

**PEOPLE LIVING WITH HIV/AIDS USING TRADITIONAL MEDICINES TOGETHER
WITH ANTIRETROVIRAL THERAPY IN THE MANZINI REGION OF SWAZILAND**

by

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DECLARATION

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I declare that the above dissertation/thesis is my own work and that all the sources that I have used or quotes have been indicated and acknowledged by means of complete references.



SIGNATURE

07/09/2017

DATE

DEDICATION

“To all People Living with HIV/AIDS, never lose hope”

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At first, it seemed like an impossible journey. This dissertation was made possible with the contributions of some individuals. It is not possible to mention all those who contributed to the success of this study. However, I wish to express my sincere gratitude to the following:

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PEOPLE LIVING WITH HIV/AIDS USING TRADITIONAL MEDICINES TOGETHER WITH ANTIRETROVIRAL THERAPY IN THE MANZINI REGION OF SWAZILAND

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ABSTRACT

The purpose of the study was to explore perceptions of PLWHA towards using traditional medicines (TM) together with antiretroviral therapy (ART).

The study was conducted in two ART health facilities in the Manzini Region in Swaziland. Audiotaped individual interviews were conducted to collect data. The study population was PLWHA using TM and ART and were aged 18-49 years.

Voice recording was used to capture data during the in-depth interviews until saturation was reached. One grand tour question was asked and follow-up probing questions were asked dependent on participant responses and study objectives.

Findings of the study revealed that PLWHA are still searching for a cure, and the pre-existence of TM prior to ART is influencing them to combine TM and ART. Several reasons for combining the two treatment modalities were, to boost the immune system, enhancing appetite, to treat opportunistic infections and ART side effects. There was stigma associated with long-life ART and discrimination for using TM experienced by PLWHA.

It could benefit the country to repeat the similar research at National level, to include all the four regions, in both rural and urban settings.

Keywords: antiretroviral therapy, health service provider, people living with HIV, perceptions, traditional medicine.

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral drugs
CTX	Cotrimoxazole
HIV	Human Immunodeficiency Virus
MOH	Ministry of Health
NERCHA	National Emergency Response Council on HIV and AIDS
NHRRB	National Health Research Review Board
OIs	Opportunistic Infections
PLWHA	People Living With HIV and AIDS
RFMH	Raleigh Fitkin Memorial Hospital
STIs	Sexually Transmitted Infections
TH	Traditional healer
TM	Traditional Medicine
UNAIDS	United Nations against AIDS
WHO	World Health Organization

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

It is a well-known fact that there is still no known cure for the Acquired Immuno-Deficiency Syndrome (AIDS) yet. This allows for all health systems globally to give their 'best practices' in treatment, care and support for People Living with HIV/AIDS (PLWHA), until a breakthrough is realised. Biadgilign and Aklilu (2013:15) stated that by the end of 2011, about 34 million people were living with HIV worldwide. Globally, in 2010 alone, about 1.8 million people died worldwide because of HIV related illnesses; of which about 67% (1.2 million) were living in sub-Saharan Africa. Sub-Saharan Africa is the worst affected region compared to other regions in the world (Bene & Darkoh 2014:167).

Swaziland, a country in sub-Saharan Africa Region is among those countries mostly affected by the HIV pandemic with the highest prevalence in the world. NERCHA (2014: vii) hold a view that about 26% among the adult population (15-49 year olds) are living with HIV. Women are disproportionately affected, with the prevalence as high as 31% compared to 20% in men. Though life-saving antiretroviral therapy (ART) is available, access is not yet widespread in many countries of sub-Saharan Africa. By 2010, more than 6.6 million people were on life-saving ART, of whom more than 5 million were living in Sub Saharan Africa (Bene & Darkoh 2014:167).

The availability of Antiretroviral Therapy (ART) for People Living with HIV and AIDS (PLWHA) enables them to maintain and lead relatively normal lives even in developing countries like Swaziland. ART is challenged by an increase in popularity and use of traditional medicine and 'alternative' therapies (Mandizadza & Chavunduka 2013:149). Health service providers articulated that, these traditional remedies had contributed in poor adherence to ART, liver damage and in some instances; some people end up

discontinuing ART and opt for traditional and complementary medicine. There has been less research on the life perceptions of PLWHA who combine the various HIV therapies in Swaziland. The researcher felt the need to explore perceptions of PLWHA on the use of both traditional medicine and ART concurrently.

1.2 BACKGROUND

Hughes, Puoane, Clark, Wondwossen, Johnson & Folk (2012: 470) states that there are about 24.1 million individuals in sub-Saharan Africa living with HIV. Compared to other countries in this region, Swaziland is among the countries mostly affected by the HIV pandemic, and has the highest prevalence in the world.

Ever since the introduction of ART in Swaziland, there is a noticeable decline in HIV and AIDS related deaths (MOH 2014:36). Njeru (2013:167) stated that there is improved quality of life among PLWHA, but the weakness of ART is that, they do not promise a cure for HIV and AIDS. Swaziland had an estimated 190 000 population who are living with HIV and of these about 87 534 (46%) were actively on ART in 2012 (MOH 2012:9). NERCHA (2014:16) articulate that data from the ART programme revealed an increase number of people on ART. There were about 100, 138 people on ART at the end of December 2013. Of which 92,249 adults on ART, 36, 600 were males and 59, 620 were females.

The Manzini region has documented the highest number of PLWHA actively on ART from 2011 to 2013 compared to the other regions in Swaziland (MOH 2014:38). There are factors influencing the uptake of ART in Swaziland. This was evident in a study conducted by the Ministry of Health (MOH) on assessment of loss-to-follow-up and associated factors in Swaziland. Participants voiced out reasons why they dropped from taking ART. Their major reasons were not limited to belief in alternative therapy, influence of culture and tradition, poor support for ART from religious organizations and traditional healers (MOH 2010:28).

Mandizadza and Chavunduka (2013:149) attest to the same notion that even globally, there is a noticeable increase in popularity and use of traditional medicine and 'alternative' therapies among PLWHA. African traditional medicine and traditional healing has been in existence well before the introduction of Western medicine.

Even in Swaziland, PLWHA opted for alternative therapy such as traditional medicine, which is available from traditional healers, as well as over-the counter preparations respectively. Opting for alternative therapy such as traditional medicine have been perpetuated by the Swazi tradition regarding their own way of treating ailments and sexually transmittable infections (STIs) effectively of which HIV was viewed as an STI. The researcher has discovered in different forums, where health service providers had articulated that, traditional medicine had contributed in poor adherence to ART, liver damage, and some patients end up discontinuing ART.

Traditional medicine(TM) is the sum total of knowledge, skills and practices based on theories, beliefs and perceptions indigenous to different cultures, used to maintain health, as well as prevent, diagnose, improve or treat physical and mental illness (Hughes et al 2012:470). Tjale and De Villiers (2013:5) found that TM had endured the introduction of Western medicine because people retain their traditional views to differentiate between symptoms that can be treated by impersonal western health technology and symptoms that needed the more personal attention of the traditional healer. Even in Swaziland, in most cases community members first try the traditional health care system and then go to a western health facility, giving the reason that traditional healers treat the whole person; they do not simply give medication for particular symptoms but they also know how to calm a patient's fears.

Njeru (2013:166) hold a view that, about 80 percent of the populations in the sub-Saharan Africa use traditional healers as their first line of contact for health support. Traditional healers claim a big market slot since they "can be consulted before, during or after seeking Western health treatment, as they tend to provide patient-oriented and culturally appropriate care".

Van Dyk (2012:229) articulates that traditional healers can act as vehicles of change, and states that no HIV and AIDS prevention programme can succeed in sub-Saharan Africa without the help of traditional healers because they have the authority to change and to influence their people in matters relating to sex.

Traditional healers had a greater credibility in their communities than health service providers. Even in Swaziland, the use of TM had been, based on availability, accessibility of traditional healers and socio-cultural acceptability in the communities. Unfortunately, health service providers had been still hesitant about traditional healers, they debated that the benefits of traditional healing were unknown and many of their care practices were dependent on magical ideas that were not well defined (Tjale & De Villiers 2013:5).

Mandizadza and Chavunduka (2013:139) revealed that initial attempts to foster collaborative work between western and traditional medicine in light of the AIDS epidemic began in the early 1990's when the WHO recommended that traditional medicine must be roped into national responses to HIV. Collaborative health programmes involving traditional healers are still at infancy stage in Swaziland and indications are that, traditional healers can effectively be involved in HIV and STI prevention programmes. These collaborative programmes are mostly aimed at promoting use of condoms, safer sex practices, and sterilizing instruments but are silent on the use of traditional medicine (Van Dyk 2012:229). Surprisingly up to the present, Swaziland had not yet formulated its own national policy that clearly states the nature and scope of the collaboration between traditional and Western medicine.

Ndlovu (2014:13) have this to say, "...the current National Health Policy recognises the existence of both the traditional and Western health health systems in the country, but seemingly there has been no attempt to promote and foster this integration". Mandizadza and Chavunduka (2013:140) argue that, they are several reasons for 'integrating' traditional medicine in the national response against HIV and AIDS and in the national health delivery system. Firstly, the handiness of traditional healers in most developing countries and the extreme health fees which are not affordable to many people. Secondly

the scarcity of health service providers together with the cultural acceptability of traditional medicine.

Several studies in sub-Saharan Africa have revealed that PLWHA were taking TM together with ART, however in Swaziland, the researcher did not find any research material in this regard. Supporting the same notion, results of a study done in South Africa by Hughes et al (2012:472) revealed that 92.9% participants TM was self-administered and 7.1 % TM was administered by a traditional healer. Results of a study in Ghana revealed that about 88% participants obtained TM from traditional healers (Gyasi, Tagoe-Darko & Mensah 2013:121). The researcher concluded that if the 92.9 % participants in South Africa had self-administered the TM, this was an indication that TM is readily available as over-the counter medicine without any prescription and controls whereas in Ghana TM was mostly prescribed by a traditional healer .

Participants in South Africa and Ghana indicated that they used TM to gain strength, increase their appetite, and relieve symptoms of numbness, ulcers, bad dreams, stress, immune supplementation and improving the overall well-being. The researcher had also discovered that, even in Swaziland, PLWHA used TM to treat and manage similar symptoms including side effects of ART but their perceptions were not scientifically explored.

Several studies revealed that most participants preferred non-disclosure of TM use to health care providers (93.9 % in Kumasi Metropolis, Ghana, followed by 92.9 % in the rural and urban areas of South Africa and 90% in KwaZulu-Natal, South Africa). Some participants were ready to disclose the use of ART to their traditional healers and some indicated that their traditional healers were aware that they were on ART (Gyasi et al 2013:121; Hughes et al 2012:472). Participants gave reasons that if they disclose to health care professionals this would result in lack of support and understanding, as well as the potential for punitive repercussions. There is a need to strengthen the collaboration between the traditional health system and the biomedical health system. Either this collaboration would help PLWHA disclose easily to a health service provider or a traditional healer concerning other medicines they would be taking.

This collaboration could also help increase adherence to ART thus improving the quality of life and suppressing the viral load to undetectable levels. Van Dyk (2012:121) argue that PLWHA did not adhere to ART for various reasons, not limited to; the relationship between PLWHA and the health service provider, who display lack of support and using medicines from traditional healers together with ART without disclosing to the health service provider.

Since there is lack of documented evidence regarding the use of TM together with ART in Swaziland, the researcher decided to conduct the study, to provide evidence that would inform policy makers to speed up attempts of fostering the integration of the two health systems in Swaziland. This integration would also ease the existing tension between health service providers and traditional healers; thus promoting openness and disclosure among PLWHA. The essence is that both traditional healers and health service providers are concerned about improving the quality of life and the wellbeing of PLWHA.

1.3 RESEARCH PROBLEM

Though Hughes et al (2012:472) reveal that PLWHA are taking TM together with ART, it could not establish as to why they use TM and ART together. The MOH (2010:28) observe that traditional remedies have contributed in poor adherence to ART and in some instances poor health. These results were revealed by interviews of the PLWHA at the clinics whose adherence to ART was regarded as poor. Poor adherence was reported by the clinic nurses through poor honouring of return dates by the PLWHA. The PLWHA verbalising that the collected treatment was not finished as expected was part of evidence of poor adherence. The PLWHA gave the use of TM as reasons for poor adherence. The government launched campaigns to educate the PLWHA about the importance of using ART without mixing with TM. Irrespective of these campaigns, the PLWHA continued to use TM together with ART. The PLWHA said they either stop using ART and use TM hence skip return dates or alternate ART with TM and not finish ARVs at the expected time. Their reasons towards the use of TM together with ART were not explored.

Since their perceptions with regard to use of TM together with ART in Swaziland were not explored, the researcher felt there is need to conduct the study, so as to provide the understanding of the PLWHA with regard to use of traditional medicines together with ART. The researcher intends to explore: 1. the belief system of the PLWHA with regard to TM use over ART (Is TM accessible or easy to use?); 2. What their understanding of the functioning of the TM in relation to ART is (Is TM stronger than ART or question of side effects?); 3. Do the PLWHA perceive TM differently from ART, (Is TM working differently in the body? On the other hand, is TM better than ART? Alternatively, are these two medications helping each other?).

1.4 AIM OF THE STUDY

1.4.1 Research purpose

The purpose of this study is to explore the perceptions of PLWHA with regard to the use of traditional medicines together with ART.

1.4.2 Research objectives

The objectives of the study are to:

- explore the PLWHA perceptions on the use of traditional medicines.
- identify factors influencing those perceptions.
- describe factors influencing PLWHA to use traditional medicines together with ART
- identify the challenges PLWHA face when using traditional medicines together with ART.

1.5 RESEARCH QUESTION

One grand tour question was asked to explore the perceptions of the PLWHA, followed by the sub-questions: “What are your perceptions with regard to the use of traditional medicines together with antiretroviral therapy?”

1.6 SIGNIFICANCE OF THE STUDY

Having a clear understanding of the reasons, opinions and beliefs (perceptions) regarding use of TM together with ART, the study may assist health authorities in planning the health provision to the PLWHA. This may help the health authorities to work with the PLWHA in discussing the TM and ART instead of launching campaigns without understanding the perceptions of PLWHA.

The study may contribute to the existing body of knowledge towards improving the quality of life for PLWHA, help to change attitudes in both health service providers and PLWHA and help to improve adherence to ART. Moreover, the study may inform and remind stakeholders that, to improve HIV and AIDS prevention intervention strategies, Swaziland also need to incorporate the cultural context. Furthermore, the study may contribute to the political agenda; informing policy makers to formulate a national policy on collaboration between the biomedical and traditional health systems operating in the country for the betterment of the Swazi nation (Ndlovu 2014:13).

1.7 DEFINITION OF TERMS

1.7.1 Perceptions

Perceptions are defined as the processes by which we organize and interpret our sensory impressions in order to give meaning to the environment (Manning, Gale & Krupinski 2015:683). In this study, perception refers to understanding, opinion or belief held by the PLWHA based on their perceptions on the use of TM and ART.

