

**PERCEPTIONS OF TRADITIONAL HEALERS ON COLLABORATING WITH  
BIOMEDICAL HEALTH PROFESSIONALS IN UMKHANYAKUDE DISTRICT OF  
KWAZULU NATAL**

**by**

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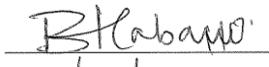
**DECEMBER 2013**

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is my original work, and that it has not been submitted before for any degree or examination at any other institution. All the sources used or quoted have been acknowledged by means of complete references in the text and bibliography.

**BONIFACE HLABANO****DATE:** 22 November 2013

# **PERCEPTIONS OF TRADITIONAL HEALERS ON COLLABORATING WITH BIOMEDICAL HEALTH PROFESSIONALS IN UMKHANYAKUDE DISTRICT OF KWAZULU NATAL**

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## **ABSTRACT**

This qualitative study explored traditional healers' perceptions on collaborating with biomedical professionals. Purposive sampling was used to select study participants, and individual in-depth interviews were used to collect data. Thematic data analysis was conducted. The main findings of the study were that healers are very popular and highly respected amongst African communities. Traditional healers experienced mistrust and disrespect by biomedical health professionals who demonstrated ignorance on traditional medicine. Lack of motivation, incentives and financial support to conduct collaboration activities was another key finding including lack of clear policies and management structures for collaboration. Due to concern for their patients, healers resorted to practising covert collaboration such as not using official referral slips. Positively, healers experienced transformation in terms of knowledge gained from the training on basic HIV-TB epidemiology. There was clear evidence of high ethical practices amongst healers where they put their patients' welfare ahead of their business interests.

**Key words:** perceptions; collaboration; traditional healers; biomedical health professionals; experiences on collaboration.

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## TABLE OF CONTENTS

### CHAPTER 1

#### **Introduction and overview of the study**

<b>1 INTRODUCTION .....</b>	<b>1</b>
<b>1.2 BACKGROUND TO RESEARCH .....</b>	<b>1</b>
1.2.1 Background information on UMkhanyakude District .....	1
1.2.2 The AMREF Traditional Healers Project .....	3
1.2.2.1 Project achievements.....	4
1.2.2.2 Challenges of the project .....	4
<b>1.3 LEGISLATION RELATED TO TRADITIONAL HEALERS AND HEALING.....</b>	<b>5</b>
1.3.1 The National Drug Policy .....	5
1.3.2 The Traditional Health Practitioners Act.....	6
1.3.3 The Traditional Healers Organisation .....	7
<b>1.4 LITERATURE ON TRADITIONAL HEALERS AND HEALTH SYSTEM .....</b>	<b>7</b>
<b>1.5 THE RESEARCH PROBLEM.....</b>	<b>9</b>
<b>1.6 AIM OF THE STUDY .....</b>	<b>10</b>
1.6.1 Research purpose .....	10
1.6.2 Research objectives .....	11
1.6.3 Research questions .....	11
<b>1.7 SIGNIFICANCE OF THE STUDY .....</b>	<b>11</b>
<b>1.8 DEFINITIONS OF TERMS.....</b>	<b>11</b>
1.8.1 Perceptions.....	12
1.8.2 Collaboration.....	12
1.8.3 Traditional healers and traditional medicine.....	12
1.8.4 Biomedicine .....	13
<b>1.9 FOUNDATIONS OF THE STUDY .....</b>	<b>13</b>
1.9.1 Metatheoretical assumptions .....	14
1.9.1.1. Epistemological assumptions.....	14
1.9.1.2 Ontological assumptions.....	15
1.9.1.3 Axiological assumptions.....	15
1.9.1.4 Methodological assumptions.....	16
<b>1.10 RESEARCH DESIGN AND METHODS .....</b>	<b>16</b>
1.10.1 Population.....	17

1.10.2 Sampling.....	17
1.10.3 Data collection approach .....	18
1.10.4 Data analysis .....	19
1.10.5 Data quality.....	19
<b>1.11 ETHICAL CONSIDERATIONS.....</b>	<b>20</b>
<b>1.12 SCOPE AND LIMITATIONS OF THE STUDY .....</b>	<b>20</b>
<b>1.13 STRUCTURE OF THE DISSERTATION.....</b>	<b>21</b>
<b>1.14 CONCLUSION.....</b>	<b>21</b>

## CHAPTER 2

### LITERATURE REVIEW

<b>2.1 INTRODUCTION .....</b>	<b>22</b>
<b>2.2 OVERVIEW OF TRADITIONAL HEALING .....</b>	<b>23</b>
2.2.1 Clarification of concepts.....	23
2.2.1.1 Diviners.....	23
2.2.1.2 Herbalists.....	24
2.2.2 Traditional healing in Sub Saharan Africa.....	25
2.2.3 Traditional healing in South Africa .....	26
<b>2.3 TRADITIONAL HEALERS LEGISLATION AND MANAGEMENT.....</b>	<b>26</b>
2.3.1 The Traditional Health Practitioners Act.....	26
2.3.2 The National Drug Policy .....	28
2.3.3 Management Bodies .....	29
2.3.3.1 The Traditional Healers' Organisation.....	29
2.3.3.2 The Interim Traditional Healers' Council .....	29
<b>2.4 COLLABORATION .....</b>	<b>30</b>
2.4.1 The concept of collaboration.....	30
2.4.2 The concept of integration .....	31
2.4.3 Collaboration between traditional healers and biomedical professionals .....	31
2.4.4 Rationale and importance of collaboration.....	32
2.4.4.1 Rationale for collaboration at international level .....	33
2.4.4.2 Rationale for collaboration at sub Saharan level.....	33
2.4.4.3 Rationale for collaboration at South African level .....	35
2.4.5 Challenges on collaboration.....	36

2.4.6 Examples of successful collaboration projects.....	37
2.4.6.1 Nepal .....	37
2.4.6.2 Central Africa Republic .....	38
2.4.6.3 Botswana .....	38
2.4.6.4 Uganda .....	39
2.4.6.5 South Africa .....	40
<b>2.5 PERCEPTIONS OF TRADITIONAL HEALERS ON COLLABORATION .....</b>	<b>41</b>
2.5.1 Tanzanian experience.....	42
2.5.2 South African experience.....	43
2.5.3 Mistrust .....	44
2.5.4 Disrespect.....	45
2.5.5 Competition.....	46
<b>2.6 ETHICAL AND REGULATORY ISSUES TRADITIONAL HEALING .....</b>	<b>46</b>
<b>2.7 CONCLUSION.....</b>	<b>48</b>

## CHAPTER 3

### RESEARCH DESIGN AND METHODS

<b>3.1 INTRODUCTION .....</b>	<b>49</b>
3.1.1 Research aim/purpose.....	49
3.1.2 Research objectives .....	49
3.1.3 Research questions .....	50
<b>3.2 RESEARCH PARADIGM .....</b>	<b>50</b>
3.2.1 Characteristics of the qualitative research paradigm .....	50
3.2.2 Rationale for the qualitative research paradigm.....	51
<b>3.3 RESEARCH DESIGN.....</b>	<b>51</b>
3.3.1 Rationale for the chosen design .....	52
3.3.2 Characteristics of the chosen research design .....	52
3.3.2.1 Interpretative .....	52
3.3.2.2 Non-manipulative .....	53
3.3.2.3 Flexibility and contextualization .....	53
3.3.2.4 Intensity .....	54
<b>3.4 RESEARCH METHOD .....</b>	<b>54</b>
3.4.1 Drawing a sample .....	55
3.4.1.1 Population.....	55

3.4.1.2 Target population.....	55
3.4.1.3 Accessible population .....	55
3.4.2 Sampling.....	56
3.4.2.1 Sampling method.....	56
3.4.2.2 Inclusion and exclusion criteria .....	57
3.4.2.3 Sample size .....	58
3.4.2.4 Ethical issues related to sampling.....	59
3.4.2.4.1 Autonomy.....	59
3.4.2.4.2 Justice.....	59
3.4.2.4.3 Beneficence and non-maleficence.....	60
3.4.3 Data collection .....	60
3.4.3.1 Data collection approach and setting .....	61
3.4.3.1.1 The interview approach.....	61
3.4.3.1.2 The interview guide.....	62
3.4.3.1.3 Advantages and disadvantages of using an interview guide.....	63
3.4.3.1.4 Developing and testing the data collection tool.....	63
3.4.3.2 Conducting the interviews.....	64
3.4.3.3 Interviewer self reflexivity.....	65
3.4.3.4 Ethical considerations related to data collection .....	67
3.4.3.4.1 Autonomy.....	67
3.4.3.4.2 Justice.....	67
3.4.3.4.3 Beneficence and non-maleficence .....	68
3.4.4 Data analysis .....	69
3.4.4.1 Organising data .....	69
3.4.4.2 Reading and memoing.....	70
3.4.4.3 Content and thematic analysis.....	70
3.4.4.4 Interpreting data.....	71
3.4.4.5 Presentation.....	71
<b>3.5 DATA QUALITY: TRUSTWORTHINESS.....</b>	<b>71</b>
3.5.1 Credibility .....	72
3.5.2 Transferability .....	73
3.5.3 Dependability .....	73
3.5.4 Confirmability .....	74
<b>3.6 CONCLUSION.....</b>	<b>74</b>

**CHAPTER 4**  
**ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH**  
**FINDINGS**

<b>4.1 INTRODUCTION .....</b>	<b>75</b>
<b>4.2 DATA MANAGEMENT AND ANALYSIS .....</b>	<b>75</b>
<b>4.3 RESEARCH RESULTS .....</b>	<b>75</b>
4.3.1 Sample demographics .....	75
4.3.2 Data Themes .....	77
4.3.3 Summary of themes and categories .....	78
4.3.4 Description of research findings.....	79
4.3.5 Theme 1: THs' perceptions of their role in HIV/AIDS-TB programs .....	80
4.3.6 Theme 2: Experience of collaborating with BHPs .....	82
4.3.6.1 Positive experiences .....	82
4.3.6.2 Negative experiences .....	85
4.3.7 Theme 3: Pertinent reasons for discontinuing collaboration .....	92
4.3.8 Theme 4: Implications of discontinued collaboration .....	94
4.3.9 Theme 5: The role of money: business factor.....	96
4.3.10 Theme 6: Recommendations for strengthened collaboration.....	98
4.3.10.1 Suggestions for DOH .....	98
4.3.10.2 Suggestions for THs .....	102
4.3.10.3 Suggestions for facilitating agencies (AMREF) .....	104
<b>4.4 OVERVIEW OF RESEARCH FINDINGS .....</b>	<b>106</b>
4.4.1 Information I had expected to find.....	106
4.4.1.1 Respect for and popularity of THs amongst African populations .....	106
4.4.1.2 Disrespect, mistrust & ignorance by BHPs about traditional medicine.....	107
4.4.1.3 Lack of material support, resource allocation and incentives.....	107
4.4.1.4 Poor management structures and mechanisms for collaboration .....	108
4.4.1.5 Policy deficiencies on guiding the traditional healing practice.....	109
4.4.1.6 Acknowledgement of capacity building benefits.....	109
4.4.2 Information I had not expected to find.....	110
4.4.2.1 Upholding of ethical principles by THs .....	110
4.4.2.2 Conduction of intra-referrals .....	111
4.4.2.3 Weak or poor exit strategy by AMREF (lack of contingency) .....	111
4.4.2.4 Competition or fear of business loss .....	112

4.4.3 Information I found conceptually interesting.....	113
4.4.3.1 Covert collaboration (Lack of transparency) .....	113
4.4.3.2 Lack of reciprocity in referrals for mutual collaboration .....	114
4.4.3.3 Autonomy and professionalisation of traditional medicine .....	114
<b>4.5 CONCLUSION.....</b>	<b>115</b>

## **CHAPTER 5**

### **CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS**

<b>5.1 INTRODUCTION .....</b>	<b>116</b>
<b>5.2 RESEARCH DESIGN AND METHOD.....</b>	<b>116</b>
<b>5.3 SUMMARY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS.....</b>	<b>117</b>
5.3.1 Popularity and respect for THs amongst African populations .....	117
5.3.2 Disrespect, mistrust and ignorance by BHPs about traditional medicine .....	117
5.3.3 Lack of material support, resource allocation and incentives.....	118
5.3.4 Poor management structure and mechanisms for collaboration .....	129
5.3.5 Policy gaps on the traditional healing practice and professionalism .....	120
5.3.6 Acknowledgement of capacity building benefits.....	121
5.3.7 Upholding of ethical principles by THs .....	122
5.3.8 Conduction of intra-referrals .....	122
5.3.9 Weak or poor exit strategy by AMREF .....	123
5.3.10 Covert collaboration- Lack of transparency, trust and reciprocity .....	124
<b>5.4 CONTRIBUTIONS OF THE STUDY.....</b>	<b>125</b>
<b>5.5 LIMITATIONS OF THE STUDY.....</b>	<b>126</b>
<b>5.6 FINAL CONCLUDING REMARKS.....</b>	<b>127</b>

**LIST OF SOURCES**

BOOKS.....	128
JOURNAL ARTICLES .....	132
ACTS .....	137
INTERNET SOURCES .....	138

**LIST OF TABLES**

Table 4.1 Biographical information about the participants .....	76
Table 4.2 Themes and data categories .....	78

**LIST OF FIGURES**

Figure 1.1 Map of UMkhanyakude District.....	1
Figure 4.1 Biographical information about the participants .....	76
Figure 5.1 Conceptual model for successful collaboration.....	126

**LIST OF APPENDICES**

<b>Appendix A:</b> Approval from UNISA- Ethical Clearance .....	143
<b>Appendix B:</b> Research Site Letter of clearance: Traditional Healers.....	144
<b>Appendix C:</b> Consent form .....	145
<b>Appendix D:</b> Data collection instrument .....	146
<b>Appendix E:</b> Letter of confirmation of translation of interview transcripts .....	149

**LIST OF ABBREVIATIONS AND ACRONYMS..... xv****AFSA:** AIDS Foundation South Africa**AIDS:** Acquired Immunodeficiency Syndrome**AMREF:** African Medical and Research Foundation**ART:** Anti-retroviral Therapy**ARV:** Anti-retroviral**AVERT:** international HIV and AIDS charity**BHPs:** Biomedical Health Professionals**CHBC:** Community Home Base Care**CD4:** Cluster of differentiation 4**DOH:** Department of Health**DIP:** Detailed Implementation Plan**DOTS:** Directly Observed Treatment-short course**GHWs:** Government Health Workers**HIV:** Human Immunodeficiency Virus**HSRC:** Human Sciences Research Council**HCWs:** Health Care Workers**IDP:** Integrated Development Plan**KAP:** Knowledge, Attitudes and Practices**KZN-DOH:** KwaZulu Natal Department of Health**KZN:** KwaZulu Natal**MOH:** Ministry of Health**NGO:** Non Governmental Organisation**STIs:** Sexually Transmitted Infections**TAC:** Treatment Action Campaign**TB:** Tuberculosis

**THETA:** Traditional and Modern Health Practitioners Together against HIV/AIDS

**THs:** Traditional Healers

**THO:** Traditional Healers Organisation

**THPs:** Traditional Health Practitioners

**UNAIDS:** Joint United Nations Programme on HIV/AIDS

**UNISA:** University of South Africa

**UPATHPU:** Unitary Professional Association for Traditional Health Practitioners of uMkhanyakude

**VCT:** Voluntary Counselling and Testing

**WHO:** World Health Organisation

# CHAPTER 1

## INTRODUCTION AND OVERVIEW OF THE STUDY

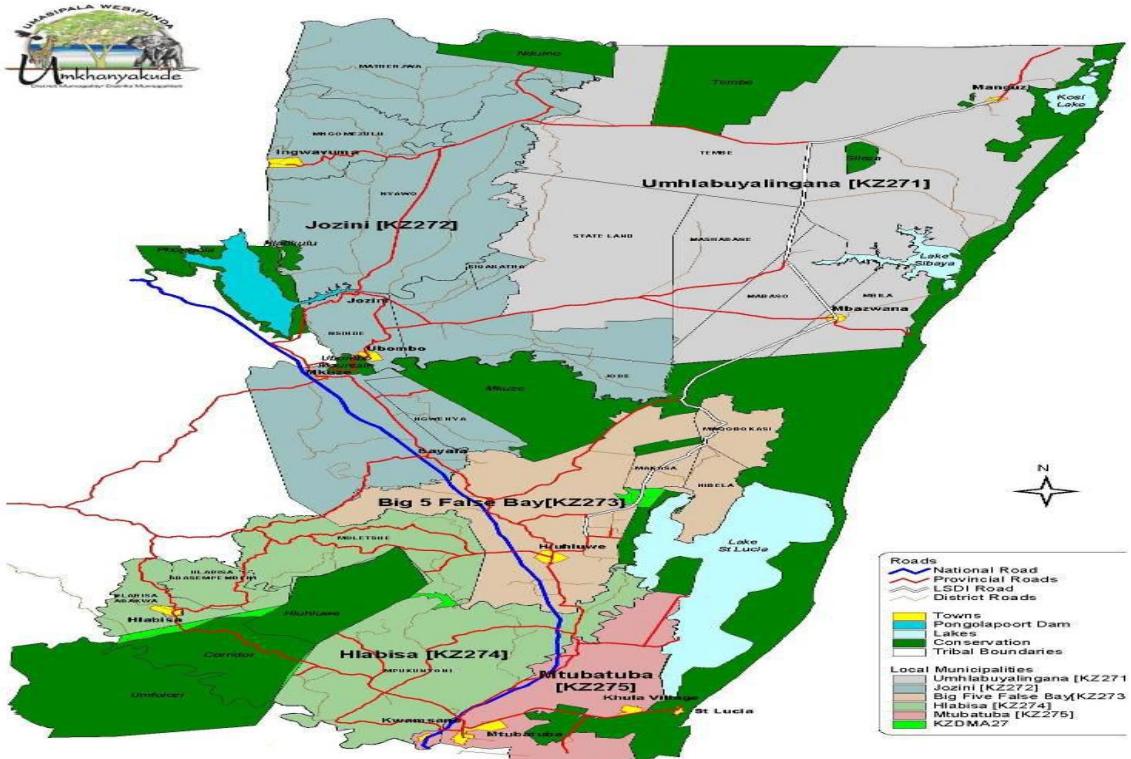
### 1.1 INTRODUCTION

The researcher carried out this qualitative research study to provide insights into the concept of collaboration and mutuality between traditional healers (THs) and biomedical health practitioners (BHPs) in HIV/AIDS and tuberculosis (TB) programs in UMkhanyakude district on KwaZulu Natal in South Africa. The study was conducted to explore and describe perceptions of THs collaborating with BHPs in health service delivery and gain an understanding of underlying reasons for THs dropping out of collaboration with BHPs in HIV/AIDS and TB programs.

### 1.2 BACKGROUND TO THE RESEARCH

#### 1.2.1 Background Information on UMkhanyakude District

The current research was conducted in the Mtubatuba municipality in the district of UMkhanyakude in northern KwaZulu-Natal (KZN) (See figure 1).



**Figure 1.1:** Map of UMkhanyakude District (UMkhanyakude District Municipality, 2011:8)

According to the UMkhanyakude District Municipality Integrated Development Plan (IDP) (2012:8), UMkhanyakude District is one of 11 District Municipalities in KwaZulu-Natal Province, South Africa. Covering an area of 13,000 square kilometres, it has a population of between 575,000 and 600, 000. UMkhanyakude is the poorest and most rural of the 11 KwaZulu Natal districts, and one of the poorest and most rural areas within South Africa. The poverty to population ratio in the district of uMkhanyakude is above 80%. While South Africa as a whole has experienced rapid economic growth since the attainment of democracy in 1994, UMkhanyakude has lagged behind like most rural areas in the country (UMkhanyakude District Municipality, 2012:39).

The district's health indicators are quite poor as stated in the KZN DOH annual report (2012:38) where HIV prevalence among anti-natal clinic attendees stood at 41.9% and TB incidence at 1,090/100 000. According to the profile of the UMkhanyakude DIP (2012:38):

- 98% of persons live in rural homesteads
- Adult unemployment is 67%
- Per capita income is less than 1/3 of the national average.
- Only 10% of households are within 15 minutes' travel time of a health clinic,
- Only 22% of the population have access to safe water,
- Only 19% of people have access to use of electricity for lighting.

According to Gqaleni, Hlongwane, Khondo, Mbatha, Mhlongo, Ngcobo, Mkhize, Mtshali, Pakade, & Street, (2011:36), THs play a critical role in assisting the KwaZulu-Natal Provincial Council on AIDS achieve its targets specified in the Multi-Sectoral Provincial Strategic Plan for HIV and AIDS STIs and TB. Gqaleni et al (2011: 37) also quote a study carried out by Wilkinson et al in 1999 in which patients with TB indicated that 10% of them had used a THP as the first health care provider, 40% had visited a THP at some point before diagnosis, and 84% would consider a THP as a treatment supervisor.

It is through this acknowledgement of the critical role of THs that partners like the African Medical and Research Foundation (AMREF) have initiated projects that seek to build capacity of healers to collaborate with BHPs.

### **1.2.2 The AMREF Traditional Healers Project**

Between 2005 and 2006, AMREF implemented a pilot project that sought to increase the recognition of TH's by building their capacity in understanding basic epidemiological processes of HIV/AIDS and TB. After the training, THs were expected to refer patients suspected of having HIV or TB to local clinics for HIV Voluntary Counselling and Testing (VCT) and TB screening. The THs were also expected to offer palliative care services (home-based care), DOTS and ARV adherence counselling. The project also aimed to establish effective collaboration and patient referral mechanisms between 82 THs and four health facilities around the Mtubatuba municipality of UMkhanyakude district in KwaZulu Natal. According to the AMREF evaluation report (AMREF 2007:18), the project was based on the perspectives from both the Department of Health and THs themselves that have a role to play in the fight against HIV/AIDS, TB and other diseases. This view is supported by Mbatha, Street, Ngcobo & Gqaleni (2012:4) who quotes the Department of Health (DOH)'s white paper for transforming the health system in South Africa as recognising the importance of THPs in primary healthcare.

AMREF launched the THP pilot project to try to get the two parties (THs and BHPs) to appreciate each other's roles in the provision of HIV and TB services. Through this project, AMREF and the DOH developed and implemented a training curriculum for 82 TH's for the purposes of providing basic understanding of primary health care and HIV/TB case identification for referral purposes. After 2 years of implementation and close monitoring and support, AMREF commissioned an external evaluation of the pilot project to determine the extent to which it had achieved its objectives of building capacity for the traditional healers in HIV/AIDS and TB and strengthening collaboration with BHPs. Some of the findings of the evaluation report (2007:19) are that the project had positive impacts on the targeted traditional healers. Similarly, there were a number of challenges observed as described in the following sections.

### **1.2.2.1 Project achievements**

According to the AMREF Evaluation report (2007:11), participants reported that they had been taught to recognize signs and symptoms that are suggestive of TB and HIV/AIDS and that this led to improved understanding in the management of these cases. The THs reported having learnt to distinguish between *idliso* (*herbal inducement of chronic cough for vindictive or witchcraft purposes*) and TB. Most black Africans and THs believe that vindictive people or enemies can be be-witched/poisoned by certain herbs that induce chronic cough that has the same fatal consequences as TB if left untreated. THs in the HIV/AIDS and TB program said that they had learnt that it is more beneficial to first refer clients who presented with weight loss, coughing and night sweats for sputum tests to their local clinics before making conclusions that they had '*idliso*'. Only when TB had been excluded would they then proceed with their own traditional healing treatment for '*idliso*'. Similarly, when someone came to them indicating that they were suspecting being be-witched and yet they were presenting with symptoms suggestive of HIV infection, the THs will first refer them for VCT in order to exclude HIV/AIDS.

This change in knowledge and practice was seen as particularly important because the presentation of *idliso*, TB and HIV/AIDS can be confusing as all have common symptoms like weight loss and coughing. This means that the trained healers had learnt how to avoid confusing TB and HIV/AIDS with other illnesses brought about by witchcraft and evil spirits. This was a positive sign of improved management of HIV/AIDS and TB patients (AMREF 2007).

### **1.2.2.2 Challenges of the project**

Despite all the successes cited by the AMREF evaluation report (2007) there were also key challenges. These include lack of resources on the part of the THs, lack of mutual respect between BHPs and THs themselves. Concerning resources and infrastructure, THs spoke about difficulties that they experienced in implementing all the lessons learnt from the training. Other challenges include lack of clean water and limited accommodation resources needed to provide extra rooms for proper home-based care. Deficiencies such as over-crowding in healers' homes often put their own families at risk of TB infection.

Further challenges identified related to concerns about the lack of government support for the work of THs. Their lack of skills in securing funding was compounded by their own poverty as well as that of the clientele.

The researcher is an employee of AMREF at its head office in Pretoria in the Program Management Unit. Out of a starting cohort of 82 THs in the AMREF pilot project 25 healers had broken ranks or stopped collaborating with BHPs for unknown reasons (AMREF, 2007:28). Another 20 healers had been lost to follow up and only 37 were reported as still having an active relationship with their local clinics at the time of the research. The reasons for such high dropout rates are largely not known. The researcher thus decided to explore the THs' perceptions towards collaborating with BHPs in HIV/AIDS and TB prevention, treatment and care and support programs.

## **1.3 LEGISLATION RELATED TO TRADITIONAL HEALERS AND HEALING**

The National Drug Policy of 1996 (National Department of Health 1997) and the Traditional Health Practitioners Act (Act No. 22 of 2007) (South Africa 2008) provide the most comprehensive legal framework for the collaboration of THs with BHPs in South Africa. The full discussion of provisions of these pieces of legislation will be dealt with in chapter 2. In the following sub sections of this chapter, the researcher merely gives brief overviews.

### **1.3.1 The National Drug Policy**

According to the Department of Health (1996), Article 11 of the National Drug Policy encourages cooperation between THs and other health workers in the mainstream health service delivery. The drug policy specifically calls for the investigation of traditional medicines for safety, efficacy, toxicity and quality with the view to incorporate them into the national health care system. This will enable the DOH to register, monitor and control the marketing of traditional medicines.

The policy goes on to say that a national reference centre for traditional medicines must be established for the purposes of developing a national database for indigenous plants that have medicinal value. Such plants will be propagated for sustainability. This act was seen as the best possible way of strengthening collaboration through calling for putting in place systems that ensure an adequate and reliable supply of safe, cost-effective traditional medicines that are of acceptable quality.

### **1.3.2 The Traditional Health Practitioners Act (Act No. 22 of 2007)**

The South African Traditional Health Practitioners Act (Act No. 22 of 2007) is seen as a concrete step in implementing the National Drug Policy. Whereas the THP Act (Act No. 22 of 2007) calls for registration, training and monitoring of TH practitioners, the National Drug Policy (1996) stresses the importance of THs to cooperate with other health workers in the formal health sector. This collaboration is particularly important in programs such as immunizations and HIV/AIDS. The THP Act No 22 of 2007 defines traditional health practice as “performance of a function, activity, process, or service based on a traditional philosophy that uses indigenous African techniques and principles that include traditional medicine or practice, including the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth, and death” (Government Gazette 2008).

According to the Act, the “traditional health practitioner” means a person registered under this Act in one or more of the categories of traditional health practitioners (South Africa 2007). There are four categories of traditional health practitioners who can register under the THP Act. These are the herbalists (*izinyanga* or *amaxhwele*), diviners (*izangoma* or *amagqirha*), traditional surgeons (*iingcibi*) who mainly do circumcisions and traditional birth attendants (*ababelethisi* or *abazalisi*). These TH categories are discussed in more detail in chapter 2 of this dissertation. The THP Act is very clear that practice for gain by non-registered healers is an offence punishable by a fine and/or imprisonment of up to one year. To qualify as a traditional healer, one has to serve an apprenticeship of between one and five years and must be well known within the community and amongst other traditional healers.

Qualified traditional healers who register with the Traditional Healers' Organization (THO) are awarded a membership certificates that show all their practising details. This certificate is awarded after some training which marks their "rite of passage". After completing the five day training workshop, healers are then certified as members who can lawfully practise their trade.

### **1.3.3 The Traditional Healers Organisation**

In its website, the Traditional Healers' Organisation (THO) claims to be the largest TH organisation and the most organised in South Africa (Traditional Healers Organisation 2008). Through the THP Act No. 22 of 2007, the Government has given the THO the sole mandate to offer accredited training and education services to member healers and has links in a number of countries in Africa. In its website; the THO boasts that it has the sole mandate to train members in Traditional Primary Health Care which includes STIs, TB and HIV /AIDS. AIDS education is done in partnership with AIDS associations and the Department of Health. The THO (2008) says that in South Africa, there are over 90 associations from district, provincial and national levels who are its affiliates. However, the THO says that some of these associations exist in name and not in practice.

