembe	<u>Musina</u>	7,577	68,359	9.0
13. <u>Mutale Local Municipality</u>	Vhembe	<u>Mutale</u>	3,886	91,870	23.6
15. <u>Makhado Local Municipality</u>	Vhembe	<u>Louis Trichardt</u>	8,300	516,031	62.2
14. <u>Thulamela Local Municipality</u>	Vhembe	<u>Thohoyandou</u>	5,835	618,462	106.0