1.7.2 People living with HIV/AIDS

People living with HIV/AIDS (PLWHA) is defined as persons either males or females who have had a positive HIV test result, and already had been initiated or not yet initiated on ART but living a productive life (UNAIDS 2011:22). In this study PLWHA were community members who are HIV positive and monitored in one of the two health facilities. PLWHA who are health care providers will not be included in the study.

1.7.3 Health service provider

Health service provider is any person rendering help in the biomedical health system (National Health Act 61, 2003:7). In this study health, service providers refer to doctors and nurses.

1.7.4 Traditional medicine

Traditional medicine (TM) is defined as the sum total of knowledge, skills and practices based on models, beliefs and perceptions, ethnic to different cultures that are used to maintain health, as well as prevent, diagnose, improve or treat physical and mental illness (WHO 2003) cited in (Hughes et al 2012:470).

1.7.5 Antiretroviral therapy

Antiretroviral therapy is a combination of drugs to prevent the duplication of the human immune deficiency virus (HIV) in cells (Van Dyk 2012:493). In this study, ART refers to pharmaceutical combination of drugs used to treat human immune deficiency virus.

1.8 RESEARCH METHODOLOGY

1.8.1 Research Design

Qualitative research is defined as the enquiry of phenomena, usually in an in-depth and holistic fashion, through the collection of rich narrative materials using flexible research design (Polit & Beck 2014:389). The researcher followed a qualitative explorative design. This design allowed participants to give careful description of their perceptions with regard to use of TM together with ART. An exploratory design is conducted about a research problem when there are few or no earlier studies to refer to or rely upon to predict an outcome. In this study, exploratory design was used to establish an understanding of how PLWHA perceive the use of TM together with ART.

1.8.1.1 Qualitative exploratory design

The qualitative exploratory design was used to answer the question: “What are the perceptions of using TM and ART by PLWHA in Swaziland”? This design required the researcher’s creativity and flexibility because the exploration was guided by the participant’s response towards this grand tour question. Neuman (2014:38) hold a view that, an exploratory design is conducted about a research problem when there are few or no earlier studies to refer to or rely upon to predict an outcome. In this study, exploratory design is used to establish an understanding of how PLWHA perceive the use of TM together with ART.

1.8.2 Sampling

Convenience sampling as “a non-probability sampling method” was used in which the researcher estimated to select about 20 participants according to the inclusion and exclusion criteria of between 18-49 years of age and receiving ART from the health facilities. According to Brink, Van Der Walt and Van Rensburg (2014:140) convenience sampling is referred to as ‘accidental sampling’. It involves the choosing readily available participants, meaning that these participants are sampled because they happen to be available at the right place and at the right time. This convenient sample was selected from the known PLWHA coming to refill their treatment by being asked if they were also using TM at home.

1.8.3 Data collection

Individual face-to-face in-depth interviews were audiotaped. Interviews were conducted in SiSwati language for clarity and understanding. The researcher opted for interviews because they were a suitable method in order to get quality information.

The researcher used unstructured interviews because participants were freely responding to open-ended questions, using their own words, thus sharing their own perspectives with the researcher. The researcher was the interviewer and took field notes at the same time. Each participant signed a consent form before the commencement of the interview.

1.8.4 Data management

According to Polit and Beck (2014:304) data management in qualitative research is reductionist in nature: It involves converting masses of data into smaller, manageable segments. It is an inductive process that involves putting segments together into meaningful conceptual patterns.

1.8.5 Data analysis

Qualitative data analysis is an inductive process, which involves putting fragments of raw data together into meaningful conceptual patterns (Polit & Beck 2014:304). However, other researchers define qualitative data analysis as “a process of examining and interpreting data in order to elicit meaning, gain understanding and develop empirical knowledge” (Grove et al 2013:279).

Tjale and De Villiers (2013:244) have this to say, “...the purpose of data analysis is to convert the inner world and actions of research participants into meaningful broad ideas that serve as abstract representations of the details those participants had revealed”. Data was analysed manually using the thematic data analysis procedure according to Colaizzi's (1978) cited in (Shosha 2012:34). This is a systematic approach, which involves searching for themes or categories. Inductive reasoning was used to interpret the resulting thematic structures to discover commonalities, relationships, overarching patterns, and variations across participants.

The researcher followed seven steps process as stated by Colaizzi's (1978) as cited in (Shosha 2012:34).

Step one

The researcher read each transcript several times to gain a sense of the whole content and by translating the data from SiSwati to English. While reading, any thoughts, feelings, and ideas that arose by the researcher due to previous work with PLWHA were added to the bracketing diary.

Step two

In this stage of analysis, the researcher extracted significant statements and phrases from each transcript. These statements were written on separate sheets, and coded based on their "transcript, page, and line numbers".

Step three

Meanings were formulated from the significant statements. Each underlying meaning was coded in one category as they reflect an exhaustive description. Thereafter, an expert researcher checked all statements and their meanings for correctness and consistency.

Step four

The researcher formulated meanings and grouped all these formulated meanings into categories that reflect a unique structure of clusters of themes. Each cluster of theme was coded to include all formulated meanings related to that group of meanings. After that, groups of clusters of themes that reflected a particular issue were incorporated together to form a distinctive construct of theme.

Step five

At this stage of analysis, all emergent themes were defined into an exhaustive description. Thereafter all themes were merged and the researcher reassessed for richness and completeness to provide sufficient description to be validated by the research supervisor.

Step six

In this step, a reduction of findings was done in which redundant, misused or overestimated descriptions were eradicated from the overall structure. Some amendments were applied to generate clear relationships between clusters of themes. However, some ambiguous structures that weakened the whole description were eliminated.

Step seven

The researcher validated study findings using "member checking" technique. It was undertaken through returning the research findings to the participants and discussing the results with them.

These broad themes were further categorised and reduced to a limited number of themes and this process is called data reduction (Tjale & De Villiers 2013:245). When the data were reduced, then the researcher synthesised the data and created a meaningful whole, discovering commonalities, relationships, overarching patterns, and variations across participants.

1.8.6 Trustworthiness

The researcher utilised Lincoln and Guba's (1985) framework of quality criteria to ensure trustworthiness in the study namely Credibility, Dependability, Confirmability, and Transferability.

1.8.6.1 Credibility

Credibility refers to assurance in the truth-value of the data and interpretations (Polit & Beck 2014:323). The researcher applied the following procedures to ensure credibility; triangulation, peer debriefing and member checks.

Creswell (2013:251) define triangulation as the use of several and diverse sources, methods and investigations to provide supporting evidence. In this study, data was collected through in-depth individual interviews. An interview guide was used to facilitate interviews. Field notes were taken to capture even the non-verbal communication demonstrated by the participants.

The research work was reviewed by a peer debriefer, who asked questions about the study in a form of an external check. Member checking was done during data collection through probing, to ensure that the interviewer had properly interpreted participant's meanings (Polit & Beck 2014:328). After analysing the data, the researcher conducted follow-up interviews, which provided an opportunity for participants to comment on the findings of the study.

1.8.6.2 Transferability

Transferability refers to “the extent to which qualitative findings can be transferred to or have applicability in other settings or groups” (Polit & Beck 2014:323). The researcher ensured transferability through convenience sampling and thick descriptions.

Convenience sampling in the study ensured maximum range of specific information obtained from purposively selected study sites and diverse participants who deliberated and yielded rich data (Babbie & Mouton 2011:277).

Polit and Beck (2014:331) describe a thick description as a rich, detailed and intense description of the research context, the people who participated in the study, the perceptions and processes observed during the inquiry. The researcher included quotations as revealed by participants to add richness of the discussions. The research communicated results using detailed descriptions of specific themes that have emerged from the study. Tjale and De Villiers (2013: 247) holds a view that, these descriptions were the reflection of the events, views and perspectives shared by the participants and the researcher during data collection.

1.8.6.3 Dependability

According to Babbie and Mouton (2011:278), dependability entails that “...an inquiry must also provide its audience with evidence that if it were to be repeated with the same or similar participants in the same or similar context, its findings would be similar”. This study utilised external audits as a strategy to ensure dependability where by the researcher’s supervisor acted as an external auditor. The external auditor assessed whether or not the findings, interpretations and conclusions were supported by data (Creswell 2013:252).

1.8.6.4 Confirmability

Confirmability is defined as “...the degree to which the findings are the product of the focus of the inquiry and not of the biases of the researcher” (Babbie & Mouton (2011:278).The researcher clarified her own biases in the beginning of the study.

1.8.7 Ethical considerations

In this study, firstly the researcher visited the institutions informing the clinic authorities about the study and accessing the clients. Secondly, for informed consent, explained the purpose of study to participants, their expectations, their voluntarism, confidentiality, benefits and risks and the researcher's name and contacts (Refer to ANNEXURE G: Information and Consent).

1.8.7.1 Respect for Autonomy:

To respect the participants' autonomy the researcher considered the participants' opinions and choices while refraining from withholding information necessary to make a considered judgment. There were no names or defining character required from the participants on audio tapes or field notes. Names of the participants were not linked to the data collected during the interview and field notes (McCormic 2013:253).

1.8.7.2 Beneficence:

The researcher took into consideration the principle of beneficence in a way that there was assurance that no direct benefits were associated with participating in the study. The study benefitted the participants by allowing them to reflect back at their experiences without any harm to their wellbeing (McCormic 2013: 253). The researcher respected the decisions made by the participants and protected them from any physical or emotional harm.

1.8.7.3 No maleficence:

The study did not anticipate any discomfort to the participants as it did not entail any manipulations of experimentations to the participants. The study confined to the concept of discussion in order to avoid psychological effects that may arise from the practical experiences of the participants. The researcher calmed participants through reassurance and five participants were referred to the social worker within the facility due to instances of psychological discomfort which aroused as these participants were relating about their experiences (McCormic 2013:255).

1.8.7.4 Justice:

The study applied the purposive sampling technique, selecting participants regarded as having information for the study. The research participants' selection was based on the research requirements and not on the vulnerability or compromised situation of specific people (McCormic 2013:259). The researcher afforded the participants equal benefits of justice in the study by providing confidentiality according to individual needs; giving equal share in responding to questions; respecting individual cultural and societal contributions to the interview.

1.9 SCOPE OF THE STUDY

The study followed a qualitative research approach, involving the use of the un-structured interviews as the primary method of data collection. The purposive sampling method was a limitation because it had a small sample size as compared to other sampling methods. The sample size limited the study to only two study sites hence the region have other sites which can be included thus limiting the views of other prospective participants. Data collection was through in-depth individual interviews where data saturation was reached with only 20 participants. In-depth interviews were a limitation because of the time constraints involved in transcribing and subsequent steps followed during data analysis.

1.10 STRUCTURE OF THE DISSERTATION

The dissertation is divided into five chapters namely:

Chapter 1: Orientation to the study

The chapter gave an overview of the study. It has outlined the background, purpose, and problem statement, objectives of the study and the significance of the study. This chapter mainly introduced the research study.

Chapter 2: Literature review

The second chapter reviewed literature pertaining to the topic under study. It laid out different views from several authors in relation to the topic under study.

Chapter 3: Research design and method

The third chapter covered the various methodological steps involved in conducting the research. A qualitative, exploratory design was used in this study. Sampling and data collection procedures were spelt out. Ethical issues related to sampling and data collection were discussed. Colaizzi's seven steps of thematic data were employed. Lastly, Lincoln and Guba's framework of quality criteria to ensure trustworthiness was applied.

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

In this chapter the researcher analysed data using thematic data analysis. Data were presented in themes.

Chapter 5: Conclusion and recommendations

This is the last chapter of the dissertation where the researcher drew conclusions and made recommendations pertaining to the findings of the study.

1.11 CONCLUSION

This chapter has given an overview of the research study entitled "People living with HIV/AIDS using traditional medicines together with antiretroviral therapy in the Manzini region of Swaziland". The researcher illustrated the background information with the support of relevant literature from studies conducted in sub-Saharan Africa, however there was no documented evidence regarding this research topic in Swaziland. The research design used was the qualitative exploratory design, which explored perceptions as perceived by the participants.

The study used the purposive sampling technique, which is a non-probability sampling strategy to select the participants. In-depth individual interviews were conducted to collect data. The interviews were audio taped and later transcribed verbatim. Thematic data analysis was employed. Trustworthiness was ensured using Lincoln and Guba's

framework of quality criteria. Ethical considerations were highly monitored by observing the four basic bioethical principles throughout all the steps of the research process.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Third world countries such as Swaziland, are still struggling with new HIV infections and AIDS related deaths. HIV and AIDS related illnesses may be treated by practitioners who come from traditional backgrounds as varied as biomedicine, traditional medicine and faith healing. This concurrency of traditions has raised concerns on the potency and limitations of various healing practices in HIV prevention and treatment (O'Brien & Broom 2014:95).

While the introduction of antiretroviral therapy (ART) has contributed positively to the quality of life of People living with HIV/AIDS (PLWHA), its relatively late arrival and accessibility in developing countries such as Swaziland has led to the use of TM. O'Brien and Broom (2014:95) says that ART was introduced into a context where the traditional health system already existing and well established.

Approximately 8 out of every 10 black South Africans are believed to rely on traditional medicine (TM) alone, or in combination with biomedicine(Njeru 2013:166). PLWHA have been noted for their "health plurality" because of their search for immediate, durable, affordable and effective healing solutions. Either PLWHA have chosen one route or they have mixed different health solutions in an attempt to cure unbearable sickness like HIV and AIDS. Njeru (2013:166) hold a view that, biomedical health practitioners discourage this. It is interesting although to note that the greatest response to the impact of the AIDS pandemic has been the PLWHA's ability to use both the biomedical and traditional health systems concomitantly.

This chapter is mainly a literature review, deliberating on the perceptions towards taking TM and ART concurrently, the associated factors influencing such behaviour and related challenges.

2.2 PERCEPTIONS OF PLWHA TOWARDS TRADITIONAL MEDICINES(TM)

2.2.1 Pre-existence of TM

Mandizadza and Chavunduka (2013:138) argue that TM and traditional healing have been in existence even before the introduction of Western medicine, which resulted in “health plurality”. PLWHA have been noted for their “health plurality” because of their search for immediate, durable, affordable and effective healing solutions. They have visited traditional health practitioners and biomedical health practitioners concomitantly in quest of medicines that will heal the symptoms of HIV and AIDS (Njeru 2013:166). Agreeing on the same notion, O’Brien and Broom (2014:95) states that, ART was introduced into a context where traditional health systems were pre-existing and well established in developing sub-Saharan African countries, so it is difficult to detach from TM. PLWHA accessed TM from traditional health practitioners and herbal outlets (Musheke, Bond & Merten 2012:5).

TM has endured the introduction of Western medicine, thus people have retained their traditional views to differentiate between symptoms that can be treated by impersonal western health technology and symptoms that needed the more personal attention of a traditional health practitioner (Tjale & De Villiers 2013:5).