## **1.4 LITERATURE ON TRADITIONAL HEALERS AND HEALTH SYSTEM**

Although the full literature review on the role of THs in the health delivery system is discussed in chapter 2, it is important to point out certain aspects of importance in this chapter as a way of introduction. A number of studies have been conducted in most African countries and particularly South Africa and Tanzania to determine the role of traditional healers in sexually transmitted infections including HIV/AIDS as well as with addressing collaboration between traditional and biomedical health care systems (Gqaleni et al 2011, Nxumalo Alaba, Harris, Chersich, & Goudge 2011, Kayombo, Uiso, Mbwambo, Mahunnah, Moshi, & Mgonda 2007). Mngqundaniso and Peltzer (2008) did one such study. This study found that professional nurses had mixed attitudes towards traditional healers.

There were both positives such as acknowledgement of THs' contributions to the management of opportunistic infections (STIs) as well as negatives such as the belief that THs lacked training. The BHPs also believed that THs use expired medicines, give improper dosages, and keep poor or no records at all.

According to the study by Mngqundaniso and Peltzer (2008), traditional healers also had mixed attitudes towards nurses. In this study, the traditional healers believed that nurses undermined their work by questioning the efficacy of their medicines and unwillingness to refer patients back to the healers for further support after diagnosis in clinics and hospitals. The study noted that although most of the traditional healers were willing to learn from and refer patients to clinics and hospitals, nurses and doctors were not willing to refer patients back to the healers.

The Human Sciences Research Council (HSRC) (2009) says that South Africa has made attempts towards strengthening collaboration between THs and BHPs. In August 1998, the South African Parliament decided to enlist the help of traditional healers in achieving major goals in primary health care. Despite all these important attempts, available literature shows that the recognition of the role that THP's play in the health care service delivery is still very low. According to Ritcher (2003:4), the South African popular media houses usually carry negative stories regarding THs and especially those who claim that their medicines can cure AIDS. Such negative stories have ultimately stigmatised all THs as fraudsters who are out to swindle poor people of their hard-earned cash. Consequently, this has affected reputable and ethical THs who contribute positively to South Africa's fight against the HIV and TB pandemics. Such negativity tends to worsen the spread of the HIV and AIDS epidemic where unethical THs operate "underground" and thus exposing patients to grave dangers.

Despite the WHO's recognition of the importance of traditional medicine to primary health care and of the need to include healers in national health strategies and policies, the WHO (2003) and UNAIDS (2000) acknowledge that there is still considerable prejudice that remains embedded among many BHPs about the efficacy and integrity of traditional medicine.

According to Opaneye and Ochogwu (2007:68), most friction between biomedical and traditional healing stems from the conventional science notion of "material causation". Biomedical doctors generally look at the physical causes of an illness and treat them accordingly. On the other hand, traditional healers generally look at other factors including spiritual causes. A number of South African conservative-minded and pro-western physicians view the traditional healing sector as unscientific and therefore deserving to be kept out of South Africa's health care system (Ritcher 2003:8).

## **1.5 RESEARCH PROBLEM**

Collaboration between THs and BHPs is generally unsustainable, misunderstood, weak or ignored altogether (UNAIDS; 2006:14, AMREF 2007:12, Gqaleni et al 2011:36). From the findings of the evaluation exercise of the AMREF pilot project implemented in KZN (2007), it is evident that the major challenge to the overall success of the AMREF collaboration project between THs and BHPs on HIV/AIDS and TB was identified as the high attrition or dropout rate of trained THs from the project. Out of a starting cohort of 82, only 37 reported still having an active relationship with their local clinics and 20 had been lost to follow up. The project evaluation report could not provide concrete evidence why the other 25 healers or 30% had broken ranks with their health facilities in less than a year after the pilot project ended (AMREF 2007:12). The evaluation report noted that there was a problem of sustaining THs collaboration with BHPs after having received training and support to refer patients and support those on ARVs and TB treatment.

This study was carried out within a context where AMREF partnered with the KwaZulu Natal Department of Health (KZN-DOH) to establish effective collaboration and patient referral mechanisms between 82 THs and four health facilities around the Mtubatuba municipality of UMkhanyakude district between 2005 and 2007. As indicated previously, after 2 years of implementation and close monitoring and support, an external evaluation of the pilot project determined that 25 healers had broken ranks or stopped collaborating with BHPs for unknown reasons. Another 20 healers had been lost to follow up and only 37 were reported as still having an active relationship with their local clinics.

This research therefore; sought to answer the question: "*What are the perceptions of THs on collaborating with BHPs in HIV/AIDS and TB programs?*"

Traditional healers are considered as individuals who are recognized by their communities as competent health care service providers who use a range of substances and methods based on the communities' social, cultural and religious belief systems (WHO 2003, The Macmillan Dictionary 2012, Moodley 2009). Collaboration between THs and BHPs is provided for by the National Drug Policy (Department of Health 1996) as well as the South African Traditional Health Practitioners Act (Act No. 22 of 2007) (Government Gazette 2008). Collaboration between traditional healers and biomedical practitioners is now being accepted by many African countries including South Africa because of the increasing problem of HIV/AIDS (WHO 2003, UNAIDS 2006, DOH 2007).

Both the WHO (2003, 2007) and UNAIDS (2006) have confirmed that there is enough evidence that interventions where THs collaborate with BHPs in the areas of HIV/AIDS, STIs and TB (DOTs) can be very effective and beneficial to communities. In South Africa, both AMREF (2007) and the HSRC (2006) demonstrated that 89% of TB patients supported by THs completed treatment when compared to 76% of those supervised by others. However, there remains a challenge of sustainability of collaboration between BHPs and THs.

## **1.6 AIM OF THE STUDY**

The aim of the study was to gain an understanding of traditional healers' perceptions of and experience of collaborating with biomedical health professionals

### **1.6.1 Research purpose**

The purpose of the study was to explore and describe perceptions of THs collaborating with BHPs in health service delivery, and gain an understanding of underlying reasons for THs dropping out of collaboration with BHPs in HIV/AIDS and TB programs.

### **1.6.2 Research objectives**

The specific objectives set for the study were to:

- i. Explore the perceptions of THs in collaborating with BHPs in HIV/AIDS and TB programs.
- ii. Describe the context in which THs collaborate with BHPs through the experiences of research participants.
- iii. Identify reasons underlying THs dropping out of collaboration with BHPs in HIV/AIDS and TB programs.

### **1.6.3 Research questions**

- i. What are the perceptions of THs on collaborating with BHPs?
- ii. How is the context in which THs collaborate with BHPs?
- iii. What are the reasons underlying THs dropping out of collaboration with BHPs in HIV/AIDS and TB programs?

## **1.7 SIGNIFICANCE OF THE STUDY**

The conclusions and recommendations of the study as presented in chapter 5 help highlight areas that need further investigation or assessment in improving sustainable collaboration between THs and BHPs in the context of HIV/AIDS and TB programs. This research is of significance to the domain of traditional healing as it:

- Contributes to the understanding of the contextual issues around collaboration between THs and BHPs
- Generates wider interest amongst other researchers to expound on the work of THs and BHPs collaborating in the fight against HIV/AIDS and TB
- Lays the foundation for better programming by service providers including the Department of Health.

## **1.8 DEFINITIONS OF TERMS**

The main concepts of the study are explained in this section.

### **1.8.1 Perceptions**

The Business Dictionary (2012), Oxford Dictionary (2012) and MacMillan Dictionary (2012) define perception as the process by which people translate sensory impressions into coherent and unified views of the world around them. Cozby and Bates (2011:131) say that perceptions involve people's attitudes and beliefs on the way they evaluate and think about an issue. Baines, Fill & Page (2012:56) concurs to these definitions by saying that perceptions refer to memories and feelings about a topic. Thus, perceptions are all about the way in which something is regarded, understood, or interpreted. It is an intuitive understanding and insight into some phenomenon. For the purposes of this study, perceptions shall be taken to mean the ability of THs to understand and make good judgments about their collaboration with BHPs in an HIV/AIDS and TB project.

### **1.8.2 Collaboration**

Collaboration is defined as “cooperative arrangement in which two or more parties (which may or may not have any previous relationship) work jointly towards a common goal” (The Business Dictionary 2012). The UNAIDS (2006:7) states that collaboration between THs and BHPs means bringing the two parties together to assist people afflicted by different diseases such as TB and HIV/AIDS. It is a means of creating mutual understanding between THs and BHPs.

### **1.8.3 Traditional healers and traditional medicine**

A traditional healer is a figure whose primary function is to secure the help of the world of spirits (spiritual) and traditional medicine for the benefit of the community's health and wellbeing. According to the Traditional Healers Act of 2007, the “traditional health practitioners” include *herbalists*, *diviners*, *traditional surgeons* and *traditional birth attendants*. The WHO (2003) and World Bank (2011) define traditional medicine as “the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures used in the maintenance of health”.

### **1.8.4 Biomedicine**

The MacMillan Dictionary (2012) refers to biomedicine as “the principles of biology and biochemistry applied to the practice of medicine” doctors, nurses, pharmacists, surgeons, dentists and therapists. The Medical Dictionary (2012) defines biomedicine as the branch of medicine that deals with clinical medicine based on principles of the natural sciences. The National Cancer Institute (2012) defines biomedicine as “a system in which medical doctors and other healthcare professionals treat symptoms and diseases using drugs, radiation, or surgery”. In general, biomedicine is also called conventional, mainstream, orthodox or western medicine”. This therefore means that biomedical health practitioners (BHPs) are those western-trained medical professionals who practice biomedicine. They employ methods developed according to western medical and scientific principles that are mostly used in modern medical care. Whereas THs use a range of substances and methods based on social, cultural and religious belief systems; BHPs use scientific methods and focus on the person’s biological processes rather than the social and emotional processes of the individual.

## **1.9 FOUNDATIONS OF THE STUDY**

Meta-theory helps the researcher to choose and use the right tools and processes in order to explore the phenomenon under consideration. Bates (2005:24) defines meta-theory as “the philosophy behind the theory: the fundamental set of ideas about how phenomena of interest in a field should be thought about and researched.” Abrams and Hogg (2004:98) say that meta-theory helps to place specific research questions within a broader framework of the structure and methods of social inquiry. Barbara, Sally, Connie & Carol (2009:3) go on to say that, meta-theory is a critical exploration of the theoretical frameworks or lenses that provide direction to research and to researchers in a particular field of study. . This therefore means that meta-theory is an abstract way of helping researchers understand and interpret concepts being studied.

### **1.9.1 Metatheoretical assumptions**

Unlike quantitative studies; which are largely based on theories and conceptual models and frameworks, qualitative research is based on meta-theoretical assumptions that provide for a researcher to approach research with an open mind that follows inductive thinking as opposed to the quantitative approach's largely deductive thinking (Chinn & Kramer 2008:299). Meta-theory helps to place specific research questions within a broader framework of the structure and methods of social inquiry. It helps the researcher to choose and use the right tools and processes in order to explore the phenomenon under consideration. In this study, epistemological, ontological, axiological and methodical assumptions were considered as described.

#### **1.9.1.1 Epistemological assumptions**

The interpretive paradigm of research holds the epistemological belief that "what is learned in research does not exist independently of the researcher" (Bailey 2007:54). According to the Sage Dictionary of Social Research Methods (2006), epistemology deals with the issue of knowledge, and specifically, who can be a 'knower'. This means that whatever the researcher learns or gets to know from the participants is also based on the researcher's own insights and beliefs about the phenomenon. In this study, the researcher came to know the meaning of the THs' perceptions of collaboration with BHPs by using his own (researcher's) interpretation and description of that meaning. However, this does not mean that the researcher went on to arbitrarily manipulate the information gathered to satisfy his preconceptions.

The researcher was consistently aware of the fact that he was part of an interactional process of creating meaning about collaboration between THs and BHPs in a HIV-TB project. This called for the need to consciously make efforts not to let their own values override the participants' perspectives. In this way, the trustworthiness of interpretive research was enhanced.

### **1.9.1.2 Ontological assumptions**

The Sage Dictionary of Social Research Methods (2006) says that ontology is concerned with questions pertaining to the kinds of things that exist within society. Bailey (2007:53) says that by using an interpretive paradigm of research, the researcher holds the ontological belief that there is no objective social reality out there. Instead, the researcher believes that there are multiple context dependent realities. Guizzardi (2005:55) cites Ferreira by saying that social reality is not a static concept. Social reality changes with time and is unique to a particular context. This therefore means that unlike physical reality, social reality is neither permanent nor fixed. Social phenomenon like “collaboration” can have multiple meanings derived from particular settings or contexts. In this study, the researcher sought to establish the meaning of collaboration with BHPs through the social lens of THs who were trained and supported in an HIV and TB program in KwaZulu Natal. It was therefore assumed that although many realities exist around the subject of collaboration, the perceptions of the interviewed THs were accurate enough to understanding the issue at hand through the “insider” perspective.

### **1.9.1.3 Axiological assumptions**

“Axiology is the study of the nature of value(s) and value judgments” (Lawson 2008:124). This is corroborated by the Bock (2009:87) which says that axiology is the study of the nature, types, and criteria of values and of value judgments especially in ethics. Axiology is a collective term for beauty (aesthetics) and ethics. From these definitions, it can then be extrapolated that axiology studies the values of “right” and “good” in social research. The researcher’s background, insights, value judgments and experiences became part of the knowledge creation process in this study. The researcher was highly sensitive to the social context in which the research took place by paying attention to axiological elements. Since my values were part of the inquiry, the researcher continuously reflected upon them throughout the research process.

#### **1.9.1.4 Methodological assumptions**

In this study, the researcher assumed that the chosen method of qualitative descriptive research of using in-depth interviews would generate the right data to answer the research question. This is based on the views of Cooper and Endacott as quoted in the Emergency Medical Journal (2007:816) saying that a qualitative descriptive and contextual approach is suitable in “seeking to discover and understand a phenomenon, a process, or the perspectives and worldviews of the people involved”. In this study, this method was assumed to be better placed to assist in exploring and describing THs perceptions on collaboration between THs and BHPs. With appropriate application of means and measures to ensure credibility, dependability, confirmability and transferability, the method together with its data instrument yielded scientifically valid findings. Data quality is fully discussed in chapter 3 in the section on research design.

## **1.10 RESEARCH DESIGN AND METHOD**

The research design is defined as a procedural plan that is adopted by the researcher to answer questions vividly, objectively, accurately and economically (Kumar 2011:396). According to Parahoo (2006:119), the design selected for research should be the most suited to answer to the proposed research question. Padgett (2008:15) says that qualitative descriptive and contextual approach to research is the one in which the researcher often makes knowledge claims based on “lived experiences” of the research participants.

In this study, the qualitative research paradigm was suitable because it allowed THs to portray the “true” picture of collaborating with BHPs based on their practical experiences. The study was conducted with main aim of understanding THs’ perceptions on collaborating with BHPs without any form of manipulation or testing of any hypothesis. The THs were studied in their natural environment to freely express their opinions and feelings towards collaboration with BHPs.

### **1.10.1 Population**

Kumar (2011:398) uses the term population to define the entire set of objects and people that are the object of research and about that which the researcher wants to determine some characteristics. Babbie and Rubin (2011:627) define population as “the group or collection that a researcher is interested in generalising about”. The population for this study consisted of all the THs in UMkhanyakude District who had discontinued collaboration with BHPs (25 THs).

### **1.10.2 Sampling**

The researcher used purposive sampling by recruiting participants from the group of THs who had dropped out after having been trained and supported to collaborate with BHPs in the HIV/AIDS and TB program. Kumar (2007:206) defines purposive sampling as being judgmental. Barbie and Benaquisto (2010:508) say that purposive sampling is the non-probability selection of participants where the researcher selects the participants based on judgment about which ones will be the most useful or representative. In this study, the inclusion and exclusion criteria was that the participating THs were registered with the THO and must have received training and post training support from the AMREF HIV/AIDS and TB project. They should also have begun some form of collaboration with BHPs before stopping to collaborate.

A convenient sample size of 6 THs who had stopped collaborating with BHPs after having been trained was selected through being guided by the principle of saturation. Kumar (2011:398) says that in qualitative descriptive and contextual research, the concept of a point of redundancy refers to the stage in data collection where very little or no more new information is coming out of the participants. The exclusion/inclusion criteria for selecting the sample was that the THs who were interviewed must have received training and post training support from the AMREF HIV/AIDS and TB project. The participants must also have begun some form of collaboration with BHPs before stopping to collaborate in order to ensure that the researcher obtained only the opinions of those THs with sufficient information about the collaboration program.

The THs who participated in this study were also registered with the THO; which is the official body for all “genuine healers” and are therefore officially recognised by the Government. The study excluded any healer who was not trained and supported in the HIV/AIDS and TB program and all those healers who were still collaborating with BHPs in order to remain focused on the research problem (unsustainable collaboration) and research questions.

### **1.10.3 Data collection approach**

Semi-structured interviews using open-ended questions were conducted in IsiZulu where all the 6 interviews were audio recorded and then transcribed verbatim. An independent reviewer who is fluent in both IsiZulu and English was asked to listen to the audio tapes and compare them with the transcripts to ensure accurate translation. (See annexure E for the profile of the reviewer). The interviews consisted of a few, core and open-ended questions or discussion points which had been developed by the researcher specifically for this study. These questions were developed based on the findings of the AMREF report (2007) as well as on the researcher’s experience and literature review. Polit and Beck (2008:392) recommend in-depth open ended interviews. These authors also suggest that interviews should go in directions that are beyond the bounds of a rigid format and give the participants the opportunity to describe their experiences in, and the understanding of their life-worlds.

Throughout the interview process, the researcher was always “sensitive” to the ways in which he could affect the data collection process (reflexivity). This included understanding the role of the researcher’s prior assumptions and experience on the subject of collaboration between THs and BHPs. Since the human person (the researcher) is the primary data collection instrument; Pezalla, Pettigrew and Miller-Day (2012) say that the level of researcher involvement in qualitative research “embodies the researcher as the instrument for qualitative data collection”. The researcher maintained a sense of high consciousness of all sorts of mannerisms and reactions that could influence the way in which the participants responded.

#### **1.10.4 Data analysis**

The raw data were transcribed verbatim from the audiotapes. During this phase of data preparation, the audiotapes were played and replayed while reading the transcribed data to ascertain that the transcriptions were accurate. The researcher then used the “data spiral” as proposed by Creswell (2013:182-188) in managing and analysing the data. The data analysis steps that were followed are organising the data by filing and preparing it on computer for better storage and the analysis. This was followed by reading and memoing all the transcripts in their entirety several times in order to get a good feel for it. This involved writing notes on key concepts and insights emerging out of the data. The third step was that of describing, classifying and interpreting data into codes and themes based on the nature of the data and the syntax and coherence of the responses of the participants in order to help in content and text analysis.

Coding involved summarising and labelling information according to different themes. The fourth step was that of interpretation where the codes and themes were put into meaningful context based on the researcher’s interpretation, formal theory on aspects of collaboration between THs and BHPs in HIV/AIDS and TB programs. This largely involved giving the data some insights and intuition on the part of the researcher, which was greatly influenced by existing background knowledge (Creswell 2013:187). The final data analysis step was that of presentation where data was displayed on tables that contained all data units pertaining to a single category or sub category and the grammatical expression of relationships among themes and categories.

#### **1.10.5 Data Quality**

This being a qualitative study; the researcher ensured that the data collected was credible or trustworthy and believable (credible) by employing the strategies of employing rigorous strategies throughout the research process to ensure trustworthiness of the results. The measures taken to ensure trustworthiness are credibility, transferability, dependability and confirmability that are all discussed in detail in chapter 3.

Trustworthiness in qualitative research designs is associated with rigor throughout the research process (Burns and Grove 2010). Fenton and Mazulewicz (2008: 296) say that the aim of trustworthiness in a qualitative inquiry is to support the argument that the inquiry's findings are "worth paying attention to". It includes aspects or principles such as credibility, transferability, dependability and confirmability. The researcher endeavoured to establish and maintain trustworthiness as explicated in chapter 3 on research methodology.

## **1.11 ETHICAL CONSIDERATIONS**

Kumar (2011:384) says that ethical research practice means carrying out research in accordance with principles of accepted codes of conduct of a given profession or group. Similarly, the National Directorate of Public Prosecutions (2004:iv) says ethics can be defined as the branch of philosophy that is concerned with human character and conduct and deals with questions of right and wrong, good and evil..

Resnick (2011) says that "ethics" are norms for conduct that distinguish between acceptable and unacceptable behaviour. This study was carried out in accordance with the provisions of ethical principles of respect for autonomy, justice, beneficence and non-maleficence with regard to the participants, the traditional healing institution, the integrity of the researcher, and the TH specific ethical issues that are described in detail in chapter 3 of this dissertation. Ethical clearance was given by UNISA (see appendix A). The researcher was cautious of the fact that the two health systems work from very different world views and therefore did not question or challenge either of the two systems.

## **1.12 SCOPE AND LIMITATIONS OF THE STUDY**

Maree and Van der Westhuizen (2009:38) define scope as delimiters or the "ways in which the researcher specifies boundaries in his or her research". The study was conducted in Mtubatuba municipality of UMkhanyakude district of KZN.

Mtubatuba has 5 wards where the participants were selected from. Through purposeful sampling, the researcher ensured that each ward was represented by a healer who fit in the exclusion and inclusion criteria. Kumar (2011:239) refers to limitations as those “structural problems relating to methodological aspects of the study”. Limitations also refer to the inherent design or methodology parameters that can restrict the scope of the research findings and are outside the control of the researcher.

One of the limitations of the study is its narrow focus on those healers who have stopped collaborating with BHPs. This could present some form of bias, as it connotes that the researcher just looked at ‘one side of the coin’ – of ignoring the positive aspects of what make some THs stay within collaboration. This limitation was largely due to the study’s design and focus which was concerned about the sustainability of collaboration post training and support. It therefore could have limited opinions and views about the broader subject of collaboration.

## **1.13 STRUCTURE OF THE DISSERTATION**

This research report (dissertation of limited scope) is structured as follows:

Chapter 1: Introduction and overview of the study

Chapter 2: Literature review

Chapter 3: Research methodology

Chapter 4: Analysis, presentation and description of the research findings

Chapter 5: Conclusions and recommendations.

## **1.14 CONCLUSION**

This chapter has given both the overview and served as an introduction to the study report. A detailed background of the research problem as well as the definition of key terms has been provided in this chapter. Chapter 1 has also given a broad overview of the research problem, aim, purpose, objectives and the research design that includes population, sampling and data management as well as ethical considerations, scope and limitations of the study. In chapter 2, the researcher presents the results of the literature review that was conducted for this study.

## CHAPTER 2

### LITERATURE REVIEW

#### 2.1 INTRODUCTION

According to Barbie and Rubin (2013:68), the review of literature is an essential part of any academic research project as it tests the research question against what is already known about the subject in context. Holloway and Wheeler (2010:35) say that a researcher must search for information on the topic area from academic journals and books in order to review important aspects that are related to the area of the research topic. “The purpose of the review of the literature in a qualitative study is to tell the reader how the study fits into what is already known about the phenomenon”- (Streubert and Carpenter 2011:25). All these definitions confirm that the literature review helps the researcher to discover what others have already said or found out about the research question, and what the research needs to do to contribute new knowledge towards the existing pool of scientific knowledge.

The literature review for this research topic focused on secondary sources such as published research reports in scholarly journals, books, databases and electronic sources about the subject of perceptions of THs on collaboration with BHPs in HIV/AIDS and TB programs. Although other qualitative researchers tend to carry out literature reviews after collecting and analysing their primary data, the researcher preferred to do the literature review before data collection. This was done in order to get a better understanding of the subject of collaboration, identify gaps in existing knowledge, avoid duplicating what is already known or searching for existing answers and enhancing the significance of this study.

This chapter on literature review discusses 4 main issues that emerged with regards to traditional healing in the context of HIV/AIDS and TB. These issues are: overview of the practice of traditional healing, legislative provisions for traditional healing and the concepts of “collaboration” and perceptions of THs on collaboration.

## 2.2 OVERVIEW OF TRADITIONAL HEALERS AND HEALING

### 2.2.1 Clarification of concepts

The WHO (2007) considers traditional healers as individuals who are recognized by their communities as competent health care service providers who use a range of substances and methods based on the communities' social, cultural and religious belief systems and indigenous knowledge. Similarly, the Medical Dictionary (2012:1) defines traditional healing as "any system of health care that has ancient roots, cultural bonds, trained healers, and a theoretical construct; traditional systems include ayurvedic medicine, ethno medicine, shamanism and traditional Chinese medicine". These definitions are congruent with the World Bank (2011:1) who refers to traditional healing as services rendered to maintain health, as well as the prevention, diagnosis, and improvement of physical and mental illness through the application of knowledge, skills, and practices based on the experiences indigenous to different cultures. This therefore means that a traditional healer is someone who uses traditional medicine to prevent ill health, disease or cure people who are ill or injured.

According to Moodley and West (2005:63), Southern African traditional healers who fit in this definition are herbalists and diviners. Nyika (2006:27) concurs with Moodley by saying that African traditional medicine has two main branches of supernatural healing (spirit mediums) and herbalism. Whereas supernatural healing is based on occult or supernatural powers, herbalism is based on the premise that some herbs and botanical components have therapeutic properties. Kangwa and Catron (2010:2), state that witchdoctors (medicine men) and spirit mediums constitute the biggest categories of African traditional healing.

#### 2.2.1.1 Diviners

According to The Health Systems Trust (2011:251), diviners are considered the most important intermediaries between humans and the supernatural. Unlike herbalists, no one can become a diviner by personal choice. The ancestors call them (*most usually a woman*) and they regard themselves as servants of the ancestors.

Diviners concentrate on diagnosing the unexplainable and they analyse the causes of specific events and interpret the messages of the ancestors. They use divination objects and explain the unknown by means of their particular mediumistic powers. The diviners or spirit mediums combine the role of herbalist with the role of psychotherapist, community historian, priest, council and judge and they are believed to have a closer relationship with, or to be in constant communication with, the ancestral spirits. The ancestral spirits are the ones who actually give guidance in healing practice, whereas the diviner acts only as a 'middleman' or servants of the ancestors who intercede between the ancestral spirits and humans The Health Systems Trust (2011:251). In an article on indigenous healing, the University of Witwatersrand (2006:1) says that diviners are often utilised when western medicine fails to provide a cure, when misfortune (often seen as having spiritual/magical causation) arises, or where health and fortune are to be maintained as in the use of protection muti.

Diviners are also reputed for their clairvoyance, their abilities to read patients' minds and their power to manipulate and use cosmic energy to ensure health and wealth. Moodley and West (2005:53) go on to say that, the traditional African medicine perspective sees disease not only as a microbiological infection, but also as a breakdown in the physical, social and spiritual mechanisms. Disease is more of a social construction, with focus on person-environment relationship. Disease is also associated with other aspects of life, like the intellectual, emotional, social, familial, occupational and spiritual dimensions. The traditional African view on causes of diseases includes the mystical, animistic and magical. Moodley and West (2005:125) go further to explain that the magical causes of diseases refer to those ailments inflicted or cast by others, living either in the material (or magical) or super-material (animistic) world.

### **2.2.1.2 Herbalists**

According to Moodley (2009:307) and Nyika (2006:28), herbalists use remedies made from plants to stimulate a patient's own bodily defences to produce relief of, or to cure ailments and diseases.

The Health Systems Trust (2011:251) says that herbalists are ordinary people who have acquired an extensive knowledge of magical technique and who do not, typically, possess occult powers. They are expected to diagnose and prescribe medicines for everyday ailments and illnesses, to prevent and to alleviate misfortune or evil, to provide protection against witchcraft and misfortune, and to bring prosperity and happiness. Herbalists diagnose patients by having them explain their symptoms and provide detailed medical and dietary histories dating back to their childhood. Once a diagnosis has been made, the herbalist gives the patient a remedy made from certain plants, which are specifically blended to deal with the patient's particular condition. Some of the requirements to qualify as a herbalist include:

- Having an interest in the healing properties of plants
- Having a desire to cure sick people
- Being dedicated to the profession through integrity.
- Being empathetic but firm
- Having deep interest in medicine and disease

Although there are other groups who include traditional surgeons and traditional birth attendants, it must be noted that the term “traditional healer” in this document specifically refers to diviners and herbalists (THP Act; Act No. 22 of 2007).

### **2.2.2 Traditional healing in sub Saharan Africa**

Literature shows that the African indigenous health system dates back to ancient times. However, it was only around the 1970s that a number of international resolutions began to be passed to promote regulation of traditional medicines and to govern traditional healers who are also known as traditional health practitioners in countries such as South Africa (Mills et al 2006; Peltzer et al 2006; Kange'ethe 2009; Cook 2009; Simmons 2011). It is also estimated that between 60% and 80% of sub-Saharan African community members utilize traditional healers. All these authors clearly state that traditional medicine is part of the culture and heritage in Africa and that it is affordable and easily accessible. A detailed discussion on the popularity and prevalence of traditional healing in sub Saharan Africa is presented in section 2.4.1.

### **2.2.3 Traditional healing in South Africa**

Puckree, Mkhize, Mgobhozi and Lin (2002:249) found that in 2002, 70% of the KwaZulu Natal patients would consult local traditional healers as first choice. Diviners were the most popular type of healers and could attend to as many as 20 patients per day. Puckree et al (2002:251) concluded that traditional healing is an integral component of health care in South Africa. This view serves as a strong argument for the need of health care professionals to consider collaborating with traditional healers. The National Department of Health (NDOH 2007:27) says that there are approximately 200,000 active traditional health practitioners in South Africa; and that 80% of the South African black population consults traditional health practitioners. Traditional healers evidently play a major role in providing health services for many people in South Africa, especially in rural areas (where western health care is generally difficult to access). Collaboration between traditional healers and biomedical practitioners has been accepted by the South African Government because of the increasing problem of HIV/AIDS (Department of Health 2007:24). Section 2.3 of this document details the legislative framework and practice of traditional healing within the context of HIV/AIDS and TB in South Africa.

## **2.3 TRADITIONAL HEALERS LEGISLATION AND MANAGEMENT**

The Traditional Health Practitioners Act (Act No. 22 of 2007) (South Africa, 2007) and the National Drug Policy (South Africa, 1996) are the two most comprehensive pieces of legislation that provide the legal framework for the practice of traditional healing in South Africa.

### **2.3.1 The Traditional Health Practitioners Act**

After prolonged debates over many years, the South African government enacted the Traditional Healers Act (Act No. 22 of 2007. Before 2007, the South African government had enacted the Allied Health Service Professions Act (Act No. 51 of 1982; Government Gazette, 2000), which repealed the Homeopaths, Naturopaths, Osteopaths and Herbalists Act of 1974. The Act was meant to provide for:

- A regulatory framework to ensure efficacy, safety and quality of traditional health services.
- Treatment, and preventative measures in traditional medicines.
- Objectives, quality, universal norms and standards on traditional medicine.

The Traditional Healers Act (Act No. 22 of 2007) specifically provides for the registration and licensing of healers. Registration entitles healers to practise for gain and the right to call themselves members of that traditional healing profession. Practice for gain by a non- registered person is an offence punishable by a fine and/or imprisonment of up to one year. To qualify as a traditional health practitioner, an apprenticeship programme of varying duration (between one and five years) with a well-known tutor or traditional health practitioner is emphasized.

Qualified traditional healers are given a certificate by the Traditional Healers Organisation (THO) to certify them as qualified healers who can practise in South Africa. Upon examining the certificate, I found that it says that these qualifications are valid in Africa, Asia, Latin America, Europe and Australia. Section 1 of the THP Act (Act No. 22 of 2007) also imposes restrictions on traditional healers in that they cannot use the title of "Medical Practitioner" or any other title that may suggest that they are qualified as similar to those who practise western medicine, biomedicine, evidence-based medicine or modern medicine" (South Africa, 2007).

The THP Act (Act No.22 of 2007) proclaims the dignity and respect of traditional medicine and offers a framework to ensure the efficacy, safety and quality of traditional health care services from registered and trained traditional healers (South Africa, 2007). The Act also provides management and control over regulations, training and conduct of practitioners. Colvin Gumede, Grimwade & Wilkinson (2007:625) argue that this piece of legislation on traditional healers is vital in guiding intervention efforts to make collaboration work better.

### **2.3.2 The National Drug Policy (1996)**

Article 11 of the National Drug Policy (South Africa, 1996:23) makes provisions for use and regulation of traditional medicines in the South African health care sector. The Act encourages cooperation between THs and other health workers in mainstream health service delivery. The drug policy stresses the importance of THs to cooperate with other health workers in the formal health sector. The policy calls for systems to be in place to ensure an adequate and reliable supply of safe, cost-effective drugs of acceptable quality to all citizens of South Africa and the rational use of drugs by prescribers, dispensers and consumers. Traditional healers are encouraged to cooperate with other workers in the formal health sector, particularly in programs such as immunization monitoring and AIDS management.

The National Drug Policy (South Africa, 1996:23) goes further to say that traditional medicines have to be investigated for efficacy, safety and quality before their public use or incorporation into the formal health care system. This is effected by one of the provisions of the Drug Policy (South Africa, 1996:26) namely that there must be a National Reference Centre whose functions include:

- a) Development of a national database of indigenous plants that have been screened for efficacy and toxicity
- b) Testing for toxicity and efficacy
- c) Compiling a national formulary of Medicines Control Council approved "essential traditional medicines"
- d) Propagation of medicinal plants.

The National Drug Policy of 1996 (South Africa, 1996:26) goes further to say that those traditional medicines that are being marketed must be registered and controlled through a national reference centre for traditional medicines. Unfortunately, the researcher could not establish from the DOH whether the National Reference Centre was functional or not during the literature review period.

## **2.3.3 Management Bodies**

### **2.3.3.1 Traditional Healers' Organisation**

In 1970, the Traditional Healers' Organization (THO) was created and started a process of educating all healers and establishing its advocacy work to fight against discrimination and abuse of healers; especially member healers (Traditional Healers Organisation 2008). According to the Department of Health (2007:27), healers were (at the time) directly accountable to the Department of Health through an existing Traditional Medicines Desk. However, at times there seem to be clashes over who should directly work with healers between different government departments; and especially those of Health, Social Development, Science and Technology, Environmental Affairs and Agriculture (Human Sciences Research Council (HSRC 2009:1).

### **2.3.3.2 The Interim Traditional Health Practitioners Council**

According to the Government Gazette No. 34546 (South Africa 2011:2), an interim traditional health practitioners' council has been put in place to assist the National Department of Health to integrate traditional health medicine into the national health system. The Council has 20 members constituted by representatives of Practitioners from all nine provinces in the country. Other members are a legal expert; a member of the Health Professions Council of South Africa (who is a Medical Practitioner); a Member of the SA Pharmacy Council (who is a Pharmacist); Community Representatives; Diviners; Herbalists; Traditional Birth Attendants; Traditional Surgeons; Academics; Researchers and the National Department of Health.

The mandate of the ITHPC is drawn from section 2; paragraph 5 of the Traditional Health Practitioners Act (Act No. 22 of 2007) which states that the primary objective of the council is to protect and enhance the indigenous knowledge system in the field of medicine and to address public concerns over unscrupulous and bogus traditional medicine practitioners and practices.

The objects of the Council as provided for in terms of Section 5 of the Act are to:

- a) Promote public health awareness
- b) Ensure quality of health services within traditional health practices

- c) Protect and serve the interests of members of the public who use or are affected by the services of traditional health practitioners
- d) Promote and maintain appropriate ethical and professional standards required from traditional health practitioners
- e) Promote and develop interest in traditional health practice by encouraging research, education and training
- f) Promote contact between the various fields of training within traditional health practice in the Republic [of South Africa] and to set standards for such training
- g) Compile and maintain a professional code of conduct for traditional health practice
- h) Ensure that traditional health practice complies with universally accepted health care norms and values.

According to Clause 5e of the THP Act No. 22 of 2007, the Interim Traditional Health Practitioners Council of South Africa must promote and develop interest in traditional health practices by encouraging research, education and training. Section 6 of the Act explains that the Council must promote and regulate, and encourage liaison between traditional health practitioners and other health professionals registered under any law. The AMREF project and this research fall within this clause of the THP Act (Act No. 22 of 2007).

## **2.4 COLLABORATION**

Given the nature of this study on collaboration between THs and BHPs, it was important to define collaboration in the face of a usually conflicting perspective of *integration*.

### **2.4.1 The concept of collaboration**

The Business Dictionary (2012:1) defines collaboration as “cooperative arrangement in which two or more parties (which may or may not have any previous relationship) work jointly towards a common goal.”

The US Department of Health and Human Services (2012:1) concurs to say that “collaboration is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve results they are more likely to achieve together than alone.” Similarly, UNAIDS (2010:7) says that collaboration between THs and BHPs means bringing the two parties together to assist people afflicted by different diseases such as TB and HIV/AIDS.

#### **2.4.2 The concept of integration**

In simple terms, integration literally means combining or adding different parts to make a unified whole. Integration is similar to bringing traditional healers into mainstream health service delivery where they are recognised and operate as part of the biomedical health professional teams.

#### **2.4.3 Collaboration between THs and BHPs**

In this study, collaboration between traditional healers and biomedical practitioners in UMkhanyakude was defined in the scope of a working relationship between the two parties in the management of TB and HIV/AIDS. Collaboration means creating mutual understanding through dialogue, exchange of information and materials and patient referrals in a freely negotiated agreement between the two systems for the mutual benefit of their patients. Literally, collaboration is taken to mean working together with one or more others on mutual understanding. Collaboration is usually accompanied by signing a memorandum of understanding.

In South Africa, collaboration between THs and BHPs is provided for by the National Drug Policy (South Africa, 1996) as well as the Traditional Health Practitioners Act (Act No. 22 of 2007) (South Africa, 2007). Since THs are deeply interwoven into the fabric of social, cultural and spiritual life of South Africans, traditional healers play a crucial role in providing health care to about 80% of South Africa’s population (Richter, 2003:10). Furin (2011:850) confirms this view by saying that Traditional Healers provide a substantial proportion of health care in resource-poor settings, including countries with high burdens of HIV in sub-Saharan Africa.

Collaboration between THs and BHPs is now being accepted by many Sub-Saharan African countries largely because of increasing problems of HIV/AIDS and TB, and health systems that are not coping with the burden of disease (Mills et al, 2006:361). Meel (2010:154) affirms this view by saying that traditional healers contribute significantly to the level of health-care systems in Africa. It therefore is understood that collaborating with traditional healers in South Africa's primary health care system is vital for effective management of communicable diseases since it has been demonstrated beyond any reasonable doubt that they play an important role in the prevention and care of patients with HIV/AIDS in the community.

The traditional healing system deals with psychosocial stress associated with HIV/AIDS as well as herbal medications. A study by Kayombo et al (2007:4) found that traditional healers not only provided remedies for illnesses/diseases of orphans, but also provided other basic needs such as psychosocial support (allowing children to cope with orphan hood life with ease). Kalombo et al (2007:6) argue that; since traditional healers live within communities and are often members of the community or relatives, their role; particularly with activities such as providing care for orphans - needs to be recognised and even scaled up.

#### **2.4.4 Rationale and importance of collaboration**

The search for relevant literature revealed that there is overwhelming evidence that shows that collaboration of THs with BHPs is imperative especially in managing health conditions like HIV, STIs and TB. According to the WHO (2007:1), most Governments in Africa strongly believe that THs can be a valuable resource in communities if they work closely with BHPs in clinics and hospitals. It is for this reason that the WHO (2010:1) says that collaboration between the traditional healing and biomedical health systems can help to stem the tide of many of the disease pandemics that afflict the people of Africa.. In order to strengthen collaboration, the UNAIDS (2006) has put together a collection of best practices on collaborating with THs in Sub Saharan Africa. Earlier, in 1995, the WHO had already developed training guidelines that can enable Traditional Healers to play an important role in primary health care.

#### **2.4.4.1 Rationale for collaboration at international level**

In response to the rise in both the HIV and TB epidemics, the WHO published guidelines for national programs and other stakeholders on collaborative TB/HIV activities HIV and TB prevention, treatment and care to support governments, civil society, and health care workers (HCWs) in adequately addressing a burgeoning health crisis in 2004 (revised in 2012). The STOP TB Partnership meeting held in Geneva in 2010 with representatives of civil society sought to find practical ways to put community engagement into practice, by exchanging experiences and sharing innovative ways of working together so as to strengthen efforts aimed at prevention, care and control of tuberculosis (TB) worldwide (WHO 2010:1). The STOP TB Partnership has also worked together with civil society groups to produce guidelines for community engagement at all levels from policy to implementation (Stop TB Strategy and Guidelines on Community Involvement in Tuberculosis Care and Prevention). These guidelines spell clearly the key role of civil society in the delivery of services on the ground.

The resolutions of the meetings held by STOP TB/Partnership, UNAIDS and the International AIDS Society and other international institutions in Geneva and Johannesburg reiterated that it has become good practice to work with community representatives such as traditional leaders, traditional healers and community health workers in developing treatment protocols for both HIV/AIDS and TB in order to better manage treatments and diagnostics (WHO 2010:1). Furthermore, it is envisaged that communities (including THs) are increasingly being relied upon as key partners in the Anti-retroviral Therapy (ART) rollout. Engaging THs in the delivery of the HIV/AIDS and TB prevention, testing, treatment and care services is important in expanding the reach and reducing costs of these services, especially in the overstrained and resource-poor health systems of third world countries.

#### **2.4.4.2 Rationale for collaboration at sub Saharan level**

As has been stated in the sections above, Sub-Saharan Africa is a region in which most people first consult traditional healers when they fall ill (AVERT 2009:154). Some of the reasons for preferring traditional healers include their perceived superior interpersonal skills, confidentiality and discretion, professionalism, as well as effectiveness (Botswana, 2006).

Traditional healers are respected within their communities and are regarded as cultural authorities. Given the respect that they are accorded, traditional healers are well positioned to deliver HIV-TB prevention messages, distribute condoms, conduct counselling, encourage HIV/TB testing, collaborate with clinics and set up support groups for patients on treatment (AVERT 2011:1).

Most Sub-Saharan governments have developed some sort of plan on working with traditional healers because they have acknowledged that these healers are a resource that can play a key role in the fight against HIV and AIDS. An example of such evidence can be seen in the Botswana Ministry of Health's Plan on strengthening the capacity of traditional healers (Botswana 2006) and the South African Traditional Healers Act (Act No. 22 of 2007) (South Africa; 2008).

According to Mills et al (2006:362), there is now mounting evidence of the importance of involving traditional healers in the management of the HIV/AIDS epidemic. BHPs have finally begun, though slowly and often in a sceptical manner, to consider collaboration with Traditional Health practitioners as potential allies in the battle to prevent the spread of HIV/AIDS. This recognition is underpinned by a realisation that THs have a longstanding trust and credibility in their communities. Thus, Liverpool et al (2004:823) argue that collaboration between traditional healers and western medical health systems is an innovative and effective strategy that can play a vital role in Africa's AIDS prevention and control programs. A number of studies such as the one cited by Moodley and West (2005:53) and Mills et al (2006:363) suggest that THs who are trained on HIV and TB prevention and treatment are able to counsel their clients.

These are the reasons why a number of Southern African countries have heeded the call to engage THs as well as supporting the provision of appropriate knowledge and skills to traditional healers on HIV and AIDS as well as TB. A number of organisations such as AMREF have recognised the influence of THs and have implemented training programs to further build the capacity of traditional healers.

On the 31<sup>st</sup> of August, 2007, African ministers of health assembled in Congo-Brazzaville for the 57<sup>th</sup> session of the WHO Regional Committee for Africa and made an undertaking to “develop mechanisms for institutionalizing the positive aspects of traditional medicine into health systems and improve collaboration between biomedical health and traditional health practitioners” (WHO 2007). South Africa was part of that declaration. The only country in Southern Africa that seems to have made great strides in implementing this commitment is Botswana (Botswana; 2008:4). The government of Botswana for a long time had a policy of promoting mutual collaboration between THs and BHPs. The first reference to the official acceptance of THs in Botswana appears in Section 14.86 of the National Development Plan of 1976-1981. It took over 20 years for the Botswana Ministry of Health (MOH) to begin facilitating activities for traditional healers including seminars on AIDS. The Botswana government has implemented a number of initiatives to promote cooperation and collaboration between traditional healers and BHPs.

#### **2.4.4.3 Rationale for collaboration at South African level**

South Africa remains one of the countries with a heavy burden of people living with HIV and TB. According to the UNAIDS Global report (2010) on HIV, an estimated 5.6 million people were living with HIV in 2009. The KZN Province is the epicentre of the HIV and AIDS epidemic in SA with UMkhanyakude District having an estimated prevalence rate of 39.5% amongst antenatal clinic women in 2009, TB smear conversion rates of up to 44% and a low TB cure rate of 39% (KZN Department of Health, 2012). Given this scenario, there is an urgent need for innovative approaches to combat further unnecessary loss of human lives, halt, and begin to reverse the HIV and AIDS epidemic. The engagement of Traditional Healers may offer a most useful conduit in identification of TB and HIV symptoms as well as with referrals to health services.

## **2.4.5 Challenges facing collaboration of THs with BHPs**

Collaboration between THs and BHPs remains poorly researched and understood. While there are a growing number of collaborative programs between traditional healers and biomedical health providers, there seems to be a wide range of problems facing collaborative projects and thereby threatening the sustainability of such efforts or programs. There appear to be several issues that affect the collaboration of THs with BHPs even in many countries other than South Africa. Opaneye and Ochogwu (2007:68) say that most friction between biomedical health practitioners and traditional healers stems from the conventional science notion of "material causation". Biomedical doctors generally look at the physical causes of an illness and treat them accordingly. Traditional healers generally look at other factors including spiritual causes.

From the findings of an evaluation of a collaboration project in Tanzania, Kayombo et al (2007:10) say that the key problem facing sustainable collaboration between the two health systems is the different perspectives in theory of disease causation and management. Opaneye and Ochogwu (2007:68) agree with this observation and further state that the belief by BHPs that THs are poorly trained is largely responsible for lack of meaningful collaboration. Despite traditional healers having played many roles in HIV prevention, care and support, some biomedical health professionals view them as obstacles in providing HIV treatment (Furin, 2011:852).

Projects like those implemented by AMREF in UMkhanyakude have shown that there is high enthusiasm on the part of traditional healers to collaborate and learn from their western-trained counterparts. However, the reverse seems to be true on the part of BHPs. Peltzer, Mngqundaniso, & Petros (2006:673) say that up to 65% of BHPs feel that THs do not have sound knowledge and therefore must not be entrusted with HIV/AIDS and TB patients. Despite all these challenges, collaboration between THs and BHPs remains vital to HIV/AIDS-TB programs.

## **2.4.6 Examples of successful collaboration projects on HIV/AIDS and TB**

A number of factors have been identified within different community initiatives as key in the success of collaborations with THs in HIV and AIDS service delivery. AMREF (2007:49) asserts that collaboration between traditional healers and western medicine trained doctors can improve if THs are trained on basic HIV/TB epidemiological processes so that they practise better infection control and hygiene within their healing practices. Training can also assist traditional healers in better understanding of diseases that are beyond their capacity to treat so that they promptly refer them to clinics.

### **2.4.6.1 Nepal**

A study by Poudyal et al (2003:957) in far western Nepal showed that training of THs significantly improved their knowledge of HIV transmission, misconceptions and preventive measures. Focus group discussions and key informant Interview results showed that trained traditional healers provided culturally acceptable HIV/AIDS education to the local people, distributed condoms and played a role in reducing the HIV/AIDS-related stigma.

In a separate and earlier study among THs in Nepal, Poudyal et al (2003:958) found that THs trained using a western medical training model in rural Nepal had a better knowledge of allopathic medicine, practised modern treatment using first aid kits, and were more likely to refer patients to Government Healthcare Workers (GHWs). They also improved their relationships with the GHWs. These findings show that traditional healers are willing and able to be integrated into western medical systems. However, as reported by a number of studies (Somsé et.al 1998; Mngqundaniso and Peltzer 2008; Mills et al 2006), it is western biomedical health practitioners who seem to mistrust traditional medicine and healers, and are usually sceptical of traditional healers' approaches in mainstream health delivery.

#### **2.4.6.2 Central African Republic**

As far back as 1998 in a study to evaluate an AIDS training program for traditional healers in the Central African Republic (Somse 1998:559), reported that AIDS training can be successfully delivered to traditional healers. This does improve the quality of life for HIV and AIDS patients. Improvements in knowledge and/or attitudes were observed amongst the trained THs especially on prevention of HIV transmission during traditional practice such as skin cuts/incisions for the purposes of administering herbal medicines. THs participating in this project began to use gloves and mouth masks when examining patients as well as sticking to the gold standard of one patient, “*one razor blade*”. The training programme which was conducted by traditional healers with the assistance of staff from the Ministry of Health was designed to improve AIDS knowledge, attitude and practice was delivered to 96 traditional healers in the Central African Republic. Training included topics such as infection control and prevention of HIV transmission during traditional practice; diagnosis, treatment, and prevention of sexually transmitted diseases; condom promotion; AIDS education at the community level; psychosocial support for people with AIDS and promotion of a positive image for traditional healers.

#### **2.4.6.3 Botswana**

In a study to evaluate the role of caregivers in a community and home based care (CHBC) project for HIV/AIDS patients and other chronically ill persons in Kanye village of Botswana, Kange'ethe (2009:116) noted that traditional healers were important players in care giving of persons with various ailments. However, their role, position and contribution in the battle against HIV/AIDS got lost after the end of the project. Because of these findings, Kange'ethe notes that the Botswana government was challenged to map out strategies of collaboration between the two systems as traditional healers can complement the services of biomedical practitioners in this era of HIV/AIDS.

Chipfakacha (1997:420) also studied THs way back in the late 90s in Botswana and found that before any training, THs had inadequate knowledge on the risks of HIV transmission through blood products. There was a lack of proper documentation on the safety and efficacy of TH services.

This makes it difficult for governments to include such treatments in national programs to reduce its disease burden. In addition, public health officials and allopathic physicians tend to have biases against working with THs due to prejudice or fear of competition. THP services were initially not officially recognized and supported in Botswana's national health system prior to 2008 when the Government took a bold step to develop and implement a policy of promoting mutual collaboration between THs and BHPs.

#### **2.4.6.4 Uganda**

In Uganda, Birungi, Mugisha, Nsabagasani, Okuongzi & Jeppsson (2001:83) found that the absence of a central traditional healers association made it difficult for the public sector to collaborate with THs to improve overall health services. Bodeker, Kabatesi, King, & Homsy (2000:1284) point out that many TH services for AIDS prevention and care in Uganda lacked the evidence-base to convince the government to support such services. Traditional healers are often poor in biomedical knowledge, which can lead to harmful procedures to patients.

However, several efforts of collaboration between THs and BHPs have been made in the country. According to the WHO (2010:1), one such initiative in Uganda is the one by a Non-Governmental Organisation known as 'Traditional and Modern Health Practitioners Together against HIV/AIDS and other diseases' (THETA). This NGO is dedicated to improving mutually cooperation between THs and BHPs. Its objectives are education, counselling and better clinical care for people with STIs including HIV/AIDS.

Although the Ugandan Medical Practitioners and Dental Surgeons Act of 1968 prohibits unlicensed persons from practising medicine, dentistry and surgery, section 36 of the Act allows for the practice of any system of therapeutics by persons recognised by their communities as duly trained in such practice provided that the practice is limited to that person and their community. In the same spirit, the WHO (2001) states that the Ugandan Health Review Commission of 2000 recommended that the ministry of health must work closely with THs, especially by incorporating them into community health teams.

#### **2.4.6.5 South Africa**

A study by Peltzer et al (2006:688) among 233 traditional healers in four district of KwaZulu-Natal province of South Africa found that after 7-9 months after receiving HIV/AIDS, STI, and TB prevention training (over 3.5 days), traditional healers showed significant improvements in HIV knowledge and HIV and STI management strategies including conducting risk behaviour assessments and counselling, condom distribution, community HIV/AIDS and STI education, and record keeping. The study also found a high level of preparedness among traditional healers to work with and refer patients to biomedical health practitioners. Unfortunately, no higher levels of referral by biomedical practitioners were found after the training. This was attributed to different clinical and ethical standards between BHPs and THs as has been discussed in section 2.3.2.1. This difference was also reported by other studies (Chifakacha, 1997; Mills et al 2006; Burnett et al, 2007; Meel 2010).

According to (Colvin *et al*, 2001) the state of poor relations and misunderstandings between the Department of Health healthcare workers and traditional healers often hampers the improvement of the care and treatment of South Africans with HIV/AIDS. Gqaleni et al (2011:12) also reports on another collaboration project carried out by the University of KwaZulu Natal and the EThekweni Municipality's health department to establish strategic collaboration between public health clinics and THPs in 3 districts of eThekweni, Umgungundlovu and Ilembe. The project's specific focus was on prevention and referral for voluntary counselling and testing (VCT) and palliative care.

Gqaleni et al (2011:13) goes further to say that the project managed to establish a district and local government level collaboration with clinics and THPs. The success of the project lay in the willingness of THPs to promote HIV prevention (health promotion) to all their patients and communities. Here, THPs were willing to refer their patients to local clinics for HIV voluntary counselling and testing (VCT) and to offer palliative care service (home-based care). One of the key success factors for this project is reported as having been the efforts put to ensure that the two systems (BHP and TH) have to learn about each other's practices.

In that way, a better understanding was eventually established leading to THs having an increased amount of biomedical knowledge of HIV and AIDS by providing them with an alternative perspective of the disease. At the same time, THs were willing to promote HIV prevention (health promotion) to all their patients and communities as well as referring their patients to local clinics for HIV voluntary counselling and testing (VCT) and to offer palliative care service (home-based care). In a reciprocal manner, the BHPs also began to acknowledge that THs can contribute positively to South Africa's fight against the spread of HIV and thus referred patients to THs who have special knowledge in certain diseases including for the purposes of supporting patients taking either ARVs or TB treatment.

## **2.5 PERCEPTIONS OF TRADITIONAL HEALERS ON COLLABORATION**

In its "*Best practice collection on collaboration between THs and BHPs*", UNAIDS (2006:28) says that a number of common determinants or factors that are associated with successful collaborative initiatives between traditional medicine and biomedicine have been documented and presented as guidelines to inform the planning of successful collaborations. UNAIDS (2006:28) says that these factors have been selected for their universal relevance and their practical usefulness in planning, implementing and evaluating different collaborative projects. They include:

- Building mutual respect between biomedical and traditional health practitioners;
- Stressing the complimentarity of both systems;
- Showing humility;
- Cultivating transparency;
- Selecting 'genuine' healers;
- Involving community leaders and members;
- Involving mainstream biomedical health workers;
- Planning for a long-term collaboration;
- Discussing differences and conflicts in world views;
- Discussing the evolution and changes in both health systems;
- Forming a dedicated and caring team;

- Collaborating with local institutions;
- Opening/running or advocating a collaborative clinic;
- Including herbal research and/or provision of herbal medicine;
- Adopting a comprehensive 'training' approach; and
- Including a strong monitoring and evaluation component.

In this study on collaboration between THs and BHPs, the researcher reviewed literature from the evaluations of two projects from Tanzania and South Africa that were developed and implemented along the UNAIDS guidelines in order to get an idea of the kind of perceptions that the participating healers had about collaboration.

### **2.5.1 Tanzanian experiences**

Evidence learned from a collaborative research project carried out in Tanzania by Kayombo et al (2007:11) shows that the participating traditional healers were generally receptive to the idea of collaboration. They also demonstrated eagerness to learn more about the epidemiological process around HIV/AIDS. However, THs also generally exhibited a sense of being suspicious especially around issues of their indigenous knowledge on traditional medicines for fear of being stolen by western-trained medical professionals. The second challenging perspective by healers was that they felt like they were still generally being considered as witches, criminals, quacks and charlatans by BHPs, as was the case during colonial times. On the other hand, the BHPs who participated in the Tanzanian project were also generally willing to collaborate with the traditional healers.

Most of the BHPs who were in this study were more than willing to become partners with THs although they remained very sceptical on the belief by healers that HIV/AIDS was man-made. This is because such beliefs are not in line with the theory of HIV/AIDS causation in biomedicine. These experiences coming out of the Tanzanian project clearly show that the initiation of collaboration based on the UNAIDS best practice collection guidelines takes a lot of time, effort and resources.

It requires patience and tact in order to facilitate that each party (traditional healers or western medicine professionals) learns from the other in every possible way on how they can best collaborate. Kayombo et al (2007:15) says that it is imperative to encourage western-trained medical practitioners to learn to value and respect the contributions of traditional healers in the prevention and management of HIV/AIDS so that they genuinely enlist their services. Dialogue between traditional healers and western medical professionals was noted to be important in alleviating mistrust, building confidence, providing knowledge, and leading to a coordinated approach for controlling HIV/AIDS and other opportunistic infections.