Findings of a study by Belisle, Hennik, Ordonez, John, Ngubane-Joye, Hampton, Sunpath, Preston-Whyte and Marconi (2015:9) reveals that traditional health practitioners supported concurrent use of TM and ART and state, “...*we feel that [ART is] complementary to traditional medicine*”. Echoing the same sentiments, Davids, Blouws, Aboyade, Gibson, De Jong, Klooster and Hughes (2014:7), agrees that about 89% of traditional health practitioners encouraged PLWHA to consume TM together with ART.

2.2.2 Traditional methods as comforters

It has been seen that in most cases community members in sub-Saharan Africa first try the traditional health care system and then go to a western health facility, giving the reason that traditional health practitioners treat the whole person; they do not simply give medication for particular symptoms but they also know how to calm fears. O’Brien and Broom (2014:101) observes that the community-based and locally resourced traditional

health practitioner could offer more accessible and private treatment than the often distant, under-resourced and expensive biomedical clinic. Traditional health practitioners provide the greater part of the care and treatment for PLWHA.

Tjale and De Villiers (2013:5) articulate that, the indigenous worldview has different schools of thought regarding the traditional and western health care system. It argues that TM is superior, more effective and holistic than western medicine. Traditional health practitioners do not only know their clients as 'people' but also understand the social mingling in which their clients live. Njeru (2013:182) argue that, the anxiety caused by the biomedical approaches to PLWHA, often pushes them to seek refuge in the traditional healing methods.

2.2.3 Immune boosters and appetite stimulant

According to Gyasi, Tagoe-Darko and Mensah (2013:121), PLWHA use TM to boost the immune system weakened by HIV. In a study done in Zambia, a participant stated, *"I have different types of herbs; some boost the immune system and some cleanse body toxins"* (Musheke et al 2012:5). O'Brien and Broom (2014:101) attests to the same notion that TM is aimed to boost the immune system and relieve other symptoms but their participants had different views, some participants disagree. *"...people sometimes skip the ARVs by going to a witch doctor, the traditional healers but they are only wasting their time, even [immune] boosters . . . I was given the recipe for those herbs -the Moringa tree . . . It didn't work quite well with me"*. Several studies revealed that PLWHA use TM to stimulate their appetite (Belisle et al 2015:7; Gyasi et al 2013:123; Puoane, Hughes, Uwimana, Johnson & Folk 2012:498; Rai & Maibani 2012:8).

2.2.4 Biomedical methods as threat to life

Biomedical methods cause anxiety to the PLWHA because these methods describe and explain HIV and AIDS in a psychologically frightening way. Biomedical methods are too personal and sometimes impose a feeling of guilt and anxiety. One participant stated that the numbers (CD4 counts) that were used to show the state of HIV in the body caused anxiety because these numbers were fluctuating (Njeru 2013:180).

According to Musheke et al (2012: 4) have this to say "...PLWHA articulated concerns about the dangers of treatment to their lives and long-term health". ART-related side effects were viewed as a threat, though some PLWHA acknowledged that side effects were expected. They felt that, these side effects were unfavourable to their health and comfort because side effects inhibit their livelihood activities. A participant who narrated as follows revealed this: "...*The time I was on treatment, I used to feel weak all the time. I used to feel dizzy. I used to fail to carry even a 10 litre container of water. I could not do any piece works to make money. Although I still cough, it's much, much better now than when I was on treatment*".

2.3 FACTORS INFLUENCING THE USE OF TM TOGETHER WITH ART

2.3.1 Desperation and the quest for cure

Desperation and uncertainty about their future has made PLWHA to be more open and non-selective to potential sources of help. Desperation has pushed PLWHA to mix both TM and ART because they are seeking for cure (Njeru 2013:179). Agreeing on the same notion Belisle et al (2015:7) hold a view that biomedical health practitioners felt that PLWHA who used TM to treat or 'cure' HIV did so out of 'desperation,' or due to lack of knowledge about the effectiveness of ART.

O'Brien and Broom (2014:101) argues that TM is strongly supported by PLWHA regardless of the fact that the biological effectiveness of TM is still under research. The quest to be cured attracted PLWHA to use TM: "...*I never had any problem with the health workers. But I just decided on my own when I heard that crocodile fats cure, so I decided to start taking crocodile fats in the hope of being healed*" illustrated by a participant (Musheke et al 2012:5). Informants in study done in Botswana articulated that most people still believe that traditional health practitioners can cure HIV and AIDS. PLWHA sometimes discontinue ART and opt for TM while others take both TM and ART concurrently (Bene & Darkoh 2014:174).

The results of a study done in South Africa revealed that traditional health practitioners have denied that they can 'cure' HIV but they would rather help treat the symptoms of

HIV. This is how one of the participants articulated it: “...you will help [a patient with symptoms of HIV], but you are not going to cure him completely” (Belisle et al 2015:9). Agreeing on the same point, Davids et al (2014:7) in their study, a majority of traditional health practitioners testified that HIV was a relatively new, incurable disease and they are not trained to deal with HIV.

2.3.2 Cause of illness

Van Dyk (2012:218) hold a view that traditionally, Africans strongly believe that witches and sorcerers are causative agents of illness, thus the immediate and ultimate cause of illness is acknowledged. PLWHA understand that, the virus is an immediate cause of HIV and AIDS but the ultimate cause is bewitchment. The traditional health practitioner is consulted to treat the ultimate cause and the biomedical health practitioner is consulted to treat the immediate cause of the same illness. Davids et al (2014:8) have this to say, the initial treatment by the traditional health practitioners involves purging so that the *idliso* is excreted from the body through sweating, throwing up and urinating.

Moshabela, Zuma, Orne-Gliemann, Iwuji, Larmarange and Mcgrath (2016:27) argues that even denial can also cause PLWHA, who are aware of their status to go to traditional health practitioners claiming that witchcraft is the cause of their illness. As a result, traditional health practitioners are expected to consult with the spirits in search for answers, and after that, they confess their HIV diagnosis to traditional health practitioners in search for their direction. This is how one participant from their study articulated: “...When someone is ill from this (HIV) they run to us (traditional healers)...we have a very big challenge. They come to us and say that Makhosi I dreamt at night that someone was giving me *idliso* (“bewitching” by food)... [While] he knows that the illness is eating him away”.

Belisle et al (2016:8) share the same sentiments. In their study, PLWHA and biomedical health practitioners agreed that ART should be used to treat HIV, but also TM was found to be appropriate for some reasons, as one participant illustrated: “...If the person is being [bewitched] by the other person, the herbal medication it does help.... Really, there are things that need to be treated by [traditional healers]”

2.3.3 Traditional medicine as part of African culture

According to Njeru (2013:166), it is estimated that about 80 percent of the populations in the sub-Saharan Africa use traditional health practitioners as their first line of contact for health support. Traditional health practitioners claim a big market slot since they “can be consulted before, during or after seeking western health treatment. They provide patient-oriented and culturally appropriate care”. Sharing the same sentiments Belisle et al (2015:7) agrees that TM is vital, as part of African identity and Africans will not simply withdraw from TM when they become HIV positive. One participant narrated as follows: *“...As Zulu people use [traditional medicine] in the home....Sometimes it does help. Yes, that is how I would define it, that back in our religion and in rural areas; people are still using it for particular things. These are old beliefs, but they do work”*.

Tjale and De Villiers (2013:144) have this to say, “....traditional health practitioners know and understand the cultural orientation of PLWHA in their community, usually speak the same language, hence they are more comfortable and private”. The fact that PLWHA receive treatment without being removed from their social environment facilitates their recovery as opposed to the impersonal environment of the hospital.

2.3.4 Opportunistic infections (OIs) and ART side effects

According to Davids et al (2014:8), opportunistic infections (OIs) such as red sores, thrush, and rashes to name a few, are treated with plant mixtures. OIs are treated with a topical herbal remedy administered three times a day or when experiencing discomfort. Agreeing on the same notion Belisle et al (2014:9) in their study of traditional health practitioners articulated that, they prepare TM in both liquid and topical preparation form with ingredients, which are sensitive to symptoms of OIs such as sores, swollen lymph nodes, or loss of appetite.

Ketema and Weret (2015:77), in their study in Ethiopia, results reveal that, among the 291 respondents, 282 respondents used TM to treat OIs and ART side effects. Davids et al (2014:8) concurs that, PLWHA visits traditional health practitioners to combat ART induced side effects such as vomiting, abdominal cramps and headaches. Traditional health practitioners prescribe a mixture of plants to be taken after the ingestion of ART to

counteract these side effects. Musheke et al (2012:5) said that PLWHA have used TM concurrently with ART; however, some PLWHA have exclusively opted for TM. Their decision was mainly triggered by ART-induced side effects and disappointment with ART care.

2.4 CHALLENGES FACED WHEN USING TM TOGETHER WITH ART

2.4.1 Negative attitude towards TM

According to Nloto (2015:6) non-disclosure of the use of TM to biomedical health practitioners was estimated at about 92.3 % among PLWHA in western Uganda. Even biomedical health practitioners did not enquire about the use of TM during consultations. Poor communication between PLWHA and biomedical health practitioners has intensified negative perceptions and attitudes towards traditional methods of care.

Sharing the same sentiments, Van Rooyen, Pretorius, Tembani and Ten Ham (2015:4) discovered that, biomedical health practitioners who participated in a study in South Africa revealed that they have a negative attitude towards traditional health practitioners. They discourage PLWHA against pursuing the services of traditional health practitioners, giving a reason that traditional health practitioners use unscientific methods and delayed referrals. “...*We do have a negative attitude and ask a person [patient]. Why didn't you come to hospital? Now, can you see how you look like? What do you want us to do now?*” an illustrative from a biomedical health practitioner.

According to Puoane et al (2012:498), PLWHA preferred not to disclose their use of TM to biomedical health practitioners because they foresee lack of support and loss of services from the biomedical health system after disclosure.

2.4.2 Drug toxicity

Concurrent administration of ART and TM is likely to increase toxicity and sub therapeutic effects of ART. Open and effective communication about the use of TM is essential to prevent potential adverse reactions and drug interactions. Awareness of TM use is critical to optimize care given to PLWHA (Gyasi et al 2013:122).

Findings from a study by Van Rooyen et al (2015:4) revealed that traditional health practitioners and relatives interfere with the effectiveness of hospital treatment by supplying with TM, this cause changes in drug interaction, possible deterioration, and sometimes the death: *“...The relative will come and give the medicine [...]. While the hospital treatment was about to be effective, the condition suddenly changes and we won't know that there is another type of medicine that is being given secretly...”*

2.4.3 Poor adherence to ART

According to results of a study on assessment of adherence to ART in Ethiopia, “researchers found a statistical association between the use of TM and adherence; PLWHA who received ART while using TM were 4.7 times more likely to miss at least one dose of treatment than those who did not use TM” (Ketema & Weret 2015:79). Kloos (2013:146) hold the view that, concurrent use of TM and ART has been associated with defaulting from treatment in Ethiopia. Belisle et al (2015:10) argue that traditional health practitioners are talented and culturally relevant ART adherence counsellors because they have accepted ART as an effective treatment for HIV.

2.4.4 One sided referral system

Van Rooyen et al (2015:5) stated that traditional health practitioners described their relationship with biomedical health practitioners as a one-sided referral system: *“If only they can stop depriving us of patients. [...] They [doctors] keep a person saying to him/her “come again for injection, or come again to fetch your treatment. [...] They do not send them [to us]. This must not be one-sided”.*

2.5 COLLABORATIVE BENEFITS OF THE TWO HEALTH SYSTEMS

Collaboration of these two health systems will benefit both traditional and biomedical health practitioners as well as the consumers of the services who are PLWHA.

2.5.1 Reciprocal education and training

Reciprocal education and training can be fostered through workshops and information sharing sessions. Traditional health practitioners can teach biomedical health

practitioners some traditional healing therapies and biomedical health practitioners can teach traditional health practitioners basic biomedical practices, like basic personal and environmental hygiene, treatment of cases within their scope, identification and referral of complicated cases (Pinkoane, Greeff & Koen 2012:16).

The HIV Rights Charter (2000:23) holds a view that “traditional health practitioners should be educated and informed about the transmission of HIV and AIDS related issues. Traditional and biomedical health practitioners should collaborate on the care and management of HIV and AIDS”. Moshabela et al (2016:27) have this to say, “...traditional health practitioners, who received HIV education, agreed that education is essential to correct misinformation and misconceptions surrounding HIV and AIDS”. Traditional health practitioners can also work as ART adherence counsellors because they have accepted ART as an effective treatment for HIV (Belisle 2015:10; Mandizadza & Chavunduka 2013:153).

2.5.2 Two-way referral system

Van Rooyen et al (2015:5) hold a view that traditional health practitioners described their relationship with biomedical health practitioners as a one-sided referral system. According to Pinkoane et al (2012:16), a two-way referral system can be “facilitated based on shared information regarding the progress of the client”. The biomedical health practitioners reciprocate the referral by identifying cases, which fail to respond to biomedical treatment and refer them to traditional health practitioners of which the traditional health practitioners should do the same.

2.5.3 Effective communication

Pinkoane et al (2012:16) found that a professional relationship exists between traditional health practitioners and biomedical health practitioners. Information sharing which enables understanding of each other’s world and treatment methods can reinforce this relationship. Opening up to each other enhances mutual respect and trust among traditional health practitioners and biomedical health practitioners.

2.5.4 Safe structures for consultation

Pinkoane et al (2012:16) have this to say, collaboration will assist in lobbying for construction of safe consultation structures for traditional health practitioners. These structures should be situated in strategic areas for easy access to enhance the process of referral between the two health systems. Van Rooyen et al (2015:6) hold a view that collaboration includes sharing the health budget, information and resources for HIV prevention.

2.6 CONCLUSION

PLWHA have different perceptions towards TM; and the pre-existence of TM prior to ART makes it difficult for them to stick only to ART. The African culture of TM also has a great influence in this regard. Research has revealed that a person's belief system is so intimate and so sacred to one's identity that it can go a long way in offering psychosocial support, and it is an important ingredient, which influences treatment. The "causality of illness" has influenced PLWHA to take TM and ART concurrently.

The existence of an uneasy relationship between TM and biomedicine dates back to the introduction of Western medicine and the challenge cannot be resolved any time soon to the satisfaction of either party. The most thoughtful decision to make in light of a life-threatening pandemic like HIV and AIDS is to look for areas where the two can collaborate to the best interests of PLWHA.

However, a professional relationship between biomedical health practitioners and traditional health practitioners in running HIV prevention programmes exists. It has been found that traditional health practitioners act as ART adherence counsellors, they manage OIs and they refer PLWHA to biomedical health practitioners. Collaboration of the traditional and the biomedical health system can benefit the nation at large because, it can yield sharing of information through reciprocal education and training, a two-way referral system and sharing of resources in HIV prevention programmes. Researchers are looking forward on how such collaboration can be realised in sub-Saharan Africa.