### **2.5.2 South African experiences**

In the AMREF project implemented along the UNAIDS guidelines in KwaZulu Natal, some traditional healers interviewed during the final evaluative research survey stated that their standing within the community had improved and their relationships with the doctors and nurses had changed from ‘bad’ to either ‘fair’ or ‘good’ after the opportunity to collaborate. These healers also said that they had begun to interact with BHPs more frequently than before the project (AMREF 2007:27).

In the same breath, biomedical health practitioners collaborating with those traditional healers in the AMREF project reported having been greatly inspired and motivated by the rapid change in healers’ attitudes from mistrust to interest and also by the amount and quality of work that traditional healers were able to do after training (AMREF 2007:41). However, THs still felt being undermined by the western medicine health care. As an example, they highlighted how they never received any feedback from clinics about clients that they refer for assessment and treatment. In that regard, they felt that the referral system was a one-way, with western medicine not referring to THs cases that they were unable to help.

The examples cited from both South Africa and Tanzania show that collaborative initiatives need to focus on the important element of both parties learning the value of cooperating with each other if they are to create a meaningful relationship that ultimately benefits their patients.

It is therefore a question of each party having the right perception of collaboration. On the same note, these examples from both Tanzania and South Africa clearly demonstrate that despite the guidelines put forward by UNAIDS (2006), there remain serious challenges to the process of strengthening and sustaining collaboration between THs and BHPs.

The literature review the researcher conducted for the current study went further to explore the elements of mistrust, disrespect and fear of competition for clients/patients as these came out strongly as reasons for poor collaboration in both Tanzania and South Africa. This is dealt with in the sections that follow: sections 2.6.3 to 2.6.5.

### **2.5.3 Mistrust**

In most cases, established researchers do not work with healers as co-researchers but mere subjects or participants. It is therefore not surprising that most THPs perceive collaborating with BHPs in research initiatives as exploitative on their part where the western-trained health workers are bent on stealing their traditional medicine knowledge for their own gain. According to the HSRC (2009:7), the National Departments of Arts and Culture, Science, and Technology usually fund consortium research projects into traditional medicines and indigenous knowledge (Gqaleni (2011:3). Peltzer (2001:684) and Richter (2003:10) agree with this observation by saying that there is generally a lack of trust between traditional healers and biomedical health professionals. Kayombo et al (2007:18) says that from the Tanzanian experience, the sustainability of collaboration where there is no mutual understanding is highly questionable.

Gqaleni et.al (2011:13) goes on to say that such research projects encourage principal researchers to further exploit knowledge holders and do not emphasize on collaborative research to empower the healer economically and through capacity building. Inadequate protection of traditional medicine knowledge and intellectual property rights can result in scepticism by traditional healers to biomedical approaches for documenting bioactivity of traditional plants.

Kangwa and Catron (2010:2) also say that the tension that exists between traditional healing and western medicine is historically based on the lack of trust and mutual understanding where the early missionary doctors from America and Europe discarded traditional healing, beliefs and practices of the locals as belonging to the devil.

Given this insight, this researcher was very conscious of the potential for mistrust by the participating healers. It was therefore crucial that the participants fully understood that the findings of this research were not entirely for academic purposes but could also provide maximum benefits or makes meaningful contributions to HIV/AIDS and TB management programs as well as contribute to the advancement of knowledge on improving the understanding of the contextual issues around collaboration between THs and BHPs in health service delivery.

#### **2.5.4 Disrespect**

Kangwa and Catron (2010:8) state that some western medical and nursing professionals believe that other cultures do not have anything special to offer in the medical field. Such lack of humility has a potential to negatively affect collaboration between THs and BHPs. For example, Thindisa & Seobi (2009) (of the Doctors for Life International-a body that represents about 1,300 medical doctors) says that they only recognise medical doctors, specialists, dentists, veterinary surgeons, and professors of medicine from various medical faculties across South Africa and abroad who demonstrate sound science in the medical profession. Such groups maintain that the practices of traditional healers are not based on empirical truth and licensing them will have a negative impact on patients and the economy of South Africa. Masauso, Romano, Anyangwe, Wiseman, Macwan'gi, Kendall, & Green (1996:3) noted that this perception is an unresolved issue with traditional healers because they are often perceived by modern medicine as treating only symptoms of diseases, but not curing them.

### **2.5.5 Competition**

According to the Health Systems Trust (2011:187), the trade in traditional medicines in South Africa is estimated to be worth R2.9 billion per year, representing 5.6% of the National Health budget. The trade is vibrant and widespread boasting around 27 million consumers. Traditional medicine is affordable and easily accessible to most poor people who can even negotiate to pay in kind or easily arranged terms. Given that most healers solely make a living out of the traditional healing practice, some of them may find it difficult to refer suspected HIV and TB patients to health facilities due to fear of losing out on business. This may mean that BHPs are viewed as competition by THs.

The THs' perception of competition from western medicine is exacerbated by the general tendency of most BHPs not to refer back to THs those patients that they would have initially referred to them. In the AMREF evaluation report (2007:41), THs highlighted how they never receive any feedback from clinics about clients that they refer for assessment and treatment. They felt that the referral system was a one-way one, where western medicine was not referring back to THs.

## **2.6 ETHICAL AND REGULATORY ISSUES REGARDING TRADITIONAL HEALING IN THE CONTEXT OF HIV/AIDS**

Nyika (2006:31) strongly argues that although traditional healers have been playing a major role as providers of primary health care to the majority of people in Africa, users of traditional medicine are exposed to harm because active components had not been scientifically identified and proved efficacious. In the same line of argument, the National Drug Policy (South Africa, 1996:26) says that those traditional medicines that are being marketed must be registered and controlled through a national reference centre for traditional medicines. Nyika (2006:31) goes further to cite a list of disadvantages of advocating for the recognition of African traditional medicine especially in the fight against HIV/AIDS. Some of such shortcomings include:

- That the herbs are generally used as crude mixtures without adequate information about safe dosages and potential harmful side effects.

- That the patients may be used for ‘experimentation’ without their knowledge or consent.
- That the privacy and confidentiality of the patients could be compromised since the consultations at the traditional healers usually involve families rather than individuals; and in some cases, the sick person does not even go to the healer but family members go on their behalf.
- That since there are no scientifically proven traditional methods of detecting HIV infection, patients presenting to traditional healers may have their diagnosis delayed. This may mean that infection may have spread to many other sexual partner(s) and thus increase HIV incidence rates before the correct diagnosis is made.

Although Nyika (2006:33) puts up a very strong argument that such practices by THs violate almost all the ethical principles of justice, autonomy, confidentiality and beneficence and non-maleficence; other scholars such as Tangwa (2007:41) counter argues this. Tangwa says that it is not fair and right to compare western scientific medicine with African traditional medicine. Tangwa’s argument is based on a number of considerations that include:

- That such comparison is a recipe or prescription for invasion, colonisation and exploitation that characterises the relationship between the western world and Africa.
- That traditional African medicine has its own ethos and values that guarantees patient protection in a similar or better way than the Nuremberg code.

Tangwa’s major argument point is that there is no need to ostracize a health care system that takes care of the needs of almost 80% of the African population (traditional healing) and hail a health care system that only takes care of 20% of the African population (western biomedicine). Both THs and BHPs can comfortably exist side by side in a complimentary manner, as has been the case in Tangwa’s Cameroonian village of Shisong. The way in which the current study on collaboration between THs and BHPs dealt with ethical issues related to working with traditional healers is discussed in full in chapter 3 under research design.

## **2.7 CONCLUSION**

This chapter has discussed literature that was reviewed and is related to the topic of traditional healers' perception on collaborating with biomedical health professionals in HIVAIDS and TB programs. The reviewed literature indicates that Traditional Healers (THs) constitute an important resource that has a potential to improve access to comprehensive HIV prevention, care, treatment and support for HIV/AIDS and TB through various entry points. The researcher managed to search deep on issues surrounding collaboration under 4 major themes of an overview of traditional healing, legislative provisions for traditional healing, concept of collaboration and perceptions of THs on collaboration. The next chapter (4) focuses on the research design for this study.

## CHAPTER 3

### RESEARCH DESIGN AND METHODS

#### **3.1 INTRODUCTION**

This chapter fully describes the research design and methods that was followed to answer the research question. the researcher provide details on the methods of sampling, data collection and data analysis as well as details on ethical considerations and the measures the researcher took to ensure trustworthiness.

##### **3.1.1 Research aim/purpose**

The purpose of this study was to explore and describe perceptions of THs collaborating with BHPs in health service delivery, and gain an understanding of underlying reasons for THs dropping out of collaboration with BHPs in HIV/AIDS and TB programs. The findings of the study highlight areas that need further investigation or assessment in improving sustainable collaboration between the AMREF training program and trained THs and BHPs in the context of HIV/AIDS and TB treatment programs. This understanding might assist in recruiting and sustaining THs into health programs.

##### **3.1.2 Research objectives**

The specific objectives the researcher had in mind for this study were to:

- Explore the perceptions of THs in collaborating with BHPs in HIV/AIDS and TB programs.
- Describe the context in which THs collaborate with BHPs through the experiences of research participants.
- Identify reasons underlying THs dropping out of collaboration with BHPs in HIV/AIDS and TB programs.

### **3.1.3 Research question**

Based on the problem statement, the researcher sought to answer the following research question directed at traditional healers: "How did you experience your collaboration with BHPs in HIV/AIDS and TB programs?"

## **3.2 RESEARCH PARADIGM**

The researcher chose the qualitative research paradigm for this study to explore and describe traditional healers' (THs) perceptions and experiences on collaboration with biomedical health professionals (BHPs). Qualitative research is a form of social inquiry that focuses on the way people interpret and make sense of their own experiences and settings. This view is supported by Padgett (2008:15), who says that a qualitative study is that type of inquiry where the understanding of a social or human problem is based on exploring a topic about which little is known - especially from the "insider" perspective. Bailey (2007:2) describes a qualitative study as a systematic inquiry carried out through face to face interactions and observations in order to understand daily life from the perspectives of people in that setting. Kumar (2011:104) states that qualitative research is a deductive process the focus of which is to understand, explain, explore, discover and clarify situations, feelings, perceptions, attitudes, values, beliefs and experiences of an individual or a group of people. All of these definitions point at qualitative research as a form of inquiry that seeks to gain understanding of a phenomenon by closely looking at people's words and actions in their natural environment.

### **3.2.1 Characteristics of the qualitative research paradigm**

Both Padgett (2008:16) and Holloway (2008:6) mention the generation of textual data, extensive interaction with participants, flexible plan of inquiry and reflexivity as key characteristics of the qualitative research paradigm. This is corroborated by Babbie and Rubin (2011:446) who say that flexibility and naturalism are central features of qualitative research. These characteristics emphasize the importance of looking at research variables in the natural setting in which they are found.

In this study, the researcher collected data through open ended questions during face-to-face interviews. The researcher thus formed an integral part of the whole research process.

### **3.2.2 Rationale for the qualitative research paradigm**

Padgett (2008:45) and Speziale and Carpenter (2011:114) say that the choice of the research design is mainly influenced by the research question, the sensitivity of the subject matter and the availability of resources. Given this description, the study on perceptions of THs on collaborating with BHPs seemed to be well suited to descriptive, contextual, qualitative research. In the context of poor sustainability of collaboration between THs and BHPs in HIV and TB programs, the researcher believed that the THs themselves could accurately portray the true picture based on their experiences. This meant that the researcher could only ‘know’ about collaboration through observing or hearing from the participants (THs). Based on the saying that “you better *hear it from the horse’s mouth*”, there was certainly no better source of information about collaborating with BHPs than the healers themselves. There was certainly no better way of describing perceptions other than through the lived experiences of the traditional healers. The researcher thus deemed a qualitative study best suited to answer the research question.

## **3.3 RESEARCH DESIGN**

In this section, the researcher describes the overall plan he used to address the research question. The researcher also goes to length to explain and justify the measures he took to enhance the integrity of my study. According to Parahoo (2006:119), the design selected for research should be the most suited to answer the research question. Kumar (2011:119) defines the term research design as a procedural plan that is adopted by the researcher to answer questions vividly, objectively, accurately and economically. The above stated views are corroborated by the Business Dictionary (2012:1) which says that the research design details an outline of how an investigation will take place. This means that a research design includes the way that participants are to be selected, the type of instruments to be used, data collection and approach, analysis and communicating findings.

### **3.3.1 Rationale for the chosen design**

As has already been alluded to in the earlier sections of this chapter, the researcher chose a descriptive, contextual qualitative design because it seemed to be better placed to assist me in exploring and describing THs' perceptions regarding and experiences of collaborating with BHPs. Cooper and Endacott (2007:816) state that a qualitative descriptive and contextual study design is the one that "seeks to discover and understand a phenomenon, a process, or the perspectives and worldviews of the people involved". In the same vein, Padgett (2008:15) says that qualitative descriptive and contextual approach to research is the one in which the researcher often makes knowledge claims based on "lived experiences" of the research participants. This approach helped me to understand the research topic in its natural (contextual) settings.

### **3.3.2 Characteristics of the chosen research design**

In order to provide a better understanding of the chosen design, I discuss a range of characteristics of qualitative descriptive and contextual research in the sub sections that follow.

#### **3.3.2.1 Interpretative**

According to Bowling (2009:380), qualitative descriptive and contextual research is largely interpretative. Interpretation means assigning significance to, or a coherent meaning of something (Neuman (2012:94). This approach allows researchers to explore behaviours, perspectives, feelings and experiences in an in-depth and holistic framework. Padgett (2008:15) confirms this view by emphasising that qualitative descriptive and contextual research helps the researcher to make knowledge claims based on "lived experiences" of the research participants. In qualitative descriptive and contextual research, the researcher seeks to establish the meaning of a phenomenon from the views of research participants. Streubert and Carpenter (2011:20) say that commitment to participants' viewpoints is another characteristic of qualitative descriptive research.

The qualitative descriptive and contextual approach requires that once the concepts have been described using data collected from the research participants, the researcher then interprets the meaning and then finally comes up with conclusions about that particular phenomenon or problem situation. In this study, the researcher used the individual experiences of participants to construct meanings around the question of collaboration between THs and BHPs.

### **3.3.2.2 Non-manipulative**

One of the main characteristics of the descriptive and contextual approach is the non-manipulation of variables that are involved in the study. According to Streubert and Carpenter (2011:22), this type of research requires that there be no disturbance to the natural context of the phenomenon being studied. Holloway and Wheeler (2010:4) concur to this view by saying that it is important to respect the context and culture in which the study takes place without any manipulation. In a descriptive and contextual design, the study variables are looked at in their natural environment without any form of comparison, control or treatment (Holloway and Wheeler, 2010:4). In this study on the question of collaboration between THs and BHPs, the researcher did not attempt to manipulate the context or to check if there would be any difference in collaboration within different settings such as economic, social, or technological environments.

### **3.3.2.3 Flexibility and contextualisation**

The other main characteristic of the descriptive and contextual design is found in its flexibility concerning data collection procedures (Bowling, 2009:387). Flexibility, unobtrusiveness and unlimited data sources make the descriptive design the best choice for this study on collaboration between THs and BHPs. Similarly, this design's sampling approach is generally non-probabilistic where the researcher uses his/her knowledge of the study population to select the sample that will best represent the phenomenon being studied (Padgett, 2008:19). My involvement in AMREF thus positioned me favourably.

All the authors cited here concur that qualitative descriptive and contextual approach allows the researcher to draw data from an unlimited variety of sources that go beyond what was planned. The totality of the environment in which the participants are found is a potential source of data that can be used to describe the problem under investigation. It is also a design that accommodates the unexpected and unintended findings since the research questions are open-ended (Burns & Grove, 2010:351; Polit & Beck, 2010:16). It allows participants to say what they feel and believe in without the pressure of responding to controlled and guided questions. In this way, the researcher was most likely to come up with the most honest interpretation of the situation as participants were at liberty to talk at length and depth about their experiences and viewpoints; the subject matter of this research.

### **3.3.2.4 Intensity**

Although qualitative descriptive and contextual studies tend to be straight forward, they nevertheless demand intensive data collection and interpretation in order to ensure credibility and dependability of findings. Streubert and Carpenter (2011:21) emphasise the need for the researcher to commit to extensive and in-depth data collection in order to obtain the most accurate representation of reality as per the participants' views. Similarly, Holloway and Wheeler (2010:6) emphasise the need for "thick description" where the researcher goes beyond the surface by providing detailed portrayals of participants' experiences. According to Neuman (2012:312), the level of intensity of data collection is measured by data saturation. The researcher discusses the concept of saturation in full in section 3.4.2.3 below.

## **3.4 RESEARCH METHODS**

The research method describes the technique used to investigate or search for knowledge Kumar, 2011, Babbie and Rubin, 2011 & Polit & Beck, 2010). The research method includes elements such as population, sampling, data collection and analysis.

### **3.4.1 Drawing a sample**

A number of concepts relating to sampling such as population, target population and accessible population need to be clarified before sampling can commence.

#### **3.4.1.1 Population**

According to Kumar (2011:398), population means the entire group of units which is the focus of the study or the entire set of objects and people that are the object of research and about that which the researcher wants to determine some characteristics. Babbie and Rubin (2011:627) also define population as “the group or collection that a researcher is interested in generalising about”. The population is a collection of individuals who belong to an organisation or group that the researcher wants to research. This is also known as the study population. The population for this study consisted of all the THs in UMkhanyakude District who were involved in the AMREF program and then stopped collaboration with biomedical staff after receiving training. There were 25 traditional healers in the project who make up the population for this study.

#### **3.4.1.2 Target population**

Polit and Beck (2008:258) state that the target population is the “total number of people or elements that fit the specific set of specifications of the study”. This is also defined by the Medical Dictionary (2012:1) as a term that refers to the population from which the researcher wishes to draw an unbiased sample and make inferences about it. According to Metterns (2009:345), the target population is the one about desirable information. The target population for this study was all 25 THs from UMkhanyakude District who were trained but had stopped supporting collaboration with BHPs in the AMREF project. .

#### **3.4.1.3 Accessible population**

The accessible population is defined as all subjects that are available for a particular study-often a non-random sub-set of the target population (Mertens 2009:347); the group of people that the researcher is able to interview or collect data from in the research.

It is that portion of the population to which the researcher has reasonable access to (Johnston and Christensen, 2012:316). The accessible population for this study was those THs from Mtubatuba municipality in UMkhanyakude district who were available and willing to participate in the study even though they had broken ranks with their health facilities. This is the group that the researcher had access to and was available to be studied.

### **3.4.2 Sampling**

Sampling is the purposeful selection of an element of the population from which to gain knowledge or information (Holloway and Wheeler, 2010:137). Neuman (2012:313) calls it “selecting some cases to examine in detail” whilst Barbie and Benaquisto (2010:508) refer to sampling as the process of selecting a few elements from the population to represent the entire population. The elements of sampling method, inclusion/exclusion criteria, size and ethical considerations are central to the process of sampling.

#### **3.4.2.1 Sampling method**

The researcher used purposive sampling (non-probability) by recruiting participants from the THs who dropped out of the programme after having been trained and supported to collaborate with BHPs in the AMREF HIV/AIDS and TB program. Purposive sampling is defined by Kumar (2007:206) as judgmental. This means that the researcher goes to those people who in his opinion are judged to be best positioned to provide the needed information for the study. The researcher selected the participants by using his knowledge of who had dropped out of collaboration having been trained by the AMREF project. Barbie and Benaquisto (2010:508) say that purposive sampling is the non-probability selection of participants where the researcher selects the participants based on judgment about whom will be the most useful or representative. It requires that there be clear inclusion and exclusion criteria: (a concept that is explained in 3.4.2.2).

Polit & Beck (2010:312) go on to elaborate that purposive sampling is a type of non-probability sampling in which the researcher consciously selects specific elements or subjects for inclusion in a study to ensure that the elements will have certain characteristics that are relevant to the study. The researcher combined purposive sampling with elements of quota sampling to ensure that the different traditional healers' categories that operate within the confines of the 5 clinics of Mtubatuba local municipality of the UMkhanyakude district were included in the study to enhance credibility and dependability of findings. Quota sampling refers to segmenting the study population into mutually exclusive sub-groups (Polit & Beck, 2010:179; Kumar (2007:208).

The researcher chose purposive sampling (*a type of non-probability sampling*) for this study. This type of sampling has its own limitations as well as advantages. Its major disadvantage is that it does not allow for generalization from the sample to the population, as there is no format for calculating sampling error. Again, it does not guarantee accurate representativeness of participants. However, non-probability sampling provides for wider and in-depth understanding of the phenomenon being studied. It is also less expensive and is, consequently, time saving. The limitations of non-probability sampling can be mitigated by having clearly defined inclusion/exclusion criteria as discussed in 3.4.2.2 below.

### **3.4.2.2 Inclusion and exclusion criteria**

The first thing the researcher did regarding purposive sampling was to verify that the participants met the criteria for selection into the sample. This is known as inclusion criteria or the reasons why a person may/may not qualify for participation in a study (Medical Dictionary 2012). In this study, the THs whom the researcher interviewed needed to have had training and post training support from the AMREF HIV/AIDS and TB project. They also had to have started on some form of collaboration with BHPs and must have discontinued such collaborate. This was done in order to ensure that the researcher obtained the opinions of those THs with sufficient information about the collaboration program and reasons for stopping collaboration.

The THs who participated in this study needed to be registered with the THO which is the official body for all “genuine healers” and were therefore officially recognised by the Government. Another exclusion-inclusion criterion for the participants was that they needed to be residing not more than 5km from the local health facility. This was done to exclude the factor of long distance being the reason for their stopping collaboration with BHPs. The study excluded any healer who was not trained and supported by the AMREF HIV/AIDS and TB program, as well as those healers who were still collaborating with BHPs at the time of data collection. This was done to keep me focused on the research question and problem of why THs dropped out of collaboration with BHPs in HIV/AIDS and TB programs.

#### **3.4.2.3 Sample size**

In qualitative descriptive and contextual studies, sample size is immaterial (Holloway and Wheeler, 2010:146). Instead, the focus is on the quality of the information that is obtained from the participants. This means that it is sufficient to have a few participants who provide high quality data that provide a full insight into the research problem. Kumar (2011:398) says that in qualitative descriptive and contextual research, such as this one on THs collaboration with BHPs, researchers are usually guided by the concept of “saturation” or redundancy which refers to the stage in data collection where very little or no more new information is coming out of the participants. Holloway and Wheeler (2010:146) explain that data saturation implies informational redundancy which means that no more new concepts or dimensions of the study variables are emerging.

The researcher selected a convenient sample size of 6 THs from those who had stopped collaborating with BHPs after having been trained based on the inclusion/exclusion criteria described under sampling method in 3.4.2.2. This sample size was decided through the belief that the researcher will hear most or all of the perceptions about collaboration that are important from the 6 selected participants. The study collected data through in-depth, semi-structured interviews from 6 THs based on the principle of saturation.

#### **3.4.2.4 Ethical issues related to sampling**

The ethical principles of autonomy, justice, beneficence and non-maleficence must apply to the sampling process. Ethics are defined by Kumar (2011:432), Van der Wal (in Pera & Van Tonder 2005:151) and Resnick, (2011:1) as carrying out research in accordance with principles of accepted codes of conduct of a given profession or group or norms for conduct that distinguish between acceptable and unacceptable behaviour. It is about carrying out research in a morally justifiable manner. The researcher carried out the sampling procedure for this research in full conformity to the ethical principles as detailed in this section:

##### **3.4.2.4.1 Autonomy**

- The researcher fully respected the THs' rights of free choice and ensured that informed consent was secured in writing before doing the interviews.
- The researcher provided the selected participants with full information about the study through the consent form (Appendix C): pointing out the study's purpose, the procedures to be used, and the voluntariness of participation including the right to withdraw at any stage of the interviews.
- The researcher also assured participants' confidentiality and protection of their identities, as he did not leave any link between the person and the tape-recorded interview or the later transcript.
- The researcher also ensured potential participants that their refusal to participate would not lead to any penalties.

##### **3.4.2.4.2 Justice**

- The researcher did not discriminated against any participant be it through the selection criteria as all those who met the inclusion criteria were approached and requested for a voluntary interview. A quota sampling approach was applied to ensure that the sample was adequately representative in terms of TH categories (*3 herbalists and 2 diviners*), geographic areas (*1 healer per clinic catchment area*), age (*3 were above 30 years of age and 2 below the age of 30*) and gender (*3 females and 2 males*).

- The researcher assured all participants of full protection for their identities and privacy.
- The researcher allowed participants the right to terminate the interview at any point should they so wished without them suffering any negative consequences.
- The researcher also avoided all forms of bias against participants during and after the interviews including in the research report.

#### **3.4.2.4.3 Beneficence and Non-maleficence**

- The researcher took due care to ensure that no part of the sampling process would cause any harm to the participants.
- During the sampling process and throughout the study the researcher guarded against any harm, risk or embarrassment to the participants; including any form of discomfort, anxiety, harassment, invasion of privacy or demeaning or dehumanising procedures.

If there would have been any occurrences, the researcher would have recorded them in the field notes and reflected upon during data analysis as well as reporting them in the results section (chapter 4).

#### **3.4.3 Data collection**

Holloway and Wheeler (2010:322) emphasise that in qualitative research, “the methodology is of particular interest because the researcher is the main research tool” and therefore must be explicit about the path of the research so that readers know the details of the design, biases, relationships and limitations. This requires a detailed description and explanation of the data collection method, instrument and the process itself including ethical considerations.

### **3.4.3.1 Data collection approach and setting**

Research data in qualitative research are often collected through unstructured or semi-structured plans that allow for extensive interaction or exploration usually with a small group of participants through open ended interviews and detailed taking of notes (Neuman, 2012; Kumar 2011and Polit & Beck, 2008). In this study, the researcher used semi-structured interviews to gather information in the natural setting. The setting for this study was in the homesteads of the THs where they operate from. All the 6 participants offered a quiet room to provide a natural setting that is free from any distractions. Before each interview began, the researcher asked the participants for their permission to be interviewed and then followed up this with the explanation of consent and subsequent signing of the consent form. This was done with the view to conform to the ethical principle of autonomy as explained in 3.4.3.4.1.

#### **3.4.3.1.1 The interview approach**

The researcher chose to use the semi-structured interviews with the selected participants (see appendix D). The Business Dictionary (2012:1) defines an interview as a formal discussion between a researcher and a participant or participant. This discussion is typically in person; where information is exchanged with the intention of establishing the participant's opinions or views about the subject being researched. Kumar (2011:144) describes an interview as a verbal interchange, often face to face in which the interviewer tries to elicit information, beliefs or opinions from the participant. Polit and Beck (2008:124) agree with these views by saying that interviews allow the researcher to observe non-verbal communication as well as allowing both the interviewer and participant to seek any clarifications where necessary. The researcher chose semi-structured interviews to allow participants to discuss their opinions, views and experiences in full detail. According to Brink, Van der Walt & Van Rensburg (2012:152), a semi-structured interview allows the researcher to ask certain specific questions and follow up probes. The questions in the interview guide were pursued in depth.

### **3.4.3.1.2 The interview guide**

In this study, the researcher was the main data research instrument using an interview guide to direct me. (See section 3.4.3.3 on how the researcher dealt with the element of reflexivity where the researcher is the main data collection instrument.) Kumar (2011:389) defines an interview guide as a list of issues, topics, or discussion points that the researcher wants to cover in an in-depth interview. It is a document that the researcher or interviewer uses to help direct the conversation toward the topics and issues they want to illuminate. Interview guides vary from highly scripted (structured) to relatively loose (unstructured and semi-structured).

Whichever type of interview guide is used, they all need to be able to help the researcher to know what to ask, in what sequence, how to pose the questions and follow-ups. The interview guide provides guidance about what to do or say next after an interviewee has answered the last question. Streubert and Carpenter (2011:34) quote Robinson (2000) as saying that the open ended interview strategy is considered as the gold standard in qualitative research. It usually uses one or more lead questions to guide the conversation which usually features audiotape and verbatim transcription of data.

In this study, the interview guide comprised a list of questions that was drawn around issues of the research question and objectives with the aim to ensure that there was consistency and standardisation in questioning. (See appendix D for sample of the interview guide). The interview guide provided me with options to record the biographical and geographic information of participants as well as the length or duration of time that they collaborated with BHPs in the AMREF HIV/AIDS and TB program. The lead question was plain and simply focused on getting the participants to describe their experiences and perceptions on collaboration with BHPs.

Several follow up questions were consciously on my mind with the view to ensure that participants gave full and detailed explanations and examples of their experiences and perceptions. The researcher designed the lead question in such a way that the participants would be free to expand on the subject matter as they saw fit and relate their own experiences about collaboration with BHPs.

The researcher only intervened to follow up on hints and cues given by interviewees and to encourage them to clarify and elaborate where necessary. The researcher was constantly alert not to guide interviewees to keep to the research topic. Towards the end of the interview, the researcher asked interviewees to provide recommendations on how best collaboration between THs and BHPs can be sustained beyond the training phase of a program.

### **3.4.3.1.3 Advantages and disadvantages of using an interview guide**

According to Streubert and Carpenter (2011:36), Kumar (2011:387) and Polit and Beck (2008:392), some of the advantages of using an interview guide include being able to collect data even if the participant lacks reading skills to answer a questionnaire. The interview guide is very useful for untangling complex topics and helps the interviewer to probe deeper into a response given by an interviewee. All the authors cited above say that the disadvantages of using interview guides include the need for prolonged engagement with participants and thereby not being able to collect data from large numbers of people.

Inexperienced interviewers can find it very difficult to use an interview guide and instead resort to asking leading or close-ended questions. In this regard, the researcher was very cautious and alert throughout the interview process to avoid asking leading questions. He also planned to conduct one interview per day in order to accommodate prolonged engagement with interviewees. Prior to conducting the actual interviews, the researcher had also practised the art of putting questions across to participants without asking leading or close ended questions. The researcher did this himself through practising putting up questions to imaginary participants or interviewees.

### **3.4.3.1.4 Development and testing of the data collection instrument**

After the researcher had developed and discussed the interview guide with his supervisor and peers, he pre-tested it with a convenient sample of 2 participants who were outside the study area of Mtubatuba municipality.

These participants were a man (herbalist) and a woman (diviner) who voluntarily agreed to help test the instrument (interview guide-refer to appendix 3). According to Neuman (2012:122), pre-test of research instruments helps to improve the trustworthiness of findings since all the pitfalls and shortfalls of an instrument can be identified well before the actual data collection and can therefore be fixed. The pre-test also gave me the necessary experience to administer the interview and to involve myself in the data collection process as the main research instrument. After the pre-test, the researcher reviewed the structure and wording of the interview guide in close consultation with my supervisor to eliminate some of the challenges he experienced.

Whereas the original interview guide had 13 direct questions, the final one (appendix 3) had only 4 with the rest being used as follow up questions based on how the participants responded. The challenges the researcher encountered included clarity of questions, the sequence of questioning and the re-adjustment of the time frame to complete each interview.

### **3.4.3.2 Conducting the interviews**

Each interview lasted between an hour and one and a half hour. Each of the participants was interviewed at the initial stage and then was consulted again after the completion of data analysis to validate the interpretation of their responses. The initial interviews were audio recorded and then transcribed verbatim. Depending on how participants responded to the main research question on their “*experiences on collaborating with THs in an HIV/AIDS and TB program*”, I used a series of follow up questions and extensive use of probes to elicit more detail, elaboration and clarification about participants’ experiences. The researcher picked up cues and clues from the responses (including non-verbal cues to follow up on the main questions. Some of the most frequently used probes included the following:

- *In your opinion, what would be the ideal situation around collaboration between THs and BHPs?*
- *Can you give an example of what you are talking about?*
- *I am not sure if I understood you well; what do you mean by being cheated?*

- *Can you please help me understand that better, and maybe give some examples?’*

During introductions at the data collection phase, the researcher clearly pointed out to participants that although he was employed by AMREF, the research was a relatively independent project largely driven by the researcher's personal and academic interests. However, the findings were still expected to benefit all the concerned parties (AMREF, DOH and THPs) in one way or the other.

### **3.4.3.3 Interviewer self-reflexivity**

Pezalla, Pettigrew and Miller-Day (2012:166) say that the level of researcher involvement in qualitative research “embodies the researcher as the instrument for qualitative data collection”. This means that the human person (the researcher) is the primary data collection instrument. This observation calls for researcher reflexivity throughout the research by reflecting on how the interviewer affects the development and outcome of all phases of the research, most notably the interview process. The Forum for Qualitative Social Research (2003:11) says that reflexivity is an explication of the researcher's impact on the research process. It explains the relationship between the researcher and people being studied. The presence of the researcher affects the people being studied (Hawthorne Effect!) and implies that the researcher should control his reactions to participants' views. The people studied also influence the researcher. Reflexivity in qualitative research also pertains to the requirement that the researcher thinks about what he or she has found as well as the process of doing research.

Reflexivity is an important factor in the interview approach because the researcher is an integral part of the whole research process. In an analysis of their own research work, Pezalla, Pettigrew and Miller-Day (2012:168) argue that unique researcher attributes can, and usually influence the way in which the researcher and participants interact during the data collection process. By analysing their own transcripts and audio recordings of interviews, the researchers established that characteristics or interviewing styles do affect the way interviewees respond to questions.

These attributes include interviewing styles or mannerisms such as demonstration of empathy, use of affirmations, maintaining neutrality, displaying naivety and employment of self-disclosure and interpretive tendencies. Reflexivity requires that the researcher must be aware of his/her own personal attributes since they can play a major role in determining the context and conduciveness of their interaction with the participants. An attribute such as interpretive tendencies or making conclusive statements on behalf of the participants (such as *completing sentences on behalf of the participants*) can inhibit participants and therefore least effective in discussing highly sensitive, risky or personal topics.

Throughout the research, and especially during the interview process, the researcher was very “sensitive” to the ways in which he could impact the research and the data collection process. This included his understanding, and bringing into consciousness, assumptions and experiences he held with regard to the research field and topic. This was particularly the case during this research where sensitive issues such as the stereotype of labelling most healers as bogus. It became very useful for me to have allowed these to surface; to acknowledge my value position, views and beliefs about the phenomenon of collaboration between THs and BHPs, the value the researcher attached to the success of the programme and the like.

Through the literature review and practical experiences of working with both THs and BHPs, the researcher had come to believe that each of the two groups wanted to protect the integrity and benefits on their practices and viewed the other party with at least a measure of scepticism. However, as advised by Speziale and Carpenter (2007:27-28) and Polit and Beck (2008:228), “bracketing” was extensively used where the researcher had to continuously and consciously suspend any preconceived notions or personal experiences that may unduly influence what the participants were saying.

At the same time, the researcher had to ensure that he equalized power differentials since the research participants knew that he came from AMREF who were the main sponsors of the project. The researcher emphasized that this time around, he was on a different mission where he wanted to learn from the research participants.

This is also part of the ethical principle of observing scientific integrity by letting the participants know in full about my objectives of the research project. Further to the researcher's self-reflection, see also the section on what he expected to find, what he did not expect to find and what he found conceptually interesting (section 4.4).

#### **3.4.3.4 Ethical considerations related to data collection**

In order to conform to the ethical principles of justice, autonomy and beneficence and non-maleficence, the researcher considered the following:

##### **3.4.3.4.1 Autonomy**

- Before beginning the interview, the researcher asked permission from the population for this study consisted of all the THs in UMKhanyakude District who had discontinued collaboration with BHPs participants to audio record the interviews and the researcher assured them of full anonymity, confidentiality and protection of their identities (see consent forms in both English and isiZulu (appendix C)).
- The researcher also informed the participants of their right to terminate the interview at any time during the process.
- The researcher also chose an environment and conditions in which the participants would feel comfortable, secure, and at ease enough to speak openly about their viewpoints. The researcher made sure that interviews were conducted in private settings within the healer's home where privacy was guaranteed by the THs themselves.

##### **3.4.3.4.2 Justice**

- The researcher remained highly conscious of all forms of bias against participants during and after the interviews and avoided them as fully as possible.
- The researcher treated the different categories of THs equally with no form of bias to any group, be they herbalists or diviners, male or female, young or old.

- During the entire research process and particularly during data collection, the researcher did not question or disrespect any part of the traditional healing or practice in whatever sense.
- The researcher acted professionally and remained focus on the scope and purpose of the study throughout.
- The researcher did not collect data on behalf of anybody else or for any reason other than for the purposes of this study.
- The researcher maintained impartiality and fairness in the manner in which he treated the research participants regardless of status, age, gender, ethnicity or citizenry.
- The researcher committed to uphold and protect the rights of the participants in every way possible.
- The researcher exercised reflexivity throughout the data collection and analysis as discussed in section 3.4.3.3 of this report.

#### **3.4.3.4.3 Beneficence and Non- maleficence**

- The researcher consciously guarded against any harm, risk or embarrassment he might cause the participants; including any form of discomfort, anxiety, harassment, invasion of privacy or demeaning or dehumanising questions, reactions or conduct
- The researcher carried out the research with the view to ensure that it provided maximum benefits or makes meaningful contributions to HIV/AIDS and TB management programs.
- The researcher assured participants that the findings of the research would be used to contribute to the advancement of knowledge on improving the understanding of the contextual issues surrounding collaboration between THs and BHPs in health service delivery; that their cooperation by way of providing honest and in-depth answers would help achieve this goal.

- The researcher ensured that interviewer privacy and confidentiality was maintained and that it was guaranteed throughout the research process by having removed all personal identifiers for transcripts and reports by using codes and pseudo-names where necessary. The researcher also used passwords to protect folders of stored data.
- The researcher ensured that the findings would benefit both the participants and their organisations.
- The findings of the research remained focused on the purpose of the study and did not negatively portray any institution or label it as incompetent or in any other disrespectful manner-be it AMREF, DOH, THO and other institutions or bodies that work with THs and BHPs. (See chapters 4 and 5).

### **3.4.4 Data analysis**

Babbie and Rubin (2011:419) refers to qualitative data analysis as a non-numeric process of examining and interpreting data in order to elicit meaning, gain understanding and develop empirical knowledge. Corbin and Strauss (2008:1) confirm this view by saying that qualitative data analysis entails working through textual data and organising it into meaningful units, synthesizing it, searching for patterns and coming up with themes and categories that help inform interpretations about the research questions or problem. In this study, the researcher used the qualitative content and thematic analysis approach to manage and analyse data according to Creswell's (2013:182-188) 5 step "data spiral" of qualitative research. The researcher started data analysis by first providing a clear description of the socio-demographic characteristics of the research participants. This was important in order to ensure that the data collected was placed in a clear context of who provided it, why and how they were selected and in what circumstances were they interviewed.

#### **3.4.4.1 Organising the data**

Since the researcher collected data through audio-recorded interviews, organising the data began by transcribing the audio recordings verbatim.

After having transcribed all the audio tapes, the researcher organised the data into individual files that he prepared on computer for easy storage and search of information. The researcher assigned a code to each interviewee and subsequent interviews, meeting part of my promise of anonymity.

#### **3.4.4.2 Reading and memoing**

The researcher then read the transcripts in their entirety several times with the view to get a good feel for it. He compiled notes based on the initial and first understandings of sections of the data; the units of meaning that emerged from the transcripts, or rather, my comprehension of the text. He achieved this by identifying key concepts and issues based on the research question and new insights that he developed based on the data coming out of the interviews.

#### **3.4.4.3 Content and thematic analysis**

Based on the syntax and coherence of the concepts emerging out of the memos, the researcher began content and thematic analysis by coding an aggregation of concepts into smaller units (categories). Babbie and Rubin (2013:273) say that in qualitative research, content analysis is a way of discovering patterns and meanings from data elements through coding or classifying data into conceptual frameworks. Neuman (2006:460) corroborates this view by saying that codes are tags or labels assigned to chunks of words, phrases, sentences or even whole paragraphs. Brief notes or memos are written about each category of data in the description step.

As put forward by Creswell (2013:186), analysing qualitative data involves dismantling dichotomies, examining silences, attending to contradictions, focusing on elements most alien, interpreting metaphors, analysing doubled entendres and attending to sources of bias. The researcher summarised the data into a data summary matrix for easy and logical reading. He then arranged data in columns or boxes that represented the research objectives. The summarisation of data according to the research objectives and questions then helped to provide answers to the research question and objectives by each study participant.

#### **3.4.4.4 Interpreting data**

Interpreting data implies “abstracting beyond the codes and themes to larger meaning of data” (Creswell 2013:186). Corbin & Strauss (2008:49) says that interpretation is a productive process that sets forth the multiple meaning of the phenomenon. It is more about “making the data make sense”. In this regard, the researcher put the summarized data themes into the context of available literature and added my own insights and experiences about the research topic in order to draw conclusions.

Existing theories and literature on aspects of the research question also come in to play at this point in time. According to Creswell (2013:187), interpretation also calls for link up with other existing formal theories as well as background knowledge, insights and intuition on the part of the researcher. Thus the researcher used evidence available from previous research results and my personal knowledge to put it together with the views of the research participants. The researcher then interpreted or gave meaning to the participants’ description of their experiences in collaborating with BHPs. In this way, the researcher was able to provide plausible answers to the research question and elaborations to the research objectives.

#### **3.4.4.5 Presentation**

The researcher displayed data firstly in summary tables that contained all data units pertaining to a single theme or category. This prevented me from presenting mere anecdotal data units selected with a certain bias to promote a point the researcher might have held. He then presented relationship among categories and sub-categories in meaningful sentences and paragraphs. In this way, the findings were presented in a logical manner as shown in chapter 4 (section 4.3.3).

### **3.5 DATA QUALITY: TRUSTWORTHINESS**

Trustworthiness in qualitative research designs is associated with rigor throughout the research process. Rigor refers to strict adherence to research principles, thoroughness in collecting, analysing and interpreting data (Burns and Grove (2010:33).

In this study, my concern for quality, rigour and trustworthiness are reflected by my ethical orientation towards the sampling approach, data management and my scientific integrity. Fenton and Mazulewicz (2008: 296) say that the aim of trustworthiness in a qualitative inquiry is to support the argument that the inquiry's findings are "worth paying attention to". It includes aspects or principles such as credibility, transferability, dependability and confirmability.

### **3.5.1 Credibility**

Credibility in qualitative research is defined by Shenton (2006:197), Polit and Beck (2008:107) and Bailey (2007:182) as the extent to which the results of a qualitative study are believable and dependable from the perspective of a participant or subject in the research itself. It implies believability, authenticity and plausibility of results. It refers to the extent to which research findings are truthful. One of the ways in which the researcher pursued credibility was by having enlisted the experience and expertise of my supervisor to critique each and every stage of the research process. In addition to that, participants who were actually involved in the phenomenon under investigation were purposively selected and interviewed for their perceptions based on their lived experiences on collaborating with BHPs in an HIV/AIDS and TB program. The researcher also employed the following measures toward establishing credibility:

- **Prolonged engagement:** the researcher conducted the research in an area and with individuals that the researcher has been involved with over the past five years. This relationship allowed for extensive and prolonged engagement where both parties trusted each other and therefore were less likely to provide false or misleading information.
- **Member checking:** After data collection and analysis, the researcher returned to the interviewees asking them to assess the final analyses and interpretation and confirm if it was an accurate representation of what they said.

- **Peer debriefing-** According to Streubert and Carpenter (2011:48), one of the measures to enhance credibility of research findings is to brief peers about the research process and findings.

### **3.5.2 Transferability**

By virtue of being highly contextualized and using non-probability sampling, qualitative research poses serious challenges to generalization. The concept of generalisability is usually substituted with the concept and practice of transferability in qualitative research. Transferability refers to the extent to which findings can be transposed to other groups or settings (Polit and Beck 2008:107). Both Bailey (2007:182) and Shenton (2006:198) confirm this view by describing transferability as a criterion that refers to the applicability of findings beyond the settings, situations and participants who were included in the research. Where qualitative descriptive and contextual research is done, it is largely the readers of the research report who can determine whether the research findings are transferable or not. By being elaborate on the whole process, the researcher endeavoured for my research report to allow readers to decide whether the results are transferable or not.

### **3.5.3 Dependability**

Kumar (2001:383) defines dependability as a concern with whether or not the same results are obtainable if the same measurement or observation is carried out at a different time or by someone else. According to Bailey (2007:184), dependability is about internal consistency among core elements of the whole research process. These elements include data collection, analysis and conceptual definitions. Shenton (2006:198) goes on to say that dependability relates to researchers' response to changes in the setting of the study and how these changes affect the research. The researcher pursued dependability by having left an audit trail of the entire research process. This audit trail shows a correspondence between the methodology used and conclusions arrived at. In this study, the researcher kept clear and accurate records that described the research process in detail (the audit trail) as well as field notes and the data analysis process.

### **3.5.4 Confirmability**

Kumar (2011:185) states that confirmability “refers to the degree to which the results could be confirmed or corroborated by others”. “Confirmability refers to whether other scholars could corroborate the researcher's findings (Shenton 2006:198). ‘Member checking’ is one of the strategies used by qualitative researchers to enhance confirmability (Shenton 2006:198 and Bailey 2008:184). As stated previously, the researcher approached colleagues who are experts on the research topic to scrutinise my analyses, interpretations and findings to indicate whether they corroborated my findings. Since in this study all the interviews were audio recorded and transcribed, the researcher asked an independent reviewer to listen to the tapes and compare them with the transcripts to ensure trustworthiness. My supervisor also scrutinised my analyses of data. As the researcher has indicated previously, the participants themselves were given a chance to confirm that the interpretation of findings was a true reflection of their input.

## **3.6 CONCLUSION**

In this chapter, the researcher has explained in a step-by-step manner how he conducted my research on the topic *“Perceptions of traditional healers on collaborating with biomedical health professionals in UMkhanyakude District of KwaZulu Natal”*. The researcher discussed the research methodology, the research design, sampling method, the data collection approach/method, data analysis, measures taken to establish and to maintain trustworthiness and ethical considerations. In the next chapter (4), he presents and discusses the research findings.

## CHAPTER 4

### ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

#### **4.1 INTRODUCTION**

In this chapter, the researcher presents the findings of the research in themes, categories and sub categories. The unedited data units are presented in the actual words of the participants (*verbatim*) in section 4.3. Before presenting the findings, the researcher lays out the biographical details of the participants in order to contextualise the findings. In discussing the findings, (4.4); the researcher integrated the findings with literature on collaboration between traditional healers (THs) and biomedical health professionals (BHPs) that he had reviewed.

#### **4.2 DATA MANAGEMENT AND ANALYSIS**

The researcher audio recorded six interviews and transcribed all of them. He then organised and stored all the transcripts in electronic files using unique identification codes for each of them. The researcher then read each transcript repeatedly to gain an overall insight and familiarity with the content (data). Through these readings, the researcher identified 6 major themes based on the research questions that further lead to the emergence of supporting sub categories.

#### **4.3 RESEARCH RESULTS**

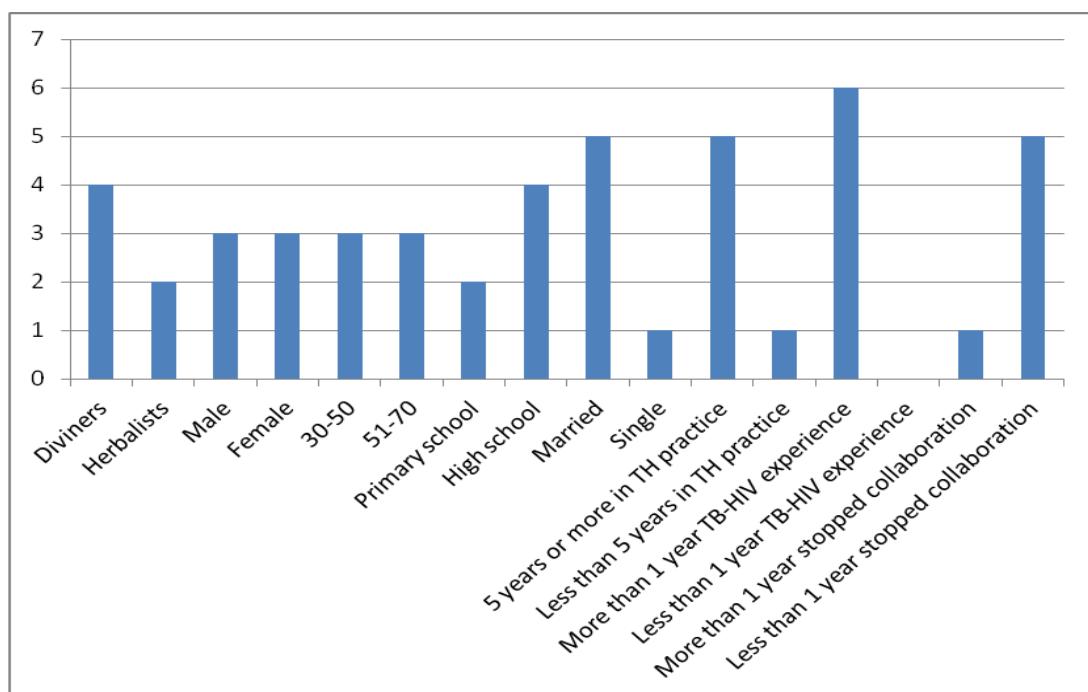
##### **4.3.1 Sample demographics**

Table 4.1 and figure 4.1 show the demographic details of the participants.

These include the category of the healer, age, gender, marital status, highest level of formal education, years of experience practising traditional medicine, length of time working with TB and HIV patients and length of time since he/she has stopped collaborating with BHPs.

**Table 4.1:** Biographical information about the participants

BIOGRAPHICAL DETAILS	CATEGORY	NUMBER
Category of healer	Diviners	4
	Herbalists	2
Gender	Male	3
	Female	3
Age group	30-50	3
	51-70	3
Level of education	Primary school	2
	High school	4
Marital status	Married	5
	Single	1
Length of time practising traditional medicine	5 years or more in TH practice	5
	Less than 5 years in TH practice	1
Length of time working with HIV & TB patients	More than 1 year TB-HIV experience	6
	Less than 1 year TB-HIV experience	0
Length of time since stopped collaborating with BHPs	More than 1 year stopped collaboration	1
	Less than 1 year stopped collaboration	5

**Figure 4.1:** Biographical information about the participants

The information displayed shows that at the time of data collection, 4 of the participants were diviners and 2 were herbalists. There was a gender balance of 3 males and 3 females. Half of the participants were between the ages of 30 to 50 with the other half aged between 51 and 70. Four of the participants had high school education ranging between grade 8 and 10 whilst the other 2 had gone up to grades 4 and 7. Only one participant was single having been widowed whilst the rest were married. Similarly, 5 of the respondents had more than 5 years of practising traditional medicine with the exception of one who had less than 5 years of traditional medicine practice experience. All the participants had more than one year experience of working with HIV-TB patients in a collaborative program with BHPs. Only one participant stopped collaborating with BHPs more than a year prior to data collection whilst the other 5 stopped less than 1 year prior to data collection.

In this qualitative descriptive and contextual study, the researcher did not analyse the data in relation to specific demographic factors or details, that is, he did not compare what informants of differing demographic detail said. As was presented in section 3.4.2.2 of the research methodology chapter, the researcher hereby re-affirm that all the participants resided not more than 5km from the local health facility. This was done to exclude long distances as a reason for stopping collaboration with BHPs.

### **4.3.2 Data Themes**

In this section, the researcher presents 6 themes and their related categories that emerged from the data. These are:

- i. THs' perceptions of the of THs in HIV/AIDS and TB programs
- ii. Experiences of THs regarding collaboration
- iii. Reasons for THs' discontinuation of collaboration
- iv. The implications of discontinued collaboration
- v. The role of money in discontinuing collaboration: business factor
- vi. THs' suggestions for strengthening sustainable collaboration

### 4.3.3 Summary of themes and data categories

**Table 4.2:** Themes and data categories

THEMES	CATEGORIES
<b>1. Perceptions of THs on their role in HIV-TB programs</b>	Identify patients with signs and symptoms for HIV and TB Make referrals to health facilities for HIV/TB/CD4 screening/testing Provide pre-test counselling Treat opportunistic infections Manage side effects (of ARVs/TB drugs)
<b>2. THs' Experiences of collaborating</b>	<b>2.1 Positive experiences</b> <ul style="list-style-type: none"> <li>-Benefits of capacity building (<i>epidemiological knowledge on HIV/TB</i>)</li> <li>-Benefiting from western medicine's proficiency to diagnose patients' HIV/TB status helps THs to prescribe appropriate traditional medicine (avoiding resistance)</li> <li>-Opportunities for intra-referrals amongst THs</li> <li>-Getting recognition and respect from BHPs and traditional leaders and communities</li> <li>-Cooperation with enlightened/trained nurses who appreciate collaboration and back referrals</li> <li>-Receiving material support for improving TH practice</li> <li>-Good facilitation of collaboration by an intermediary- AMREF</li> <li>-Receiving supervision and support at health facilities with focal persons (nurses)</li> </ul> <b>2.2 Negative experiences</b> <ul style="list-style-type: none"> <li>-One way referrals; no reciprocation by BHPs</li> <li>-Disrespect and poor knowledge/education about indigenous medicine/ traditional healing of BHPs</li> <li>-Abdication of duty by DOH and transgressed promises</li> <li>-Lack of supportive supervisory systems for THs and poor structural management of collaboration</li> <li>-Lack of a contingency plan/exit strategy (post-AMREF support) for continuation of collaboration</li> <li>-Verbal abuse and ill-treatment by BHPs</li> <li>-Neglect, abandonment, isolation by DOH</li> <li>-High turnover of health facility staff members who have been oriented on working with THs and their replacement with the 'uninitiated ones'.</li> <li>-Lack of a consultative forum and representative structure to discuss challenges or issues around collaboration</li> </ul>
<b>3. Reasons for THs' discontinuation of collaboration</b>	<ul style="list-style-type: none"> <li>-Peer influence, internal conflict</li> <li>-Breach of contract by DOH; unfulfilled promises</li> <li>-Lack of recognition from DOH and BHPs</li> <li>-Being disrespected by BHPs; particularly as individuals and traditional medicine in general</li> <li>-Lack of funding, resources and materials for carrying out collaboration activities</li> <li>-Lack of collaborative management structures</li> <li>-Lack of motivation to collaborate (lack of incentives)</li> <li>-Conflicts amongst different THs' associations</li> <li>-Departure of cooperative staff at health facilities</li> <li>-Lack of feedback on referred patients (back referrals)</li> </ul>
<b>4. Implications of discontinued collaboration</b>	<ul style="list-style-type: none"> <li>-Conducting referrals under cover (covert referrals)</li> <li>-Hiding from BHPs that the referred patients consulted the healers first</li> <li>-Not using referral slips to refer patients to health facilities</li> <li>-Doing informal referrals- verbally encouraging patients to go for HIV-TB screening</li> <li>-Stopped some collaboration activities</li> <li>-Stopped accompanying patients to health facilities</li> <li>-Stopped making follow ups on patients referred to health facilities</li> <li>-Stopped attending clinic committee meetings</li> <li>-Carrying out overt referrals for only those patients that need specialised western medical treatment (conditional referrals)</li> </ul>
<b>5. The role of money in discontinuing collaboration: business factor</b>	<ul style="list-style-type: none"> <li>-Money or protection of TH business practice is not the major reason for stopping collaboration</li> <li>-Cultural and spiritual convictions of THs supersede the need for money</li> <li>-Running an ethical traditional healing practice enhances business growth- income for THs</li> </ul>

	<ul style="list-style-type: none"> <li>-By seeing or attending to different categories of people (not necessarily those that are sick), THs have a wide range of clients and therefore making referrals for just HIV-TB suspects is not a threat to their business</li> <li>-Money is a minor reason for stopping collaboration</li> <li>-Frustration with using own resources (money) to fund collaboration activities such as transport when going to meetings</li> <li>-Collaboration (making referrals) has an effect of boosting THs' businesses/ income growth as it is easier to prescribe the right medication and thus save on time and resources</li> <li>-Healers charge a certain fee for all consultations before making referrals to minimise chances of income loss</li> </ul>
<b>6. THs' suggestions for strengthening sustainable collaboration</b>	<p><b>6.1 Suggestions for DOH</b></p> <ul style="list-style-type: none"> <li>-Provide basic infection control materials and kits to THs</li> <li>-Develop and implement policy guidelines to inform collaboration between THs and BHPs</li> <li>-Educate/ train or orient BHPs on how to collaborate with THs as well as the role that THs play in HIV/AIDS-TB programs</li> <li>-Monitor and strengthen back referrals to THs by health facilities/ BHPs</li> <li>-Strengthen and recognise THs as professional partners in the health care delivery system</li> <li>-Develop and implement a continuous education and training program for THs</li> <li>-Strengthen collaborative management structures and systems</li> <li>-Designate some health facilities as model centres for collaboration</li> <li>-Appoint focal persons/nurses for THs' collaboration and ensure their retention</li> <li>-Promote transparency between THs and BHPs through regular dialogue and engagement</li> </ul> <p><b>6.2 Suggestions for THs</b></p> <ul style="list-style-type: none"> <li>-Eliminate all self-imposed obstacles to successful collaboration such as improving acceptability through good hygienic practices</li> <li>-Cultivate a sense of initiative and responsibility to improve the image of their practice</li> <li>-Institute and adhere to policies and guidelines that professionalise TH as a practice as well as self-regulation</li> <li>-Mobilise and motivate other THs to undergo training and carry out mutually beneficial collaboration</li> <li>-Avoid factionalism amongst different THs' associations and unite for the purpose of gaining respect and recognition from Government</li> <li>-Provide peer support</li> </ul> <p><b>6.3 Suggestions for facilitating agencies (AMREF)</b></p> <ul style="list-style-type: none"> <li>-Ensure that collaboration programs have a clear and effective exit strategy to ensure continuity post project funding</li> <li>-Plan for and implement two way education and training for both THs and BHPs for effective collaboration</li> <li>-Build capacity and put in place mechanisms in the project that ensure proper structures and systems for management of collaboration</li> <li>-Maintain impartiality when dealing with TH members from different associations</li> <li>-Cultivate a sense of mutual respect between THs and BHPs through training and orientation of both groups</li> </ul>

#### 4.3.4 Description of research findings

In the presentation and description of the findings, the researcher use unique identifying codes for 6 participants using the following key:

- Mt.1/Dv/M = Respondent number 1 from Mtubatuba, a male Diviner.
- Mt.2/Dv/F = Respondent number 2 from Mtubatuba, a female Diviner.
- Mt.3/Dv/F = Respondent number 3 from Mtubatuba, a female Diviner.