CHAPTER 3

METHODOLOGY AND RESEARCH DESIGN

3.1 INTRODUCTION

This chapter presents the research design and methods used in the study. Research design, the study population, sample and sampling are discussed. Data collection procedures, as well as the data collection instrument are described. Ethical issues relating to sampling and data collection that were considered are clarified. Furthermore, the researcher explained how trustworthiness was ensured in the study.

3.2 RESEARCH DESIGN

Research design is the overall plan for addressing a research question, including strategies for enhancing the study's integrity. It is considered "the backbone of the study" (Polit & Beck, 2014:390). Brink et al (2014:128) argue that, the best design is always the one that is most appropriate to the research problem and research purpose; hence, a qualitative exploratory design was used. This design allowed participants to give careful description of their perceptions with regard to use of TM together with ART.

3.2.1 Qualitative exploratory design

The qualitative exploratory design was used to answer the question: "What are the perceptions of using TM and ART by PLWHA in Swaziland"? This design required the researcher's creativity and flexibility because the exploration was guided by the participant's response towards this grand tour question. Neuman (2014:38) says that an exploratory design is used when there are few or no earlier studies to refer to or rely upon to predict an outcome. In this study, exploratory design is used to establish an understanding of how PLWHA perceive the use of TM together with ART.

3.3 RESEARCH METHOD

Polit and Beck (2014:390) holds a view that, a research method “is a technique used to structure a study, to gather and analyse information in a systematic fashion”. A research method entails sampling procedures, data collection and data analysis.

3.3.1 Sampling

Oppong (2013:203) have this to say, “...sampling is a process of selecting subjects to take part in a research study on the basis that they provide information considered relevant to the research problem”. Polit and Beck (2014:391) defines sampling as a process of selecting a portion of the population to represent the entire population. The researcher used two non-probability sampling techniques to select the study sites and participants, namely purposive and convenience.

3.3.1.1 Purposive sampling

Purposive sampling in the study ensured maximum range of specific information obtained from purposely-selected study sites which have diverse participants who deliberated and yielded rich data (Babbie & Mouton 2011:277). These purposely-selected study sites were Raleigh Fitkin Memorial Hospital (RFMH) ART facility and LaMvelase Help Centre. RFMH and LaMvelase Help Centre are located around Manzini town, which is in the hub of Swaziland, so they are convenient for PLWHA because they easily access treatment while in town. These facilities have the highest number of ART enrolment compared to other sites in the Manzini region. The RFMH ART facility has 16445 PLWHA enrolled on ART care since the facility started initiating ART in 2004 and LaMvelase Help Centre has 16078 PLWHA enrolled on ART care since the facility started initiating ART in 2007 (ART data 2017).

3.3.1.2 Convenience sampling

According to Grove et al (2015:502), convenience sampling “...is including participants in the study who happened to be in the right place at the right time, with the addition of available participants until the desired sample is reached; also referred to as accidental sampling”. Polit and Beck (2014:377) defines convenience sampling as “a non-probability

sampling method in which the researcher selects the most readily available persons as participants in a study. De Vos et al (2013:232), concurs that in convenience sampling the participants are usually those who are nearest and most available to the researcher, and this is a haphazard sample.

The researcher adopted convenience sampling, to select diverse participants who were willing to share their perceptions concerning the use of TM and ART. They were both males and females, who have been on ART for more than two years and were confident to speak up about their perceptions.

3.3.1.3 Population

Brink et al (2014:131) define a population “...as the entire group of persons that are of interest to the researcher, these persons meets the criteria the researcher is interested in studying”. According to Neuman (2014:247), a population is the abstract idea of a large group of many cases from which a researcher draws a sample. The population in this study were all PLWHA in the Manzini Region. It was impossible for the researcher to access the entire population, hence only the study population was accessed. The latter is the population that the researcher has access to and actually studies. The study population were PLWHA aged 18-49 years who had been enrolled in ART chronic care in two ART health facilities in the Manzini region.

3.3.1.4 Sample

Opping (2013:203) defines a sample as “...a subset of a population selected to participate in the study”. In this study, a convenient sample was chosen for the convenience of the researcher in terms of time and costs (Brink et al 2014:140). Opping (2013:203) concurs that an advantage of a convenient sample is that it is a less demanding method given that the researcher selects the most reachable participants. It is less demanding in terms of costs, time and effort. A convenient sample was drawn from PLWHA who had been already enrolled in chronic care and initiated on ART. Participants were eligible to participate in the study were those enrolled in chronic care and initiated on ART and were willing to share their views on the use of TM and ART. These participants indicated the use of TM at home. The sample size was not determined prior

to data collection, addition of participants continued (Grove et al 2015:502) until data saturation.

3.3.2 Data collection

3.3.2.1 Data collection procedure

After obtaining ethical clearance, the researcher wrote letters to Lamvelase Help Centre and Raleigh Fitkin Memorial hospital requesting to conduct the study (Refer to ANNEXURE E and F). Then researcher visited these study sites to deliver the letters. The clinical authorities granted permission to conduct the study (Refer to ANNEXURE C) on condition that the National Health Research Review Board (NHRRB) approves the study. Upon receipt of approval from the NHRRB (Refer to ANNEXURE B), the researcher went to the sites to arrange for the data collection. The clinical authorities sensitized the staff about the research and highlighted to the researcher that the appropriate days are the ART refill days, which are Wednesdays, and Fridays when there is high population of PLWHA.

On the first day of data collection the researcher was also introduced to the accessible population. In the consultation rooms, the participants were asked whether they are also using TM at home and are they willing to share their perceptions on using TM and ART? If the answer was yes, those participants were included in the study then referred to a private interview room.

In the interview room, the researcher introduced self as well as the study and then requested each participant to share perceptions regarding using TM together with ART. If that participant was still willing to participate, the data collection procedure was explained to the participant, and then the researcher obtained consent. The participant was then engaged in an in-depth unstructured interview conducted in siSwati following an interview guide. The interview guide provided the researcher with some control over the interview process and ensured uniformity during the interviews. The face-to-face interview technique enabled the researcher to seek clarifications and probe deeper when necessary, to enhance the participant's responses (Brink 2014:158).

The interviews were audiotaped and field notes were also taken throughout the interview and nonverbal communication was observed. Audiotaping the interviews and taking field notes helped the researcher to ensure accuracy and clarity in transcription of the interviews, without missing important information.

Participants' responses were then translated into English for easy transcribing. Interview notes were transcribed and analysed immediately following the interviews. Transcription of the interview notes immediately after the interview ensured the accuracy of the interview data, aided by the memory of the researcher of any events that occurred during the interview process (Polit & Beck 2014:327). Each individual interview took approximately 30-45 minutes.

Bracketing was done throughout the interview process to control any bias and preconceptions of the researcher on the using TM together with ART so that these did not influence the information supplied by the participants (Brink 2014:122). Interviews continued until data saturation was reached.

3.3.2.2. Data saturation

Data collection was terminated when the researcher no longer yielded any additional insight to the research problem being addressed (Oppong 2013:203) and that was an indication that data saturation has been reached.

Brink et al (2014:141) concurs that data saturation is the point at which new data no longer emerge during the data collection process. In this study, data saturation was reached after the researcher had interviewed 20 participants. There was enough information to replicate the study, and the ability to obtain additional new information and new themes were no longer feasible (Fusch & Ness 2015:1408).

3.3.2.3 Data collection approach and method

In-depth individual interviews were conducted and audiotaped. Interviews were conducted in SiSwati language for clarity and understanding. The researcher opted for interviews because they were suitable method in order to get quality information.

The researcher used unstructured interviews because participants freely responded to open-ended questions, in their own words, thus sharing their own perceptions with the researcher. The researcher was the interviewer and took field notes at the same time. Each participant signed a consent form before the commencement of the interview.

3.3.2.4 Development and testing of the data collection instrument

The researcher was the main instrument in the study because the researcher was subjectively involved in the research process by conducting unstructured individual interviews (Brink et al 2014:121). The researcher developed an interview guide, which started with a grand tour question “What are the perceptions of using TM and ART by PLWHA in Swaziland?” Dependent on the participants’ responses, unstructured interviews allowed for probing which enhanced detailed responses as participants explore their perceptions regarding the use of TM together with ART (Brink et al 2014:158).

In unstructured interviews, broad questioning guidelines are developed. The researcher as an interviewer, allowed flexibility to change the line of questioning in accordance with the responses obtained from participants through probing. The interview guide comprise of open-ended questions, which allow participants the freedom to provide in-depth responses, using their own words. Tjale and De Villiers (2013:244) holds a view that collecting data in depth and over time enhances the validity and contributes towards the credibility of the research.

3.3.2.5 Ethical considerations related to data collection

Autonomy and respect for human dignity

According to Groove, Gray and Burns (2015:101) participants should be treated as autonomous agents so that their right to self-determination is not violated. Autonomous agents have the freedom to conduct their lives as they choose, without external controls. Participants as autonomous agents were informed about the purpose of the study which was, “to explore perceptions of PLWHA with regards to the use of TM together with ART”. The information on the purpose of the study was given so that participants can make an informed decision whether or not to participate in the study. The researcher considered participants’ opinions and choices while refraining from withholding information necessary

for participants to make judgment (McCormic 2013:253). Participants were given liberty to withdraw from the study at any time during the research process when they felt uncomfortable. This withdrawal was not going to harm their relationship with the researcher.

Informed Consent

Informed consent means that participants have sufficient information about the study, understand the information and have the power of free choice, enabling them to consent to or decline participation voluntarily (Polit & Beck 2014:87). The aim and purpose of the study were explained verbally in details to the participants. Those who wanted to voluntarily participant in the study were asked to sign an informed consent form immediately before the commencement of the interview. The informed consent form explained to participants; the purpose of study, expectations, voluntarism, confidentiality, benefits and risks, the name and contacts details of the researcher.

Non-maleficence

Jacobsen (2012:153) articulates that, the ethical principle non-maleficence supplements the autonomy principle and requires the researcher to ensure that no harm occurs to participants as direct or indirect consequences of the data collection process.

The in-depth interviews were associated with some instances of psychological discomfort for some of the participants as they were relating their experiences concerning the use of TM together with ART. The researcher calmed participants through reassurance (McCormic 2013:255). The researcher respected the decisions made by the participants and protected them from any emotional harm. Apart from the psychological discomfort during data collection, the researcher did not anticipate any other harm or risks to the participants because there were no manipulations and experimentations.

Beneficence

Beneficence is an ethical principle that seeks to maximize benefits for study participants (Jacobsen 2012:151). The researcher took into consideration the principle of beneficence in a way that there was assurance that no direct benefits were associated with participating in the study. Indirectly participants were able to reflect back on their perceptions with regards to use of TM together with ART. The knowledge obtained helped add on information already available regarding the perceptions of PLWHA on use of TM together with ART to improve existing health services for PLWHA. The study sites received a copy of the final research report.

Justice

The ethical principle of justice is broad because it includes participants' right to fair selection and treatment, as well as issues concerning privacy, anonymity and confidentiality (Polit and Beck 2014:85).

Right to fair selection and treatment

Jacobsen (2012:153) hold a view that, according to the principle of justice, participants must be treated fairly and receive what they are owed. The principle requires that the researcher treat participants with fairness and equity during all the stages of research. The study applied the purposive sampling technique; selecting participants regarded as having information for the study and these participants were not related to the researcher. Participants' selection was based on the research requirements and not on the vulnerability or compromised situation of specific people (McCormic 2013: 259).

During data collection, participants were given equal share in responding to questions because; with all participants, the interviewer provoked the discussion by asking the grand tour question. The grand tour question was followed by probing questions, which were dependent on participants' responses. Individual cultural and societal contributions to the interview were respected.

Right to Anonymity, Privacy and Confidentiality

Participants' identity were not linked with their responses, their identity were kept anonymous because participants were referred to by pseudonyms in the research report (Jacobsen (2012:157). Groove et al (2015:107) holds a view that, privacy is the freedom participants have to determine the time, extent and general circumstances under which their private information is shared with or withheld from others whilst confidentiality is the researcher's safe management of information or data shared by participants to ensure that the data was kept private from others.

The researcher afforded the participants equal benefits of justice in the study by providing confidentiality according to individual needs. Audiotapes of individual interviews and field notes were kept securely in a password storage computer, so that no one apart from the research team could have access to these data.

3.3.3 Data analysis

Grove et al (2013:279) have this to say, "... data analysis is a process of examining and interpreting data in order to elicit meaning, gain understanding and develop empirical knowledge". Polit and Beck (2014:304) said that qualitative data analysis is an inductive process that involves putting fragments of raw data together into meaningful conceptual patterns. It is a rigorous process, where the researcher immerses in the data, and this is referred to as dwelling with the data (Grove 2015:89). Dwelling with the data indicates that the researcher has spent considerable time reading and reflecting on the data.

Tjale and De Villiers (2013:244) articulates that, "...the purpose of data analysis is to convert the inner world and actions of research participants into meaningful broad ideas that serve as abstract representations of the details those participants had revealed". Data was analysed manually using thematic data analysis according to Colaizzi's (1978) cited in (Shosha 2012:34).

3.3.3.1 Thematic data analysis

Thematic data analysis is systematic approach, which involves searching for themes or categories. Inductive reasoning was used to interpret the resulting thematic structures to discover commonalities, relationships, overarching patterns, and variations across

participants. The researcher followed a seven-step process of thematic data analysis as stated by Colaizzi's (1978) as cited in (Shosha 2012:34).

Step one

The researcher read each transcript several times to gain a sense of the whole content and by translating the data from SiSwati to English. While reading, any thoughts, feelings, and ideas that arose by the researcher due to previous work with PLWHA were added to the bracketing diary.

Step two

In this stage of analysis, the researcher extracted significant statements and phrases from each transcript. These statements were written in separate sheets and coded based on their "transcript, page, and line numbers".

Step three

Meanings were formulated from the significant statements. Each underlying meaning was coded in one category as they reflect an exhaustive description. Thereafter, the whole statements and their meanings were checked by an expert researcher for correctness and consistency.

Step four

The researcher formulated meanings and grouped all these formulated meanings into categories that reflect a unique structure of clusters of themes. Each cluster of theme was coded to include all formulated meanings related to that group of meanings. After that, groups of clusters of themes that reflect a particular issue were incorporated together to form a distinctive construct of theme.

Step five

At this stage of analysis, all emergent themes were defined into an exhaustive description. Thereafter all themes were merged and the researcher reassessed for richness and completeness to provide sufficient description to be validated by the research supervisor.

Step six

In this step, a reduction of findings was done in which redundant, misused or overestimated descriptions were eradicated from the overall structure. Some amendments were applied to generate clear relationships between clusters of themes. However, some ambiguous structures that weaken the whole description were eliminated.

Step seven

The researcher validated study findings using "member checking" technique. It was done through returning the research findings to the participants and discussing the results with them.

These broad themes were further categorised and reduced to a limited number of themes and this process is called data reduction (Tjale & De Villiers 2013:245). When the data was reduced, then the researcher synthesised the data and created a meaningful whole, discovering commonalities, relationships, overarching patterns, and variations across participants.