- Mt.4/Hb/F= Respondent number 4 from Mtubatuba, a female Herbalist.
- Mt.5/Hb/M = Respondent number 5 from Mtubatuba, a male Herbalist.
- Mt.6/Dv/M = Respondent number 6 from Mtubatuba, a male Diviner.

#### **4.3.5 Theme 1: THs' perceptions of their role in HIV/AIDS-TB programs**

To answer the research question on THs' perceptions of collaborating with BHPs in HIV/AIDS and TB programs, one of the objectives of this research was to explore and describe the perceptions of THs in collaborating with BHPs in health service delivery. All the participants viewed the call by the Government and AMREF to collaborate with BHPs as very important as it helped in addressing challenges of managing patients presenting with HIV and TB.

The participants acknowledged their complimentary role by stating:

- *If we do not help each other and we work separately; THs on their own and BHPs on their own, we are likely to compromise the health of our patients (Mt.5/Hb/M).*

The findings also show that capacity building of THs by AMREF helped to make collaboration with BHPs possible as evidence by:

- *After being trained by AMREF we were more than ready to collaborate (Mt.3/Dv/F).*
- *We now understand the need for testing or screening by clinics and hospitals. Health facility can screen/ test especially to check on the levels of CD4 cell count. (Mt.4/Hb/F).*

The participants recognised and appreciated the fact that they had a very important role to play in HIV/AIDS and TB. The first role that emerged from the data is that of ***Identifying patients with signs and symptoms for HIV and TB.*** In this regard, participants indicated that:

- *We have been trained to identify signs and symptoms of HIV and TB to enable us to make referrals to health facilities and that is major role for us*

- *Most of our people start by consulting us as healers first before they go to the clinics. This gives us an opportunity to examine them for any signs and symptoms for HIV and TB (Mt.3/Dv/F)*
- *By seeing these signs and symptoms, we are required to collaborate with health facilities. (Mt.5/Hb/M)*

Participants further indicated that ***Making referrals to health facilities for HIV/TB/CD4 screening/testing*** were all obligations they were prepared to take on in view of their newly acquired insight into these issues:

- *Ever since we were taught on the dangers of HIV and TB, we now understand the need for testing or screening by clinics and hospitals that have the means/capacity to test (Mt.2/Dv/F)*
- *We counsel the patients and encourage them to go to the clinic to be tested for HIV or TB (Mt.3/Dv/F)*
- *We realise the need to refer patients to the health facility to be screened/tested especially to check on the levels of CD4 cell count (Mt.4/Hb/F)*
- *We are required to collaborate with health facilities. This is because as THs we cannot test for HIV and TB (Mt.5/Hb/M)*

The participants also took on the role of “pre-test counselling and counsellors”:

- *We have also learnt to provide pre-test counselling before referring to clinics (Mt.1/Dv/M)*
- *We counsel the patients and encourage them to go to the clinic to be tested for HIV or TB (Mt.3/Dv/F)*

In their identification of their role in HIV/AIDs and TB, participants distinguished between those aspects in which they could actively and positively contribute, and those that clearly needed western medical attention. In this regard, participants indicated that they could treat certain ***opportunistic infections*** successfully:

- *We have a role and opportunity to play because as things stand, the healers are able to treat opportunistic infections; and not the real virus (Mt.4/Hb/F)*
- *If a patient is suffering from diarrhoea related to a low CD4 cell count THs are able to give patients herbal treatment to stop such diarrhoea (Mt.4/Hb/F).*

Participants also indicated that their role (contribution) was to successfully ***manage side effects (of ARVs/TB drugs):***

- *There are other patients who suffer from sore feet due to ARVs side effects, THs also know how to treat or eliminate such side effects (Mt.5/Hb/M).*

In addition to the more physiological and patho-physiological claims that the THs made with regard to their role and contribution in the treatment of HIV/AIDs and TB, they also indicated a fundamental cultural belief and issue important to indigenous persons:

- *"We also have our strengths where we help people such as giving them herbs for luck, for love, for wealth, money, for promotions at work, having many cattle". "We are happy when they come back from hospitals with no TB, with no HIV and then we give them our African medicines to cleanse them and strengthen their livelihoods. (Mt.1/Dv/M).*

#### **4.3.6 Theme 2: Experience of collaborating with BHPs**

Through the interviews, the research participants said that they had experienced both positive and negative aspects of collaboration with BHPs, prior to their discontinuing.

##### **4.3.6.1 Positive experiences**

The most positive experience, from a western medical point of view that participants indicated is that of benefitting from ***the epidemiological detail on HIV/IADs and TB.*** In this regard, informants had the following to say:

- *I was taught very well and I understood things very well. I know when I see someone who could be having TB or HIV (Mt.1/Dv/M)*
- *The training that they gave us transformed us from what we used to do. It was enlightening and we were very excited after learning new things. As THPs, we need to be told and appreciate that new diseases come up every day.*
- *And, when these new diseases come, we need to be educated on how they occur and how they can be managed. These nurses and doctors must educate us such things (Mt.2/Dv/F).*

- *Since we have been trained by AMREF, we now know how to look out for these signs and symptoms and tell if they are there or not (Mt.3/Dv/F).*
- *This was very good for me because it helped me as a healer to know those patients with or without TB. This knowledge helps me to decide whether or not I can give my patient medicines or herbs to induce vomiting, because I cannot give a TB patient such. I had learnt that if someone comes to me coughing a lot, this could be an indication for TB and by collaborating with health facilities; it helped us make better decisions on what types of herbs to give or not give (Mt.5/Hb/M).*

The participants also indicated that their newly acquired knowledge and insights did not only benefit their collaboration with BHPs but also amongst traditional healers. This facilitated **opportunities for smooth patient referrals and intra-referrals amongst THs.**

- *We also chain-refer to each other and we get many more people coming through friends and relatives (Mt.1/Dv/M)*

The insights acquire were also put in motion by referring patients directly to BHPs as indicate by the following statement:

- *You will then refer the patient to the clinic by writing a paper for him or her; to the health facility, when the patient got to the clinic, they would do everything that they need to do and then refer that patient back to you (Mt.4/Hb/F).*

In one instance at least, **a multi-sectorial collaborative** involvement sprang up. As a participant reported:

- *It was a joint venture where the Chief provided land, DOH the building and AMREF came in with supplies, furniture as well as employing the focal nurse (Mt.2/Dv/F).*
- *Even our leaders from our TH committees who represent us will engage both AMREF and DOH to deal with issues affecting us (Mt.3/Dv/F).*

Special mention was made of nurses at one clinic who facilitated the collaboration effort positively. This, to me, clearly indicates the importance of collaboration at the “PHC” level. In this regard, participants indicated that:

- *We as THPs really felt honoured and respected by the nurse who would openly welcome us and acknowledge our role in health care (Mt.2/Dv/F).*
- *It will not be fair to paint all nurses with the same brush. Some of them are well informed and respectful. I still remember that when we were trained, it was by the same nurses and when we got to the clinics, they were happy to tell their colleagues that now things have changed and can be done differently between healers and clinics (Mt.2/Dv/F).*
- *Having a facility which had a professional nurse was employed by AMREF to specifically attend to patients that were being referred by THPs (Mt.2/Dv/F).*
- *We viewed that clinic as ours too because we could practise our medicine there alongside BHPs. (Mt.2/Dv/F).*
- *Another good thing about this facility was that THPs could also bring in their own medicines especially those that help to chase away evil spirits affecting TB/HIV patients so that the nurse's job would be easier (Mt.2/Dv/F).*
- *It was very good because we used to send all our suspected patients to the clinic and they would attend to them and check/test if they had the virus or not (Mt.5/Hb/M).*
- *It was so nice at the beginning because there was a nurse at the clinic who had been selected to liaise with THs (Mt.3/Dv/F).*

This evidence (data unit) also indicates the importance of inviting TH into the National Health System and allowing them space alongside the western medical team, albeit under their supervision, to conduct some of their (THs) practices and ritual in clinics. This in my opinions is excellent reciprocation on the part of the BHPs as they expect THs to promote their (BHPs) scientific views among the general population.

It appears that THs in some instances also benefitted **financially** by the collaboration effort and that their **relationships with the community** were also strengthened. As a participant indicated:

- *Most people that we refer and get well; they come back and thank us with good money (Mt.1/Dv/M).*

Another positive result from the AMRAF initiated collaboration was that THs received material support for improving their practice. In this regard, participants indicated:

- We were even given materials to use in our surgeries; gloves, razor blades, masks and home based care kits (Mt.3/Dv/F).
- We would even receive materials and resources to do our work during that time (Mt.4/Hb/F).

It also became evident that the benefits gained from collaboration and the positive results from collaboration were brought about by **AMREF's intermediate role**. In this regard, participants said:

- AMREF staff used to represent us as healers at DOH. They will call meetings between DOH and healers where we would discuss in detail about how to better collaborate (Mt.3/Dv/F).
- They (AMREF) used to encourage us and they had opened doors for us to work closely with health facilities. In that way, collaboration was going on very well (Mt.4/Hb/F).
- "THs have an opportunity to collaborate and work closely with health facilities. This has even been made most possible by the arrival of AMREF (Mt.6/Dv/M).

The past tense used in these narratives indicates that discontinuation of both THs' participation in collaboration and the cessation of AMREF's involvement.

The following data unit indicates the necessity of an **intermediate mediation** or supervisory agency such as AMREF to coordinate collaboration.

- If there is someone else pushing or encouraging them to carry on, someone who follows them up ensuring that they are referring people to health facilities and also checking to find out how things are moving at the health facilities (Mt.4/Hb/F).

#### **4.3.6.2 Negative experiences**

A major negative experience of THs who ceased to participate in the collaboration project with BHPs, and a factor which in my opinion reflects many of the perceptions

THs held about BHPs' perception of them, is the fact that ***one-way referrals with no reciprocation by BHPs*** appeared to be the norm. In this regard, participants indicated:

- *You refer your suspects to clinics, but you find that clinics do not acknowledge your efforts (Mt.1/Dv/M).*
- *As a TH, I got frustrated because of not getting feedback from the clinics about those patients that I would have referred to them (Mt.5/Hb/M).*
- *This made me feel frustrated. No one from the clinic would come back to me and tell me exactly what they found out or did with the referred patient (Mt.5/Hb/M).*
- *If I refer my patients, they ignore them. If I refer patients using the referral slip, they insult them. The referral slip does not come back to us to confirm that the patient we referred got to the clinic (Mt.1/Dv/M).*

The lack of feedback from BHPs left THs with the idea that BHPs ***Lack of recognition from DOH- BHPs, disrespect, poor knowledge about indigenous medicine and traditional healing.*** In addition patient whom had been referred to clinics by THs was often scolded for having done so.

- *Nurses insult and shout at patients who are seen to have started at the healer (Mt.1/Dv/M).*
- *These nurses need to be educated on how to work with us. Not this thing of looking down upon us as inferiors. They need to know how to take us as partners (Mt.2/Dv/F).*
- *The other nurses do not have time to welcome our referred patients. They are insulted and called names. "Hey! You! You start at the healer's place wasting time to come to the clinic! Hi? These healers of yours! Do you think they know anything about TB? Hey! Wake up! They will finish you up by cutting you using one razor blade and you will get HIV!" (Mt.3/Dv/F).*
- *At times the person that I am accompanying has already been cut to make incisions to administer herbs, and yet he or she must have a blood test; the nurse will complain and say that where do we expect the patient to have blood when the TH has finished it (Mt.4/Hb/F).*

- *That also makes feel bad and more so when I have cut the person by razor blade to administer traditional herbs and nurse shout and make mockery of it (Mt.5/Hb/M).*
- *However, the main reason is being ignored by BHPs when you take your patients to the clinic (Mt. 1/Dv/M).*
- *What even complicated things was the ill-treatment and even being insulted by nurses. This made me to really make a decision to stop collaborating and do my own work in my surgery. It pains them to be ignored or looked down upon. So, my colleagues cite the same reasons that they such as facing trouble at the clinic at the hands of BHPs (Mt.2/Dv/F).*
- *They are insulted and called names. "Hey! You! You start at the healer's place wasting time to come to the clinic! Hi?*
- *These healers of yours! Do you think they know anything about TB? Hey!*
- *Even when you accompany the patient to the clinic, they do not care about you or worse still, they insult you (Mt.3/Dv/F).*
- *If I had accompanied my patient to the clinic and I was not treated well, there is no one to go back to and tell that so and so did not treat me well at the clinic. This is exactly what makes working closely with health facilities to be difficult. This then makes us withdraw a bit by bit (Mt.4/Hb/F).*
- *Some of our referred patients feel that they are not well treated at the clinic by nurses who do not have full knowledge and information about how this collaboration is supposed to work (Mt.5/Hb/M).*
- *What made me withdraw is that as a TH, I got frustrated because of not getting feedback from the clinics about those patients that I would have referred to them. No one from the clinic would come back to me and tell me exactly what they found out or did with the referred patient (Mt.5/Hb/M).*
- *That also makes me as healer to feel bad and more so when I have cut the person by razor blade to administer traditional herbs and once the nurse sees the razor cut marks, they shout and make mockery of it (Mt.5/Hb/M).*
- *We are looked down upon as inferior. When you go to the clinic, these nurses do not even know or recognise who you are as the local healer (Mt.6/Dv/M).*

- *The only challenge is that these BHPs do not refer our patients back to us after they have done what we have asked them to do. It then becomes a one way referral (Mt.6/Dv/M).*

Linking up with these statements, verbal abuse and ill-treatment by BHPs, neglect, abandonment and isolation by DOH also contributed to THs disillusionment with the project. In this regard participants reported:

- *You physically accompany the patient to the clinic yourself, you get there and health workers do not even consider you ... as if you are not there or have not done something good (Mt.1/Dv/M).*
- *When you go to the clinic, you are just sent from one person to another and this discourages you (Mt.2/Dv/F).*
- *The problem is that we are not treated well by nurses when we get to the clinics and wanting to collaborate with them (Mt.3/Dv/F).*
- *We just saw ourselves as orphans left in the open (Mt.3/Dv/F).*
- *At times you go there (health facility) and find someone who will not be ready to accommodate you. It is like when I go to the clinic; I want or expect to be recognised as a TH. Even if I am putting on my TH regalia, it must be seen that I am a healer (Mt.4/Hb/F)*

These utterings are in shrill contrast to the more accommodating and outreaching nursing staff reported on under “positive experiences” of THs. As alluded to previously, an intermediate, mediating and supervisory body such a AMREF who initiated the collaboration project, seems indispensable to maintain such a project and to keep it viable.

The ***abdication of duty by DOH and its transgression on promises made*** appears to be a major reason for THs to withdraw from collaboration as the whole. In this regard, participants indicated:

- *The people from DOH whom we had been told would coordinate us just disappeared or totally ignored us.... just abdicated duty and forgot about their commitment to link us with health facilities (Mt.2/Dv/F).*

- *All this (receiving material support from DOH) ended when AMREF left (Mt.3/Dv/F)*
- *It is even worse because the books also got finished (Mt.4/Hb/F)*
- *The referral slips got finished and this is when we all stopped to use these papers. We then decided to just stay in our homes and stop everything (Mt.2/Dv/F).*
- *We had been promised that as health workers, we would also get some small stipend to enable us to buy a few basics for our livelihoods. Just imagine that every month we need to go to the clinic to submit reports on patients that we have seen, referred, treated or monitored. As soon as we realised that we were using our own money to travel to the clinics with no re-imbursements, we lost interest to collaborate (Mt.2/Dv/F).*
- *It is all about money Mr Hlabano. As you would know, AMREF used to assist with money for transport to attend meetings with DOH. Amref did not mind whether it was a meeting called by DOH, they will just assist with money. Now, since they left, this kind of money was no longer available and no one was there to assist healers with transport money (Mt.3/Dv/F).*
- *On the other hand, it is about that you are not able to get the working materials and resources (Mt.4/Hb/F).*
- *The reasons why they stop, firstly; it is this whole subject of money. When you are still working nicely, you are suddenly told that the project money is finished.*
- *This means that the support that AMREF has been giving stops and this leads to all those people who have been trained to stop working in the project (Mt.6/Dv/M).*

**Lack of supportive supervisory systems for THs and poor structural management of collaboration** were pertinently pointed out by THs as problematic with regard to the maintenance of a system of collaboration between THs and BHPs. Organisational structures seem to have also collapsed with the withdrawal of AMREF from the project once AMREF decided that it had attained its goals with the project. As participants indicated:

- *Nobody mobilised us to attend meetings or coordinate our efforts (Mt.2/Dv/F).*

- *DOH has no such coordinators for THs; it becomes difficult for us to know who to approach when we need help. When you go to the clinic, you are just sent from one person to another and this discourages you (Mt.2/Dv/F).*
- *If someone knows that there is no one who will come and check on how I am working or giving me support and link me with the health facility and explain to me some of the things that I do not understand*
- *The motivation goes down because whatever challenges that I face, no one is available to help me (Mt.4/Hb/F).*
- *DOH is not organising meetings with us to discuss our working relationships and conditions (Mt.1/Dv/M).*
- *The leaders whom we were looking up to stopped following up with DOH and we had no one to represent us (Mt.2/Dv/F).*
- *There is no specific person who was appointed to look at and facilitate coordination between THPs and DOH (Mt.2/Dv/F).*
- *There were lots of changes at the clinic. You will find that the nurse who was there and whom we worked very well has left. When a new nurse comes in, they change the way we were working. This new nurse does not care about our relationship and especially receiving our referred patients in the right way (Mt.5/Hb/M).*
- *When AMREF left, collaboration was no longer as strong as it used to be. It became weak and weaker until it totally stopped (Mt.4/Hb/F).*
- *I think that many people believe in doing something if there is someone else pushing or encouraging them to carry on doing that.*
- *If someone knows that there is no one who will come and check on how I am working or giving me support and link me with the health facility and explain to me some of the things that I do not understand, the motivation goes down because whatever challenges that I face, no one is available to help me (Mt.4/Hb/F).*
- *Clinic committees were not there during the time of the AMREF project. These are new structures and as THs, we did not have anyone sitting in those committees to represent us. This could probably be one of the reasons why it was so difficult to collaborate with BHPs since no one represented us in the clinic committees (Mt.5/Hb/M).*

These statements also indicate, to me that there is what is referred to as “*taking it in your strides*” where THs have to “go” to meetings at western medical facilities and that the reverse does not seem to happen as BHPs are never seen to visit or meet with THs outside of the “clinic” which is the most grassroots level of entry into the biomedical health care system.

The ***lack of a contingency plan or exit strategy of AMREF*** to ascertain the continuation of collaboration was pointed out by participants by stating:

- *Things suddenly changed when AMREF left. That is when trouble began because after the exit of AMREF, no one cared anymore about us (Mt.2/Dv/F)*
- *However, when AMREF left, collaboration was no longer as strong as it used to be. With time, it became weak and weaker until it totally stopped (Mt.4/Hb/F)*
- *These new people do not get to know about the THs that have already been trained and were already involved with the project. Instead, these new staff members select new THs and start afresh ignoring us the old horses. All those Master Trainers have been sidelined and have stopped collaboration because when AMREF came, they did not invite us as Master Trainers but instead, they selected new people (Mt.6/Dv/M).*

These statements are of importance to the current research and the aim (objectives) of the study.

***High staff turnover at health facilities and the replacement of BHPs who have been oriented on working with THs with the ‘uninitiated ones’”*** also caused problems for THs and the project as a whole. In this regard, participants reported

- *Even this nurse; Sister X, left! I do not know where they sent her to, but everything just changed and we found things being done differently after she left (Mt.3/Dv/F).*
- *There were lots of (staff) changes at the clinic. You will find that the nurse who was there and whom we worked very well has left. When a new nurse comes in, they change the way we were working. This new nurse does not care about our relationship and especially receiving our referred patients in the right way (Mt.5/Hb/M).*

- *It is the frequent changes of staff and personnel from both AMREF and DOH. When you think you are working well with this person, they go and another one comes (Mt.6/Dv/M).*
- *On the other hand, the problem is with health facilities. We as THs go there and see different people all the time. When you ask on what has happened to the focal person that we used to work with closely, no one can give you a proper answer (Mt.6/Dv/M).*

The placement of BHPs (nurses) who have no background or training related to the collaboration at clinics made for a one-sided attempt to maintain collaboration. This gap involves challenges or limitations with human resource development for health. It points to serious problems around the whole process of managing collaboration coupled with lack of structures and the absence of medical staff (BHPs) to assist THs led to a ***lack of a consultative forum to discuss challenges or issues around collaboration.*** As participants indicated:

- *If I had gone to the clinic to ask for gloves and they refused to give me, there is no one that I will tell that or appeal to. No one will be there to go to the clinic to speak on my behalf. Similarly, if I had accompanied my patient to the clinic and I was not treated well, there is no one to go back to and tell that so and so did not treat me well at the clinic (Mt.4/Hb/F).*
- *It became very difficult for us to do that (collaborate) because we did not know who to approach or talk to at DOH (Mt.2/Dv/F).*

#### **4.3.7 Theme 3: Pertinent reasons for discontinuing collaboration**

During the fieldwork, each participant was asked a direct question of: '*what made you stop collaborating with BHPs?*' The researcher asked this question in order to explore the primary reasons for THs dropping out of collaboration with BHPs in HIV/AIDS and TB programs; besides the negative experiences presented in section 4.3.5.2 above. The researcher therefore presents these primary (pertinent) reasons by quoting the exact words said by the participants under different sub-categories.

**Peer influence** appeared as another reason for withdrawing from collaboration with BHPs. This is unique as only one TH stated it by indicating that:

- *If you are working and you see other healers being reluctant. For example, there 4 or 5 of us in my village and then you see 2 or 3 dragging their feet, it also affects you and you lose interest (Mt. 1/Dv/M).*

My interpretation is that this emphasises the importance of intra-collaboration amongst THs themselves and not only with BHPs.

Further relating to peer influence, is another inter THs issue of **internal conflicts amongst different THs' associations**. On checking with the leaders of THs, the researcher found that THs in the UMkhanyakude district fall under 4 main associations namely; *Unitary Professional Association for Traditional Health Practitioners of uMkhanyakude (UPATHPU)*, *Traditional Healers Organisation (THO)*, *Ingwe Idla Ngamabala and Vukuzenzele*. Indications from the research participants, AMREF staff and leaders of THs indicate that there is intense rivalry amongst these associations where membership issues reign supreme. Participants indicated that:

- *I still go to some of these meetings but the other challenge is that we now have too many TH Associations and I end up not knowing which one to work with (Mt.4/Hb/F).*
- *The challenge is with this practice of ignoring Master Trainers because this means we are losing track and direction as we sideline the experienced THs (Mt.6/Dv/M).*

Master trainers were established by another NGO (AIDS Foundation South Africa-AFSA) in 2003 where they identified THs in each district of KZN and trained them as HIV/AIDS Trainers of other THs in their respective districts. UMkhanyakude had 15 of these Master Trainers. Unfortunately, the AFSA project ended in 2004 before these Master Trainers could cascade the trainings to fellow trainers. When AMREF came aboard in 2005, they did not consider these Master Trainers from AFSA and started as if nothing had been done to involve THs in HIV/AIDS-TB programs. This is therefore seen by THs as lack of continuity and coordination amongst NGOs and DOH when it comes to dealing with THs.

#### **4.3.8 Theme 4: Implications of discontinued collaboration**

During fieldwork, the researcher realised that the participants had different meanings for the concept of ‘*stopping collaboration with BHPs*’. As a follow up to the question on ‘*reasons for stopping collaboration*’, the researcher asked each participant to explain ‘*how they were dealing with patients who present with HIV/TB signs and symptoms*? Interesting responses came out which lead to a realisation that the healers had a different perceptions or definitions for ‘*stopping collaboration*.’ Three main categories emerged that ranged from carrying out covert collaboration, stopping carrying out some collaborative activities to total or full termination of collaboration.

In the following sub section, the researcher presents the sub categories of the data on the meaning or implications of stopped or poor collaboration.

My understanding and interpretation is that THs maintained a high level of professionalism and professional ethics by having **resorted to “covert referrals”** of patients. Participants reported that they tried to hide the fact ***patients had consulted the healer first to the BHPs***. Participants indicated that:

- We end up resorting to telling these patients with TB/HIV symptoms that when they get to the clinic, they must not say that they have passed through us (Mt.1/Dv/M).
- *I advise my patients that when they get to the clinic, they must not dare tell the nurses that they have been referred by me... so that I protect them from being insulted. Once they have received help, and know their status, they come back to me and report how the results came out. Most of them thank me thank me with gifts or big moneys (Mt.3/Dv/F).*

To further advance their covert operations, THs also **stopped using referral slips**. Participants indicated that:

- *We no longer give the patients those referral slips because if we do, our patients will be insulted on what they want from healers (Mt.1/Dv/M).*

- *I still refer such patients to the clinic after I have counselled them. However, I no longer give them the referral slip. This I do so that I protect them from being insulted (Mt.1/Dv/M).*
- Even though we are still referring people to the clinics, we no longer use those papers. I mean that which is known as referral slip (Mt.3/Dv/F).

The maintenance of a strict ethical code and commitment to the AMREF project, despite the relative withdrawal from the project is also reflected in participants' statements that:

- *It does not mean that I have totally turned my back to collaboration. When these patients who present with HIV/TB symptoms come to us, I still counsel and encourage them to go and get tested at their nearest health centre (Mt.2/Dv/F).*
- *This means that when I see that when I see when I see that my patient when I see that my patient needs to be tested, I counsel them and encourage them that it is important to know your status. I make them see the need to be tested (Mt.3/Dv/F).*
- Even though we still encourage our patients to go to the clinic, we are not able to make follow ups (Mt.4/Hb/F).

To further **advance their** covert commitment to the project, informants indicated that:

- *You face such things such as insults and disrespect on your own at the hands of BHPs when you accompany patients there. This is what makes us stop accompanying patients to health facilities and just let them go there especially those that are willing to go there on their own (Mt.4/Hb/F).*
- *That (accompanying patients to the clinic) used to happen and I would go with them or follow them up to see if they got there (Mt.5/Hb/M).*

Some of the participants also indicated that they did not merely resorted to covert actions but refrained from referring all suspect cases to BHPs. In this instance they, **carrying out overt referrals for only those patients that need specialised western medical treatment (conditional referrals)**

- *We cannot stop referring patients when there is need because, can you imagine if a patient needs to be put on drip, as healers we cannot do that. It is only doctors who can do that (Mt.6/Dv/M)*

A more pertinent indication of THs withdrawal from collaboration is reflected by their ***having stopped visiting/going to the clinic or attending clinic committee meetings.*** Participants indicated that:

- *You just feel it is better not to go to these people at the clinic (Mt.2/Dv/F).*

#### **4.3.9 Theme 5: The role of money: business factor**

From the time the researcher conceptualised this research topic on unsustainable collaboration between THs and BHPs, he had this strong feeling that one of the main reasons for THs stopping collaboration was associated with money; the fear of losing business through referring patients. During data collection, the researcher therefore directly put it to each participant as to whether this was true or not. It emerged that although the money-factor had a role in their stopping collaboration; it was not directly related to the fear of losing out on business. Rather, it emerged that for participant to use their own money to fund or finance collaboration activities was problematic. In addition, cultural and spiritual considerations (innate ethics) also played a part in the “issue of money”.