3.4 TRUSTWORTHINESS

The researcher utilised Lincoln and Guba's framework of quality criteria to ensure trustworthiness in the study namely Credibility, Transferability, Dependability, and Confirmability respectively.

3.4.1 Credibility

Credibility refers to assurance in the truth-value of the data and interpretations (Polit & Beck 2014:323). To ensure credibility in this study, the researcher applied the following procedures; prolonged engagement, triangulation, peer debriefing and member checks.

3.4.1.1 Prolonged engagement

During the data collection, the researcher remained in the study site for sufficient time to have an in-depth understanding about perceptions of PLWHA using TM and ART. The

researcher prolonged engagement until data saturation was achieved. Saturation was achieved after interviewing 20 participants.

3.4.1.2 Triangulation

Creswell (2013:251) defined triangulation as the use of several and diverse sources, methods and investigations to provide supporting evidence. The researcher conducted in-depth face-to-face interviews as a data collection method, where a grand tour question was asked and depending on individual participant's response, follow up probes were asked. Probing allowed participants to expand and give more information on their perceptions towards the use of TM and ART. The researcher took field notes to capture even the non-verbal communication demonstrated by the participants.

3.4.1.3 Member checking

Member checking was done throughout the data collection process by probing to ensure that the interviewer had properly interpreted what the participants were saying (Polit & Beck 2014:328). Member checking was done in order to correct errors and to assess the overall adequacy of the data.

3.4.1.4 Peer debriefing

The research work was reviewed by a colleague, who is outside the context of the study but have a general understanding of PLWHA using TM and ART. The colleague asked questions about the study in a form of an external check.

3.4.2 Transferability

Transferability refers to “the extent to which qualitative findings can be transferred to or have applicability in other settings or groups” (Polit & Beck 2014:323). The researcher ensured transferability through thick descriptions.

3.4.2.1 Purposive sampling

Purposive sampling in the study ensured maximum range of specific information obtained from purposely-selected study sites which have diverse participants who deliberated and yielded rich data (Babbie & Mouton 2011:277) as already discussed under sampling.

3.4.2.2 Thick description

Polit and Beck (2014:331) describes a thick description as a rich, detailed and intense description of the research context and the people who participated in the study. The research results were communicated using detailed descriptions of specific themes and sub themes that have emerged during data analysis. Verbatim quotes from participants during data collection were included to add richness and contributed to the authenticity of the study. These descriptions demonstrated the true reflection of the events and perspectives shared by the participants relating to the use of TM together with ART (Tjale & De Villiers 2013: 247).

3.4.3 Dependability

According to Babbie and Mouton (2011:278), dependability entails that “an inquiry must also provide its audience with evidence that if it were to be repeated with the same or similar participants in a similar context, its findings would be similar”. This study utilised external audits as a strategy to ensure dependability where by the researcher’s supervisor acted as an external auditor. The external auditor assessed whether or not the findings, interpretations and conclusions were supported by relevant data (Creswell 2013:252).

3.4.4 Confirmability

Confirmability is defined as “the degree to which the findings are the product of the focus of the inquiry and not of the biases of the researcher” (Babbie & Mouton (2011:278).The researcher clarified her own biases in the beginning of the study.

3.5 SCIENTIFIC INTEGRITY OF RESEARCH

The study has the approval from the University of South Africa (Refer to ANNEXURE A). The researcher also compiled and submitted ethics application to the National Health Research Review Board of the Ministry of Health and approval was granted (Refer to ANNEXURE B). All health institutions that were selected for the study granted permission (Refer to ANNEXURE C). The researcher has conformed to methodological requirements of a qualitative study. All data and information collected from the participants and

authorities of health institutions were stored in a password protected computer file to ensure confidentiality. The researcher did data collection and entry. This arrangement minimised issues of bias and manipulation of data by the investigator.

3.6 CONCLUSION

In this chapter, the researcher covered the various methodological steps involved in conducting this research. A qualitative exploratory design was followed. Conducting unstructured individual interviews and compiling field notes led to achievement of data collection. Audiotaped interviews were transcribed later. Data were analysed using a seven-step process of thematic data analysis as stated by Colaizzi's (1978) as cited in (Shosha 2012:34).

Utilizing Lincoln and Guba's framework of quality criteria, which includes credibility, transferability, dependability, and confirmability ensured trustworthiness. Ethical consideration related to data collection was adhered to by observing the four bioethical principles.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

The previous chapter dealt with methodology where data collection procedures and steps of thematic data analysis were discussed. This chapter presents data obtained from in-depth interviews. The researcher managed the data prior to analysis where seven themes and sub themes emerged. These themes were presented together with quotes from participants to give a clear description of the research findings.

4.2 DATA MANAGEMENT

Data management in qualitative research is reductionist in nature: It involves converting masses of data into smaller, manageable segments (Polit & Beck 2014: 304).

A grand tour question was asked to collect data; in-depth interviews were conducted, where the researcher asked one broad question and probe according to the response of each participant. Data collected by using a voice recorder to capture responses and field notes were also taken to support the recorded information. Data collection commenced on the 22nd May 2017, where 20 participants were interviewed on Mondays, Wednesdays and Fridays as advised by health authorities. The researcher interviewed not more than four participants per each interview day. Data saturation was reached on the 2nd June 2017. The interview was conducted in a private room to maintain privacy and confidentiality of the participants. Code names were used instead of real names to ensure anonymity.

Data management was done according to Bazeley's (2013:63) seven steps followed when managing Qualitative Databases. Steps for data management are as follows:

Step 1 ACCURACY: The researcher checked data if it was of good quality and accuracy before commencing with a major analysis. Data was collected from 20 PLWHA who had come for their medication refills, aged 18 years and above until no new information was coming up. All the interviews started from the central question of the study.

Step 2 MAINTAIN COPIES: Prepare backups of the data management system. These backups should be updated as data preparation and analysis proceeds. Two voice recorders used to capture data from participants; transcribed data is stored in two different information storages, to ensure that data is not lost. The field notes were also written and kept as a backup for the management of data.

Step 3 ARRANGEMENT: Field notes are arranged in the voice recorder based on the date and the time when the data was collected, and kept for future reference.

Step 4 ORGANIZATION: The researcher organized narrative information into word document for data analysis. Colaizzi (1978) adapted seven steps of analysing data as cited in Shosha (2012:35) were used to identify the themes and the sub-themes of this study. The researcher grouped related types of information together in order to be able to identify themes and categories. The researcher organized information, which was relevant to research problem from participant's response.

Step 5 LABELING: The voice recorded interviews stored by the researcher in a securely locked place only accessible to the researcher for future reference. The participants were labelled Participant 1 to Participant 20 as a way of identifying them as the researcher record their responses in the interviews.

Step 6 CATALOGUING: List of all documents was kept alphabetical in the researcher personal password protected computer. All the field notes are kept sequentially from the first interview to the last interview and are kept in the securely locked place.

Step 7 MISSING DATA AND SAFE STORAGE: All rough work of transcription, field notes, typed transcription, and the voice-recorded information are kept in a securely locked place accessible only to the researcher for future reference.

4.3 ANALYSIS

The researcher transcribed the data from the voice recorder verbatim. The voice recorder was secured with a password and transcribed data were kept securely locked up in a locker only accessible to the researcher.

Grove et al (2013:279) hold a view that qualitative data analysis is, "...a process of examining and interpreting data in order to elicit meaning, gain understanding and develop empirical knowledge". Biographical information was quantitatively analysed. Data were analysed according to themes that had emerged, and the seven steps of Collaizzi's (1978) were employed.

Firstly, each transcript was read several times to explore and gain a sense of the whole content on perceptions of PLWHA. Secondly, significant statements pertaining to combining TM and ART were extracted from each transcript. Significant statements were displayed in a table. They were labelled according to transcript number, page number and lines number. Thirty-five significant statements were extracted from twenty transcripts. Thirdly, meanings were formulated from these significant statements; in this step, the researcher employed creative insight.

Fourthly, a process of organizing all formulated meanings into categories that reflect a unique structure of cluster of themes was initiated. Each underlying meaning was grouped to form one category as they reflect an exhaustive description. Groups of cluster of themes that reflect a particular issue were incorporated together to form a distinctive construct of theme. Seventeen clusters of themes were later grouped into seven themes and twelve sub themes as illustrated in Table 4.1.

Table 4.1: Themes

THEMES	SUB-THEMES
1. Searching for cure	1.1 Improving the quality of life 1.2 Reasons to combine TM and ART
2. Cultural aspects surrounding TM	2.1 Pre-existence and previous benefits of TM

3. Appreciation of ART chronic care	3.1 Understanding the physiology of HIV/AIDS 3.2 Adverse effects caused by combining TM and ART
4. Consequences of combining the two treatment modalities	4.1 Decreased CD4 cell count 4.2 Negative effects of drug overdose
5. ART chronic care related stigma	5.1 Secrecy, fear and non-disclosure 5.2 Awareness of ARV drug resistance
6. Psycho-social barriers to lifelong ART	6.1 Criticism surrounding ART 6.2 Considerations of TM in HIV/AIDS chronic care
7. Social discrimination by health service providers	7.1 Negative attitudes towards TM

4.4 RESEARCH RESULTS

4.4.1 Accessible sample

The accessible sample met the inclusion criteria, which were both male and female PLWHA; being on ART; residing in Manzini and being in the age range of eighteen to forty-nine years. The sample was conveniently selected to include a wide variation on age, including gender, education status, number of years on ART and willingness to share information with the researcher.

4.4.2 Socio-demographic characteristics of participants

Table 4.2: Socio-demographic characteristics of participants

Participant number	Gender	Age (years)	Highest Educational level	Period on ART
1	Female	27	High school	5 years
2	Female	25	High school	3 years
3	Female	42	High school	10 years
4	Female	35	High school	7 years

5	Male	36	Primary school	5 years
6	Male	34	High school	2 years
7	Male	45	High school	5 years
8	Female	47	High school	12 years
9	Female	49	Tertiary	10 years
10	Male	30	High school	4 years
11	Female	34	High school	6 years
12	Male	32	Tertiary	3 years
13	Male	31	High school	2 years
14	Female	45	High school	8 years
15	Female	33	Tertiary	7 years
16	Female	32	High school	5 years
17	Female	35	Tertiary	6 years
18	Female	28	Primary school	4 years
19	Female	32	Tertiary	4 years
20	Male	49	Primary school	5 years

Twenty PLWHA participated in the study. The sample consisted of both males and females. There were more females (65%) compared to males (35%). The majority of the participants ranged between 26-35 years (60%), and have attended high school (60%). Saturation of data was reached easily with this sample size.

4.5 THEMES

Themes associated with combining TM and ART

4.5.1 Theme 1: Searching for cure

Searching for the best treatment to cured HIV, boost CD4 count, relieve the side effects of ART and speed recovery were the most frequent statements used to describe the world of the PLWHA. These statements demonstrated that PLWHA are desperately searching for cure. Desperation has been shown by participant number 16, female, age 32 years who said *that "...we [PLWHA] have been advised not to combine the two but due to illness it is better to take both[TM and ART] ... at the end you will never know which one have healed you"*. Desperation and uncertainty about their future has made PLWHA to be more open and non-selective to all potential sources of help. Njeru (2013:179) concur that desperation has pushed PLWHA to mix TM and ART because they are seeking for

cure. O'Brien and Broom (2014:101) states that TM is strongly supported by PLWHA irrespective of the fact that the biological effectiveness of TM is still under research.

4.5.1.1 Sub-theme 1.1: Improving the quality of life

HIV and AIDS impinge the quality of life; this is when PLWHA's physical health, psychological state, level of independence and social relationships are affected. It is for this reason that PLWHA want to improve their quality of life. PLWHA believe that TM keeps them healthy and strong. Participant number 2, female, age 22 years supported this and mentioned that *"...TM makes us strong even though we are positive, we won't be ill"*. Searching for the best treatment to improve their quality of life has lead PLWHA to be caught in the middle to choose between TM and ART. To reiterate this, participant number 1, female, age 27 years said *"... due to the HIV in my body I find myself caught in the middle, I don't know which one to choose because I want to be healed"*.

4.5.1.2. Sub-theme 1.2 Reasons to combine TM and ART

PLWHA have their own reasons for combining TM and ART; they want to be cured from HIV as mentioned by participant number 4, female, age 35 years *"...traditional healers tell us that they cure HIV, so we take their medicines too"*. PLWHA combine TM and ART because they want to boost their CD4 cell count, supporting this statement, participant number 8, female, age 47 years said *"...we drink Mvuthuza to boost the CD4"*. PLWHA take TM in order to relieve the side effects of ART as stated by participant number 6, male, age 34 years who mentioned that, *"...TM will treat the side effects of ARVs and the ARVs will work on the HIV"*. Another reason for combining TM and ART was to speed up their recovery by suppressing HIV in their body. To reiterate this, participant number 16, female, age 32 years said that *"...sometimes we feel that the pills are not helping much, and then we decide to take both [TM and ART] for speeding up recovery..."* Several studies in Sub-Saharan Africa had similar findings on the reasons to combine TM and ART (Davids et al 2014:8; Belisle et al 2014:9; Musheke et al 2012:5).

4.5.2. Theme 2: Cultural aspects surrounding TM

The culture of traditional remedies and availability of traditional healers, knowledge of how to prepare the roots and prior benefits of TM in treating OIs before the availability of

ART in Swaziland made it difficult for PLWHA to stop taking TM even after they have been initiated on ART. These cultural aspects surrounding TM has made PLWHA to combine TM with ART.

PLWHA know that certain roots can be helpful to treat OIs, participant number 10, male, age 30 years concurs and said “... *as males we know the leaves and roots...we prepare them for ourselves..., like the ones to treat cough*”. Mandizadza and Chavunduka (2013:138) argue that TM and traditional healing have been in existence even before the introduction of Western medicine, which resulted in “health plurality”. PLWHA visit traditional healers and biomedical health practitioners concurrently in quest of medicines that will heal the symptoms of HIV and AIDS. This is associated with the African culture of using certain roots and leaves to aid healing and this knowledge makes it difficult to stop taking TM.

4.5.2.1 Sub-theme 2.1: Pre-existence and previous benefits of TM

Pre-existing knowledge on minor ailments and their traditional remedies is influencing the lives of PLWHA because they have benefitted from TM in treating OIs before ART initiation. TM is also readily available in pharmacies and herbal clinics.

To reiterate this, participant number 13, male, age 31 years said “... *I know that sibhaha can treat cough, even now I take sibhaha to treat my cough...and I also drink my ARVs*”. Supporting the same statement, participant number 10, male, age 30 years said “...*the illness in our body makes us to combine the two [TM and ART]... we use to take TM prior to ART, to boost the circulation and to treat cough*”.

O’Brien and Broom (2014:95) argue that, ART was introduced into a context where traditional health systems were pre-existing and well established in developing sub-Saharan African countries, so it is difficult to detach from TM because PLWHA have experienced the benefits of using TM.

4.5.3 Theme 3: Appreciation of ART chronic care

PLWHA appreciate the advent of ART because they are no longer ill. They are able to work for their children and they are now leading a normal life. Participant number 5, male,

age 36 years showed appreciation when he said, “...most illnesses these days are no longer traditional illnesses, so it is better to use western medicine rather than TM... I recommend ART”. This showed an understanding of HIV and AIDS as well as ART and the adverse effects of combining TM and ART because participants kept on referring to what they were taught during pre-ART counselling.

4.5.3.1 Sub-theme 3.1 Understanding the physiology of HIV and AIDS

HIV/AIDS is not a traditionally known illness and Western medicine is required for its treatment. ARVs are effective to stop HIV progression. Participant number 6, male, age 34 years stated that “...it is their belief; they believe TM will treat the side effects of ARVs and the ARVs will work on the HIV.” This was concurred by participant number 14, female, age 45 years who further said that “...some [PLWHA] think TM can help, yet if you are positive, you have to take ARVs only, TM only helps those who are negative, ... if you are positive you have to go to the clinic when you are ill...” These findings are similar to a study done in Ethiopia by (Ketema & Weret 2015:77).

4.5.3.2 Sub-theme 3.2: Adverse effects caused by combining TM and ART.

Participant number 4, female, age 35 years stated that, “...traditional healers are telling people that they cure HIV so people go for that and they tend combine which is not good”. Concurring to the same statement; participant number 19, female, age 32 years said, “...I think when you combine, TM lowers the effects of ARVs, like my brother, he used to drink both medications at the same time, ... it was like the TM is washing away the ARVs, because he didn't recover, he was getting weak each and every day until he died”

4.5.4 Theme 4: Consequences of combining the two treatment modalities

Results of this study revealed that there were consequences faced by PLWHA who are combining TM and ART and drug overdose was among those consequences. Drug overdose can be viewed as a two-fold challenge namely; overdose leading to lowered CD4 cell count and negative effects of drug overdose leading to hepatotoxicity.

4.5.4.1 Sub-theme 4.1: Decreased CD4 cell count

The commonest adverse effect of TM is diarrhoea and vomiting. Participant number 13, male, age 31 years said “...*what I know is that TM is not measured, they say take a sip, you might take more, TM may be strong, then it can cause diarrhoea and you become weak. Diarrhoea decreases the CD4 count*”. It transpired that vomiting might disturb the dosage of ART in the body because vomiting can occur immediately after swallowing ARVs. To substantiate this, participant number 3, female, age 42 years stated that “...*is not good because ARVs are measured and side effects are known and controllable yet with TM, side effects are severe and you end up vomiting. You will vomit your medication yet you will take another tablet the following day*”. These findings are similar to a study by Van Rooyen et al (2015:5) on allopathic and traditional health practitioners’ collaboration.

4.5.4.2 Sub-theme 4.2: Negative effects of drug overdose

PLWHA suspected the abuse of ARVs by traditional healers to make their concoction more powerful and this may lead to drug toxicity. This information was revealed by participant number 4, female, age 35 years who stated “... *the problem here is that traditional healers add some chemicals in their solutions, some add the ARVs, then you have an overdose of medication and this will affect your liver, then you become ill.*” Suspicions of adding ARVs in traditional medicine seemed to be new information because previous studies did not reveal such results.

4.5.5 Theme 5: ART chronic care related stigma

Fear, denial, secrecy and ART drug resistance, were the most frequent terms used to describe the world of PLWHA in relation to ART chronic care. ART chronic care was associated with HIV related stigma. Bene and Darkoh (2014:175) stated that, PLWHA are fearful of involuntary disclosure of their status, to their either marital partners or social network members and facing prospects of social exclusion. Consequently, to avoid involuntary disclosure of their HIV status they opted not to initiate on ART and rather use TM.

4.5.5.1 Sub-theme 5.1: Secrecy, fear and non-disclosure

Participant number 8, female, age 47 years said, “...I have not seen anyone who have used TM only and felt well, I have seen them getting weaker, and they end up going to hospital... they are scared of going to hospital. I think, they deny their [HIV] status... they also fear that their friends will see them going to hospital every month then they will suspect that they are collecting ARVs”. These results are similar to a study done in South African rural communities on experiences of traditional health practitioners within the HIV treatment as prevention trial (Moshabela 2016:27).

The behaviour associated with ART perpetuates involuntary disclosure of their HIV status. This was according to participant number 3, female, age 42 years, who said “...with TM it is better, you can alternate days but with ART even if you are gone for a funeral you will ask for water. They will see that you are on ART... with ART even if you haven’t disclosed to your boyfriend and if he is around ART is taken on time”.

4.5.5.2 Sub-theme 5.2: Awareness of ARV drug resistance

PLWHA tend to miss some doses of ART because of TM. Supporting this statement participant number 18, female, age 28 years said, “...he [my boyfriend] used to alternate the time, he took ART and CTX in the morning and instead of repeating his second dose of ART in the evening, he will take the TM...” Similar results yielded in a study conducted in Ethiopia on assessment of adherence to ART (Ketema & Weret 2015:79).

Recovering from illness and gaining weight were other factors that influence PLWHA to discontinue ART secretly and opt to TM secretly. To reiterate this, participant number 17, female, age 35 years said, “...I know a lady who recovered and gained weight, she then stopped ART, and unfortunately she died”. Similar findings noted in a study done in Zambia on factors influencing patient attrition from ART (Musheke et al 2012:4). The above factors may trigger ARV drug resistance. To substantiate this, participant number 20, male, age 49 years said, “...when you go back to hospital you may find that you are now resistant to the ARVs you were taking and nurses have to give you another type of pills”.

4.5.6 Theme 6: Psycho-social barriers to lifelong ART

Anticipated treatment fatigue associated with lifelong ART has triggered PLWHA not yet initiated on ART scared to enrol into chronic care, and those already enrolled discontinue ART and opt for TM. PLWHA felt that there is a need to consider TM in HIV chronic care. Musheke et al (2012:4) argue that, there is decreased motivation to continue treatment among PLWHA, because the moment they swallow ARVs, they are reminded of their status and the criticism surrounding ART.

4.5.6.1 Sub-theme 6.1: Criticism surrounding ART

PLWHA are scared of taking ART because of the criticism surrounding ART. Supporting this statement participant number 5, male, age 36 years said “...PLWHA *complain that ART is a lifelong treatment and if you stop taking ART you die, so people are scared of taking ART...*” PLWHA perceive lifelong ART as a burden and tiresome but they still want to be well like any other person, so they take TM to make them strong. To reiterate this participant number 2, female, age 25 years stated “...*they believe TM will make them strong and they won't be ill. They want to alternate because ART is taken daily; they alternate so that they rest from taking ART*”

4.5.6.2 Sub-theme 6.2: Considerations of TM in HIV/AIDS chronic care

It is worth noting that a laboratory investigation to identify the chemical properties of TM so that TM can be considered in HIV/AIDS chronic care was a concern among PLWHA. To attest to this participant number 6, male, age 34 years said, “...*maybe if the TM may also be tested in the laboratories to see what chemicals are in those herbs, because people won't stop stealing TM even if they know it not a good thing to do*”. Another concern was that it might be helpful to know ailments, which can be treated by TM, and those that need western medicine. To support this statement participant number 9, female, age 49 years said “...*maybe if health workers can meet with traditional healers and come to the open, which ailments are treated by traditional healers it can be better*”.

4.5.7 Theme 7: Social discrimination by health service providers

Social discrimination and rejection by health service providers has been reported among PLWHA who combine TM and ART. Health service providers discourage PLWHA from

pursuing the services of traditional healers giving a reason that they use unscientific methods and delayed referrals (Van Rooyen et al 2015:4). This was viewed as a negative attitude by PLWHA.

4.5.7.1 Sub-theme 7.1: Negative attitudes towards TM

“...As long as health service providers are against combining TM and ART, PLWHA won’t disclose that they are also taking TM”, this was said by participant number 3, female, age 42 years. Participant number 13, male, age 31 years said *“...health care provider’s attitude is influencing PLWHA not to disclose if they are using TM”*. PLWHA perceive rejection by health service providers for using TM. To support this, participant number 10, male, age 30 years said *“... but we are scared, that Doctors will say let’s continue with TM and stop the ART, most people also believe in TM, we also want to benefit from TM”*. These results are similar to findings of a study in South Africa by (Puoane et al 2012:499).

4.6 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

4.6.1 Theme 1: Searching for cure

It is very difficult to accept that HIV, as a virus is incurable. When a person is diagnosed with such a virus, that person feels like an outcast. The person would want to get rid of the virus and that is the reason why even today in Swaziland, 30 years after the first person was diagnosed with HIV, PLWHA are still searching for a cure. PLWHA are utilizing all sources of help from both the traditional health system and biomedical health system so that they can keep well. Concurring to findings of the current study, Nlooto and Naidoo (2017:152) holds the view that “the search for a cure for HIV infection” is the main reason for using TM prior to ART initiation and after ART initiation.

4.6.1.1 Sub-theme 1.1: Improving the quality of life

Improving the quality of life is one of the goals of all PLWHA. They want to lead a normal life like any other person and work for their families. The use of TM was to improve the quality of life and increase life expectancy in PLWHA before ART was introduced (Sibanda, Naidoo and Nlooto 2016:3).The use of the different treatment modalities

available in Swaziland, be it TM or ART has helped to improve the quality of life among PLWHA.

The National ART Programme (2012:29) have this to say, "...although it is difficult to attribute the achievements in life expectancy to ART services alone there is evidence of reduced mortality among PLWHA and the improvement of life expectancy at birth for both males and females in Swaziland from 43 years in 2007 to 49 years in 2012".

4.6.1.2 Sub-theme 1.2: Reasons to combine TM and ART

PLWHA combine TM and ART for several reasons, ranging from cultural beliefs, and treatment of OIs, curbing the side effects of ART and boosting the CD4 count. Supporting the findings of the current study, Sibanda et al (2016:3) concurs that studies show that PLWHA use TM supplement dietary intake, to boost energy levels, to alleviate side effects of ART, to cure OIs, to improve immune response as well as a misguided belief that some TM can even cure HIV/AIDS.

4.6.2 Theme 2: Cultural aspects surrounding TM

As part of Swazi culture, plant roots, leaves and barks have medicinal properties, so Swazis were using them to treat ailments before western biomedicine was introduced. It has been discovered that even with HIV and AIDS, PLWHA as Swazis would want to use these plants and roots. It is for this reason PLWHA, as in Swazis, it is difficult for them to detach from their culture of TM even with the advent of ART.

4.6.2.1 Sub-theme 2.1: Pre-existence and previous benefits of TM

As already said TM has been in existence before ART when people were dying of AIDS, others have survived on TM till ART was available. Previous benefits from TM are making PLWHA to cling to TM even when they are using ART. Supporting the results of the current study Sibanda et al (2016:3) concurs that, during the peak of the HIV/AIDS pandemic in the late 1990's, when ARVs were largely unaffordable and inaccessible, TM were the pillar of HIV management amongst PLWHA in sub-Saharan Africa. The advent of ARV rollout programs did not substitute TM use amongst PLWHA.

4.6.3 Theme 3: Appreciation of ART chronic care

According to Heestermans, Browne, Aitken, Vervoort and Klipstein-Grobusch (2016: 5), PLWHA's positive perceptions of ART, such as a strong belief in value of treatment and understanding the importance of adherence, were a sign of appreciating ART and it is associated with adherence. PLWHA live longer and orphan-hood due to AIDS has been reduced in Swaziland.

4.6.3.1 Sub-theme 3.1: Understanding the physiology of HIV/AIDS

PLWHA are now accepting that HIV is a chronic manageable condition, with the help of ART chronic care they can live longer with minimized OIs. Unlike before PLWHA are no longer critically ill and dying, they are working for their children and are supporting their families as long as they take ART correctly. Umgubudla (2016:22) found that, PLWHA who are on ART with good adherence have a suppressed viral load at 85% while only 12% of PLWHA who are not on ART have a suppressed viral load.

4.6.4 Theme 4: Consequences of combining the two treatment modalities

It is worth noting that there are consequences faced by PLWHA combining TM and ART, with the fact that the measure of the dosage of TM is not clear, this can lead to diarrhoea and vomiting and drug toxicity.

4.6.4.1 Sub-theme 4.1: Decreased CD4 cell count

Traditional healers measure their dosage in sips, in some cases the sip might be more, thus resulting in diarrhoea and vomiting which further weakens the immune system resulting to decrease CD4 cell count. A decreased CD4 cell count makes PLWHA vulnerable to other OIs that will further deplete the immune system thus fast tracking to the AIDS disease. When vomiting occurs, ARVs may be vomited too and the person will not recover because the body will not absorb the ARVs.

4.6.4.2 Sub-theme 4.2: Negative effects of drug overdose

Combining TM and ART put PLWHA at risk of drug overdose, which in turn may lead to a liver toxicity because all drugs including TM and ARVs are metabolised by the liver. It is worth noting that the person might be suffering from other chronic illnesses and might

be on other drugs like anti TB or antihypertensive drugs. PLWHA on ART chronic care are taken blood samples for a liver function tests at three to six months intervals to assess and monitor the status of the liver, thus guarding against early signs of liver toxicity.

4.6.5 Theme 5: ART chronic care related stigma

PLWHA experience some form of stigma when they visit health facilities routinely for follow up care and ART refills. Supporting the results of this current study, Church, Wringe, Fakudze, Kikuvi, Simelane and Mayhew (2013:6) concurs that, ART provision in specified rooms appears stigmatizing, suggesting, “people can see that, the long line is for those who are positive”. Although in some facilities health service providers make effort to label the ART room as “Room 1” to reduce stigma, the status exposure risk still is worsened by the announcements “those who have come to refill their pills go to Room 1” The most dangerous form of stigma experienced is internal stigma of living with HIV. Internal stigma is a strong negative feeling experienced inwardly by PLWHA, which is a result of actions, or labelling by other people (MOH 2016:61). PLWHA experiences internal sigma when others label them as HIV positive people. PLWHA tend to stop taking ART and opt for TM.

4.6.5.1 Sub-theme 5.1: Secrecy, fear and non-disclosure

According to Church et al (2013:5) in their study in Swaziland, they found that most PLWHA, across all models of care, felt discomfort about attending ART facilities, caused mainly by fear of status exposure at the facility and concern about bumping into colleagues. The anxiety was also related to PLWHA’s own acceptance of their HIV status. Those experiencing greater discomfort were those who had failed to disclose their status to partners, family or friends. These findings are similar to the findings of the current study, because PLWHA who had accepted their status have disclosed their status. They receive psychosocial support from the people who are aware of their status. They are not scared of visiting facilities for routine reviews and ART refills. On the other hand those who are still struggling with acceptance of status and disclosure may be missing their refill dates due to fear thus substituting ART with TM. Non-disclosure, hiding or skipping medication to avoid disclosure of HIV status leads to poor adherence (Heestermans et al

2016:5) and risk of developing drug resistance. Some participants in the current study were scared to drink their ARVs when visiting their boyfriends and during funerals, instead they substituted ARVs with TM.