***Cultural and spiritual convictions of THs (ethics and principles) supersede the need for money*** as indicate by the following evidence:

- *Our ancestral spirits are not bought. We do not just put money upfront. We put someone's life in front of money. Some people pay, some do not even pay (Mt.1/Dv/M).*
- *We have feelings too and we want only the best for our patients and hence when there is a clear need to refer to the clinic, we do that without fear of losing business (Mt.6/Dv/M).*

The unique aspects of traditional healing and medicine, and the popularity thereof among the general population (60-80%), do not only provide for a large catchment area for referral to BHPs but also assure THs healers of client and income despite their relationship of collaboration with BHPs. As participants indicated:

- *By seeing or attending to different categories of clients means a diversified business practice and therefore making referrals for HIV-TB suspects is not a threat to the TH business*
- *Some pay using goats, chickens, cows or even promise to pay back later and we don't mind. We therefore are not worried about losing business through referrals to clinics (Mt.1/Dv/M).*
- *I have nothing to worry about losing business but instead, I view this collaboration as enhancing my business. Again, our clients are not just HIV or TB patients, we see many different others (Mt.5/Hb/M).*

It thus appears that collaboration (making referrals) has an effect of boosting THs' businesses/income growth, as it is easier to prescribe the right medication and thus save on time and resources

In addition to the above, ***healers charge a certain fee for all consultations before making referrals to minimise chances of income loss.*** So, standard HT practice fees secure THs' business without exploiting patients. In this regard, participants indicated:

- *We are not bogus healers but genuine healers. We do not see making referrals as a threat to our business.*
- *If someone comes to me, I examine them in our own traditional medicine practice way and try to see what could be their problem. Even when I see some signs and symptoms for TB or HIV, I first of all examine them and charge them the appropriate costs. (Mt.3/Dv/F).*
- *I do everything here in my surgery and the patient will pay a cow for the services that I would have rendered. Only after that do I refer them to the health facility. It is not like I just look at someone and if I see signs and I just send them to the health facility. So, I cannot just lose business like that. At times people come to us not because they have started taking ARVS or TB treatment. Maybe they have lost their cows (Mt.4/Hb/F).*

The researcher's understanding is that patients consult THs knowing that it is going to cost them. Traditional healers then do what they are trained to do and expected to do. In addition, if the case requires, the patient is referred to a BHP. Money really appeared to be a minor reason for having stopping collaboration with BHPs. The ***frustration with using their (THs')own resources (money) to fund collaboration activities such as transport when going to meetings*** seemed more of an issue. In this regard, a participant indicated:

- *Just imagine that every month we need to go to the clinic to submit reports on patients that we have seen, referred, treated or monitored. As soon as we realised that we were using our own money to travel to the clinics with no reimbursements, we lost interest to collaborate. I must not therefore use money coming from my practice to finance collaboration activities such as going for all these frequent meetings at the clinic (Mt.2/Dv/F).*

#### **4.3.10 Theme 6: THs suggestions for strengthening sustainable collaboration**

During fieldwork, the researcher asked each participant to provide some suggestions or recommendations on how collaboration between THs and BHPs can be improved and sustained. The suggestions are summarised under 3 sub-categories according to whom they are directed to:

- the Department of Health,
- THs themselves
- AMREF or other supporting agencies.

##### **4.3.10.1 Suggestions for DOH**

The suggestions participants made to National Department of Health include providing basic resources, policy formulation and implementation, education and training of traditional healers, the equal recognition of THs. The researcher find all of these interrelated and foundational to establishing and maintaining collaboration in the fields of HIV/AIDS and TB. The subcategories can thus be presented in different sequences.

It seems appropriate that the National Department of Health first need to ***develop and implement more clear policy guidelines to inform collaboration between THs and BHPs.*** Participants suggested in this regard:

- *Doctors, clerks, teachers; all have policies that guide them. All these groups have. But as THPs and doctors, we need a policy that will bind both us and BHPs to work together, we must be equals. There must also be rules on how to work with each other. I can go back to collaborate if there is a clear program of collaboration driven by the Government (Mt.1/Dv/M).*
- *THPs want to work openly and under proper guidance and policies (Mt.2/Dv/F).*
- *We want each clinic to know the names of all the healers who were trained, to know us by our names. Again, when we arrive get there, even if there is a new nurse, she must see this list and know who the THs in the area are that she needs to collaborate with (Mt.3/Dv/F).*

The suggestions towards clearer policies also indicate the participant HPs request for acknowledgement, not only is health care worker but as persons. Awareness and acknowledgement of the contribution and existence of both parties, at all levels, are called for. Such acknowledgement becomes more evident in participants direct request to ***strengthen and recognise THs as professional partners in the health care delivery system.*** In this regard, participant suggested:

- *It is also important to get protection from the law and support. At times these people who have consulted healers die, in as much as they can die at the hospitals. However, if they die at the hands of healers, it's a huge problem. We need to be protected because we are not killers (Mt.1/Dv/M).*
- *You see we are also health workers like nurses (Mt.2/Dv/F).*
- *The Government must enforce laws for all healers to be registered and monitored by the THP committees (Mt.2/Dv/F).*

It appears that the participants' views are that their quest for recognition might be advanced by ***strengthening collaborative management structures and systems.*** Participants suggested amongst other things that nurse be trained to collaborate and cooperate with THs, that staff turnover in this regard be kept to a minimum and that referrals be acknowledged by back referrals to THs. Participants had the following on their mind:

- *The focal nurse for THPs knew very well that we also had our own way of dealing with patients. The good thing is that when we were being trained, she was also trained. In that way, she understood clearly that there was need to refer back patients to us for further observation and management so that a patient will fully recover (Mt.2/Dv/F).*
- *We need to revive the clinic that I spoke about earlier on. The way in which that clinic functioned was very good. A professional nurse was employed by AMREF to specifically attend to patients that were being referred by THPs. That is where you would find a THP and nurse working side by side in a complimentary manner (Mt.2/Dv/F).*
- *DOH must not remove those nurses who have been trained because this causes that a new person who has not been trained is brought in without any knowledge or even becoming just arrogant (Mt.3/Dv/F).*

The joint training of BHPs, especially nursing staff and THs could improve knowing one another, understanding one another's viewpoints and thus supporting collaboration. THs' perception of their contribution and the need for consultation with HPs to arrive operational policies are reflected by the following suggestion:

- *To DOH, I would like to say that they must make an effort to bring us on board so that we discuss and correct all the things that have not been going well. In that way, we can see some improvements in the way we work together (Mt.5/Hb/M).*

However, a crucial point still seems to be equal and reciprocating recognition. That is:

- *Where we cannot help, we refer to BHPs. Health facilities must also refer back to us. It should not be a one way thing (Mt. 1/Dv/M).*

In addition to policies to establish reciprocal recognition and providing guidelines for collaboration, participants were also aware of their need for education and also continued education initiated and maintained by the DOH. It was suggested that not only should HIV/AIDS and TB feature in such educational programmes but also information for BHPs on traditional healing, medicine and healers to ***educate/ train or orient BHPs on how to collaborate with THs as well as the role that THs can play in HIV/AIDS-TB programs.*** In this respect, informants suggested:

- *They must accept that we can help communities*
- *I think this issue calls for a lot of education; not only for us as THPs but for the BHPs as well. These nurses need to be educated on how to work with us (Mt.1/Dv/M)..*
- *They need to know how to take us as partners. Therefore, this education is more needed on the part of nurses so that they get to know and understand how to treat us (Mt.2/Dv/F).*
- *DOH must teach nurses at the clinics to respect THs. There is need for AMREF to train nurses so that they learn about the right ways in which they should collaborate with THs (Mt.3/Dv/F).*
- *Nurses must welcome the patients that we refer in a nice manner (Mt.3/Dv/F).*

Further to the call on DOH to include pertinent attempts at promoting collaboration, participants also called on the Government to ***develop and implement a continuous education and training program for THs*** to keep THs up dated on disease profiles. Participants thus suggested:

- *Even ourselves as THPs, we need to be told and appreciate that new diseases come up every day. And when these new diseases come, we need to be educated on how they occur and how they can be managed. These nurses and doctors must educate us such things (Mt.2/Dv/F).*

It appears that policies, recognition and training would all go to waste without providing basic resources needed by the THs such as ***basic infection control materials and kits.*** Participants suggested:

- *It was just for one or 2 or 3 months when we received Home Based Care kits. After 3 months, nothing ever came. I can say that this is the most important thing which makes our work to be very difficult (Mt. 1/Dv/M).*
- *DOH must help us with materials and resources to help us with our work. We want money for travelling to meetings. Our patients need food, sleeping places, blankets and water when they come to us for treatment (Mt.3/Dv/F).*
- *Why does the Government not help us with these things as they do with hospitals? Is it not that when you are admitted at Hlabisa hospital you are given a bed with blankets, you are given food and water? We also work almost like hospitals (Mt.3/Dv/F).*

This piece of information from THs has some major implications (and misconceptions) as to what hospitals are and what consulting rooms are. It is a fact that THs operate in almost similar fashion with private western medical practices that fully fund their operations without Government grants or subsidies. This demonstrates some form of misconception of collaboration amongst THs as they expect to be funded or subsidised like public health facilities and therefore calls for education for THs about Government subsidies for health facilities.

#### **4.3.10.2 Suggestions for THs**

Participants were not ignorant of their own shortcomings and their role in the breech of collaboration with BHPs. Participants indicated that they themselves had to **eliminate all self-imposed obstacles to successful collaboration such as improving acceptability through good hygienic practices.** The evidence includes reference to personal appearance in which instance a participant remarked:

- *On one hand, the blame should be on us as healers. This practice and tendency of healers to behave and treat themselves in an unpleasant manner. How can people want to have you close by if you are dirty? (Mt. 1/Dv/M).*

Participants also indicated that THs have to **cultivate a sense of initiative and responsibility to improve the image of their practice.** They mentioned that:

- *It's not just that you must always be introduced by an NGO, but you can go and introduce yourself. You can attend clinic meetings so that you get to be known. So, some of the blame lies with us (Mt.1/Dv/M).*
- *There is a need for us to also participate in clinic committee meetings so that we get to know what is happening there and the changes that have taken place because we are no longer aware of any new developments (Mt.4/Hb/F).*
- *I can only encourage our TH committee members such as the chairpersons to ensure that our members are represented at the clinic committees. This will help ensure that our issues are addressed and heard at that clinic. This will make everyone see how important this collaboration is (Mt.5/Hb/M).*
- *Since we take AMREF as our go between with health facilities, THs must accept AMREF's help and not think that they are being judged or being accused of wrongdoing (Mt.6/Dv/M).*

The call to take initiative and responsibility on the part of THs is reverberated in participants' call **adherence to policies and guidelines that professionalise TH as a practice as well as self-regulation**. Participants mentioned that:

- *Another challenge is about bogus healers who do not know anything. They rob and kill people. The law must deal with them if they are not registered. The law says that all healers must be examined for their knowledge and be monitored by senior and experienced healers. We cannot be examined by BHPs because they do not know of our practices (Mt.1/Dv/M).*

In the same vein, participants indicated that THs should **mobilise and motivate other THs to undergo training and carry out mutually beneficial collaboration**.

This is reflected by statements such as:

- *The most important is to prioritise training or education in order to enlighten people. Most of the healers who missed the training that was provided by AMREF are still in the dark. If money can be found, I will strongly recommend that training be provided to all healers (Mt.2/Dv/F).*
- *Our leaders or representatives in our associations can try to mobilise us again and especially those people who were selected to visit us in our homes to come again (Mt.4/Hb/F).*

Internal cooperation among traditional healers was also requested by participants. They called for ***avoidance factionalism amongst different THs' associations and unity for the purpose of gaining respect and recognition from Government.***

Participants said:

- You see we have our own challenges as healers especially that we belong to different associations. When AMREF comes to work with us as healers, they must not segregate us according to the different associations that we belong to (*Mt.6/Dv/M*).

The call for unity among THs is also reflected by participants call for ***peer support*** among THS. Participants said:

- *If you are working and you see other healers being reluctant, then you see 2 or 3 dragging their feet, it also affects you and you lose interest (Mt.1/Dv/M).*
- *We could meet as THs and discuss our concerns together and also help each other understand the importance of collaboration with clinics (Mt.5/Hb/M).*

#### **4.3.10.3 Suggestions for facilitating agencies (AMREF)**

The suggestions participants had with regard to AMREF are of special importance to the current study as they help in determining factors that affect collaboration between THs and BHPs. This reflects directly on the problem statement for this research project as was stated in section 1.5 which was identified as the high attrition or dropout rate of trained THs from HIV/AIDS-TB collaboration projects between BHPs and THs.

Participants were adamant that AMREF needs to ***ensure that collaboration programs have a clear and effective exit strategy to facilitate continuity of post project funding.*** Participants said suggested that:

- *AMREF started very well but I think they must consider putting aside money that can be used to sustain the project beyond the agreed funding timelines with their donors (Mt.6/Dv/M).*

Such financial backup would, however, only be beneficial should AMREF ***build the necessary capacity and put in place mechanisms within the project that would ensure proper structures and systems for the management of collaboration.***

Participants were adamant that:

- AMREF must come back and represent us and talk to the DOH (Mt.3/Dv/F).
- AMREF must mobilise clinics and remind them that we are still around or available and we need to work together (Mt.4/Hb/F).
- We ... need to be motivated and encouraged to continue collaboration. We can also ask AMREF to come back and facilitate dialogue between us and DOH. In that meeting, the nurse in charge of our clinic must also be present to hear our concerns and only in that way can we go back and collaborate with DOH (Mt.5/Hb/M).
- The main message to AMREF is for them to come back and continue giving us more knowledge and trainings (Mt.5/Hb/M).

Participants also launched a call to AMREF to **maintain impartiality when dealing with TH members from different associations.** This also links up with participants' request that THs themselves should strive for unity.

Participants indicated that:

- They (AMREF) must not give favours to one association at the expense of another. Otherwise if they seem to take sides, this will cause problems and we will not be able to continue collaborating and participating in projects (Mt.6/Dv/M).

With the quest for unity and fair dealing, the ***cultivation of a sense of mutual respect between THs and BHPs through training and orientation of both groups was suggested to AMREF.*** Participants said that:

- Where we do not undermine each other, where we are partners, equals. Because we have knowledge as much as they have (Mt.1/Dv/M).
- Open the process of trying to improve relations with our health facilities; I think we can be motivated again and continue working in the same old way because it used to go on very well (Mt.4/Hb/F).

## 4.4 OVERVIEW OF RESEARCH FINDINGS

In this section, the researcher provides an overview of the findings by way of classifying and describing them according to my anticipation:

- *Information the researcher had expected to find*
- *Information the researcher had not expected to find*
- *Information the researcher found conceptually interesting or unusual.*

This overview is provided within the framework of cross referencing to the literature review that was largely carried out in chapter 2 of this dissertation. Uncovering my anticipation of certain findings also relates to my self-reflection (see section 3.4.3.3)

### 4.4.1 Information the researcher had expected to find

Based on my experiences from being associated with the AMREF TH project as well as the literature review the researcher conducted, he had a few expectations on what would come out of the interviews.

#### 4.4.1.1 Respect for and popularity of THs amongst African populations

Having spent almost three years providing technical support to the implementation of the AMREF project, the researcher had no doubt in my mind that the popularity of THs in their communities would be quite high. THs have a significant role in health care service delivery and especially so in those programs that aim at increasing HIV and TB case finding in communities. The findings of this research indicate that THs are aware of their popularity and therefore the participants overwhelmingly confirmed that the majority of TB and HIV suspects would consult them first before going to the health facility. This practice puts THs in a unique and advantageous position to play a significant role in making referrals to health facilities to screen all TB and HIV suspects. The findings also show that THs command a lot of respect from communities and if they advise patients to get to know their HIV and/or TB status, they usually are listened to.

This observation is confirmed by literature that says that traditional medicine is part of the culture and heritage in Africa and that it is affordable and easily accessible and is utilised by between 60% and 80% of sub-Saharan African community members (Mills, Singh, Wilson, Peters, Onia, & Kanfer, 2006; Peltzer et al 2006; Kange'ethe 2009; Cook 2009; Simmons 2009).

#### **4.4.1.2 Disrespect, mistrust and ignorance by BHPs about traditional medicine**

My personal experiences on interacting with BHPs (medical doctors and nurses) and reading literature review shows that the majority of BHPs are ignorant with regard to traditional healing, healers and medicine, or have a general tendency toward disrespecting traditional healing as was described in Chapter 2 (2.5.1, 2.5.2, 2.5.3). The findings of this research confirm this view as presented in section 4.3.3. The participants were unanimous in their experience of extreme forms of disrespect, mistrust and ignorance originating from BHPs.

#### **4.4.1.3 Lack of material support, resource allocation and incentives**

There is very limited literature written about the provision of material resources and incentives for traditional healers as being one of the critical factors associated with unsustainable collaboration. Whilst the UNAIDS (2006) does not make apparent reference to this factor, Kuenzel and Welscher (2009:18) point to the fact that one of the important ingredients of successful collaboration is the potential benefits and incentives it holds. This means that material support, incentives or resource allocation can be directly linked to inflexibility to the success or failure of collaboration.

When reading the AMREF project evaluation report (2007:23), the researcher had known that most THs who participated in the pilot project were unhappy about lack of material support and allocation of resources including money to carry out collaborative activities. The participants in the current research project were very clear about their unhappiness with lack of such support and more so, having to use their own money to attend collaborative meetings with BHPs.

This was made worse by the fact that the DOH seemed to have abdicated or reneged from its promises to continue providing THs with home based care kits and protective clothing/masks for infection control purposes after AMREF has withdrawn from the project. In some cases, THs had expected to be paid some form of allowance or incentives for their role and participation in collaborative activities. Some of the participants in this research project were very clear that lack of monetary incentives was a letdown and made them lose motivation to continue collaborating with BHPs.

#### **4.4.1.4 Poor management structures and mechanisms for collaboration**

According to Kuenzel and Welscher (2009:25), collaboration is a very complex assembly of human (people/individuals, relationships) and non-human elements such as technologies, policies, guidelines. For all these elements to work together, they require to be managed closely. In my experience, working on this project and through literature review, the researcher had known that collaboration between THs and BHPs was poorly managed. The project was too dependent on the external, though temporary, facilitation by AMREF with the DOH not taking an active role towards sustainability of the project and consequently of collaboration and involvement of THs. There were no policies or guidelines developed and deployed on how to manage collaboration.

The project seems not to have planned building and strengthening an effective mechanism or structure to manage collaboration after the end of the funding cycle. True to this observation, the participants were very vocal about their frustrations in trying to engage DOH post AMREF support. The model clinic which had been set up to demonstrate the potential and benefits of collaborative practices by both parties within the same facility died a natural death after the end of AMREF support. The UNAIDS (2006) supports the idea that a collaborative clinic is one of the most practical ways to ensure sustainable collaboration.

In these findings, the participants expressed displeasure with the closing down of the model collaborative clinic in Mtubatuba municipality. The participants blamed the lack of clear policy around management structures or mechanisms for collaboration by DOH as a key factor in this regard.

#### **4.4.1.5 Policy deficiencies on guiding the traditional healing practice**

In the literature review section of this dissertation, the researcher pointed out that there have been several negative media reports about THs and their practices. A lot has been said about bogus healers and the exploitative tendencies of THs. This is largely because there are policy deficiencies around the governance and management of traditional medicine. In as much as the Traditional Health Practitioners Act (Act No. 22 of 2007) (South Africa, 2008) and the National Drug Policy of 1996 (National Department of Health, 1997) try to provide the legal framework for the practice of traditional healing in South Africa, these two legal documents are not backed by relevant policy guidelines and standard operating and maintenance procedures. This leads to the proliferation of bogus healers who are just out to swindle people and make easy and quick money from desperate people. The findings of the current research confirmed this view whereby the participants clearly articulated their frustration with the lack of regulation of traditional healing guidelines, monitoring of the TH practice as well as lack of professional protection for genuine THs in instances of lawsuits for perceived malpractice.

#### **4.4.1.6 Acknowledgement of capacity building benefits**

The participants acknowledged that there were huge benefits of collaborating with BHPs as they have to learn things that they would not have ordinarily learnt from their own practice. This finding is corroborated by the literature review in Chapter 2 (Section 2.4.6) as seen in the examples of Botswana, Central Africa Republic, Nepal, South Africa and Tanzania (*Chipfakacha 1997:420, Somse, Chapko, Wata, Bondha, Gonda, & Johnson 1998:559, Poudyal et al 2003:957, Peltzer et al 2006:688, Kayombo et al 2007:13, Bodeker et.al; 2000:1284*).

All the examples cited above echoed the same observation that the participating traditional healers showed great keenness/interest to know more about HIV/AIDS where they acknowledged the advantages of western medicine when it came to diagnosing HIV/TB. In this current study, the participants stated that those THs who had missed out on the initial training provided by AMREF were now coming in numbers to request to be trained in basic HIV/AIDS and TB epidemiology. They overwhelmingly acknowledge being transformed and enlightened by western medicine when it comes to their gaining knowledge on HIV/AIDS and TB. Their keen interest to learn and collaborate on the referral of query HIV+ and TB patients can perhaps be explained by the fact that there are no scientifically proven traditional methods to detect HIV infection or TB. Thus, patients presenting to traditional healers will not know their HIV and/or TB status until they are tested through western medicine practice.

#### **4.4.2 Information the researcher had not expected to find**

As with any other research, this study came up with findings that were very unexpected. These are the real contribution of the current research to the existing body of knowledge.

##### **4.4.2.1 Upholding of ethical principles by THs**

In section 2.3.2.1 of the literature review, the researcher cited concerns by Nyika (2006:31) who strongly argued that although traditional healers have been playing a major role as providers of primary health care to the majority of people in Africa, they tended to expose patients to harm because of practices that violate almost all the ethical principles of justice, autonomy, confidentiality, beneficence and non-maleficence. To the contrary, the researcher was pleasantly surprised to realise that THs uphold high ethical standards in their practice. This is evidenced from the findings that THs tend to put the welfare of their patients ahead of their own gains. In one way or another, all the participants indicated that despite facing challenges to conduct mutual collaboration with BHPs they still found reason to continue referring patients who were in need of health care facilities for HIV and TB screening. This was done solely for the benefit of the patients.

In instances where THs noticed that their patients required western medical interventions, they tried hard to find their way around barriers to successfully collaborate with BHPs by using covert methods of patient referrals.

#### **4.4.2.2 Conduction of intra-referrals**

From the interviews' data, the researcher also found that THs conducted intra-patient referrals amongst themselves because they have different specialties in their practices. The literature reviewed did not show that this practice of intra-referrals amongst THs existed. In most literature reviewed about the practice of traditional medicine (Moodley and West 2009, Nyika 2006 and Kangwa and Catron 2010), the researcher found that they only define and describe different categories of THs such as diviners/spirit mediums, herbalists and others who include traditional surgeons and traditional birth attendants. The issue of specialisation and intra-referrals is therefore inconspicuous in available literature and was therefore not expected to be found from the interviews conducted during this research project.

#### **4.4.2.3 Weak or poor exit strategy by AMREF (lack of contingency)**

Although the researcher work for AMREF and indirectly provided technical support to this project on collaboration between THs and BHPs, it had never occurred to me so clearly that the exit strategy for this project was so poor or weak that it contributed to some THs (participants) '*stopping collaboration*'. In order to build long term sustainability, UNAIDS (2006:17) says that rather than short-lived interventions, a longer-term commitment allows both traditional and biomedical practitioners to improve their capacity, develop a genuine interest in each other's strengths and build a trusting relationship with each other as well as cementing these new ties.

The findings of this research shows that almost all sort of support and coordination that AMREF staff provided to this project immediately stopped or weakened as soon as the funding for the project ended. The research participants were unanimous in their views and observations that AMREF's exit was rapid and rushed without staying long enough to prepare the DOH to fully to take over these responsibilities.

This rushed pilot intervention of two years reflective of lack of long term planning contributed a lot to the weakening of collaborative activities and disillusionment amongst THs. Where AMREF used to supply THs with home based care kits and protective clothing for infection control, the DOH did not take this up despite having promised that they would do so. The same goes for the mobilisation and coordination of THs that according to the research participants also stopped when AMREF exited.

#### **4.4.2.4 Competition or fear of business loss being responsible for stopping collaboration**

In chapter 2 of this dissertation (section 2.5.3), the researcher indicated that most healers solely make a living out of the traditional healing practice in a sector valued at R2,9 billion rand annually (Health Systems Trust; 2011:187). The researcher had therefore strongly expected that the fear of losing out on business to western medicine practice would be cited as one of the reasons for trained THs to stop collaborating with BHPs. However, from the findings of this research, it is evident that when it comes to HIV/AIDS and TB, THs are fully appreciative of the benefits of referring suspects to health facilities and screening.

The participants were unanimous that making referrals of HIV and TB suspects to health facilities would not in any way affect their business and profitability. In fact, the participants boasted that by ensuring that they (THs) knew the HIV/TB status of their patients, it enabled them to make the best decisions on how to deal with such patients; in a way that would ensure that they avoid giving herbs that compromise ARVs and TB drugs. These THs said that they have now been educated and realise that the use of both traditional medicines and ARVs has a potential risk of causing ARV drug resistance amongst patients. In that way, they would instead offer complimentary traditional medicines that treat opportunistic infections, boost nutritional status and offer complimentary psycho-social support. They would still charge for their services and at the same time, the THs get to see a wide range of clients for different consultations that are not necessarily HIV/AIDS or TB related.

#### **4.4.3 Information the researcher found conceptually interesting**

In this section, the researcher presents information that has some interesting link to the concept of collaboration; especially those pertinent perceptions on this concept by the healers. In this regard, three issues emerged: covert collaboration, lack of reciprocity in collaboration and autonomy and professionalisation of the practice of traditional medicine.

##### **4.4.3.1 Covert collaboration (Lack of transparency)**

At the time of conceptualising this research topic on '*perceptions of THs on collaborating with BHPs in HIV/AIDS-TB programs*', the researcher had assumed that the concept of '*stopped collaboration*' meant dropping out, disengagement or total severance of a relationship with western medicine and its practitioners in its literal sense. With that in mind, the researcher had therefore purposefully selected those THs who claimed to have stopped collaborating with BHPs. To my surprise, all six participants still had some form of relationship or link with BHPs although in an indirect way. All of them indicated that they still referred patients who seemed to require the expertise of western medicine. In that context, the THs used covert means of collaboration such as not using referral forms, not accompanying patients to health facilities and advising patients not to reveal to BHPs that they had been referred by THs. This, they said they did in order to protect their patients and themselves from harassment and humiliation by uncooperative and abusive BHPs who despise and denigrate traditional medicine.

This practice of covert collaboration strongly symbolises lack of transparency between the collaborating parties. The UNAIDS (2006:18) states that open discussions between the two systems (THs and BHPs) can foster dialogue, acceptance and understanding on both sides. The unusual concept of '*covert*' collaboration is therefore conceptually interesting as it demonstrates that most THs who practise covert collaboration have the welfare of their patients at heart and recognise and appreciate that western medicine has its own advantages over traditional medicine and vice-versa. In this context, facilitators such as AMREF and authorities such as DOH must grab this opportunity and bring back these THs to practise overt collaboration.

#### **4.4.3.2 Lack of reciprocity in referrals for mutual collaboration**

In chapter 2 (section 2.5), the researcher stated that the UNAIDS (2006:28) says that some of the most important factors for successful collaboration are the respect of the value of complimentarity of the two health care delivery systems, showing humility and cultivating transparency. In the findings of this research all the six participants pointed out the frustrating experiences of lack of two-way referrals; back referrals and feedback on patients referred to BHPs. This was more frustrating where THs went out of their way to refer patients to health facilities (BHPs) and, in most instances, not receiving any feedback, let alone acknowledgement of their gesture. The principles of reciprocity, complimentarity and mutual respect are very important if mutual collaboration is to be achieved.

#### **4.4.3.3 Autonomy and professionalisation of traditional medicine**

The UNAIDS (2006:28) states that traditional medicine has had a history of oppression in many countries and regions in Africa. In that context, healers have tended to grab the opportunity and respond positively when biomedical health practitioners showed any genuine interest in their work. This interest seems to give THs much-deserved recognition and respect in the community. This has led to healers working hard to organise themselves in well constituted bodies such as the Traditional Healers Organisation, the National Union of Traditional Health Practitioners Association of South Africa and many others. These unions and associations have come up with codes of conduct and ethical guidelines on how traditional healing should be practised in a more professional manner. In this research study, findings echoed the need to professionalise traditional healing and institute self-regulation policies for THs.

The participants pointed out the need to conduct their business in a professional manner through officially recognised self-regulating bodies. In this context, the challenge posed by bogus healers who are usually out to swindle communities of their money and at the same time tarnishing the image of genuine healers came out strongly. The researcher had least expected to find such a strong commitment by healers to professionalise their practice through proper regulations/ policies.