4.6.5.2 Sub-theme 5.2: Awareness of ARV drug resistance

Heestermans et al (2016:6) hold a view that, improved health status and weight gain have been misinterpreted by some PLWHA. They believed to have been cured from HIV and some tend to stop taking ARVs yet this opens a window for ARV drug resistance. Even in this current study, some PLWHA were reported to have stopped ART because of weight gain and after some few months they became severely ill again, recovery was noted after being recommenced on a different treatment regimen. It is worth concluding that, this could be because they had developed resistance to the initial treatment regimen.

4.6.6 Theme 6: Psycho-social barriers to lifelong ART

The duration of taking ART was seen as a barrier to ART chronic care because some PLWHA were complaining about taking ART for life, they voiced out that they sometimes feel they want to take a break from ART. While taking the break they felt TM was a good substitute for ART to boost their immunity.

4.6.6.1: Sub-theme 6.1: Criticism surrounding ART

There are rumours and false beliefs about ART, including that ART can be harmful because of severe side effects (Heestermans et al 2016: 5). These rumours and criticism have made PLWHA to abandon ART and opt for TM, of which some are even scared to initiate ART yet they are ill.

4.6.6.2: Sub-theme 6.2: Considerations of TM in HIV/AIDS chronic care

Sibanda et al (2016:3) hold a view that, several studies done in different countries of sub-Saharan Africa on PLWHA using TM concurrently with ART showed no significant adverse effects. Another study done in 2016 on adults in South Africa taking ART and ATM concurrently found no significant differences in the CD4 cell count and inconclusive effects on HIV viral load, between PLWHA taking both ARV and ATM concomitantly and those using ARV alone. PLWHA in the current study described TM as helpful and

laboratory investigations to rule out the active ingredients found in commonly used TM are necessary so that TM can be considered in HIV/AIDS chronic care.

4.6.7 Theme 7: Social discrimination by health service providers

Grossman and Stangl (2013:1) have this to say, "...thirty years into the HIV pandemic, stigma and discrimination continue to obstruct individuals and communities from accessing and benefiting from effective prevention and treatment strategies". There is increasing evidence that HIV-related stigma and discrimination are barriers to HIV testing, status disclosure, retention in care and uptake of and adherence to ART. PLWHA who are not retained in ART chronic care are using TM as an alternative.

4.6.7.1 Sub-theme 7.1: Negative attitudes towards TM

PLWHA reported fear of discrimination by health service providers if they disclose that they are taking TM. They even said some health service providers say they should rather take TM alone and stop ART. Supporting the findings of the current study, Sibanda, Nlotoo and Naidoo (2016:1128) concurs that concomitant use of TM is generally discouraged during ARV treatment, and so there is a chance of under reporting of the use of TM use by PLWHA. There is perceived possibility of punitive consequences from the health service provider for using TM.

4.7 CONCLUSION

The majority of participants were women compared to men. The researcher followed thematic data analysis. Seven themes and twelve sub-themes were described. These themes were supported with quotes from participants. The findings showed that PLWHA acknowledge that HIV/AIDS is not a traditional illness and ART can help to improve their quality of life. However it so happens that the pre-existence of TM makes it difficult to detach from TM after ART initiation hence they are aware that there are consequences when ART taken with TM concurrently. PLWHA also voice concerns on the negative

attitude of health service providers regarding the use of TM. Nevertheless, the research findings also revealed appreciation of ART chronic care.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The previous chapter dealt with data analysis, presentation and description of the research findings. Seven themes were presented together with quotes from participants to give a clear description of the research findings. This chapter seeks to report on conclusions and recommendations drawn in relation to PLWHA using TM together with ART.

5.2 RESEARCH PURPOSE

The purpose of this study was to explore the perceptions of PLWHA with regard use of traditional medicines together with ART. Having a clear understanding of their reasons, opinions and beliefs (perceptions) regarding use of TM together with ART may assist the health authorities in planning the health provision to the PLWHA. This may help the health authorities to work with the PLWHA in discussing the TM and ART instead of launching campaigns without understanding them.

5.3 RESEARCH OBJECTIVES

The objectives of the study were to:

- explore the PLWHA perceptions on the use of traditional medicines.
- identify factors influencing those perceptions.
- describe factors influencing PLWHA to use traditional medicines together with ART
- identify the challenges PLWHA face when using traditional medicines together with ART.

5.4 RESEARCH QUESTION

One grand tour question was used to explore the perceptions of the PLWHA, followed by the sub-questions: “what are your perceptions with regard to the use of traditional medicines together with antiretroviral therapy?”

5.5 DISCUSSION

Despite the fact that HIV is incurable because it is a viral infection, it is evident that thirty years later after the first person was diagnosed with HIV in Swaziland, PLWHA are still searching for HIV cure. Several interventions are being implemented to aid towards HIV prevention, treatment, care and support to reduce HIV related deaths. ART have been made accessible to all PLWHA to suppress the virus and improve their quality of life.

Pre-existence of TM prior to ART is influencing PLWHA to combine TM with ART. PLWHA have their own reasons of combining the two treatment modalities even when ART is readily accessible in Swaziland. Combining TM and ART is not acceptable to health service providers because the combination is perceived to cause toxicity and drug-to-drug interaction.

Stigma and discrimination experienced by PLWHA has made some PLWHA to refuse ART and opt for TM. This stigma is mainly associated with secrecy, fear and non-disclosure of HIV status to friends and relatives. PLWHA feel health service providers discriminate them if they disclose that they also use TM.

Taking ART for life was perceived as a burden by some PLWHA who thought TM was better, and TM should be considered in the management of HIV and AIDS. PLWHA were aware that missing doses of ART could lead to drug resistant.

5.6 RECOMMENDATIONS

5.6.1 Traditional healers in HIV/AIDS management programs

TM is still widely used by PLWHA in Swaziland. It continues to exist as an important component of African traditional culture. The recommendation is that, if Swaziland can properly regulate and include traditional healers in HIV/AIDS management programs, traditional healers could be an important resource in the primary health care management HIV/AIDS.

5.6.2 Beliefs on TM

Due to the beliefs that PLWHA benefit from TM, laboratory investigations of TM are essential to rule out the efficacy and safety of combining TM and ART. Health service providers should continue and advise those PLWHA combining TM and ART to be cautious and perform regular liver function tests. Therefore, it is a recommendation that, health service providers should provide culture sensitive care and support as outline by Madeleine Leininger (Du Toit & Le Roux 2014:46).

5.6.3 TM use disclosure

It is very important that PLWHA inform their health service providers about their use of TM for both HIV-related illnesses and other illnesses. It is a recommendation that, Health service providers must investigate about the use of TM in PLWHA during counselling sessions as part of their routine history taking. Proper history taking and assessment may help prevent drug-to-drug interactions, which may lead to treatment failure or toxicity.

5.6.4 Stigma and discrimination

Swaziland is aiming for an AIDS free generation by the year 2022. Swazi Observer (2015) cited in MOH (2016:59) state that, in His speech from the throne, His Majesty the King said, "...today, here and now, I denounce all HIV stigma and discrimination". In His speech, the King was calling for a multisectoral approach to stop stigma and discrimination. It is a recommendation that, Swaziland can utilise multisectoral approach to strengthen psychosocial support systems to empower PLWHA on how to deal with the effects stigma and discrimination. Another recommendation is to decentralize community-

based antiretroviral therapy groups in all the four regions, where by a group of five PLWHA will rotate in collecting ARVs refills for all group members to reduce stigma and cater for the travel costs. Lastly, another recommendation is to increase the refill supply for up to 6 months if the clients are well and adhering to treatment.

5.6.5 Further research studies

This study has explored perceptions of PLWHA combining TM and ART in only one region in Swaziland yet the country is divided into four regions. The recommendation is that, it could benefit the country to repeat the similar research at National level, to include all the four regions, in both rural and urban settings so that the results can be more transferable.

5.7 CONTRIBUTIONS OF THE STUDY

Swaziland, like any other country in sub-Saharan African is still embedded in its culture and tradition. Swaziland should incorporate the cultural context in HIV and AIDS prevention intervention strategies. This incorporation is essential and may improve the acceptability of these strategies by PLWHA.

The results of the study may provide a baseline data for Swaziland concerning PLWHA combining TM and ART. Government ministries, health facilities, community based organizations, private sectors and PLWHA may use the data to design and implement long lasting HIV/ADS prevention strategies through collaborative efforts.

The findings of the study have revealed that PLWHA appreciate ART and they have benefitted from ART, but due to cultural beliefs, they also use TM. These findings may help inform the Ministry of Health to consider and design strategies on how to regulate and monitor the traditional health system for the benefit of the Swazi nation.

For PLWHA, these findings may help them continue to appreciate the existing health systems in the country and may be willing to assist government in designing programs and strategies that will be more effective and acceptable in the prevention and treatment of HIV and AIDS in Swaziland.

The findings of the study may open opportunities for further studies relating to TM because due to the dominating biomedical health system, researchers have not done much research on the traditional health system in Swaziland.

5.8 LIMITATIONS OF THE STUDY

According to Polit and Beck (2014:65), a presentation of limitations demonstrates to readers that the author was aware of the limitations of the study, and there is a significant probability that the author considered them in interpreting the findings of the study. The findings of this study should be therefore, considered against the following limitations: The current study was qualitative and exploratory in nature, thus the sample size was small, so these findings can only be transferable to PLWHA in Manzini not to Swaziland as a whole. The researcher used convenience sampling, the drawback of this technique is that readily available participants might be atypical of the population and the price of convenience is the risk of bias. Due to financial and time constraints, only two ART facilities in Manzini (urban area) were utilised for data collection. It is possible that similar research at a rural area could yield different results. The researcher is of the view that, despite these limitations, the study offers an insight of perceptions of PLWHA about combining TM together with ART in Swaziland.

5.9 CONCLUSION

This chapter presented the conclusions and recommendations of the study. Qualitative exploratory research design was utilised to explore perceptions of PLWHA using TM together with ART. Convenience sampling strategy was employed to select participants. In-depth interviews were conducted to collect data, which were later analysed using thematic data analysis. Seven themes and sub-themes emerged. Limitations of the study were also identified.

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ANNEXURES

ANNEXURE A Approval from the University



**RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)**

15 February 2017

Dear MS XMJ Fakudze

Decision: Ethics Approval

HSHDC/616/2017

MS XMJ Fakudze

Student: 4486-673-9

Supervisor: Dr TP Makua

Qualification: D Litt et Phil

Joint Supervisor: -

Name: MS XMJ Fakudze

Proposal: People living with HIV using traditional medicines together with antiretroviral therapy in the Manzini Region of Swaziland.

Qualification: MPCHS94

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 15 February 2017.

The proposed research may now commence with the proviso that:

- 1) The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
- 2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*



Open Rubric


3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:

The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,



Prof L Roets

CHAIRPERSON

roetsl@unisa.ac.za



Prof MM Moleki


ACADEMIC CHAIRPERSON

molekmm@unisa.ac.za

ANNEXURE B Approval from the National Research Review Board: Swaziland



Research Protocol clearance certificate

Type of review	Expedited	<input checked="" type="checkbox"/>	Full Board	<input type="checkbox"/>
Name of Organization	STUDENT			
Title of study	PERCEPTIONS OF PEOPLE LIVING WITH HIV ON THE USE OF TRADITIONAL MEDICINES TOGETHER WITH ANTIRETROVIRAL THERAPY IN THE MANZINI REGION OF SWAZILAND			
Protocol version	1.0			
Nature of protocol	New	<input checked="" type="checkbox"/>	Amendment	<input type="checkbox"/>
List of study sites	RALEIGH FITKIN MEMORIAL HOSPITAL, LAMVELASE HELP CENTRE			
Name of Principal Investigator	XOLILE FAKUDZE			
Names of Co- Investigators	N/A			
Names of steering committee members in the case of clinical trials	N/A			
Names of Data and Safety Committee members in the case of clinical trials	N/A			
Level of risk (Tick appropriate box)	Minimal	<input checked="" type="checkbox"/>	High	<input type="checkbox"/>
Clearance status (Tick appropriate box)	Approved	<input checked="" type="checkbox"/>	Disapproved	<input type="checkbox"/>
Clearance validity period	Start date	8/05/2017	End date	08/05/2018
Signature of Chairperson				
Date of signing	08/05/2017			
Secretariat Contact Details	Name of contact officers	Ms Simangele Masilela		
	Email address	kaluamasi@gmail.com		
	Telephone no.	(00268) 24040865/24044905		



Approval Conditions

Ref.	Conditions	Indication of conditions (tick appropriate box)				
1	Implementation of approved version of protocol	✓				
2	Reporting of adverse events within 5 days of occurrence	✓				
3	Submission of progress reporting for multi-year studies	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
		N/A	N/A	N/A	N/A	N/A
4	Submission of end of project report (Hard copy)	✓				
5	Submission of end of project report (Soft copy)	✓				
6	Submission of data sets	✓				

List of reviewed documents

Ref.	Documents	Reviewed documents (tick appropriate box)
1	Completed application form	✓
2	Cover letter	✓
3	Evidence of administrative permission to conduct the research by involved institutions/sites (where applicable)	✓
4	Detailed current resume or curriculum vitae of Principal Investigator/s including Principal investigators declaration	✓
5	Summary resume or biography for other investigator(s)	✓
6	Evidence of approval/rejection by other Ethics Committees, including comments and requested alterations to the protocol, where appropriate.	
7	Research protocol (see outline in Annex 1)	✓
8	Questionnaires and interview guides (with back-translated versions where applicable)	✓
9	Case report forms (CRFs), abstraction forms and other data collection tools	✓
10	Participant/subjects Information Statement(s) (where applicable)	✓
11	Informed consent form(s) including photographic and electronic media consent statements.	✓
12	Advertisements relevant to the study (where applicable)	
13	Source of funding and detailed budget breakdown including material and incentives to participants if applicable	
14	Notification form for adverse effects/events.	
15	Proof of payment	✓
16	Proof of insurance cover for research subjects in clinical trials or where applicable	
17	Any other special requirements should be stated, if applicable	None

ANNEXURE C Approval from the study sites



SWAZILAND NAZARENE HEALTH INSTITUTIONS (SNHI)
RALEIGH FITKIN MEMORIAL (RFM) HOSPITAL
COMMUNITY HEALTH CLINICS



At Junction of David Hynd Road & Ligusha Street

P.O. Box 14 Manzini 200 Swaziland

15 March 2017

Xolile Fakudze
P O BOX 7319
Manzini
Swaziland

Dear Madam

RE: AUTHORIZATION TO CARRY OUT A RESEARCH IN THE HOSPITAL

Your request on the fore mentioned endeavors has been duly considered and permission granted on the following conditions please:

- a). That confidentiality is strictly observed
- b). That the hospital receives a copy of the report on the proposed research.