## **4.5 CONCLUSION**

In this chapter, the researcher presented the findings resulting from interviews with selected THs in Mtubatuba municipality of the UMkhanyakude district in KwaZulu Natal. The researcher presented the findings in the form of 6 main themes, and several categories and sub categories. The presentation of findings also incorporates biographical details of the participants. These themes and categories are constituted by data units presenting the exact words of the participants. The researcher also discussed the findings within the context of relevant literature; and with specific reference to chapter 2. In the next and final chapter of this dissertation, the researcher presents the summary of key findings as well as conclusions and recommendations of this study.

## **CHAPTER 5**

### **CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS**

#### **5.1 INTRODUCTION**

In this chapter, the researcher present conclusions and recommendations based on the findings as discussed in chapter 4. The main objective of drawing conclusions is to demonstrate the extent to which the research question was answered together with the research objectives. The recommendations are aimed at highlighting areas that need further investigation or assessment in improving sustainable collaboration between THs and BHPs.

#### **5.2 RESEARCH DESIGN AND METHOD**

This study was carried out using a qualitative descriptive and contextual design where the researcher sought to discover and understand the phenomenon of collaboration between THs and BHPs. This design is recommended by several authorities for its strength in pulling out perspectives and worldviews of the people involved in a phenomenon (Cooper and Endacott; 2007:816). As was discussed in chapter 3 (3.2.2), Padgett (2008:15) and Streubert and Carpenter (2011:20) confirm that the qualitative descriptive and contextual approach to research is the one in which the researcher often makes knowledge claims based on “lived experiences” of the research participants. In that context, the researcher therefore employed the qualitative descriptive and contextual approach using semi-structured interviews with six purposefully selected participants to collect data in the natural (contextual) settings. The aim of this study was to establish the perceptions of the “*drop out healers*” and to describe their experiences on collaboration with BHPs.

## 5.3 SUMMARY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

In this section, the researcher presents a summary of the findings, drawing conclusions on the as well as making some recommendations based on these findings.

### 5.3.1 Popularity and respect for THs amongst African populations

- ***Finding:*** The study participants (THs) perceived themselves as highly popular and respected by members of their communities who in most cases consulted them first before seeing BHPs.
- ***Conclusion:*** THs are an integral part of health service delivery in most African communities and therefore could play a major role in HIV/AIDS and TB programs that the Governments (Department of Health) rolls out in communities. This is coupled by the fact that more often than not, patients are the ones who initiate the process of consultation with health service providers and will usually start with the most affordable and accessible system (i.e. traditional medicine).
- ✓ ***Recommendation:*** HIV/AIDS and TB programs should capitalise on the popularity of THs amongst community members by clearly defining mutually beneficial collaborative programs where THs play a major role in case finding/identification of TB/HIV suspects and referring them to health facilities for proper diagnostics and treatment. Their role should include that of treatment support to improve adherence to treatment (ARVs/DOTS). In this way, collaboration can be strengthened and sustained.

### 5.3.2 Disrespect, mistrust and ignorance by BHPs about traditional medicine

- ***Finding:*** The participants unanimously came out loud and clear that they had experienced high levels of disrespect, mistrust and ignorance on traditional healing by BHPs.

- **Conclusion:** Whereas THs have demonstrated a high commitment and willingness to collaborate, BHPs seem to be very ignorant of the value and benefits of working collaboratively with THs. THs have acknowledged that the 2 systems of health have their own strengths and weaknesses necessitating collaboration to ensure better patient care and health outcomes. However, BHPs tend to look down on THs compounded by high levels of mistrust. This has rendered the element of reciprocity null and void in such collaborative programs and thereby pushing some THs to discontinue collaboration.
  
- ✓ **Recommendation:** Any program that seeks to strengthen collaboration between THs and BHPs must ensure that there is a two-way education process for both THs and BHPs.

In as much as THs are being taught basic HIV/TB epidemiology and the benefits of collaborating with BHPs, the reverse is true where BHPs must also be taught about the value and place of traditional medicine and how good working relationships with THs can benefit patients who consult both health care service providers. The Government must provide for opportunities for trainee BHPs to be exposed to the practice of traditional medicine as well as planning for and carrying out dialogue sessions between THs and BHPs. Supporting agencies such as AMREF must not just focus on training/educating THs on how to collaborate but do the same thing for BHPs.

### **5.3.3 Lack of material support, resource allocation and incentives**

- **Finding:** Participants in this study expressed great disappointment with the lack of material support and resources/equipment and finances to fully carry out their collaborative activities (home based kits, protective clothing/masks-infection control, transport money). Participants had experienced the agony of having to dig deep into their pockets to fund collaborative activities such as forking out money from their pockets to attend meetings with the DOH. Such negative experiences were made worse by the apparent abdication by the DOH to provide such materials when AMREF exited.

- **Conclusion:** THs who were participating in the collaborative program led by AMREF had high expectations of continuing to receive material/equipment and financial support from the Government after the exit of AMREF. This implies that the hand-over take over process from AMREF to DOH was not well executed. Similarly, it shows that THs were not taught or encouraged to take the issue of using protective clothing and to execute infection control mechanisms as a way of improving their own practice and therefore a worth investment by themselves.
- ✓ **Recommendation:** There is need for the Government (DOH) and supporting agencies such as AMREF to balance between encouraging THs to improve the image of their private practice though investing their own resources on basic materials such as kits and masks and providing financial and transport assistance to THs for their engagement/participation in collaborative activities outside their areas. Both DOH and AMREF must ensure that there is a proper hand-over takeover of roles and responsibilities to support and strengthen collaboration. The DOH must honour promises and commitments that they make to THs instead of just vanishing and keeping silent. AMREF should also seriously consider returning to salvage the project by ensuring that there is a sustainable exit strategy where both DOH and THs are left in a position to take forward all the gains made.

### **5.3.4 Poor management structure and mechanisms for collaboration**

- **Finding:** The research participants strongly felt that the whole process, structure and mechanism of collaboration with THs were poorly managed. There were no policies, guidelines standard operational procedures to guide both THs and BHPs on how to meaningfully collaborate. This was exacerbated by the fact that even the seemingly very successful model collaborative clinic in Dukuduku in Mtubatuba municipality was left to collapse after the exit of AMREF.

In this clinic, both THs and BHPs practised within the same premises in different consulting rooms where patients would choose where to start from and get referred from one room to another easily.

- ***Conclusion:*** There was lack of policy guidance and direction by both the DOH and AMREF in terms of how successful and sustainable collaboration should be managed.
- ✓ ***Recommendation:*** The Government through the DOH must put in place clear policy guidelines on how collaboration between THs and BHPs must be managed. This entails explicit identification of roles, responsibilities, putting in place appropriate structures such as model clinics to manage this collaboration.

The DOH can start by setting up a few health facilities for collaboration in each municipality that are modelled along the same principles and structure of the Dukuduku clinic where THs and BHPs saw patients within the same health centre (but different consulting rooms) with patients being referred easily and quicker. The Government should also deploy relevant and adequate human, financial and material resources support productive and sustainable collaboration.

### **5.3.5 Policy gaps on the traditional healing practice and professionalism**

- ***Finding:*** The participants cited experiencing numerous challenges associated with lack of clear-cut guidelines and policies on the practice of traditional medicine. These deficiencies in policy have in one way or the other contributed to the proliferation of bogus THs and lack of professional protection for genuine healers in instances of lawsuits against them. This has led to numerous challenges on providing an enabling and regulative framework for the practice of traditional medicine.

- **Conclusion:** Despite having the Traditional Health Practitioners Act (Act No. 22 of 2007), this piece of legislation has not been complimented with relevant policies to implement its provisions.
- ✓ **Recommendation:** The Government must enact policies to guide and regulate the practice of traditional medicine where some degree of self-regulation and professionalism amongst THs is provided for. This will go a long way in moving traditional medicine towards being formally recognised as an integral part of the health delivery system where both patients and healers are protected from any potential harm. In that way, collaboration between THs and BHPs could be improved and sustained.

### **5.3.6 Acknowledgement of capacity building benefits**

- **Finding:** The participants stated that they were transformed and enlightened through the education/training that they received from the workshops on basic HIV/AIDS and TB epidemiology.
- **Conclusion:** From these findings, the researcher concludes that there are huge benefits of capacity building for THs that help them to understand the basic science of HIV and TB. This on its own goes a long way in making THs understand the supremacy of western medicine when it comes to these communicable diseases and thereby making them (THs) see the urgency and need to refer all suspects to health facilities for screening and proper diagnosis. Once this happens, collaboration can be enhanced through timely referrals.
- ✓ **Recommendation:** the researcher therefore recommends that both the leaders of THs and the DOH must prioritise training for all THs with the view to improve their understanding of basic HIV-TB epidemiology. The THs leaders can mobilise fellow healers for such trainings with DOH putting resources aside for continuous training of the identified THs.

The more THs are trained and exposed to such facts, the more likely will there be genuine and sustained collaboration where there is feedback, mutual trust and transparency.

### 5.3.7 Upholding of ethical principles by THs

- ***Finding:*** In this research, the researcher found that most THs uphold high ethical standards when it comes to patient welfare (beneficence, non-maleficence) as well as protecting the dignity of their practice.
- ***Conclusion:*** Contrary to widely held beliefs (*especially by some BHPs*), that THs are bent on exposing patients who consult them to harm; the opposite seems to be true. This is seen through the keenness of most of the participants who went out of their way to carry out covert referrals for the sake of the welfare of their patients, despite the barriers and resistance they faced from BHPs. This therefore demonstrates that genuine THs and traditional medical practice is ethical sound.
- ✓ ***Recommendation:*** BHPs must be educated and exposed to the practice of traditional medicine so that they dispel the myths of viewing traditional medicine as some form of mal-practice in its entirety. Once this happens, the likelihood of improving tolerance and sustainable collaboration might be attained.

### 5.3.8 Conduction of intra-referrals

- ***Finding:*** Some of the participants reported that they do conduct intra-referrals of patients amongst themselves given that they have different specialties.
- ***Conclusion:*** THs have different specialisation in their trade and acknowledge their different talents and capacities. This therefore motivates them to get to know what their colleagues specialise in for the purposes of referring their clients/patients appropriately within the traditional medicine practice.

- ✓ **Recommendation:** The practice of intra-referrals provides an opportunity for collaboration programs to facilitate interaction amongst different THs and with BHPs to get to know what each one of them specialises in.

Facilitators must encourage THs to interact amongst themselves and across with BHPs to discuss their specialisation areas so that they widen their database for potential referrals. Similarly, BHPs also need to take note of and appreciate that THs specialise in different areas of traditional medicine including their prowess to provide socio-cultural care for patients. This can easily be facilitated during training sessions or meetings that involve THs and have a potential to improve relations amongst THs for the benefit of patients.

### 5.3.9 Weak or poor exit strategy by AMREF

- **Finding:** The participants perceived the exit strategy of AMREF as very poor and significantly responsible for their “*stopping collaboration*” with BHPs. This is largely due to the fact that as soon as AMREF stopped supporting or taking a lead in ensuring that both THs and BHPs work together, relations and intensity of collaboration took a nose-dive.
- **Conclusion:** Short-term interventions and a weak exit strategy by a supporting agency such as AMREF in collaboration programs is a recipe for the collapse, discontinuation or unsustainable collaboration between THs and BHPs. It is clear that AMREF’s exit from this project was rushed and did not plan for sustainability.
- ✓ **Recommendation:** A long-term (3+years) commitment and a well-planned exit strategy to roll out and nurture collaboration are key ingredients for sustainability. This will allow enough time to build capacity of both THs and BHPs to a point where they begin to develop genuine interest, tolerance and acknowledgement of each other’s strengths and cementing working relations for genuine collaboration. In the same vein, the supporting agency (AMREF) will have enough time to prepare the Government (DOH) to fully take over the coordination and management responsibilities.

### 5.3.10 Covert collaboration- Lack of transparency, trust and reciprocity

- **Finding:** The concept of “*stopped collaboration*” denoted the practice of carrying out covert referrals of patients to health facilities. This entails practices such as of not using referrals forms, not accompanying patients to health facilities and advising patients to avoid informing BHPs that they had consulted THs prior to coming to the health facility.
- **Conclusion:** The practice of carrying out *covert referrals* is a strong indication for lack of trust, transparency, respect and reciprocity between THs and BHPs. Patients are the biggest losers in this set up as they are caught up in a feud between BHPs and THs stemming from inter professional mistrust, disrespect and lack of cooperation.
- ✓ **Recommendation:** Collaborative programs must foster open and honest dialogue between THs and BHPs to understand the benefits (strengths and weaknesses) of each system and thereby demonstrating the value of collaboration.

Efforts of supporting agencies such as AMREF and DOH as the responsible partner and leaders of THs must all recognise and push for ensuring that overt referrals are carried out where there is mutual trust, transparency, reciprocity and respect for both parties. In that way, sustainable collaboration can be realised. Cross-referrals (two-way) must be promoted. Whereas THs refer suspect HIV-TB patients to BHPs for screening and appropriate treatment, BHPs must in return refer TB-HIV/AIDS patients back to traditional healers for treatment adherence counselling and socio-cultural care for which biomedical treatment is usually not strong in. THs have also been known to manage opportunistic infections such as skin rashes, herpes zoster, chronic diarrhoea, pains and fatigue very well.

## 5.4 CONTRIBUTIONS OF THE STUDY

The researcher is hopeful that his study has made some reasonable contribution to the domain of traditional healing especially as it relates to improving sustainable collaboration between THs and BHPs in the context of HIV/AIDS and TB programs. In line with the three objectives of this study namely to:

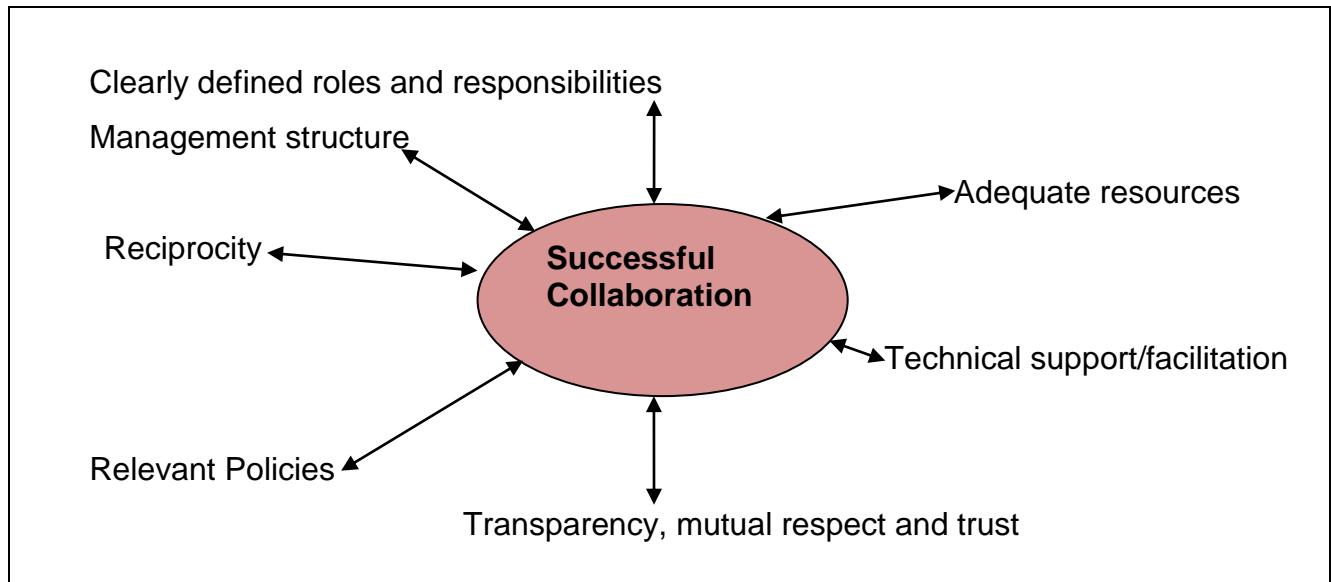
- *explore the perceptions of THs in collaborating with BHPs,*
- *describe the context in which THs collaborate*
- *identify reasons underlying THs dropping out of collaboration in HIV/AIDS and TB programs)*

The researcher believes; and is confident that he has achieved these objectives. He also strongly feels that one of the major contributions of this study is those findings the researcher had not expected to find. These are:

- Those THs have a strong desire for self-regulation and professionalisation of their practice.
- That THs are determined to weed out bogus healers and monitor adherence to high ethical practices
- That THs do conduct intra-referrals amongst themselves given that they have different specialisation areas in their practice
- The refute by THs that money or fear of loss of business is responsible for drop out of healers in collaborative programs
- That there are generally poor exit strategies by support organisations
- That the purportedly dropped out healers do carry out covert referrals of patients to BHPs/ health facilities.

All these points, in one way or the other, relate to issues, if dealt with appropriately, that would contribute towards sustaining collaboration between THs and BHPs. The researcher therefore trusts that this study will generate wider interest amongst researchers to expound on the work of THs and BHPs collaborating in the fight against HIV/AIDS and TB. Generating of models for improved collaboration through research is of the essence.

In summary, the researcher presents a conceptual model of the factors required for sustainable collaboration between THs and BHPs as adapted from Kuenzel and Welscher (2009:18) and informed by the findings of this study.



**Figure 5.1: Conceptual model for successful collaboration**

## 5.5 LIMITATIONS OF THE STUDY

The researcher has found very interesting insights on the subject of collaboration between THs and BHPs. However, like any other study, this one has its own limitations as well. One of these limitations is its narrow focus on those healers who “stopped collaborating” with BHPs. This limitation is inherent to the design that just focused on the question of sustainability of collaboration post training and support at the expense of looking at the perceptions and views of those THs who have persevered. This approach therefore can connote some form of bias, where the researcher just looked at ‘one side of the coin’ – and ignoring the positive aspects of what make some THs stay within collaboration. The focus on a small geographic area of one municipality out of a possible 5 in the whole district of UMkhanyakude also poses some limitations as the findings cannot be generalised across the whole district. The fact that the participants knew or were aware that the researcher was an employee of AMREF could also have influenced the results.

In order to mitigate this limitation, I proactively pronounced and consciously separated his role and focus in this project (see section 3.3.3.2). The researcher did this by clearly pointing out to the participants that although he was employed by AMREF, this research was largely driven by my academic interests rather than those of AMREF and the Department of Health.

## **5.6 FINAL CONCLUDING REMARKS**

This research is important as it has of the potential to influence and turn around the way in which collaboration between THs and BHPs is planned, implemented and evaluated. It also opens up, identifies or highlights areas that can further be investigated or assessed for the purposes of improving sustainable collaboration between THs and BHPs in the context of HIV/AIDS and TB programs. In this conclusion chapter, the researcher has gone to length in trying to answer the research question on experiences and perceptions of THs and its related objectives of exploring and describing perceptions of THs in health service delivery as well as their reasons for dropping out of collaboration with BHPs in HIV/AIDS and TB programs. The researcher has concluded this dissertation by presenting clear recommendations for sustain collaboration between THs and BHPs as well as presenting conceptual model or summary of ingredients for sustainable collaboration.

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## APPENDICES

### Appendix A: Approval from UNISA- Ethical Clearance

## **Appendix B: Research Site Letter of clearance: THO- UMkhanyakude District**

**Appendix B: Research Site Letter of clearance: THO-UMkhanyakude District**

**The Traditional Healers' Organisation-UMkhanyakude District**

**Office of the District Chairperson**

20 November 2012

Dear Mr B. Hlabano

This letter serves to confirm that the THO has been fully briefed on the nature and purpose of the academic research project on "Perceptions of traditional healers on collaborating with biomedical health professionals in UMkhanyakude District of KwaZulu Natal". The request by Mr. Boniface Hlabano to have our members to participate in the study has been considered by the THO and is hereby approved based on the ethical clearance by UNISA and on the following conditions:

- That the THO will expect a copy of the completed research for its own resource centre and reference materials.
- That the researcher will avoid disrupting the traditional healing services during the course of this study.
- That the researcher will be prepared to assist in interpreting and clarifying technical issues about the research process and outcomes.
- That all other relevant organisations and institutions will be made aware of this study.

*Signed: J. P. msezane*

District Chairman-THO  
**THO**  
**UMKHANYAKUDE**  
**DISTRICT EXECUTIVE**  
DATE 20 - November 2012  
SIGN J. P. msezane

## **Appendix C: Consent form**

### **Consent form-English**

This form is about asking for your permission to interview you on an academic research project about collaboration between traditional healers and biomedical health practitioners. This research is being done by I; Boniface Hlabano for the purposes of my academic work with UNISA. Before we begin the interview, we want to make sure you understand the following information about the study:

1. Your participation is entirely voluntary. You may refuse to take part in the interview, and you may stop at any time if you do not want to continue. You also have the right to skip any particular question or questions if you do not wish to answer them.
2. The time it takes to complete the interview will vary depending on how many people live in your household and whether all the sections of the questionnaire are relevant to your household, but the average amount of time for this interview is 40 -45 minutes.
3. You have the right to ask questions at any point before the interview, during the interview, or after the interview is completed.
4. All information collected for this study will be kept strictly confidential. While the data collected will be used for research purposes, information that could identify you or your household will never be publicly released in any research report or publication.
5. The intention of the study is to conduct further interviews with you in the future. As a result, your personal details will be kept on record in order that you can be re-contacted to participate in future studies that form part of this project. However, we will ask your permission to participate in the survey again each time. Agreeing to participate now does not mean you have to participate in future surveys.

By signing below, you signify that you agree to participate in the study and that your participation is entirely voluntary.

---

**Signature (Respondent)**

Date

---

**Signature (Interviewer)**

Date

### Ifomu locwaningo elinemvume- IsiZulu (Consent form)

Leli fomu ngelokucela imvume yakho ukubamba iqhaza lokuxoxisana ngocwaningo oluphathelene nokucwaninga ukudlelana phakathi kwabelaphi bendabuko nabelaphi baphesheya lumphathelane nezifundo zikamncwaningi. Lolu cwaningo olwensiwa yimina uBoniface Hlabano mayelana nokwezfundo zami engenza nenyuvesti yaseNingizimu Afrika. Le phrokethi yenziwa wumncwaningi ngokuphathelane nezifundo zakhe qha. Ngaphambi kokuba siqale ukuxoxisana, ngifuna ukuqinisekisa ukuthi uyaluqonda ulwazi olulandelayo oluphathelene nocwaningo:

1. Ukubamba iqhaza kwakho kungokuzithandela ngokuphelele. Ungenqaba ukubamba iqhaza ekuxoxisaneni, futhi ungayeka nganoma yisiphi isikhathi uma ungasafuni ukuqhubeke. Unelungelo futhi lokweqa yinoma yimuphi umbuzo noma imibuzo ethile uma ungafuni ukuyiphendula.
2. Isikhathi esizothathwa ukuqedu ukuxoxisana siyi-avareji cishe ngamaminithi angafika ku 40 kusiya ku 45.
3. Unelungelo lokubuza imibuzo nganoma yisiphi isikhathi ngenkathi ukuxoxisana kuqhubeke, noma ngemuva kokuthi ukuxoxisana sekuphelile.
4. Lonke ulwazi oluqoqwe kulolu cwaningo luzogcinwa luyimfihlo ngokuphelele. Nanoma ulwazi oluqoqiwe luzosetshenziselwa izinhloso zocwaningo, ulwazi oluzokwazisa ukuthi ungubani noma umizi wakho alusoze lwaziswa emphakathini kunoma yimuphi umbiko wocwaningo noma isishicilelo (incwadi ekhishiwe).
5. Imininingwane yobuntu bakho izogcinwa kumarekhodi ukuze kukwazi ukuxhunyanwa nawe ukuze nibambe iqhaza ezingcwaningweni zesikhathi esizayo ezakha ingxenye yale phrokethi

Ma sivumelana ke ukuthi uyangena kulolu cwaningi zizabonisa lokhu ngokusayina ngezansi, ubonisa ukuthi uyavuma ukubamba iqhaza kulolu cwaningo, nokuthi ukubamba iqhaza kulolu cwaningo kungokuzithandela ngokuphelele.

---

**ISIGNESHA** (Yophendulayo)

---

USUKU

---

**ISIGNESHA** (Yomncwaningi)

---

USUKU

## **Appendix D: Data collection instrument- Interview Guide**

Interview Schedule for the THP Study Project DIS4986

### **Biographical and geographic information for participants**

- Name of Interviewee:
- Date and Time of Interview:
- Local Municipality:
- Geographical Classification:
- Category of healer:
- Gender:
- Highest level of education:
- Marital status:
- Age:

### **Length of time working with HIV-TB patients**

- i. For less than one month
- ii. Between 1&3 months
- iii. Between 4 & 6 months
- iv. Between 7 &12 months
- v. For more than a year

### **Length of time practising traditional medicine**

- i. For less than six months
- ii. Between 6 &12 months
- iii. One year
- iv. Between 1 and 5 years
- v. For more than 5 years

### **Length of time collaborating with biomedicine health workers**

- i. For less than six months
- ii. Between 6 &12 months
- iii. One year
- iv. Between 1 and 2 years
- v. For more than 2 years

**Interview start time:**

**Interview end time:**

**Interview duration:**

### **Experiences and Perceptions on collaboration**

1. How do you see the role of THPs in HIV/AIDS and TB programs?
2. What is your view on THPs collaborating with biomedical health workers in HIV/AIDS and TB programs?

**Alternatively:** What are your beliefs about working closely with health care workers at your local health centre on HIV-TB?

3. What has been your experience in collaborating with BHPs?

**Alternatively:** How would you describe your working relationship with the health centre and nurses and doctors?

4. You had been collaborating with BHPs after having been trained by the AMREF project and later stopped. What made you to stop collaborating?

5. How do you think the meaningful collaboration between TH and BHPs can be improved and sustained?

**Alternatively:** What would make you consider going back to collaborate with BHPs in HIV/AIDS and TB programs?

**Conclusion – Expression of gratitude to the participants, giving indications for the way forward and closure of session.**

**THIS IS THE END OF THE INTERVIEW. THANK YOU FOR YOUR COOPERATION!**

## **Appendix E: Letter of confirmation of translation of interview transcripts**

I, **Maurice Vusi Ntuli** of 46 Jakkals Drive in Richards Bay, KwaZulu Natal; do hereby confirm that I am a Zulu first language speaker who is multi-lingual and have done translations in different forums and platforms. I also have an excellent comprehension of English. I was asked by Mr Boniface Hlabano to listen to 6 audio taped interviews on interviews done with Traditional Healers and compare them with the transcripts to ensure accurate translation. I did listen to the audio tapes that were in Zulu language and compared them with the English transcripts that were done by Mr Hlabano. I can vouch that the transcripts are a true record of the audio tapes.

**Signature:**



**Date:** 17/10/2013

**PROFILE:** Maurice Vusi Ntuli

### **1. DEMOGRAPHIC INFORMATION**

- Name : Vusi
- Surname : Ntuli
- Marital status : Married
- Dependants : six
- Residential address : 46 Jakkals Drive, Woodlands, Richards Bay, 3900
- Date of Birth : 19/10/1966
- Gender : Male
- Nationality : SA
- Drivers licence : 08
- Home language : isiZulu,
- Other languages : isiNdebele, siSwati, isiXhosa, English, Afrikaans, Sesotho
- Religion : Christianity
- Criminal offence : none
- Hobbies : Road running, Horticulture, choral music, and sports.

### **2. EDUCATIONAL INFORMATION**

- **National diploma in public health:** 1980 to 1982, Edendale Technical Institute
- **BA and BA Honours:** 1986 to 1992, University of Zululand
- **MA degree in Social Science** (Unfinished) 2001, Stellenbosch University

### **3. WORK EXPERIENCE**

- **1978 TO 1982:** Malaria control active surveillance officer/agent: KZN Health UMkhanyakude district
- **1983 to 1993:** Junior Environmental health practitioner: KZN Health Uthungulu district
- **1994 to 1997:** Senior Environmental health practitioner : KZN Health UMkhanyakude district
- **1998 to 2001:** Chief Environmental health practitioner: KZN Health Uthungulu district
- **2001 to 2008:** TB and Communicable Disease Control manager: KZN UMkhanyakude district
- **2008 to 2010:** Project manager on HCT/TB, sexual and reproductive health, and CHWs: African Medical and Research foundation (AMREF) UMkhanyakude district
- **2011 to January 2013:** Country M&E Manager -AMREF
- **February 2013 to date:** Technical Officer HIV Prevention Monitoring and Evaluation: Futures Group (NGO) Zululand district