Again thank you for considering the Institution for such a task and wishing you all the best.

Sincerely yours

Leonard S. Dlamini (Mr)
HOSPITAL ADMINISTRATOR

CC: Matron 1
SMO

27 April 2017

Ms Xolile Fakudze
Principal Investigator
P. O Box 7319
Manzini

REF: Permission to Conduct Study at Lamvelase Help Centre

Dear Mam

This letter serves to certify that Lamvealse Help Centre is willing to assist you conduct your research at the facility . This is subject to your getting the neccessary approval form the Swaziland Research Ethics Board .

As soon as you get the necessary approvals please contact the Medical Director to assist you with the sampling process and logitics of the study.

We are looking forward to assisting you in your study which hopefully will inform us about this issue among our cohort of patients.

Yours Faithfully



Dr Nduduzo Dube
Country Program Manager

AHF Swaziland - Lamvelase
P.O. Box 7352 Manzini
Tel/Fax: 00268 25059183 / 25056496
website: www.aidshealth.org

ANNEXURE D Letter seeking approval: National Health Research Review Board

The National Research Review Board
Mbabane
Swaziland

Dear Sir/Madam

RE: APPLICATION TO CONDUCT A STUDY AT LAMVELASE HELP CENTRE AND RALEIGH FITKIN MEMORIAL HOSPITAL.

I Xolile Manesi Jane Fakudze, a Master's student at the University of South Africa (UNISA), kindly request the Research Review Board to grant me permission to conduct a research study for the partial fulfilment of a Master of Arts in Nursing Science. I hereby kindly request permission to conduct a study entitled: "People living with HIV/AIDS using traditional medicines together with antiretroviral therapy in the Manzini region of Swaziland".

Currently I'm employed as a lecturer at Good Shepherd College of Nursing. Please find attached:

- Curriculum Vitae
- Research proposal
- Proof of ethical clearance to conduct study from the University of South Africa
- Copies of interview guide and translated consent form

I hope my request will meet your favorable consideration.

Kind regards



Xolile Fakudze

**ANNEXURE E
Help Centre**

Letter seeking permission to conduct research: LaMvelase

Xolile Manesi Jane Fakudze

P.O. Box 7319

Manzini

Swaziland

Cell: +268 7621 988 7

Health Director

LaMvelase Help Centre

P.O. Box 7352

Manzini

Swaziland

RE: REQUEST TO CONDUCT A RESEARCH STUDY

I Xolile Manesi Jane Fakudze, a Master's degree student at the University of South Africa (UNISA), kindly request the authorities of LaMvelase Help Centre to grant me permission to conduct a research study for the partial fulfilment of a Master of Arts in Nursing Science. I hereby kindly request permission to conduct a study entitled: "People living with HIV/AIDS using traditional medicines together with antiretroviral therapy in the Manzini region of Swaziland".

Confidentiality and anonymity will be maintained throughout the research process.

I hope my request will be highly considered.

Yours sincerely



Xolile Fakudze

ANNEXURE F Letter seeking permission to conduct research: RFM Hospital

Xolile Manesi Jane Fakudze

P.O. Box 7319

Manzini

Swaziland

Cell: +268 7621 988 7

The Chief Executive Officer

Raleigh Fitkin Memorial Hospital

P.O. Box 14

Manzini

Swaziland

RE: REQUEST TO CONDUCT A RESEARCH STUDY

I Xolile Manesi Jane Fakudze, a Master's student at the University of South Africa (UNISA), kindly request the authorities of Raleigh Fitkin Memorial Hospital to grant me permission to conduct a research study for the partial fulfilment of a Master of Arts in Nursing Science. I hereby kindly request permission to conduct a study entitled: People living with HIV/AIDS using traditional medicines together with antiretroviral therapy in the Manzini region of Swaziland.

Confidentiality and anonymity will be maintained throughout the research process.

I hope my request will be highly considered.

Yours sincerely



Xolile Fakudze

ANNEXURE G Information and Consent

INFORMATION LEAFLET AND INFORMED CONSENT

LIPHEPHA LESIVUMELWANO

RESEARCH TOPIC: PERCEPTIONS OF PEOPLE LIVING WITH HIV ON THE USE OF TRADITIONAL MEDICINES TOGETHER WITH ANTIRETROVIRAL THERAPY IN THE MANZINI REGION OF SWAZILAND

SIHLOKO: *IMICONDVO YEBANTFU LABAPHILA NELIGCIWANE LE-HIV LABASEBENTISA EMAKHATSAKHATSA ESINTFU BAPHINDZE BANATSE NEMAPHILISI EKUTSINTSIBALISA LIGCIWANE LE-HIV ESIFUNDZENI SAKAMANZINI*

INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in the study, you should fully understand what is involved. If you have any questions, which are not clearly explained in this leaflet, do not hesitate to ask the researcher. You may phone, **Xolile Jane Fakudze** at **+268 76219887** (cell phone) if you have further questions. You should not agree to take part unless you are completely happy about all the procedures involved.

SINGENISO

*Uyacelwa kutsi ubeyincenye yalolucwaningo. Fundza leliphapha, litakweluleka likuchazele kabanti nawunesifiso sekungenela lolucwaningo. Nakukhona lokungevakali kahle kuleliphapha, ungesabi kubuta kumcwaningi, ungashaya lucingo kunansi inombolo **+268 76219887**, libito lemncwaningi ngu, **Xolile Jane Fakudze**. Nasewenetisekile ngalokubhalwe kuleliphapha, unelilungelo lekukhatsa kulungenela nekungalungeneli lolucwaningo.*

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of the study is to explore the perceptions of People Living with HIV towards taking traditional medicines together with ART.

YINI SIZATFU SALOLUNCWANINGO

Sizatfu saloluncwaningo kutfolo imicondvo leyehlukene kubantfu labaphila neligciwane le-HIV mayelana nekusebentisa emakhatsakhatsa esintfu baphindze banatse emaphilisi ekutsintsibalisa ligciwane le-HIV.

WHAT IS THE DURATION OF THIS INTERVIEW?

In-depth interviews will be conducted. If I agree to participate in the study the interview would take approximately 30-45 minutes. The interview will be tape-recorded and will take place in one of the rooms in the clinic. No identifying information will be included when the interview is transcribed. I understand that I may not participate in the study if I am less than 18 years old and above 49 years.

KUTSATSA SIKHATSI LESINGANANI LOKUCOCISANA?

Kute kutfolakale kahle lemicondvo, kutawucociswana kabanti, letingcogcoti ngahletibe yimizuzu lengemashumilamatsatfu kuya kulengemashumilamane nesihlanu. Letingcogco titawutsetjulwa kodwva angeke timataniswe neligamalakho. Unelilungelo lekungenela letingcogco nawuneminyaka lengetulu kwelishumi nesiphohlango kuya kule ngemashumilamane nemfica.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

The Proposal of the study was submitted to the Unisa Scientific Review Committee and the National Research Review Board in Swaziland. These committees have granted a written approval to conduct the study.

LUYITFOLILE YINI IMVUME LOLUCWANINGO?

Lolucwaningo luyitfolile imvume ekomidini lase Unisa kanye nelikomidi lelitiko letemphilo kaNgwane kutsi umncwaningi angachubeka nalolucwaningo.

WHAT ARE MY RIGHTS AS A PARTICIPANT IN THIS STUDY?

Your participation in this study is entirely voluntary – you are under no obligation to participate. You have the right to withdraw anytime and your relationship with the researcher will not be affected.

YINI LILUNGLO LEMCWANINGWA KULOLUCWANINGO?

Uyatikhetsela kungenela lolucwaningo, awulungeneli ngenkhani, kantsi futsi uvumelekile kuphuma kulolucwaningo nomanini nangabe uva ungasakhululeki kuchubeka kulolucwaningo, loko angeke kone budlelwane bakho noma kukucabanise nemcwaningi.

WHAT IF THE INTERVIEW RESULTS IN DISCOMFORT OR INCONVENIENCE?

The study and procedures involve no foreseeable physical discomfort or inconvenience to you or your family. Due to the personal nature of the questions, you may experience some emotional discomfort.

ANGEKE YINI LETINGCOGCO TINGILIMATE NOMA TINGIVISE BUHLUNGU?

Kute kulimala lokubhekekile lokungalettfwa ngulokucocisana emtimbeni wakho noma kumndeni wakho, kodvwa ngenxa yaloluhlobo lwemibuto kubhekekile kutsi kungahle kubekhona kutsintseka emoyeni wakho.

WHAT ARE THE RISKS INVOLVED IN THIS STUDY?

The study procedures involve no foreseeable risks to you or your family.

YINI BUNGOTI LOBUBHEKEKILE NAWUNGENELE LOLUCWANINGO?

Kute bungoti lobubhekekile kuwe kanye nemndeni wakho kusachutjwa loluncwaningo.

CONFIDENTIALITY

All information obtained during the course of this study is strictly confidential. The study data will be coded so that it will not be linked to your name. Your identity will not be revealed while the study is being conducted or when the study is reported in scientific journals. All the data that has been collected will be stored in a secure place and not shared with any other person without your permission.

KUGCINA TIMFIHLO

Tonkhe tingcogco talolucwaningo titawugcinwa tiyimfihlo, ngobe yonkhe imininingwane angeke yatiwe kutsi yabani. Nakukhicitwa imibiko yalolucwaningo emaphephandzabeni, ligama lakho angeke livele.

INFORMED CONSENT

I hereby confirm that I have been informed by the researcher about the nature, conduct, benefits and risks of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study.

Ngiyavuma kutsi ngichazelwe ngatotonkhe tingoni talolucwaningo, futsi nginikiwe neliphepha lelichaza kabanti ngalolucwaningo, ngalifundza ngalivisisa.

I am aware that the interviewer will be using a voice recorder to audio tape the interview so that all my responses will be captured for analysis. I agree to be audio taped during the interview.

Ngiyati kutsi umcwaningi utawutsebula letingcogco, utawusebentisa umshini wekutsebula livi nasisacocisana kuze atsatse yonkhe imicodvo yami. Ngako-ke ngiyavuma kutsi umcwaningi atsebule livi lami ngalomshini wekutsebula.

I am aware that the results of the study, including personal details regarding my age, cultural group, stage of disease, histology type of disease, monthly income, transport method, educational level and marital status will be anonymously processed into a research report.

Sengiyati kutsi imiphumela yalolucwaningo, lokufaka ekhatsi imininingwane ngeminyaka yami, buve bami, kugula kwami, liholo lami, kanye nemfundvo yami, ingeke ibesebaleni nakukhicitwa lombiko.

I may, at any stage, without prejudice, withdraw my consent and participation in the study. I had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

Ngiyati kutsi nomanini nase ngingasafuni kuchubeka kulolucwaningo ngivumelekile kuyekela. Ngilitfolile litfuba lelanelle kubuta imibuto mayelana naloluncwaningo, ngako-ke ngiyavuma kungenela lolucwaningo.

Participant's name _____ (Please print)
Libito lemncwaningwa (Bhala ngabo feleba)

Participant's signature _____ Date _____
Kusayina kwemncwaningwa (Lusuku)

Researcher's name _____ (Please print)
Libito lemncwaningi (Bhala ngabo feleba)

Researcher's signature _____ Date _____
Kusayin aumncwaningi (Lusuku)

I,herewith confirm that the above participant has been informed fully about the nature, conduct and risks of the above study.

Mine,ngiyavuma, futsi ngiyafakaza kutsi umncwaningiwa uchazelwe kabanti ngemininingwane yonkhe yalolucwaningo.

Witness's name* _____ (Please print)
Libito lafakazi _____ (*Bhala ngabo feleba*)

Witness's signature _____ Date _____
Kusayina fakazi _____ (*Lusuku*)

PLEASE NOTE: The implication of completing the interview is that informed consent has been obtained from you. Thus any information derived from your interview (which will be totally anonymous) may be used for publication, by the investigator. As all information or data is anonymous, you must understand that you will not be able to recall your consent, as your information will not be traceable.

KUMCOKA: *Ungenela letingcogco ngobe imvume inikwe nguwe, ngakoke yonkhe imiphumela yaletingcogco ingasetjentiswa kukhicita liphephandzaba, kodvwa imininingwane lenjenge ligama lakho, nebuvebakho, kanye nalokunye ingeke imataniswe nawe kulombiko.*

VERBAL INFORMED CONSENT (applicable when participants cannot read or write)

IMVUME KUMUNTFU LONGAKWATI KUFUNZA NEKUBHALA

I, the undersigned (researcher) have read and have explained fully to the participant, named the information leaflet, which has indicated the nature and purpose of the study in which I have asked the participant to participate. The explanation I have given has mentioned that, the interview will be audiotaped using a voice recorder, and also both the possible risks and benefits of the study were explained to the participant. The participant indicated that he/she understands that he/she will be free to withdraw from the study at any time for any reason and without jeopardizing his relationship with the researcher.

Mine, losayinile nge ntansi.....(umncwaningi) ngimfundzele, ngamchazela kabanti umncwaningwaliphepha lelichaza injongo ne ndlela lokutawuchutjwa ngayo lolucwaningo. Lenchazelo lengiyifundzile ivete ebaleni kutsi tingcogco titawutsetjulwa ngemshina lotsebula livi nakukhulunywa, futsi ngachaza lokungahle kube bungoti kanye nebuhle bekungenela loluncwaningo. Umncwaningwa utjengise kutsi uyacondza futsi uyeva kutsi angaphuma noma nini kulolucwaningo uma eva angakakhululeki, loko angeke kucedze budlelwane kumncwaningwa kanye nemncwaningi.

I hereby certify that the participant has agreed to participate in this study and has agreed to be voice recorded.

Mine ngiyavuma kutsi umncwaningwa uvumile kungenela lolucwaningo, futsi wavuma kutsi tingcogco titsetjulwe ngemshini wekutsebula livi.

Participant's Name	_____	(Please print)
<i>Libito lemncwaningwa</i>		<i>(Bhala ngafeleba)</i>
Researcher's Name	_____	(Please print)
<i>Libito lemncwaningi</i>		<i>(Bhala ngafeleba)</i>
Researcher's Signature	_____	Date _____
<i>Kusayina umncwaningi</i>		<i>(Lusuku)</i>
Witness's Name	_____	(Please print)
<i>Libito lafakazi</i>		<i>(Bhala ngafeleba)</i>

Witness's Signature _____

Date _____

Kusayina fakazi

(Lusuku)

PLEASE NOTE: The implication of completing the interview is that informed consent has been obtained from you. Thus, any information derived from your interview may be used for publication, by the researcher. As all data is anonymous, you must understand that you will not be able to recall your consent, as your information will not be traceable.

KUMCOKWA: *Ungenela letingcogco ngobe imvume inikwe nguwe, ngakoke yonkhe imiphumela yaletingcogco ingasetjentiswa kukhicita liphephandzaba, kodwva imininingwane lenjenge ligamalakho, nebuvebakho, kanye nalokunye ingeke imataniswe nawe kulombiko.*